LC 300
2026 Regular Session
1/8/26 (EKJ/htl/ps)

D R A F T

SUMMARY

Digest: Tells some health insurers to inform health care providers when they use AI to downcode a claim for reimbursement. (Flesch Readability Score: 62.8).

Requires certain health insurers offering a health benefit plan in this state that provide utilization review or have utilization review provided on their behalf to notify a health care provider each time the insurer uses artificial intelligence or other automated technology to automatically downcode a claim for reimbursement submitted by the provider. Requires insurers to make an appeals process available to a provider who has had a claim automatically downcoded using artificial intelligence or other automated technology.

A BILL FOR AN ACT

Relating to downcoding; creating new provisions; and amending ORS 743B.423.

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

SECTION 1. 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) In addition to the requirements of ORS 743B.602, in establishing utilization review, the insurer must use clinical review criteria that are

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.

evidence-based and continuously updated based on new evidence and research, and take into account new developments in treatment.

(b) The insurer must adjudicate claims for reimbursement in accordance with ORS 743B.450 based on the information submitted by the provider and may not require the provider to resubmit the information.

(c) The criteria and the process used in the utilization review and the method of development of the criteria must be made available for review to contracting providers.

(d) The insurer must have a website where:

(A) The following information is clearly posted:

(i) All requirements for requesting coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, including the specific documentation required for a request to be considered complete.

(ii) A list of the specific treatments, drugs, devices or diagnostic or laboratory tests that are subject to utilization review.

(iii) The appeals process by which a provider who has had a claim downcoded in the manner described in paragraph (i) of this subsection may pursue a timely appeal before an appropriate medical consultant or peer review committee.

(B) A provider can make a secure electronic submission, meeting industry standards for privacy, of a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, along with needed forms and documents, and receive an electronic acknowledgement of receipt of the request.

(e) If the insurer deems as incomplete a request made for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, the insurer must inform the provider of the specific information needed for the request to be considered complete.

(f) The insurer must use a physician licensed under ORS 677.100 to 677.228 to make all final recommendations regarding coverage of a treatment, drug,

device or diagnostic or laboratory test that is subject to utilization review and to consult as needed.

(g) The insurer must give a provider notice in writing of a denial of a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review. 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 a policy or certificate of insurance, the denial must cite the specific language in the policy or certificate.

(h) The insurer must make available to 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.

(i) If an artificial intelligence, algorithm or other software tool is used in the utilization review process to automatically downcode a claim, the insurer must give the provider notice in writing not later than two business days after the date on which payment intended to satisfy the claim is made. The notice must include disclosure of the use, the specific reason for downcoding the claim and a description of the insurer's applicable appeals process and time limits within which a provider must request an appeal of a downcoded claim. If the claim is downcoded based on terms in a policy or certificate of insurance or bill coding policy, the notice must cite the specific language in the policy or certificate or bill coding policy.

(j) The insurer must make available to any provider who has had a claim downcoded in the manner described in paragraph (i) of this subsection an opportunity for a timely appeal before an appropriate medical consultant or peer review committee. The appeals process must be consistent with the process for requesting additional payment from a health insurer to satisfy a claim under ORS 743B.453.

[*(i)*] **(k)** Except as provided in paragraph [*(j)*] **(L)** of this subsection, an

insurer must issue a determination on a provider's or an enrollee's request for coverage of a nonemergency treatment, drug, device or diagnostic or laboratory test that is subject to utilization review within a reasonable period of time appropriate to the medical circumstances but no later than 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.

[*(j)*] **(L)** If the insurer requires additional information from an enrollee or a provider to make a determination on a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, no later than two business days after receipt of the request, the insurer shall notify the enrollee and the provider in writing of the additional information needed to make the determination. The insurer shall issue the determination 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.

[*(k)*] **(m)** If a change in a drug formulary or other change in coverage impacts the coverage of any enrollee's treatment plan and the enrollee has been stabilized on the treatment plan for at least 90 days, the insurer must continue to provide coverage of the treatment until utilization review and all internal appeals and external reviews are completed.

[*(L)*] **(n)** The 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.

[*(m)*] **(o)** In addition to the requirements of ORS 743B.420, an approved request for coverage of a treatment, other than a prescription drug, shall be binding on the insurer for a period ending on the later of the following:

(A) The reasonable duration of the treatment based on clinical standards; or

(B) Sixty days after the date that the treatment begins following approval

of prior authorization.

[*(n)*] **(p)** Except as provided in paragraph [*(o)*] **(q)** of this subsection, an approved request for coverage of a prescription drug shall be binding on the insurer for one year from the date that the treatment begins following approval of the request if the drug:

(A) Is prescribed as a maintenance therapy that is expected to last at least 12 months based on medical or scientific evidence;

(B) Continues to be prescribed throughout the 12-month period; and

(C)(i) Is prescribed for a condition that is within the scope of use for the drug as approved by the United States Food and Drug Administration; or

(ii) Has been proven to be a safe and effective form of treatment for the enrollee's medical condition based on clinical practice guidelines developed from peer-reviewed medical literature.

[*(o)*] **(q)** Paragraph [*(n)*] **(p)** of this subsection does not apply if:

(A) A therapeutic equivalent of the prescription drug or a generic alternative to the prescription drug is or becomes available as a substitute for the drug for which prior authorization is requested or was approved; or

(B) A biologic product is or becomes available that is determined by the United States Food and Drug Administration to be interchangeable with the drug for which prior authorization is requested or approved.

[*(p)*] **(r)** Paragraphs [*(k), (m) and (n)*] **(m), (o) and (p)** of this subsection do not require an insurer to reimburse the cost of care for a patient who is no longer enrolled in the health benefit plan offered by the insurer.

(s) As used in this subsection, "downcode a claim" means to change the billing code for a claim for reimbursement submitted to an insurer by a provider on behalf on an enrollee to a billing code that has a lower reimbursement rate than the billing code contained in the original claim submitted by the provider.

SECTION 2. The amendments to ORS 743B.423 by section 1 of this 2026 Act apply to health benefit plans issued, renewed or extended on or after the effective date of this 2026 Act.

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