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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILED
10/29/2019 10:35 AM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Uniform standards for prompt determinations in response to prior authorization requests

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/29/2019 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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350 Winter St. NE
Salem,OR 97301

Filed By:
Karen Winkel
Rules Coordinator

HEARING(S)

Auxilary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/22/2019
TIME: 1:30 PM
OFFICER: Jesse O'Brien
ADDRESS: Labor & Industries Building
350 Winter St. NE
Conference Room E
Salem, OR 97301
SPECIAL INSTRUCTIONS:
Conference phone information:
Call 888-808-6929
Access code 4969117

NEED FOR THE RULE(S):

2019 Senate Bill 249, enrolled at 2019 Oregon Laws Chapter 284, establishes new requirements for health insurance prior authorization processes.

Prior authorization requirements are included in many health insurance plans. If a covered benefit requires prior authorization, the health insurer may review a patient's condition and medical history, as well as any evidence of medical necessity supplied by the medical provider or patient, before approving or denying coverage. Oregon law prohibits health benefit plans from imposing prior authorization requirements on some services, such as emergency services (ORS 743A.012), but many non-emergency services may be subject to such requirements.

Section 2 of the law imposes new trade practice requirements on health insurer prior authorization practices. These

requirements are similar to those applied to claims for reimbursement in Oregon's unfair claims settlement practices statute, ORS 746.230, and include a requirement to act promptly, equitably and in good faith to approve requests for prior authorization for medically necessary covered services. This section expressly grants DCBS the authority to write rules to implement its provisions. These requirements apply to all policies and certificates of health insurance, as defined by ORS 731.162.

The law amends existing requirements for prior authorization codified in ORS 743B.422 and ORS 743B.423; these statutes apply only to health benefit plans as defined by ORS 743B.005. Specifically, the law requires that a determination be made in response to a prior authorization request within a reasonable period of time appropriate to the medical circumstances, but no later than two business days following receipt of a request by health insurance carrier, unless additional information is required to make a determination. If additional information is required, the carrier must issue a notice in writing to both the enrollee and the requesting health care provider (if any) specifying all of the information necessary to make a determination. If the carrier receives a response, a determination must be made no later than two business days following receipt of the response; regardless of whether a response is received, the carrier must issue a determination no later than 15 total days following the request for additional information. The amendments to ORS 743B.422 and ORS 743B.423 also clarify that these requirements apply to prior authorization requests made by enrollees, not just by health care providers.

The law revises ORS 743B.001 to make technical amendments to the existing definitions of "prior authorization" and "utilization review," as well as to add the denial of a prior authorization request to the list of actions falling under the definition of "adverse benefit determination." The law also makes a variety of non-substantive changes to other statutes.

Two rules are proposed to implement this new law:

- Revisions to OAR 836-053-1200 to align its requirements with the new requirements for health benefit plans imposed by the revisions to ORS 743B.422 and ORS 743B.423.

- A new rule (proposed OAR 836-053-1203) that applies to all policies and certificates of health insurance other than health benefit plans to establish standards for when an insurer acts promptly in response to a request for prior authorization within the meaning of 2019 Oregon Laws Ch. 284 Section 2(2)(e).

The proposed rules are necessary to correct inconsistencies between existing administrative rules and the new law and to establish uniform standards for compliance regarding timelines and communication related to prior authorization that will help ensure fairness and consistent treatment for consumers, health care providers, and issuers of all lines of health insurance.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

From Karen Winkel located at 350 Winter St. NE, Salem, OR 97301 and are available on DCBS's Web site at https://dfr.oregon.gov/laws-rules/Pages/proposed-rules.aspx.

2019 Oregon Laws Chapter 284 (Enrolled Senate Bill 249) may be found on the Oregon Legislative Assembly website at https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB249/Enrolled or for public inspection at DCBS's Division of Financial Regulation, 350 Winter Street NE, Salem, OR 97301, during regular business hours, 8:00 a.m. to 5:00 p.m., Monday through Friday.

ORS's 743B.420, 743B.422 and 743B.423 may be found on the Oregon Legislative Assembly website at https://www.oregonlegislature.gov/bills_laws/ors/ors743b.html or for public inspection at DCBS's Division of Financial Regulation, 350 Winter Street NE, Salem, OR 97301, during regular business hours, 8:00 a.m. to 5:00 p.m., Monday through Friday.

FISCAL AND ECONOMIC IMPACT:

2019 Oregon Laws Chapter 284 and the proposed rules will have a significant direct economic impact on health insurers and an indirect economic impact on health care providers. Some health care providers are small businesses.

Based on the information available to DCBS, the proposed rules will not likely have a fiscal or economic impact on state agencies, local governments, or the public.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Based on information currently available to DCBS, the proposed rule would not have a fiscal or economic impact on state agencies, local government units, nor the public.

The underlying statutory provisions may have an impact on DCBS through modifying the department's regulatory authority in the area of prior authorization, which may lead to changes in the pattern and frequency of complaints or requests for external review received, or compliance and enforcement actions undertaken. However, the proposed rule will not. The proposed rules provide finer details regarding the implementation of the law's requirements and are expected to have a negligible impact on costs to the department.

The proposed rules do not add any new requirements on public entities, but instead clarify DCBS's supervisory expectations with regard to health insurers' prior authorization practices. Other state agencies and local governments are not expected to incur any fiscal impact, because the requirements established by the law are not applicable to these entities.

Based on the information currently available to DCBS, the proposed rule does not have an economic impact on the general public beyond the underlying statutory requirements.

(2)(a) The proposed rules establish requirements for health insurers' practices in the area of prior authorization, including timelines for making determinations and required communications with health care providers and enrollees. Compliance with these requirements may require significant costs for insurers. DCBS does not have data on the specific number of employees employed by insurers authorized to transact insurance in Oregon, but it is unlikely that any of the health insurers to which this rule applies are small businesses.

DCBS convened a rulemaking advisory committee, which included representatives of health care providers, insurers, and consumer and patient advocates. Committee feedback suggested that the proposed rules were unlikely to have a significant impact on small businesses in Oregon (i.e., businesses with 50 or fewer employees).

(2)(b) The proposed rules provide clarification of the statutory requirements and do not impose additional requirements in the areas of reporting and recordkeeping.

(2)(c) Generally, the proposed rules provide clarification of the statutory requirements and do not impose additional requirements.

However, the proposed rules require health benefit plans to notify enrollees when a prior authorization request is denied in whole or in part, regardless of whether the enrollee submitted the prior authorization request, and that the notification must inform the enrollee of their right to appeal the denial. This requirement is applicable only to health benefit plans, not to policies and certificates of health insurance that are not health benefit plans. This notification requirement is not specified in Oregon Laws Chapter 284, and may impose additional administrative costs on issuers of health benefit plans. This notification is necessary to ensure that Oregon consumers are informed of their legal rights to appeal adverse benefit determinations.

DCBS does not have data on the specific number of employees employed by insurers authorized to transact insurance in Oregon. Based on the feedback of the rulemaking advisory committee, it is unlikely that any of the health insurers to which this rule applies are small businesses.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

DFR convened a rulemaking advisory committee, which included representatives of health care providers, insurers, and consumer and patient advocates. Some health care providers are small businesses.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
836-053-1200, 836-053-1203

AMEND: 836-053-1200

RULE SUMMARY: Amend administrative rules for prior authorization requirements for health benefit plans to conform with the provisions of Oregon Laws 2019, Chapter 284.

CHANGES TO RULE:

836-053-1200
Prior Authorization Requirements for Health Benefit Plans ¶

(1) The provisions of this rule implement the requirements of ORS 743.807B.420 and the amendments to ORS 743B.422 and 743.837,ORS 743B.423 by Oregon Laws 2019, chapter 284 relating to prior authorization determinations. "Prior authorization" means a determination by an insurer, prior to provision of serviceshealth care that is subject to utilization review, that the insurer will provide reimbursement for the services requested. "Prior authorization" does not include referral approval for evaluation and management services between providers.¶
(2) ORS 743.807 and 743.837 For the purposes of this rule, "health care" includes all items and services covered by a health benefit plan, including but not limited to medical, behavioral health, dental and vision care items and services.¶
(2) This rule applyies to prior authorization determinations that:¶
(a) Are issued orally or in writing by an insurer to a provider or enrollee regarding the benefit coverage or medical necessity of a medical or mental healthhealth care item or service to be provided to an enrollee; and¶
(b) Are required under and obtained in accordance with the terms of a health benefit plan.¶
(3) A prior authorization may be limited to the services of a specific provider or to services of a designated group of providers who contract with or are employed by the insurer.¶
(4) Nothing in this rule shall require a health benefit plan to contain a prior authorization requirement.¶
(5) Except in the case of misrepresentation relevant to a request for prior authorization, a prior authorization determination shall be binding on the insurer for the period of time specified in section (6) of this rule.¶
(6) A prior authorization determination shall be binding on the insurer for:¶
(a) The lesser of the following periods:¶
(A) Five business days following the date of issuance of the authorization; or¶
(B) The period during which the enrollee's coverage remains in effect, provided that when the insurer issues the prior authorization, the insurer has specific knowledge that the enrollee's coverage will terminate sooner than five business days following the day the authorization is issued and the insurer specifies the termination date in the authorization; and¶
(b) The period during which the enrollee's coverage remains in effect beyond the time period established pursuant to subsection (a) of this section, up to a maximum of thirty30 calendar days.¶
(7) For purposes of counting days under section (6) of this rule, day 1 occurs ononeone is the first business or calendar day, as applicable, following the day on which the insurer issues a prior authorization determination.¶
(8) An insurer may not impose a restriction or condition on its prior authorization determinations that limits, restricts or effectively eliminates the binding force established for such determinations in ORS 743.837B.420 and this rule.¶
(9) When an insurer answers requests byA prior authorization determination is issued when an insurer communicates orally, or in writing, a notice that meets the requirements of section (11) of this rule to the provider or enrollee who submitted the prior authorization request.¶
(10) Except as provided in section (13), a determination by an insurer on a provider's for prior authorization of nonemergency services as required by ORS 743.807(2)(d), tor an enrollee's request for prior authorization must be issued within a reasonable period of time appropriate to the medical circumstances but no later than two business days after receipt of the request. If the determination is issued orally, the insurer must mail, or send electronically, a written notice of the determination to the provider or enrollee who submitted the prior authorization request no later than two business days after the determination is issued. For the purposes of counting days under this subsection, day one is the first business day following the day on which the insurer receives the request for prior authorization or issues the determination, as applicable.¶
(11) When answer insurer issues a determination in response to a request byfrom a provider or an enrollee for prior authorization of nonemergency serviceshealth care items or services, the determination must be one of the following:¶

(a) The requested item or service is authorized.;¶
(b) The requested item or service is not authorized.; or¶
(c) The entire requested item or service is not authorized, but a specified portion of the requested item or service or a specified alternative item or service is authorized.¶
(d) The requested service is not authorized because the insurer needs additional specified information in order to make a decision on the request12) If an insurer makes a determination meeting the conditions specified in subsections (b) or (c) of section (11), the notice of that determination must be mailed, or sent electronically, to the enrollee who is the subject of the prior authorization request, regardless of whether the enrollee submitted the prior authorization request to the insurer. The notice must specify that the determination constitutes an adverse benefit determination, and that the enrollee has the right to appeal the determination, and to external review of the determination if applicable.¶
(13) If additional information from an enrollee or a provider requesting prior authorization is necessary to make a determination on a request for prior authorization, no later than two business days after receipt of the request, the enrollee and the requesting provider, if any, shall be notified in writing of the specific additional information needed to make the determination. The required notice is provided when it is mailed, or delivered electronically, by the insurer. For the purposes of counting days under this subsection, day one is the first business day following the day on which the insurer receives the request for prior authorization. Nothing in this subsection shall be construed to prohibit an insurer from seeking additional information related to a prior authorization request orally or by other means, provided that a written notice is supplied in the event that a determination cannot be made within two business days due to the need for additional information.¶
(14) Following a request for additional information submitted in compliance with section (13), the insurer must issue a determination by the later of:¶
(a) Two business days after receipt of a response to the request for additional information. For the purposes of counting days under this subsection, day one is the first business day following the day on which the insurer receives a response; or¶
(b) Fifteen days after the date of the request for additional information. For the purposes of counting days under this subsection, day one is the first calendar day following the day on which the insurer mails, or sends electronically, the request for additional information.¶
(15) When an insurer requests additional information that is necessary to make a determination on a request for prior authorization, the insurer must specify all of the information reasonably necessary to make a determination. The insurer may not request information that is substantially identical to information previously supplied by the enrollee or provider.¶
(16) Compliance with this rule by an insurer offering a health benefit plan will be sufficient to demonstrate compliance with the requirement for insurers to act promptly in making determinations in response to requests for prior authorization established by Oregon Laws 2019, chapter 284, section 2(2)(e). Nothing in this rule shall be construed to limit the department's authority under this section to require a health insurer to act equitably and in good faith with respect to approving requests for prior authorization.
Statutory/Other Authority: ORS 731.244
Statutes/Other Implemented: ORS 743.837, 743.807B.420, ORS 743B.422, ORS 743B.423, Or Laws 2019 ch 284

ADOPT: 836-053-1203

RULE SUMMARY: Establishes timeline requirements and required communications related to prior authorization requests for policies and certificates of health insurance other than health benefit plans.

CHANGES TO RULE:

836-053-1203
Prior Authorization Trade Practices for Health Insurance other than Health Benefit Plans
(1) The purpose of this rule is to establish standards for determining whether an insurer offering a policy or certificate of health insurance, other than a health benefit plan, acts promptly in response to a request for prior authorization within the meaning of Oregon Laws 2019, chapter 284, section 2(2)(e). Nothing in this rule shall be construed to limit the department's authority under this section to require a health insurer to act equitably and in good faith with respect to approving requests for prior authorization.¶
(2) "Prior authorization" means a determination by an insurer, prior to provision of health care that is subject to utilization review, that the insurer will provide reimbursement for the services. "Prior authorization" does not include referral approval for evaluation and management services between providers. For the purposes of this rule, "health care" includes all items and services covered by a policy or certificate of health insurance, including but not limited to medical, behavioral health, dental and vision care items and services.¶
(3) This rule applies to prior authorization determinations that:¶
(a) Are issued orally or in writing to a provider or enrollee by an insurer offering a policy or certificate of health insurance, other than a health benefit plan, regarding the benefit coverage or medical necessity of a health care item or service to be provided to an enrollee; and¶
(b) Are required under and obtained in accordance with the terms of a health insurance plan.¶
(4) A prior authorization may be limited to the services of a specific provider or to services of a designated group of providers who contract with or are employed by the insurer.¶
(5) Nothing in this rule shall require a policy of health insurance to contain a prior authorization requirement.¶
(6) Except in the case of misrepresentation relevant to a request for prior authorization, a prior authorization determination shall be binding on the insurer for the period of time specified in section (7) of this rule.¶
(7) A prior authorization determination shall be binding on the insurer for:¶
(a) The lesser of the following periods:¶
(A) Five business days following the date of issuance of the authorization; or¶
(B) The period during which the enrollee's coverage remains in effect, provided that when the insurer issues the prior authorization, the insurer has specific knowledge that the enrollee's coverage will terminate sooner than five business days following the day the authorization is issued and the insurer specifies the termination date in the authorization; and¶
(b) The period during which the enrollee's coverage remains in effect beyond the time period established pursuant to subsection (a) of this section, up to a maximum of 30 calendar days.¶
(8) For purposes of counting days under section (7) of this rule, day one is the first business or calendar day, as applicable, following the day on which the insurer issues a prior authorization determination.¶
(9) An insurer may not impose a restriction or condition on its prior authorization determinations that limits, restricts or effectively eliminates the binding force established for such determinations in ORS 743B.420 and this rule.¶
(10) A prior authorization determination is issued when an insurer communicates orally, or in writing, a notice that meets the requirements of subsection (12) of this rule to the provider or enrollee who submitted the prior authorization request.¶
(11) Except as provided in section (13), a determination by an insurer on a provider's or an enrollee's request for prior authorization must be issued within a reasonable period of time appropriate to the medical circumstances but no later than two business days after receipt of the request. If the determination is issued orally, the insurer must mail, or send electronically, a written notice of the determination to the provider or enrollee who submitted the prior authorization request no later than two business days after the determination is issued. For the purposes

of counting days under this subsection, day one is the first business day following the day on which the insurer receives the request for prior authorization or issues the determination, as applicable.¶
(12) When an insurer issues a determination in response to a request from a provider or an enrollee for prior authorization of nonemergency health care items or services, the determination must be one of the following:¶
(a) The requested item or service is authorized;¶
(b) The requested item or service is not authorized; or¶
(c) The entire requested item or service is not authorized, but a specified portion of the requested item or service or a specified alternative item or service is authorized.¶
(13) If additional information from an enrollee or a provider requesting prior authorization is necessary to make a determination on a request for prior authorization, no later than two business days after receipt of the request, the enrollee and the requesting provider, if any, shall be notified in writing of the specific additional information needed to make the determination. The required notice is provided when it is mailed, or delivered electronically, by the insurer. For the purposes of counting days under this subsection, day one is the first business day following the day on which the insurer receives the request for prior authorization. Nothing in this subsection shall be construed to prohibit an insurer from seeking additional information related to a prior authorization request orally or by other means, provided that a written notice is supplied in the event that a determination cannot be issued within two business days due to the need for additional information.¶
(14) Following a request for additional information submitted in compliance with section (13), the insurer must issue a determination by the later of:¶
(a) Two business days after receipt of a response to the request for additional information. For the purposes of counting days under this subsection, day one is the first business day following the day on which the insurer receives a response; or¶
(b) Fifteen days after the date of the request for additional information. For the purposes of counting days under this subsection, day one is the first calendar day following the day on which the insurer mails, or delivers electronically, the request for additional information.¶
(15) When an insurer requests additional information that is necessary to make a determination on a request for prior authorization, the insurer must specify all of the information reasonably necessary to make a determination. The insurer may not request information that is substantially identical to information previously supplied by the enrollee or provider.
Statutory/Other Authority: ORS 731.244, Or Laws 2019 ch 284
Statutes/Other Implemented: ORS 743B.420, Or Laws 2019 ch 284