Oregon Prescription Drug Affordability Board

Policy Memorandum

To: Oregon Prescription Drug Affordability Board
From: Cortnee Whitlock, program and senior policy analyst
Re: Commercial health plan continuity-of-care policy concept
Date: Sept. 8, 2026

Summary

This memorandum presents a targeted commercial health plan continuity-of-care option for prescription drugs. Illinois, Wyoming, and Tennessee require a receiving health plan to honor a documented prior authorization for at least the first 90 days of new coverage. Maine has a narrower prescription-drug model that continues the former insurer's authorization while the replacement insurer reviews it with the prescriber, for up to six months when the prescriber participates and requests continuation.

Oregon already contains meaningful prescription drug protections. Under the Medicaid transition rule, OAR 410-141-3580, temporary prescription drug coverage and clinical-records transfer when a member moves to a receiving coordinated care organization.[1] ORS 743B.602 requires a process for a commercial step-therapy exception based on contraindication, likely ineffectiveness, prior treatment failure, medical necessity, or certain positive therapeutic outcomes under current or immediately preceding coverage.[2] ORS 743B.423 protects stabilized treatment during review and appeals following certain coverage changes and makes qualifying maintenance-drug approvals binding for one year while the person remains enrolled in the plan.[3] The gap is, Oregon does not generally require a receiving commercial plan to provide temporary coverage based on a prescription-drug authorization issued under immediately preceding coverage.

A PDAB recommendation could support a 90-day prescription drugs transition period when a member changes plans. The receiving insurer could conduct its own review during that period, but it would temporarily honor a documented authorization and accept existing clinical information without requiring the prescriber to reconstruct the record. The proposal would supplement, not replace, Oregon's step-therapy exception and appeal protections. It should apply to fully insured individual and group plans regulated by the state; self-funded employer plans are generally regulated under ERISA and cannot ordinarily be compelled by state insurance law.

[1] Oregon Secretary of State. (2022, February 18). Oregon Administrative Rule 410-141-3850: Transition of care. Oregon Administrative Rules. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=285455
[2] Oregon Revised Statutes § 743B.602 (2025), Step therapy. https://www.oregonlegislature.gov/bills_laws/ors/ors743B.html
[3] Oregon Revised Statutes § 743B.423(2)(k), (n), and (p) (2025), Utilization review requirements for insurers offering health benefit plans. https://www.oregonlegislature.gov/bills_laws/ors/ors743B.html.

The problem to solve

When a person changes plans--including a change between products offered or administered by the same carrier--a prior prescription-drug authorization may not follow the person because it was issued under the former plan's contract, formulary, and clinical criteria. Oregon law permits a prescriber to request a step-therapy exception based on prior treatment failure or other clinical grounds, but it does not provide automatic transition coverage while that request or a new prior-authorization review is completed. Even when the receiving plan ultimately approves the drug, the reset can delay dispensing, require resubmission of clinical information, or contribute to treatment abandonment.

The concept should be described as a short-term transition protection. The new insurer would remain responsible for its covered-benefit terms, safety review, fraud prevention, provider network, and cost sharing.

Oregon baseline

Oregon law already protects prescription-drug access in several related circumstances. These provisions establish the baseline from which a narrower cross-plan transition policy should be evaluated.

Medicaid transition rule

OAR 410-141-3850 applies when a Medicaid member moves without a coverage gap from a predecessor plan or fee-for-service Medicaid to a receiving coordinated care organization. Continued access includes prescriptions and drug coverage. The rule establishes transition periods and requires the predecessor to provide utilization and clinical records within seven days. If records are unavailable, the receiving organization may not delay care and must treat transition-period claims as prior authorized.[4] Although this rule does not govern commercial plans, it demonstrates an existing Oregon approach to temporary coverage and record transfer during a plan transition.

Commercial step therapy

ORS 743B.602 requires a clear process through which a prescribing practitioner may request an exception to step therapy. A request must be approved when sufficient evidence establishes that the required drug is contraindicated or likely ineffective; the patient previously discontinued the required drug or a comparable drug because of lack of effectiveness, diminished effect, or an adverse reaction; the patient has experienced a positive therapeutic outcome for at least 90 days under current or immediately preceding coverage and a change may cause harm; or the required drug is not in the patient's best interest based on medical necessity. [5] The entity generally must decide the request within 72 hours or two business days, whichever is later. These protections

[4] Oregon Administrative Rule 410-141-3850, Transition of care. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=285455.
[5] Oregon Revised Statutes § 743B.602 (2025), Step therapy. https://www.oregonlegislature.gov/bills_laws/ors/ors743B.html.

recognize prior treatment history, but the prescriber must still submit an exception request and supporting evidence.

Commercial utilization review and appeals

ORS 743B.250 requires insurer to disclose prescription-drug coverage restrictions and formulary-exception procedures and establishes internal appeal rights, including continued coverage of an approved and ongoing course of treatment while an internal appeal is pending.[6] ORS 743B.423 separately establishes utilization review standards, written-denial and decision timeline requirements, continued coverage when a formulary or coverage change affects a treatment on which an enrollee has been stabilized for at least 90 days, and a one-year binding period for qualifying maintenance-drug approvals.[7] Theses protection generally apply when the enrollee remains covered by the plan that made the determination.

Remaining gap

Oregon does have regulations on how commercial plans disclose, review, and appeal prescription-drug coverage decisions and protects qualifying approvals within an existing plan. It does not generally require receiving a commercial plan to honor a prescription-drug authorization issued under a different plan for a defined transition period. ORS 743B.225 is narrower still, as it allows temporary continuity with an individual provider after a provider contract terminates and expressly does not apply when the enrollee leaves the plan.[8] The proposed policy would address this cross-plan timing gap without changing the receiving plan's formulary, exclusions, or ultimate utilization-review authority.

Other-state approaches

State and authority	Core protection	Relevance
Illinois - 215 ILCS 200/70[9]	New health insurer honors documented authorization from the previous health insurer for at least the first 90 days. New insurer may conduct its own review. Protection is subject to the new coverage agreement and does not create coverage for an excluded benefit.	Broad medical and pharmacy benefit model.

[6] Oregon Revised Statutes § 743B.250 (2025), Required notices; grievances, internal appeals, and external reviews. https://www.oregonlegislature.gov/bills_laws/ors/ors743B.html.
[7] Oregon Revised Statutes § 743B.423(2)(k), (n), and (p) (2025), Utilization review requirements for insurers offering health benefit plans. https://www.oregonlegislature.gov/bills_laws/ors/ors743B.html.
[8] Oregon Revised Statutes § 743B.225 (2025), Continuity of care. https://www.oregonlegislature.gov/bills_laws/ors/ors743B.html.
[9] 215 ILCS 200/1 et seq. (Illinois Comp. Stat. 2022) ("Prior Authorization Reform Act"). Effective Jan. 1, 2022. Retrieved August 11, 2026, from https://www.ilga.gov/Legislation/ILCS/Articles?ActID=4201&Chapter=INSURANCE&ChapterID=22&MajorTopic=REGULATION

State and authority	Core protection	Relevance
Wyoming - Wyo. Stat. 26-55-101 to -113[10]	The receiving health insurer must honor a prior insurer's approval for a covered health care service, including an applicable prescription-drug authorization, for at least 90 days. The authority also prohibits requiring a patient to repeat step therapy when the patient used the required drug, or a drug in the same class, under current or previous coverage.	Combines authorization portability and step therapy history portability; effective July 1, 2024.
Tennessee - Tenn. Code Ann. 56-7-3714[11]	Upon receipt of documentation, the receiving plan must honor a prior authorization for at least the first 90 days of the new coverage. The receiving plan may conduct its own review, effective after the 90-day period. Authorizations also continue when a member changes plans carried or administered by the same carrier.	Broad medical and prescription-drug model; enacted in 2023 and effective Jan. 1, 2025.
Maine - 24-A M.R.S. 4303(7-A)[12]	Replacement insurer honors a prescription-drug authorization until it reviews the authorization with the prescriber; continuation may last up to six months when the prescriber participates and requests it. New-plan exclusions and cost sharing remain applicable.	Narrower prescription-drug model; effective Sept. 12, 2009.
AHIP - industry voluntary commitment[13]	Participating plans commit to honor existing authorizations for benefit-equivalent in-network services for 90 days when a patient changes insurance plans during treatment.	Shows operational feasibility but is voluntary and does not ensure uniform Oregon implementation or enforcement.

[10] Wyoming Legislature, Enrolled Act No. 19 (2024), House Bill 14: Prior authorization regulations (67th Leg.). Retrieved August 11, 2026, from https://www.wyoleg.gov/2024/Enroll/HB0014.pdf

[11] Tennessee Code Annotated 56-7-3714 (2025), *Prior authorization transfers* (enacted by 2023 Tenn. Pub. Acts. Ch. 395: effective Jan. 1, 2025). https://law.justia.com/codes/tennessee/title-56/chapter-7/part-37/section-56-7-3714/.

[12] Me. Rev. Stat. tit. 24-A, 4303(7-A), enacted by 2009 Me. Laws ch. 439, pt. F, 1, effective Sept. 12, 2009. https://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4303.html.

[13] America's Health Insurance Plans [AHIP]. (2025, June 23). Health plans take action to simplify prior authorization. Retrieved from https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization

Cost and affordability rationale

The policy purpose is continuity and affordability during a plan transition, not elimination of prior authorization or a guaranteed reduction in plan spending. The receiving plan would retain authority to conduct utilization reviews and make a prospective coverage determination. Because that review may still occur, the proposal should not be presented as eliminating the plan's administrative expense or producing net savings.

The affordability rationale is that temporary coverage may prevent transition-related costs to members, such as paying cash for a prescription, obtaining an additional visit solely to recreate documentation, or abandoning treatment while review is pending. A Rhode Island review similarly concluded that the broader prior-authorization literature documents both savings and burdens but does not provide a combined cost-benefit analysis.[14]

- **Provider documentation burden.** A receiving plan may still perform utilization review, so its review expense should not be characterized as avoided. The policy could nevertheless reduce provider burden if the receiving plan must accept the prior authorization and supporting clinical information in lieu of requiring the prescriber to reconstruct the submission. A 2024 peer-reviewed study estimated average submission costs of approximately $40-$50 for private payers and $20-$30 for providers, but it did not isolate plan-transition requests.[15]

- **Provider capacity and opportunity cost.** The 2025 AMA physician survey reported an average of 39 prior-authorization requests and 13 hours of physician and staff time per physician each week, with 40 percent of respondents reporting staff dedicated exclusively to prior authorization.[16] The survey covers prior authorization across medical services and prescription drugs and does not report a drug-specific share or isolate requests caused by insurance changes.

- **Potential avoidance of transition-related utilization.** In the 2025 AMA survey, 88 percent of responding physicians reported that prior authorization led to higher overall resource use, including additional office visits, emergency care, and hospitalization.[17] This physician-reported evidence is not specific to drugs or insurance changes and should not be treated as proof of savings. It supports evaluating whether temporary drug coverage reduces avoidable transition-related utilization.

[14] Rhode Island Office of the Health Insurance Commissioner. (2024, June 28). Administrative Simplification Task Force report. https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-06/OHIC%20Administrative%20Simplification%20Task%20Force%20Report%20June%2028%202024.pdf

[15] Sahni, N. R., Istvan, B., Stafford, C., & Cutler, D. (2024). Perceptions of prior authorization burden and solutions. Health Affairs Scholar, 2(9), qxae096. https://doi.org/10.1093/haschl/qxae096.

[16] American Medical Association. (2025). 2025 AMA prior authorization physician survey. The survey addresses prior authorization generally and does not report a drug-specific share. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[17] Ibid.

- **Continuity of established treatment.** A quasi-experimental study of Medicare beneficiaries already using oral anticancer drugs found that a newly imposed prior-authorization requirement was associated with an average 10-day delay in the first refill and increased treatment discontinuation.[18] The study does not establish the fiscal effect of cross-plan authorization transfer, but it demonstrates a plausible pathway by which new utilization management can interrupt established drug treatment.

- **Member affordability and access.** A coverage transition can expose a member to a delayed prescription, an additional visit to recreate documentation, a temporary cash payment, or treatment abandonment while a new review is pending. A 90-day transition period would not carry forward the former plan's copayment or require coverage of a drug excluded under the new policy; the member would remain subject to the receiving plan's covered benefits and cost sharing.

- **Preservation of utilization management.** The receiving plan would not be bound indefinitely by the former plan's decision. It could review medical necessity, safety, formulary status, pharmacy network requirements, and whether the drug is a covered benefit during the transition. The proposal focuses on preventing an interruption while that review occurs rather than eliminating utilization management.

Oregon context and fiscal limitation

DCBS reports that commercial insurers approved 342,367 standard prior-authorization requests in 2025, representing 80.8 percent of standard requests.[19] The published data does not identify how many requests were repeated by an authorization issued by a prior insurer, the administrative cost of those repetitions, or whether affected members experienced treatment gaps. These limitations prevent a reliable estimate of the number of affected members, the administrative burden, or any resulting savings.

Here are potential elements to include in a legislative proposal, along with a recommended approach.

Recommended policy framework

Element	Recommended approach
Scope	Applies to fully insured individual and group health benefit plans subject to Oregon insurance regulation. Consider expressly including PEBB and OEBB plans through conforming provisions. Exclude or acknowledge ERISA self-funded plans beyond state authority.

[18] Kyle, M. A., & Keating, N. L. (2024). Prior authorization and association with delayed or discontinued prescription fills. Journal of Clinical Oncology, 42(8), 951-960. https://doi.org/10.1200/JCO.23.01693.

[19] Oregon Division of Financial Regulation (2026, February 28). Prior Authorization: Health insurance. Oregon Department of Consumer and Business Services. Retrieved August 11, 2026, from https://dfr.oregon.gov/insure/health/Pages/prior-authorization.aspx

Element	Recommended approach
Trigger	Enrollment in a new plan while a prescription-drug authorization or step-therapy exception issued under immediately preceding coverage remains active. Define qualifying preceding coverage, including whether it may be Oregon Medicaid, an ERISA self-funded plan, or a plan issued in another state. Include changes between products carried or administered by the same carrier.
Duration	Honor documented prior authorizations for 90 days from the effective date of new coverage, or until the receiving insurer completes its review and provides any clinically appropriate transition, whichever produces the required minimum protection. Longer protection should apply through the current course of treatment for pregnancy, chemotherapy, radiation, transplant, dialysis, and time-limited drug regimens.
Covered benefit guardrail	Limit the policy to situations with benefit equivalence meaning that the service or drug must be a covered benefit under the new plan. The law should not force coverage of a service expressly excluded without regard to medical necessity.
Step therapy	Preserve ORS 743B.602. The receiving plan would consider documented prior trials, contraindications, adverse effects, lack of efficacy, and positive therapeutic response when deciding a prescriber's step-therapy exception request. The transition policy supplies temporary coverage while the existing statutory process is completed.
Documentation	Accept documentation from the member, prescriber, former plan, PBM, or a secure electronic exchange. Require the former plan or its administrator to transmit the authorization determination, supporting clinical information, approved quantity and duration, and relevant step-therapy history within seven calendar days. Missing records may not interrupt transition-period coverage.
Review and due process	Permit receiving-plan review during the 90-day transition period. Any prospective termination or reduction must comply with Oregon requirements for qualified clinical review, specific written reasons, notice, internal appeal, and external review. Preserve continued coverage during an appeal as required by ORS 743B.250 and 743B.423.
Pharmacy and site-of-care rules	Allow the receiving plan to apply its pharmacy network, specialty-pharmacy, and clinician-administered-drug site-of-care requirements, provided those requirements do not interrupt access during the transition period and comply with other applicable Oregon law.
Exceptions	Permit immediate action for fraud, material misrepresentation, loss of eligibility, FDA safety action, new contraindication, or a material change in

Element	Recommended approach
	condition. Preserve ordinary quantity and safety edits that are clinically justified.
Oversight	Authorize DCBS rulemaking, consumer complaints, and corrective action. Require aggregate reporting on use of transition protection, review outcomes, and processing time, with an evaluation after two years. Avoid duplicative reporting when existing prior-authorization data can be adapted.

Conclusion

Oregon already recognizes the importance of maintaining access to treatment through its Medicaid transition rule, commercial step-therapy exceptions, and utilization protections. However, these provisions do not generally require a receiving commercial plan to temporarily honor a prescription-drug authorization or step-therapy exception issued under preceding coverage. Other states provide models that Oregon could adapt to address this gap.

A targeted transition requirement provides a framework for maintaining access to an approved prescription drug while a receiving plan completes its review. Temporary recognition of existing authorization, timely transfer and acceptance of clinical information, and clearly defined safeguards can reduce treatment disruptions and repeated documentation burdens while preserving the receiving plan's formulary, benefit, safety, and utilization-review authority. This policy concept addresses an identified gap in Oregon's commercial coverage protections and supports greater continuity for enrollees who change health plans.

Questions for board consideration

- Should the proposal cover both pharmacy-benefit and clinician-administered prescription drugs?
- Should the transition period be a uniform 90 days, or continue through completion of the receiving plan's review and appeals when that process extends beyond 90 days?
- Should the receiving plan be permitted to end temporary coverage before day 90 after an approval and clinically appropriate transition, or should 90 days be an absolute minimum?
- Should PEBB and OEBB be included?
- Which types of immediately preceding coverage should qualify, including Oregon Medicaid, an ERISA self-funded plan, or coverage issued in another state?
- Should the recommendation require electronic transfer of the prior-authorization determination and supporting clinical records within seven calendar days?