SB 608-A2
(LC 3268)
4/17/23 (LHF/ps)

Requested by Representative NOSSE

PROPOSED AMENDMENTS TO
A-ENGROSSED SENATE BILL 608

In line 2 of the printed A-engrossed bill, after "drugs;" insert "creating new provisions; amending ORS 243.144, 243.877, 743B.001 and 750.055;".

After line 13, insert:

"SECTION 3. Section 4 of this 2023 Act is added to and made a part of the Insurance Code.

"SECTION 4. (1) As used in this section:

"(a)(A) 'Generic equivalent' means a drug that meets applicable standards of strength, quality and purity according to the United States Pharmacopoeia or other nationally recognized compendium and that, compared to a brand name drug:

"(i) Has an identical amount of the same active chemical ingredients and the same dosage form; and

"(ii) If administered in the same amounts, will provide comparable therapeutic effects.

"(B) 'Generic equivalent' does not include a drug that is listed by the United States Food and Drug Administration as having unresolved bioequivalence concerns according to the administration's most recent publication of approved drug products with therapeutic equivalence evaluations.

"(b)(A) 'Health plan' means:

"(i) An individual or group health benefit plan, as defined in ORS

743B.005;

"(ii) A plan providing coverage for a specific disease or condition only;

"(iii) A medical services contract;

"(iv) A health benefit plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board; or

"(v) Another similar certificate, policy, contract or arrangement or any endorsement or rider that covers all or a portion of the cost of an individual's health care and that is subject to regulation by the Department of Consumer and Business Services.

"(B) 'Health plan' does not include coverages provided by:

"(i) Medicare;

"(ii) The state medical assistance program;

"(iii) The federal government to federal employees;

"(iv) TRICARE;

"(v) Workers' compensation;

"(vi) Limited benefit coverage; or

"(vii) Accident only, credit, disability or long term care insurance.

"(c) 'High deductible health plan' means a health plan described in 26 U.S.C. 223.

"(d) 'Person' includes:

"(A) An individual;

"(B) A trust;

"(C) An estate;

"(D) A partnership;

"(E) A corporation;

"(F) An association;

"(G) A joint stock company;

"(H) An insurance company;

"(I) A state;

"(J) A political subdivision, instrumentality or municipal corporation of a state; or

"(K) A nonprofit organization.

"(e) 'Pharmacy benefit manager' means a pharmacy benefit manager, as defined in ORS 735.530, that manages pharmacy benefits for a health plan.

"(f) 'Preventive services' has the meaning given that term in 42 U.S.C. 1395x.

"(2) To the extent permitted by federal law, an insurer offering a health plan that provides pharmacy benefits and a pharmacy benefit manager shall include all amounts paid by an enrollee or paid by another person on behalf of an enrollee toward the cost of a covered prescription drug when calculating the enrollee's contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement applied to the drug if:

"(a) The drug does not have a generic equivalent; or

"(b) The drug has a generic equivalent and the enrollee has:

"(A) Obtained prior authorization from the insurer or pharmacy benefit manager;

"(B) Complied with a step therapy protocol; or

"(C) Received approval from the insurer or pharmacy benefit manager through the insurer's or the pharmacy benefit manager's exceptions, appeal or review process.

"(3) For high deductible health plans the provisions of subsection (2) of this section apply only to preventive services until the enrollee has satisfied the minimum deductible under 26 U.S.C. 223(c)(2).

"SECTION 5. ORS 243.144, as amended by section 2, chapter 72, Oregon Laws 2022, is amended to read:

"243.144. Benefit plans offered by the Public Employees' Benefit Board that reimburse the cost of medical and other health services and supplies

must comply with the requirements for health benefit plan coverage described in:

"(1) ORS 743A.058;

"(2) ORS 743B.256;

"(3) ORS 743B.420;

"(4) ORS 743B.423;

"(5) ORS 743B.601;

"(6) ORS 743B.810; [*and*]

"(7) ORS 743B.287 (4)**; and**

"(8) Section 4 of this 2023 Act.

"SECTION 6. ORS 243.877, as amended by section 3, chapter 72, Oregon Laws 2022, is amended to read:

"243.877. Benefit plans offered by the Oregon Educators Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

"(1) ORS 743A.058;

"(2) ORS 743B.256;

"(3) ORS 743B.420;

"(4) ORS 743B.423;

"(5) ORS 743B.601;

"(6) ORS 743B.810; [*and*]

"(7) ORS 743B.287 (4)**; and**

"(8) Section 4 of this 2023 Act.

"SECTION 7. ORS 743B.001 is amended to read:

"743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 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,

743B.555 and 743B.602 **and section 4 of this 2023 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;

"(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; or

"(f) Denial, in whole or in part, of a request for prior authorization, a request for an exception to step therapy or a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to other utilization review requirements.

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

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

"(a) Medical necessity;

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

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

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

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

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

"(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.

"(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.

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

"(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.

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

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

"(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 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.

"(15)(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 pro-

viders 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.

"(16) 'Prior authorization' means a form of utilization review that requires a provider or an enrollee to request a determination by an insurer, prior to the provision of health care that is subject to utilization review, that the insurer will provide reimbursement for the health care requested. 'Prior authorization' does not include referral approval for evaluation and management services between providers.

"(17)(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.

"(18) 'Step therapy' means a utilization review protocol, policy or program in which an insurer requires certain preferred drugs for treatment of a specific medical condition be proven ineffective or contraindicated before a prescribed drug may be reimbursed.

"(19) '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 items, services, procedures or settings.

"SECTION 8. ORS 750.055, as amended by section 11, chapter 37, Oregon

Laws 2022, is amended to read:

"750.055. (1) The following provisions apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

"(a) ORS 705.137, 705.138 and 705.139.

"(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

"(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not including ORS 732.582.

"(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

"(e) ORS 734.014 to 734.440.

"(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to 742.542.

"(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, **743.025,** 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788 and 743.790 and section 8, chapter 37, Oregon Laws 2022.

"(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260 and section 2, chapter 771, Oregon Laws 2013, and sections 6 and 7, chapter 37, Oregon Laws 2022.

"(i) ORS [*743.025,*] 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 **and section 4 of this 2023 Act**.

"(j) The following provisions of ORS chapter 744:

"(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

"(B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

"(C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

"(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

"(2) The following provisions of the Insurance Code apply to health care service contractors except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act:

"(a) ORS 731.485, if the group practice health maintenance organization wholly owns and operates an in-house drug outlet.

"(b) ORS 743A.024, unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

"(3) For the purposes of this section, health care service contractors are insurers.

"(4) Any for-profit health care service contractor organized under the

laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

"(5)(a) A health care service contractor is a domestic insurance company for the purpose of determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

"(b) A health care service contractor's classification as a domestic insurance company under paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510 to 734.710.

"(6) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are necessary for the proper administration of these provisions.

"SECTION 9. ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59, Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon Laws 2018, section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon Laws 2019, section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97, Oregon Laws 2021, and section 12, chapter 37, Oregon Laws 2022, is amended to read:

"750.055. (1) The following provisions apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

"(a) ORS 705.137, 705.138 and 705.139.

"(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as pro-

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"(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not including ORS 732.582.

"(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

"(e) ORS 734.014 to 734.440.

"(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to 742.542.

"(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, **743.025,** 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788 and 743.790 and section 8, chapter 37, Oregon Laws 2022.

"(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260 and sections 6 and 7, chapter 37, Oregon Laws 2022.

"(i) ORS [*743.025,*] 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602

and 743B.800 **and section 4 of this 2023 Act**.

"(j) The following provisions of ORS chapter 744:

"(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

"(B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

"(C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

"(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

"(2) The following provisions of the Insurance Code apply to health care service contractors except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act:

"(a) ORS 731.485, if the group practice health maintenance organization wholly owns and operates an in-house drug outlet.

"(b) ORS 743A.024, unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

"(3) For the purposes of this section, health care service contractors are insurers.

"(4) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

"(5)(a) A health care service contractor is a domestic insurance company for the purpose of determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

"(b) A health care service contractor's classification as a domestic insurance company under paragraph (a) of this subsection does not subject the

health care service contractor to ORS 734.510 to 734.710.

"(6) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are necessary for the proper administration of these provisions.

"SECTION 10. Section 4 of this 2023 Act and the amendments to ORS 243.144, 243.877, 743B.001 and 750.055 by sections 5 to 9 of this 2023 Act apply to health plans, as defined in section 4 of this 2023 Act, and to health care service contracts offered by health care service contractors, as defined in ORS 750.005, issued, renewed or extended on or after January 1, 2024.".

In line 14, delete "3" and insert "11".
