SB 139-2
(LC 2049)
4/8/19 (LHF/ps)

Requested by SENATE COMMITTEE ON HEALTH CARE (at the request of the Oregon Medical Association)

PROPOSED AMENDMENTS TO SENATE BILL 139

1 On page 1 of the printed bill, line 3, delete "414.637," and after
2 "743B.250," insert "743B.256,".
3 Delete lines 5 through 30 and delete pages 2 through 9 and insert:
4 **"SECTION 1. Sections 2 to 4 of this 2019 Act are added to and made**
5 **a part of the Insurance Code.**
6 **"SECTION 2. An insurer offering a policy or certificate of health**
7 **insurance in this state that covers medical services, prescription drugs**
8 **or dental care shall:**
9 **"(1) Approve a request for prior authorization of a course of treat-**
10 **ment with a prescription drug for a consecutive 12-month period if:**
11 **"(a) Continued use of the prescription drug for the 12-month period**
12 **is based on clinical evidence; and**
13 **"(b) The patient continues to be insured during the 12-month pe-**
14 **riod.**
15 **"(2) In establishing prior authorization or step therapy protocols,**
16 **use clinical review criteria that are evidence-based and continuously**
17 **updated based on new evidence and research and take into account**
18 **new developments in treatment.**
19 **"(3) Adjudicate claims for reimbursement of the cost of a treatment**
20 **based on the approved prior authorization and the information used**
21 **to approve the prior authorization.**

"SECTION 3. A provider who requests prior authorization for an item or health service, an exception from step therapy or other drug protocol or any other coverage that is subject to utilization review may, upon the request of the enrollee, exercise on behalf of the enrollee 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. A written agreement entered into between a third party administrator and an insurer, as described in ORS 744.720, in connection with health insurance coverage must specify the provisions of ORS 743B.250 that will be performed by the insurer and the provisions that will be performed by the third party administrator. The insurer is responsible for ensuring compliance with all of the requirements of ORS 743B.250.

"SECTION 5. 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

1 explanation must be culturally and linguistically appropriate, as prescribed
2 by the department by rule, and must include:
3 "(A) The procedures for requesting an expedited response to an internal
4 appeal under subsection (2)(d) of this section or for requesting an expedited
5 external review of an adverse benefit determination;
6 "(B) A statement that if an insurer does not comply with the decision of
7 an independent review organization under ORS 743B.256, the enrollee may
8 sue the insurer under ORS 743B.258;
9 "(C) The procedure to obtain assistance available from the insurer, if any,
10 and from the Department of Consumer and Business Services in filing
11 grievances; and
12 "(D) A description of the process for filing a complaint with the depart-
13 ment.
14 "(c) A summary of benefits and an explanation of coverage in a form and
15 manner prescribed by the department by rule.
16 "(d) A summary of the insurer's policies on prescription drugs, including:
17 "(A) Cost-sharing differentials;
18 "(B) Restrictions on coverage;
19 "(C) Prescription drug formularies;
20 "(D) Procedures by which a provider with prescribing authority may pre-
21 scribe clinically appropriate drugs not included on the formulary;
22 "(E) Procedures for the coverage of clinically appropriate prescription
23 drugs not included on the formulary; and
24 "(F) A summary of the criteria for determining whether a drug is exper-
25 imental or investigational.
26 "(e) A list of network providers and how the enrollee can obtain current
27 information about the availability of providers and how to access and
28 schedule services with providers, including clinic and hospital networks. The
29 list must be available online and upon request in printed format.
30 "(f) Notice of the enrollee's right to select a primary care provider and

1 specialty care providers.

2 "(g) How to obtain referrals for specialty care in accordance with ORS
3 743B.227.

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

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

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

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

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

11 "(m) Procedures, if any, by which enrollees may participate in the devel-
12 opment of the insurer's corporate policies.

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

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

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

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

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

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

1 “(a) Timely notice of adverse benefit determinations.
2 “(b) A method for recording all grievances, including the nature of the
3 grievance and significant action taken.
4 “(c) Written decisions.
5 “(d) An expedited response to a request for an internal appeal that ac-
6 commodates the clinical urgency of the situation.
7 “(e) At least one but not more than two levels of internal appeal for group
8 health benefit plans and one level of internal appeal for individual health
9 benefit plans and for any denial of an exception to a prescription drug
10 formulary. If an insurer provides:
11 “(A) Two levels of internal appeal, a person who was involved in the
12 consideration of the initial denial or the first level of internal appeal may
13 not be involved in the second level of internal appeal; and
14 “(B) No more than one level of internal appeal, a person who was in-
15 volved in the consideration of the initial denial may not be involved in the
16 internal appeal.
17 “(f)(A) An external review that meets the requirements of ORS 743B.252,
18 743B.254 and 743B.255, after the enrollee has exhausted internal appeals or
19 after the enrollee has been deemed to have exhausted internal appeals.
20 “(B) An enrollee shall be deemed to have exhausted internal appeals if
21 an insurer fails to strictly comply with this section and federal requirements
22 for internal appeals.
23 “(g) [*The opportunity for*] The enrollee to receive continued coverage of
24 an approved and ongoing course of treatment under the health benefit plan
25 pending the conclusion of the internal appeal process.
26 “(h) The opportunity for the enrollee or any authorized representative
27 chosen by the enrollee to:
28 “(A) Submit for consideration by the insurer any written comments, doc-
29 uments, records and other materials relating to the adverse benefit determi-
30 nation; and

1 “(B) Receive from the insurer, upon request and free of charge, reasonable
2 access to and copies of all documents, records and other information relevant
3 to the adverse benefit determination.
4 “(3) Establish procedures for notifying affected enrollees of:
5 “(a) A change in or termination of any benefit; and
6 “(b)(A) The termination of a primary care delivery office or site; and
7 “(B) Assistance available to enrollees in selecting a new primary care
8 delivery office or site.
9 “(4) Provide the information described in subsection (2) of this section and
10 ORS 743B.254 at each level of internal appeal to an enrollee who is notified
11 of an adverse benefit determination or to an enrollee who files a grievance.
12 “(5) Upon the request of an enrollee, applicant or prospective applicant,
13 provide:
14 “(a) The insurer’s annual report on grievances and internal appeals sub-
15 mitted to the department under subsection (8) of this section.
16 “(b) A description of the insurer’s efforts, if any, to monitor and improve
17 the quality of health services.
18 “(c) Information about the insurer’s procedures for credentialing network
19 providers.
20 “(6) Provide, upon the request of an enrollee, a written summary of in-
21 formation that the insurer may consider in its utilization review of a par-
22 ticular condition or disease, to the extent the insurer maintains such
23 criteria. Nothing in this subsection requires an insurer to advise an enrollee
24 how the insurer would cover or treat that particular enrollee’s disease or
25 condition. Utilization review criteria that are proprietary shall be subject to
26 oral disclosure only.
27 “(7) Maintain for a period of at least six years written records that doc-
28 ument all grievances described in ORS 743B.001 [*(7)(a)*] **(8)(a)** and make the
29 written records available for examination by the department or by an
30 enrollee or authorized representative of an enrollee with respect to a griev-

ance 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**, report to the department annually, in a format prescribed by the department, 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;

"(e) The number of requests that were initially approved; and

"(f) The number of denials that were reversed by internal appeals or external reviews.

"(9) Allow the exercise of any rights described in this section by an au-

thorized representative.

"SECTION 6. ORS 743B.256 is amended to read:

"743B.256. (1) An independent review organization shall perform the following duties when appointed under ORS 743B.252 to review a dispute under a health benefit plan between an insurer and an enrollee:

"(a) Decide whether the dispute pertains to an adverse benefit determination and notify the enrollee and insurer in writing of the decision. If the decision is against the enrollee, the independent review organization shall notify the enrollee of the right to file a complaint with or seek other assistance from the Department of Consumer and Business Services and the availability of other assistance as specified by the department.

"(b) Appoint a reviewer or reviewers as determined appropriate by the independent review organization. **At least one reviewer must be a clinician in the same or similar specialty as the provider who prescribed the treatment that is under review.**

"(c) Notify the enrollee of information that the enrollee is required to provide and any additional information the enrollee may provide, and when the information must be submitted as provided in ORS 743B.252.

"(d) Notify the insurer of additional information the independent review organization requires and when the information must be submitted as provided in ORS 743B.252.

"(e) Decide the dispute relating to the adverse benefit determination of the insurer and issue the decision in writing.

"(2) A decision by an independent review organization shall be based on expert medical judgment after consideration of the enrollee's medical record, the recommendations of each of the enrollee's providers, relevant medical, scientific and cost-effectiveness evidence and standards of medical practice in the United States. An independent review organization must make its decision in accordance with the coverage described in the health benefit plan, except that the independent review organization may override the insurer's

standards for medically necessary or experimental or investigational treatment if the independent review organization determines that the standards of the insurer are unreasonable or are inconsistent with sound medical practice.

"(3) When review is expedited, the independent review organization shall issue a decision not later than the third day after the date on which the enrollee applies to the insurer for an expedited review or the Director of the Department of Consumer and Business Services orders an expedited review.

"(4) When a review is not expedited, the independent review organization shall issue a decision not later than the 30th day after the enrollee applies to the insurer for a review or the director orders a review.

"(5) An independent review organization shall file synopses of its decisions with the director according to the format and other requirements established by the director. The synopses shall exclude information that is confidential, that is otherwise exempt from disclosure under ORS 192.345 and 192.355 or that may otherwise allow identification of an enrollee. The director shall make the synopses public.

"SECTION 7. 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 obtained no more than [*30*] **90** days prior to the date 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 8. 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

1 Services that describes all utilization review policies, including delegated
2 utilization review functions, and documents the insurer's procedures for
3 monitoring of utilization review activities.

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

6 "(a) The criteria **and the process** used in the utilization review
7 [*process*] and the method of development of the criteria [*shall*] **must:**

8 "**(A)** Be made available for review to contracting providers [*upon*
9 *request.*]**;**

10 "**(B) Be clearly posted on an insurer's website in plain language;**

11 **"(C) Be understandable to providers and enrollees; and**

12 **"(D) Include:**

13 **"(i) All requirements for requesting prior authorization or ex-**
14 **ceptions to step therapy protocols, including the specific documenta-**
15 **tion required for a request to be considered complete.**

16 **"(ii) A list of the specific services, drugs or devices for which prior**
17 **authorization is required and a list of the specific drugs for which step**
18 **therapy is required.**

19 **"(b) An insurer must have a website through which a provider**
20 **makes a secure electronic submission, meeting standards adopted by**
21 **the department, of a request for prior authorization or a request for**
22 **an exception to a step therapy protocol, along with needed forms and**
23 **documents. The insurer must provide an electronic receipt to the**
24 **provider to acknowledge receipt of the request.**

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

29 "[*(b)*] **(d) An insurer must use** a physician licensed under ORS 677.100
30 to 677.228 [*shall be responsible for all*] **to make all** final recommendations

regarding the necessity or appropriateness of services or the site at which the services are provided and [*shall consult as appropriate with*] **to consult as needed with the appropriate** medical and mental health specialists in making [*such*] **the** recommendations.

"**(e) An insurer must give a provider notice in writing of a denial of a request for approval of a service or site or of an exception to a step therapy protocol. The notice must be written in plain language, be understandable to providers and patients 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*] **Except as provided in paragraph (h) of this subsection, a** request for prior authorization of nonemergency service **or a request for an exemption from a step therapy protocol** must be answered within **a reasonable period of time given the medical circumstances but not later than:**

"(A) Two business days **after receipt of the request**, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay**; and**

"(B) One business day after receipt of a request for an urgent service, as described in subsection (3) of this section.

"**(h) If an insurer requires additional information to make a determination on a request for prior authorization or for an exception to a step therapy protocol, the insurer shall notify the provider and the enrollee in writing, no later than two days after receiving the request, of the additional information needed to make a determination. The**

insurer shall approve or deny the request by the later of:

“(A) Two business days after receipt of a response from the provider or enrollee to the request for additional information; or

“(B) Fifteen days after the date of the request for additional information.

“(i) If an enrollee is stabilized on a treatment plan, as determined by the treating provider, 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 internal appeals and external reviews are resolved.

“(j) An insurer may not alter utilization review requirements, or initiate or implement new utilization review requirements, without giving a 60-day advance notice to all participating providers.

“(3) A service is urgent if it is:

“(a) Determined by the requesting provider to be necessary to treat an enrollee’s health condition that may seriously jeopardize the enrollee’s life, health or ability to regain maximum function; or

“(b) A course of treatment that an enrollee is undergoing using a drug that is not on the insurer’s formulary.

“<u>SECTION 9.</u> ORS 743B.602 is amended to read:

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

“**(a) ‘Beneficiary’ means an individual receiving health care that is provided or reimbursed by an entity offering a health care coverage plan.**

“[*(a)*] **(b)** ‘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, health care services and medical expenses, equipment and supplies;

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

1 “(D) A multiple employer welfare arrangement, as defined in ORS 750.301;
2 “(E) A contract or agreement with a health care service contractor, as
3 defined in ORS 750.005, or a preferred provider organization;
4 “(F) A pharmacy benefit manager, as defined in ORS 735.530, or other
5 third party administrator that pays prescription drug claims; and
6 “(G) An accident insurance policy or any other insurance contract pro-
7 viding reimbursement for the cost of prescription drugs, hospital expenses,
8 health care services and medical expenses, equipment and supplies.
9 “[*(b) ‘Step therapy’ means a drug protocol in which a health care coverage*
10 *plan will reimburse the cost of a prescribed drug only if the patient has first*
11 *tried a specified drug or series of drugs.*]
12 “[*(2) A health care coverage plan that requires step therapy shall make*
13 *easily accessible to prescribing practitioners, clear explanations of:*]
14 “**(2) An entity that offers a health care coverage plan that requires**
15 **step therapy shall post to the website of the plan clear explanations,**
16 **that are easily accessible to prescribing practitioners and beneficiaries**
17 **of the plan, written in plain language and understandable to practi-**
18 **tioners and beneficiaries, of:**
19 “(a) The clinical criteria for each step therapy protocol **and the criteria**
20 **for approving an exception to the protocol**;
21 “(b) The procedure by which a practitioner may submit to the plan**, in**
22 **accordance with subsection (3) of this section,** the practitioner’s medical
23 rationale for determining that a particular step therapy protocol is not ap-
24 propriate for a particular [*patient*] **beneficiary** based on the [*patient’s*]
25 **beneficiary’s** medical condition and history; and
26 “(c) The documentation, if any, that a practitioner must submit to the
27 plan for the plan to determine the appropriateness of step therapy for a
28 specific [*patient*] **beneficiary**.
29 “**(3) If a health care coverage plan restricts the use of a prescription**
30 **drug for the treatment of a medical condition by imposing a step**

therapy protocol for the use, the entity shall provide a clear, readily accessible and convenient process for the prescribing practitioner to request an exception to the step therapy protocol. The entity may use its existing process for practitioners to request exceptions to other coverage restrictions or limitations.

"(4) An entity offering a health care coverage plan must approve a request for an exception to a step therapy protocol if the prescribing practitioner submits sufficient evidence to establish that:

"(a) The prescription drug required by the protocol is contraindicated or is likely to cause the beneficiary to experience an adverse reaction or physical or mental harm;

"(b) The prescription drug required by the protocol is expected to be ineffective based on the known clinical characteristics of the beneficiary and the known characteristics of the prescription drug regimen;

"(c) The beneficiary has tried the drug required by the protocol while covered under the beneficiary's current or prior health care coverage plan, or tried another prescription drug in the same pharmacologic class or with the same mechanism of action, and the beneficiary's use of the prescription drug was discontinued due to the lack of efficacy or a diminished effect or because the beneficiary experienced an adverse event;

"(d) The beneficiary is experiencing, or while covered by the beneficiary's previous health care coverage plan was experiencing, a positive therapeutic outcome using the prescription drug for which the beneficiary's prescribing provider has requested the exception; or

"(e) The beneficiary's use of the prescription drug required by the protocol is not in the best interest of the beneficiary based on documentation showing that the beneficiary's use of the prescription drug is expected to:

"(A) Create a barrier to the beneficiary's adherence or compliance with the plan of care;

"(B) Negatively impact a comorbid condition of the beneficiary;

"(C) Cause a negative drug interaction that is clinically predictable; or

"(D) Decrease the beneficiary's ability to achieve or maintain the reasonable functional ability to perform daily activities.

"(5) A prescribing practitioner may not use a pharmaceutical sample for the sole purpose of qualifying for an exception to a step therapy protocol under subsection (4)(c) or (d) of this section.

"(6) A health care coverage plan must cover the prescription drug requested by the prescribing practitioner upon the approval of the practitioner's request for an exception.

"(7) This section does not prevent:

"(a) A health care coverage plan from requiring a beneficiary to try an AB-rated generic equivalent or a biological product that is an interchangeable biological product prior to covering the equivalent brand name prescription drug;

"(b) A health care coverage plan from denying a request for an exception to allow coverage of a drug that has been removed from the market due to the safety concerns of the United States Food and Drug Administration; or

"(c) A practitioner from prescribing a prescription drug that is medically appropriate.

"**SECTION 10.** ORS 743B.001 is amended to read:

"743B.001. As used in this section and ORS 743.008, 743.035, **743A.067,** 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*]

1 743B.555 **and 743B.602 and sections 2 and 3 of this 2019 Act**:

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

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

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

9 "(c) Imposition of a preexisting condition exclusion as defined in ORS
10 743B.005, source-of-injury exclusion, network exclusion, annual benefit limit
11 or other limitation on otherwise covered items or services;

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

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

17 "(2) 'Authorized representative' means an individual who by law or by the
18 consent of a person may act on behalf of the person.

19 "**(3) 'Clinical review criteria' means screening procedures, decision**
20 **rules, medical protocols and clinical guidance used by an insurer or**
21 **other entity in conducting utilization review, in evaluating:**

22 **"(a) Medical necessity;**

23 **"(b) Appropriateness of an item or health service for which prior**
24 **authorization is requested or for which an exception to a step therapy**
25 **protocol has been requested as described in ORS 743B.602; or**

26 **"(c) Any other coverage that is subject to utilization review.**

27 "[*(3)*] **(4)** 'Credit card' has the meaning given that term in 15 U.S.C. 1602.

28 "[*(4)*] **(5)** 'Electronic funds transfer' has the meaning given that term in
29 ORS 293.525.

30 "[*(5)*] **(6)** 'Enrollee' has the meaning given that term in ORS 743B.005.

"[*(6)*] **(7)** '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)*] **(8)** '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)*] **(9)** 'Health benefit plan' has the meaning given that term in ORS 743B.005.

"[*(9)*] **(10)** '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)*] **(11)** 'Insurer' includes a health care service contractor as defined

in ORS 750.005.

"[*(11)*] **(12)** 'Internal appeal' means a review by an insurer of an adverse benefit determination made by the insurer.

"[*(12)*] **(13)** '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.

"(14) 'Medical necessity' means health services, items or supplies that are appropriate, according to applicable standards of care:

"(a) To improve or preserve life, health or function;

"(b) To slow the deterioration of health or function; or

"(c) For the early screening, prevention, evaluation, diagnosis or treatment of a disease, illness, injury or other health condition.

"[*(13)*] **(15)** '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)*] **(16)(a)** 'Preferred provider organization insurance' means any health benefit plan that:

1 "(A) Specifies a preferred network of providers managed, owned or under
2 contract with or employed by an insurer;
3 "(B) Does not require an enrollee to use the preferred network of pro-
4 viders in order to receive benefits under the plan; and
5 "(C) Creates financial incentives for an enrollee to use the preferred
6 network of providers by providing an increased level of benefits.
7 "(b) 'Preferred provider organization insurance' does not mean a health
8 benefit plan that has as its sole financial incentive a hold harmless provision
9 under which providers in the preferred network agree to accept as payment
10 in full the maximum allowable amounts that are specified in the medical
11 services contracts.
12 "[*(15)*] **(17)** 'Prior authorization' means a determination by an insurer
13 prior to provision of services that the insurer will provide reimbursement for
14 the services. 'Prior authorization' does not include referral approval for
15 evaluation and management services between providers.
16 "[*(16)(a)*] **(18)(a)** 'Provider' means a person licensed, certified or otherwise
17 authorized or permitted by laws of this state to administer medical or mental
18 health services in the ordinary course of business or practice of a profession.
19 "(b) With respect to the statutes governing the billing for or payment of
20 claims, 'provider' also includes an employee or other designee of the provider
21 who has the responsibility for billing claims for reimbursement or receiving
22 payments on claims.
23 "**(19) 'Step therapy' means a protocol, policy or program that es-**
24 **tablishes a sequence in which the cost of prescription drugs for a**
25 **specific medical condition will be reimbursed by an insurer.**
26 "[*(17)*] **(20)** 'Utilization review' means a set of formal techniques used by
27 an insurer or delegated by the insurer designed to monitor the use of or
28 evaluate the medical necessity, appropriateness, efficacy or efficiency of
29 health care services, procedures or settings.
30 **"SECTION 11.** 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.

"SECTION 12. Section 13 of this 2019 Act is added to and made a part of ORS chapter 414.

"SECTION 13. (1) A coordinated care organization shall:

"(a) In establishing prior authorization or step therapy protocols, use clinical review criteria that are evidence-based and continuously updated based on new evidence and research and take into account new developments in treatment.

"(b) Adjudicate claims for reimbursement of the cost of a treatment based on the approved prior authorization and the information used to approve the prior authorization.

"(c) Report annually to the Oregon Health Authority, in a form prescribed by the authority, the following information regarding re-

1 **quests for prior authorization received by the coordinated care organ-**
2 **ization or risk-bearing entity for the coordinated care organization:**
3 **"(A) The number of requests received;**
4 **"(B) The number of requests that were initially denied and the**
5 **reasons for the denials, including but not limited to absence of medical**
6 **necessity or incomplete requests;**
7 **"(C) The number of requests that were initially approved; and**
8 **"(D) The number of denials that were reversed by internal griev-**
9 **ances or contested cases.**
10 **"(2) As used in this section:**
11 **"(a) 'Clinical review criteria' means screening procedures, decision**
12 **rules, medical protocols and clinical guidance used by a coordinated**
13 **care organization or other entity for the coordinated care organization**
14 **in conducting utilization review, to evaluate:**
15 **"(A) The medical necessity of an item or health service;**
16 **"(B) The appropriateness of an item or health service for which**
17 **prior authorization is requested or for which an exception to a step**
18 **therapy protocol has been requested as described in ORS 743B.602; or**
19 **"(C) The provision of any other care that is subject to utilization**
20 **review.**
21 **"(b) 'Step therapy' has the meaning given that term in ORS**
22 **743B.602.**".
23