Oregon Prescription Drug Affordability Board

Commercial health plan continuity-of-care

Recommendation

The Oregon Prescription Drug Affordability Board recommends legislation establishing a uniform 90-day prescription-drug continuity-of-care period when an individual changes commercial health plans. During the transition, the receiving plan would temporarily honor a documented prior authorization or step-therapy exception issued under immediately preceding coverage, accept available authorization and clinical information without requiring the prescriber to recreate the submission, and maintain access for the new member, while conducting its own review.

Problem to solve

An already approved prior authorization or completion of step therapy generally does not follow a patient when their health insurance coverage changes. The receiving plan may require a new prior authorization or another step-therapy review even when the new member is stable on current treatment. The reset can produce a first-claim denial, delayed dispensing, duplicated documentation, additional clinical visits, cash payment by the member, medication switching, or treatment abandonment. Oregon protects patients in several related circumstances, but it does not provide a general transition period for a prescription drug authorization issued under a previous commercial plan.[1,2,3]

Proposed legislative solution

- Create a 90-day minimum period for protection beginning on the effective date of the member's new health benefit coverage.
- Apply protection to insured individual and group health benefit plans regulated by Oregon; include changes between products carried or administered by the same carrier.
- Include PEBB and OEBB through conforming provisions and apply the policy to the fullest extent permitted under state law.

---

[1] Oregon Division of Financial Regulation. (2026, September 8). *Commercial health plan continuity-of-care memo* [PDF]. Oregon Prescription Drug Affordability Board. Retrieved from https://dfr.oregon.gov/pdab/Documents/PDAB-Commercial-Continuity-of-Care-Memo.pdf.

[2] Oregon Revised Statutes §§ 743B.225, 743B.250, 743B.423, and 743B.602 (2025). https://www.oregonlegislature.gov/bills_laws/ors/ors743B.html

[3] Oregon Administrative Rule 410-141-3850, Transition of care. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=285455

- Recognize documented prescription drug prior authorizations and step therapy exceptions issued under immediately preceding coverage.
- Permit the receiving plan to complete its own utilization review during the 90-day transition period, with a prospective determination effective after the protected period and subject to existing notice and appeal rights.

Core legislative elements

Element	Recommended approach
Qualifying transition	Enrollment in a receiving plan with an active drug authorization or step therapy exception under immediately preceding coverage. Include same carrier product changes. If the preceding plan covered the drug without prior authorization or step therapy, that coverage alone does not qualify for the 90-day protection. The member follows the receiving plan's prior authorization or step therapy requirements.
Covered-benefit guardrail	The protection applies when the drug is covered by the receiving plan or may be covered through the plan's formulary exception process. It does not apply to drugs excluded from coverage. The receiving plan's cost sharing, including any deductible, and pharmacy network rules apply during the transition.
Information exchange	Accept proof from the patient, prescriber, former plan, or PBM, through a secure electronic exchange. Require the preceding plan or administrator, when subject to Oregon authority, to transmit the determination, approved quantity and duration, supporting information, and relevant step history within seven business days of notification that the member is enrolled in a new plan.
Minimizing prescriber documentation	Do not require a prescriber to reconstruct or resubmit information for prior authorization or step therapy exceptions that are available from the preceding health plan. Provide a practical manual pathway for health plan communication when electronic exchange is unavailable.

Operation and safeguards

- **Temporary protection:** The receiving plan retains authority over medical necessity, safety, formulary status, fraud prevention, pharmacy network, site of care, and benefit administration after the transition.
- **No interruption for missing records:** Failure to obtain records promptly would not suspend temporary coverage while the receiving plan and the previous plan complete the exchange.
- **Step therapy history:** The receiving plan would consider documented prior trials, contraindications, adverse effects, lack of efficacy, and positive therapeutic response as currently required under ORS 743B.602; the patient would not repeat a failed step solely because coverage changed.[4]
- **Notice:** The receiving plan would notify the patient, dispensing pharmacy at the time of claim adjudication, and the prescriber regarding the transition period, expiration date, review status, needed information, next steps, and applicable exceptions or appeal rights when known. Pharmacy claim messaging may supplement, but not replace, direct notice.
- **Grievances and appeals:** The policy would not change existing rights and requirements for grievances and appeals under ORS 743B.250 to 743B.258, including procedures for requesting exceptions to a prescription drug formulary.[5]
- **Limited exceptions:** Immediate action would remain available for loss of eligibility, fraud or material misrepresentation, an FDA safety action, a new contraindication, or a material clinical change. Clinically justified quantity and safety edits would remain available.

Arguments for the recommendation

The policy addresses timing and transitions rather than eliminating utilization management. A temporary bridge can reduce avoidable treatment disruption and duplicative provider work while preserving the receiving plan's ability to review coverage.[6] Illinois, Wyoming, Tennessee, and Maine provide state precedents, and participating health plans have made a voluntary

[4] Oregon Legislature. *Oregon Revised Statutes, ORS 743B.602* (2026). Retrieved from https://www.oregonlegislature.gov/bills_laws/ors/ors743B.html.
[5] Oregon Legislature. *Oregon Revised Statutes, ORS 743B* (2025). Retrieved from https://www.oregonlegislature.gov/bills_laws/ors/ors743B.html.
[6] Oregon Division of Financial Regulation. (2026, September 8). *Commercial health plan continuity-of-care memo* [PDF]. Oregon Prescription Drug Affordability Board. Retrieved from https://dfr.oregon.gov/pdab/Documents/PDAB-Commercial-Continuity-of-Care-Memo.pdf.

national commitment to honor qualifying prior authorizations for 90 days during plan transitions.[7]

The policy could reduce out-of-pocket costs for patients during transitions in health coverage.

The recommendation does not estimate potential savings. Oregon reporting does not identify how many prior-authorization requests follow a plan change or the resulting costs for health plans, prescribers, or patients. The supportable rationale for the policy is continuity-of-care, reduced duplication, and prevention of avoidable transition-related expenses while health plans gather updated data.

Arguments against the recommendation

The policy could increase health plan costs if it leads to coverage of prescription drug claims that were previously denied. Increased health plan costs could lead to increased insurance premiums for purchasers of individual and group health benefit plans in future years. The 90-day transition period may increase a receiving plan's drug spending if it pays for claims it otherwise would have denied during that period. Plans may also incur costs to obtain prior coverage information, review the drug, and notify members and prescribers. These costs could affect future premiums, and the size of the impact is unknown. Available Oregon data do not establish how many members would use the transition protection or the resulting costs or savings.

The policy could increase health plan administrative costs if health plans need to provide additional individualized information for new members and transmit information about former members to the individual's new health plan. The recommendation does not estimate potential costs. Available data does not identify how many patients discontinue or change a medication following a health plan change.

[7] 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; 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; 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/; 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; 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

Implementation and oversight

- Authorize the Department of Consumer and Business Services to adopt rules for documentation, secure transfer, pharmacy messaging, notices to members, privacy safeguards, complaints, corrective action, and limited exceptions.
- Coordinate state requirements with evolving federal inter-operability standards without making Oregon protection dependent on a future federal rule. Currently, finalized federal prior-authorization APIs (application programming interfaces) do not provide a complete prescription drug transfer solution.[8]
- Require aggregate reporting on use of the transition period, review outcomes, processing time, treatment interruptions, and complaints; evaluate implementation after two years while avoiding duplicate reporting.
- Acknowledge that self-funded employer plans governed by ERISA are generally outside Oregon insurance authority. A receiving Oregon-regulated health plan may accept documentation from prior health coverage that the state cannot regulate. If prior coverage does not qualify for 90-day protection, the receiving plan must promptly tell the member and prescriber why, explain what is needed to obtain coverage under the new plan, and provide applicable appeal information.

Requested legislative action

Enact a targeted prescription-drug continuity-of-care requirement that establishes the 90-day prescription-drug continuity-of-care period and core payer duties in statute, with operational standards developed through rulemaking. The legislation would supplement Oregon's existing step therapy, utilization review, notice, adverse benefit determination, and appeal protections rather than replace them.

[8] Centers for Medicare & Medicaid Services. (2024, January 17). *CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)*. U.S. Department of Health & Human Services. Retrieved from https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-prior-authorization-final-rule-cms-0057-f