

Enrolled House Bill 2517

Sponsored by Representative PRUSAK, Senator HANSELL; Representatives ALONSO LEON, CAMPOS, CLEM, DEXTER, DRAZAN, FAHEY, GOMBERG, GRAYBER, KROPP, LEIF, MCLAIN, MEEK, MOORE-GREEN, NATHANSON, NERON, NOBLE, NOSSE, REARDON, SCHOUTEN, SOLLMAN, WILDE, WILLIAMS, WRIGHT, ZIKA, Senators FREDERICK, GORSEK, STEINER HAYWARD (Pre-session filed.)

CHAPTER

AN ACT

Relating to managing the utilization of health care; creating new provisions; and amending ORS 243.144, 243.877, 743.035, 743B.001, 743B.250, 743B.256, 743B.420, 743B.423 and 743B.602.

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

SECTION 1. (1) As used in this section, “coordinated care organization” has the meaning given that term in ORS 414.025.

(2) The Oregon Health Authority shall compile and annually post to the authority’s website a report of the following information, in the aggregate, that was reported to the authority by coordinated care organizations regarding requests for prior authorization received by coordinated care organizations or risk-bearing entities acting for or in concert with coordinated care organizations:

- (a) The number of requests received;
- (b) 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
- (c) The number of denials that were reversed on an appeal.

SECTION 2. 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 review 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. 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) **In addition to the requirements in ORS 743B.423 and 743B.602**, 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]* **does not require** 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 described in ORS 743B.001 *[(7)(a)]* **(8)(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, **in the format prescribed by the department, an annual summary** of the insurer's aggregate data regarding:

(a) Grievances[,];

(b) Internal appeals [*and*];

(c) 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.*]; **and**

(d) The following information about requests for prior authorization received by the insurer:

(A) The number of requests received;

(B) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or failure to provide additional clinical information requested by the insurer;

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

(D) 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 authorized representative.

SECTION 3. 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 a 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 4. 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] **60** 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 5. 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 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.

[(a)] **(c) The criteria and the process** used in the utilization review [*process*] and the method of development of the criteria [*shall*] **must** be made available for review to contracting providers [*upon request*].

(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.

(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.

[(b)] **(f) The insurer must use** a physician licensed under ORS 677.100 to 677.228 [*shall be responsible for*] **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 medical and mental health specialists in making such recommendations*] **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.

[(c)] (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.

[(d)] (i) Except as provided in paragraph [(e)] (j) of this subsection, an insurer must issue a determination on a provider's or an enrollee's request for [*prior authorization of a nonemergency service*] **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.

[(e)] (j) If [*an*] **the insurer requires additional information** from an enrollee or a provider to make a determination on a request for [*prior authorization*] **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) **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) **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) **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) **Except as provided in paragraph (o) 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) **Paragraph (n) 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) Paragraphs (k), (m) and (n) 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.

SECTION 6. 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 that provides health care coverage.**

[(a)] (b) **“Health care coverage [plan]” includes any of the following that reimburse the cost of prescription drugs:**

(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*];

(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) **Claims payments by** 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:**

(2) An entity that provides health care coverage that requires step therapy shall:

(a) **Post to the entity’s website clear explanations that are easily accessible to prescribing practitioners and beneficiaries of the coverage, written in plain language and understandable to practitioners and beneficiaries, of:**

[(a)] (A) The clinical criteria for each step therapy protocol **and the criteria for approving an exception to step therapy;**

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

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

(b) **Provide a clear, readily accessible and convenient process for a prescribing practitioner to request an exception to step therapy, which may be the same process used to request exceptions to other coverage restrictions or limitations.**

(c) **Approve a request for an exception to step therapy if the entity determines that the evidence submitted by the prescribing practitioner is sufficient to establish that:**

(A) **The prescription drug required by the step therapy is contraindicated or will cause the beneficiary to experience a clinically predictable adverse reaction;**

(B) **The prescription drug required by the step therapy 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 step therapy, a drug in the same pharmacologic class as the drug required by the step therapy or a drug with the same**

mechanism of action as the drug required by the step therapy, and the beneficiary's use of the drug required by the step therapy was discontinued due to the lack of efficacy or effectiveness, a diminished effect or an adverse reaction;

(D) For a period of at least 90 days the beneficiary has experienced a positive therapeutic outcome from the drug for which the exception is requested while enrolled in the current or immediately preceding health care coverage and changing to the drug required by the step therapy may cause a clinically predictable adverse reaction or physical or mental harm to the beneficiary; or

(E) The prescription drug required by the step therapy is not in the best interest of the beneficiary based on medical necessity.

(d) Grant or deny a request for an exception to step therapy or an appeal of a denial of coverage no later than 72 hours or two business days, whichever is later, after receipt of the request unless exigent circumstances exist. If exigent circumstances exist the entity shall grant or deny the request for an exception no later than one business day after receipt of the request. A request for an exception to step therapy or an appeal of a denial of coverage shall be deemed granted if the entity fails to act within the time frames specified in this paragraph.

(3) A prescribing practitioner may not use a pharmaceutical sample for the sole purpose of qualifying for an exception to step therapy under subsection (2)(c)(C) or (D) of this section.

(4) This section does not prevent:

(a) An entity that provides health care coverage from requiring a beneficiary to try an AB-rated generic equivalent or a biological product that is a biosimilar agent approved by the United States Food and Drug Administration prior to covering the equivalent brand name prescription drug;

(b) An entity that provides health care coverage 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 regardless of coverage.

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, [and] 743B.555 **and 743B.602** and section 2, chapter 771, Oregon Laws 2013:

(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.

[3] (4) “Credit card” has the meaning given that term in 15 U.S.C. 1602.

[4] (5) “Electronic funds transfer” has the meaning given that term in ORS 293.525.

[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.

[13] (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.

[(14)(a)] **(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 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)] **(16)** “Prior authorization” means a **form of utilization review that requires a provider or an enrollee to request a** determination by an insurer [upon request by a provider or an enrollee], 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.

[(16)(a)] **(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.

[(17)] **(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 743B.001, as amended by section 12, chapter 284, Oregon Laws 2019, 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, [and] 743B.555 **and 743B.602:**

(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.**

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

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

[(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.

[(13)] (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 ser-

vices. “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)] **(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 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)] **(16)** “Prior authorization” means a **form of utilization review that requires a provider or an enrollee to request a** determination by an insurer *[upon request by a provider or an enrollee]*, 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.

[(16)(a)] **(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.

[(17)] **(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 9. 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) 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)] **(3)** The department may adopt rules to implement this section.

SECTION 10. ORS 243.144 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;**
- [(2)] (5) ORS 743B.601; and
- [(3)] (6) ORS 743B.810.

SECTION 11. ORS 243.877 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;**
- [(2)] (5) ORS 743B.601; and
- [(3)] (6) ORS 743B.810.

SECTION 12. (1) **An entity subject to ORS 743B.423 must meet the website requirements in ORS 743B.423, as amended by section 5 of this 2021 Act, no later than June 1, 2022.**

(2) **An entity described in ORS 743B.602 must meet the website requirements in ORS 743B.602, as amended by section 6 of this 2021 Act, no later than June 1, 2022.**

Passed by House April 15, 2021

.....
 Timothy G. Sekerak, Chief Clerk of House

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 Tina Kotek, Speaker of House

Passed by Senate May 25, 2021

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 Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2021

Approved:

.....M.,....., 2021

.....
 Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2021

.....
 Shemia Fagan, Secretary of State