Senate Bill 139

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SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Imposes restrictions and reporting requirements for utilization management of health services by commercial insurers, coordinated care organizations and state medical assistance program.

A BILL FOR AN ACT

Relating to managing the utilization of health services; creating new provisions; and amending ORS 414.637, 743.035, 743B.001, 743B.250, 743B.420, 743B.423 and 743B.602.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 and 3 of this 2019 Act are added to and made a part of the Insurance Code.

SECTION 2. An insurer offering a policy or certificate of health insurance in this state that covers medical services, prescription drugs or dental care shall:

(1)(a) If a request for prior authorization for a prescription drug is approved, continue to provide coverage for the next consecutive 12-month period.

(b) If a request for prior authorization for a health service other than a prescription drug is approved, continue to provide coverage for a reasonable and customary length of time and not less than 90 days.

(2) Continue to reimburse a course of treatment with a prescription drug that is removed from a formulary after the end of an enrollment period, or for which restrictions are imposed after the end of an enrollment period, for the remainder of the plan year unless the drug is deemed unsafe by the United States Food and Drug Administration.

SECTION 3. A provider who requests prior authorization for an item or health service, an exception from step therapy, as defined in ORS 743B.602, or other drug protocol or any other coverage that is subject to utilization review may exercise any of the rights of the enrollee for whom the coverage is requested with respect to internal appeals and external reviews under ORS 743B.250, 743B.252, 743B.255 and 743B.256.

SECTION 4. Sections 5 and 6 of this 2019 Act are added to and made a part of ORS chapter 414.

SECTION 5. Prior authorization requests for prescription drugs or health services for medical assistance recipients that are made to coordinated care organizations, risk-bearing entities for coordinated care organizations or the Oregon Health Authority are subject to all provisions governing prior authorization or other utilization review in ORS 743B.250, 743B.252, 743B.423 and section 2 of this 2019 Act.

SECTION 6. A coordinated care organization must report biannually to the Department

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

of Consumer and Business Services in the format prescribed by the department the following information regarding requests for prior authorization received by the coordinated care organization or a risk-bearing entity for the coordinated care organization:

(1) The number of requests received;

(2) The type of health care providers or the medical specialties of the health care providers submitting requests;

(3) The items or health services for which the prior authorization was requested, classified by prescription drugs, diagnostic tests or medical procedures;

(4) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or incomplete requests; and

(5) The number of internal appeals and external reviews conducted and the final decisions on the appeals and reviews.

SECTION 7. ORS 414.637 is amended to read:

414.637. (1) As used in this section, "step therapy" means a drug protocol in which the cost of a prescribed drug is reimbursed only if the patient has first tried a specified drug or series of drugs.

(2) A coordinated care organization that requires step therapy shall make easily accessible to any provider who is reimbursed by the organization, directly or through a risk-bearing entity, to provide health services to members of the organization, clear explanations of:

(a) The clinical criteria for each step therapy protocol;

(b) The procedure by which a provider may submit to the organization or risk-bearing entity, the provider's medical rationale for determining that a particular step therapy protocol is not appropriate for a particular patient based on the patient's medical condition and history; and

(c) The documentation, if any, that a provider must submit to the organization or risk-bearing entity for the organization or entity to determine the appropriateness of step therapy for a specific patient.

(3) The coordinated care organization may not require step therapy if a provider submits the information described in subsections (2)(b) and (c) of this section.

SECTION 8. ORS 743B.250 is amended to read:

743B.250. All insurers offering a health benefit plan in this state shall:

(1) Provide to all enrollees directly or in the case of a group policy to the employer or other policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon request, the following information:

(a) The insurer's written policy on the rights of enrollees, including the right:

(A) To participate in decision making regarding the enrollee's health care.

(B) To be treated with respect and with recognition of the enrollee's dignity and need for privacy.

(C) To have grievances handled in accordance with this section.

(D) To be provided with the information described in this section.

(b) An explanation of the procedures described in subsection (2) of this section for making coverage determinations and resolving grievances. The explanation must be culturally and linguistically appropriate, as prescribed by the department by rule, and must include:

(A) The procedures for requesting an expedited response to an internal appeal under subsection (2)(d) of this section or for requesting an expedited external review of an adverse benefit determination;

(B) A statement that if an insurer does not comply with the decision of an independent review

organization under ORS 743B.256, the enrollee may sue the insurer under ORS 743B.258;

(C) The procedure to obtain assistance available from the insurer, if any, and from the Department of Consumer and Business Services in filing grievances; and

(D) A description of the process for filing a complaint with the department.

(c) A summary of benefits and an explanation of coverage in a form and manner prescribed by the department by rule.

(d) A summary of the insurer's policies on prescription drugs, including:

(A) Cost-sharing differentials;

(B) Restrictions on coverage;

(C) Prescription drug formularies;

(D) Procedures by which a provider with prescribing authority may prescribe clinically appropriate drugs not included on the formulary;

(E) Procedures for the coverage of clinically appropriate prescription drugs not included on the formulary; and

(F) A summary of the criteria for determining whether a drug is experimental or investigational.

(e) A list of network providers and how the enrollee can obtain current information about the availability of providers and how to access and schedule services with providers, including clinic and hospital networks. The list must be available online and upon request in printed format.

(f) Notice of the enrollee's right to select a primary care provider and specialty care providers.

(g) How to obtain referrals for specialty care in accordance with ORS 743B.227.

(h) Restrictions on services obtained outside of the insurer's network or service area.

(i) The availability of continuity of care as required by ORS 743B.225.

(j) Procedures for accessing after-hours care and emergency services as required by ORS 743A.012.

(k) Cost-sharing requirements and other charges to enrollees.

(L) Procedures, if any, for changing providers.

(m) Procedures, if any, by which enrollees may participate in the development of the insurer's corporate policies.

(n) A summary of how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization control requirements that affect coverage or payment.

(o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other providers.

(p) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information and the requirement under ORS 743B.555 that a carrier or third party administrator send communications containing protected health information only to the enrollee who is the subject of the protected health information.

(q) An explanation of assistance provided to non-English-speaking enrollees.

(r) Notice of the information available from the department that is filed by insurers as required under ORS 743B.200, 743B.202 and 743B.423.

(2) Establish procedures, in accordance with requirements adopted by the department, for making coverage determinations and resolving grievances that provide for all of the following:

(a) Timely notice of adverse benefit determinations.

(b) A method for recording all grievances, including the nature of the grievance and significant action taken.

(c) Written decisions.

(d) An expedited response to a request for an internal appeal that accommodates the clinical urgency of the situation.

(e) At least one but not more than two levels of internal appeal for group health benefit plans and one level of internal appeal for individual health benefit plans and for any denial of an exception to a prescription drug formulary. **A person involved in the consideration of the denial or internal appeal must be a clinician in the same or similar specialty as the prescribing provider.** If an insurer provides:

(A) Two levels of internal appeal, a person who was involved in the consideration of the initial denial or the first level of internal appeal may not be involved in the second level of internal appeal; and

(B) No more than one level of internal appeal, a person who was involved in the consideration of the initial denial may not be involved in the internal appeal.

(f)(A) An external review that meets the requirements of ORS 743B.252, 743B.254 and 743B.255, after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have exhausted internal appeals.

(B) An enrollee shall be deemed to have exhausted internal appeals if an insurer fails to strictly comply with this section and federal requirements for internal appeals.

(g) The opportunity for the enrollee to receive continued coverage of an approved and ongoing course of treatment under the health benefit plan pending the conclusion of the internal appeal process.

(h) The opportunity for the enrollee or any authorized representative chosen by the enrollee to:

(A) Submit for consideration by the insurer any written comments, documents, records and other materials relating to the adverse benefit determination; and

(B) Receive from the insurer, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination.

(3) Establish procedures for notifying affected enrollees of:

(a) A change in or termination of any benefit; and

(b)(A) The termination of a primary care delivery office or site; and

(B) Assistance available to enrollees in selecting a new primary care delivery office or site.

(4) Provide the information described in subsection (2) of this section and ORS 743B.254 at each level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an enrollee who files a grievance.

(5) Upon the request of an enrollee, applicant or prospective applicant, provide:

(a) The insurer's annual report on grievances and internal appeals submitted to the department under subsection (8) of this section.

(b) A description of the insurer's efforts, if any, to monitor and improve the quality of health services.

(c) Information about the insurer's procedures for credentialing network providers.

(6) Provide, upon the request of an enrollee, a written summary of information that the insurer may consider in its utilization review of a particular condition or disease, to the extent the insurer maintains such criteria. Nothing in this subsection requires an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that are proprietary shall be subject to oral disclosure only.

(7) Maintain for a period of at least six years written records that document all grievances de-

scribed in ORS 743B.001 (7)(a) and make the written records available for examination by the department or by an enrollee or authorized representative of an enrollee with respect to a grievance made by the enrollee. The written records must include but are not limited to the following:

(a) Notices and claims associated with each grievance.

(b) A general description of the reason for the grievance.

(c) The date the grievance was received by the insurer.

(d) The date of the internal appeal or the date of any internal appeal meeting held concerning the appeal.

(e) The result of the internal appeal at each level of appeal.

(f) The name of the covered person for whom the grievance was submitted.

(8) [*Provide an annual summary to the department of the insurer's aggregate data regarding grievances, internal appeals and requests for external review in a format prescribed by the department*] To ensure consistent reporting on the number, nature and disposition of grievances, internal appeals and requests for external review**, provide to the department, in a format prescribed by the department:**

(a) An annual summary of the insurer's aggregate data regarding grievances, internal appeals and requests for external review; and

(b) Biannually, the following information about requests for prior authorization received by the insurer:

(A) The number of requests received;

(B) The type of health care providers or the medical specialties of the health care providers submitting requests;

(C) The items or health services for which the prior authorization was requested, classified by prescription drugs, diagnostic tests or medical procedures;

(D) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or incomplete requests; and

(E) The number of internal appeals and external reviews conducted and the final decisions on the appeals and reviews.

(9) Allow the exercise of any rights described in this section by an authorized representative.

SECTION 9. ORS 743B.420 is amended to read:

743B.420. Except in the case of misrepresentation, prior authorization determinations shall be subject to the following requirements:

(1) Prior authorization determinations relating to benefit coverage and medical necessity shall be binding on the insurer if**:**

(a) Obtained no more than 30 days prior to the date the service is provided**; or**

(b) The claim for reimbursement is a clean claim and the enrollee is eligible for coverage at the time the service is provided.

(2) Prior authorization determinations relating to enrollee eligibility shall be binding on the insurer if obtained no more than five business days prior to the date the service is provided.

SECTION 10. ORS 743B.423 is amended to read:

743B.423. (1) All insurers offering a health benefit plan in this state that provide utilization review or have utilization review provided on their behalf shall file an annual summary with the Department of Consumer and Business Services that describes all utilization review policies, including delegated utilization review functions, and documents the insurer's procedures for monitoring of utilization review activities.

(2) All utilization review activities conducted pursuant to subsection (1) of this section shall comply with the following:

(a) The criteria **and the process** used in the utilization review [*process*] and the method of development of the criteria shall be made available for review to contracting providers [*upon request*] **and be clearly posted on an insurer's website in plain language that is understandable to providers and enrollees**. **The information must also include:**

(A) All requirements for requesting prior authorization or exceptions to step therapy protocols, including the specific documentation required for a request to be considered complete.

(B) A list of the specific services, drugs or devices for which prior authorization is required.

(b) An insurer must have a website through which providers make a secure electronic submission, meeting agency standards, of requests for prior authorization along with needed forms and documents. The insurer must provide an electronic receipt to the provider to acknowledge receipt of the request. The requirements of this section are not met through the use of proprietary payer portals, electronic forms or facsimile.

(c) If an insurer deems as incomplete a request for approval of a service or a site where a service may be provided, an insurer must inform the provider of the specific information needed for the request to be considered complete.

[*(b)*] **(d)** A physician licensed under ORS 677.100 to 677.228 **who is a provider in the same or similar specialty as the provider requesting a service or site that is the subject of the utilization review** shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the site at which the services are provided and**, in making the recommendations,** shall consult as appropriate with medical and mental health specialists **in the same or similar specialty as the provider requesting the service or site that is the subject of the utilization review** [*in making such recommendations*].

(e) An insurer must give a provider notice in writing of a denial of a request for approval of a service or site. The notice must be written in clear and plain language and include the specific reason for the denial based on evidence-based, peer-reviewed literature. If the denial is based on terms in the policy or certificate, the denial must cite the specific language in the policy or certificate.

[*(c)*] **(f)** Any provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee.

[*(d)*] **(g)** A provider request for prior authorization of [*nonemergency*] **a** service must be answered within two business days, **or one business day if the request is urgent,** and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay. **Prior authorization may not be required for emergency services as provided in ORS 743A.012.**

(h) If an enrollee is stabilized on a treatment plan and the treatment is subject to utilization review, the insurer must continue to provide coverage of the treatment until utilization review is completed and all appeals are resolved.

(3) An insurer may not alter utilization review requirements without giving a 90-day advance notice to all participating providers.

SECTION 11. ORS 743B.602 is amended to read:

743B.602. (1) As used in this section:

(a) "Health care coverage plan" includes:

(A) A health benefit plan, as defined in ORS 743B.005;

(B) An insurance policy or certificate covering the cost of prescription drugs, hospital expenses, **dental care,** health care services and medical expenses, equipment and supplies;

(C) A medical services contract, as defined in ORS 743B.001;

(D) A multiple employer welfare arrangement, as defined in ORS 750.301;

(E) A contract or agreement with a health care service contractor, as defined in ORS 750.005, or a preferred provider organization;

(F) A pharmacy benefit manager, as defined in ORS 735.530, or other third party administrator that pays prescription drug claims; and

(G) An accident insurance policy or any other insurance contract providing reimbursement for the cost of prescription drugs, hospital expenses, health care services and medical expenses, equipment and supplies.

(b) "Step therapy" means a drug protocol in which a health care coverage plan will reimburse the cost of a prescribed drug only if the patient has first tried a specified drug or series of drugs.

(2) A health care coverage plan that requires step therapy shall make easily accessible to prescribing practitioners, clear explanations of:

(a) The clinical criteria for each step therapy protocol;

(b) The procedure by which a practitioner may submit to the plan the practitioner's medical rationale for determining that a particular step therapy protocol is not appropriate for a particular patient based on the patient's medical condition and history; and

(c) The documentation, if any, that a practitioner must submit to the plan for the plan to determine the appropriateness of step therapy for a specific patient.

(3) The health care coverage plan may not require step therapy if the provider submits the information described in subsections (2)(b) and (c) of this section.

SECTION 12. ORS 743B.001 is amended to read:

743B.001. As used in this section and ORS 743.008, 743.035, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550 and 743B.555 **and sections 2 and 3 of this 2019 Act**:

(1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

(a) Denial of eligibility for or termination of enrollment in a health benefit plan;

(b) Rescission or cancellation of a policy or certificate;

(c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or

(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225.

(2) "Authorized representative" means an individual who by law or by the consent of a person

may act on behalf of the person.

(3) "Credit card" has the meaning given that term in 15 U.S.C. 1602.

(4) "Electronic funds transfer" has the meaning given that term in ORS 293.525.

(5) "Enrollee" has the meaning given that term in ORS 743B.005.

(6) "Essential community provider" has the meaning given that term in rules adopted by the Department of Consumer and Business Services consistent with the description of the term in 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 18031.

(7) "Grievance" means:

(a) A communication from an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

(A) In writing, for an internal appeal or an external review; or

(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited external review; or

(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the:

(A) Availability, delivery or quality of a health care service;

(B) Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or

(C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

(8) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(9) "Independent practice association" means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 731.098, to provide health care services to group members.

(10) "Insurer" includes a health care service contractor as defined in ORS 750.005.

(11) "Internal appeal" means a review by an insurer of an adverse benefit determination made by the insurer.

(12) "Managed health insurance" means any health benefit plan that:

(a) Requires an enrollee to use a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service; or

(b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service provision that allows an enrollee to use providers outside of the specified network or networks at the option of the enrollee and receive a reduced level of benefits.

(13) "Medical services contract" means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. "Medical services contract" does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other

similar professional organizations permitted by statute.

(14)(a) "Preferred provider organization insurance" means any health benefit plan that:

(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

(B) Does not require an enrollee to use the preferred network of providers in order to receive benefits under the plan; and

(C) Creates financial incentives for an enrollee to use the preferred network of providers by providing an increased level of benefits.

(b) "Preferred provider organization insurance" does not mean a health benefit plan that has as its sole financial incentive a hold harmless provision under which providers in the preferred network agree to accept as payment in full the maximum allowable amounts that are specified in the medical services contracts.

(15) "Prior authorization" means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. "Prior authorization" does not include referral approval for evaluation and management services between providers.

(16)(a) "Provider" means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

(b) With respect to the statutes governing the billing for or payment of claims, "provider" also includes an employee or other designee of the provider who has the responsibility for billing claims for reimbursement or receiving payments on claims.

(17) "Utilization review" means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

SECTION 13. ORS 743.035 is amended to read:

743.035. (1) The Department of Consumer and Business Services, in consultation with the Oregon Health Authority, shall develop by rule a form that providers in this state shall use to request prior authorization for prescription drug benefits. The form must:

(a) Be uniform for all providers;

(b) Not exceed two pages;

(c) Be electronically available and transmissible; and

(d) Include a provision under which additional information may be requested and provided.

(2) If a person described in ORS 743.029 (2) requires prior authorization for prescription drug benefits, the person must allow the use of the form developed under subsection (1) of this section.

(3) An insurer meets the requirement set forth in ORS 743B.423 [*(2)(d)*] **(2)(g)** if the insurer answers a provider's request for prior authorization within two business days of having received a completed form developed under subsection (1) of this section and all supporting documentation needed to process the request.

(4) The department may adopt rules to implement this section.
