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Health Care Network Adequacy

(HB 2468)

Background: It's often difficult and confusing for consumers to understand what they're buying when they purchase a health benefit plan. In order for consumers to make informed decisions about their health and finances, they need to be able to determine the value of an insurance policy and find out what providers the plan covers.. House Bill 2468 creates standards for insurers' provider networks and increases transparency about providers covered by a plan. This proposed legislation will ensure that consumers receive appropriate care within a reasonable amount of time, can determine whether providers are included in specific networks, and can compare networks when shopping for plans.

The Affordable Care Act (ACA) requires health benefit plans sold through exchanges to meet federal minimum network adequacy standards. However, it is important for Oregon to move forward with establishing network adequacy requirements now to ensure that all consumers who purchase individual and small group health benefit plans – on and off the exchange – have access to the same information and assurance of an adequate provider network.

Current Oregon law does not meet federal minimum requirements under the ACA and does not grant the Department of Consumer and Business Services (DCBS) authority to establish and enforce provisions to ensure consumers have adequate access to appropriate care. House Bill 2468 satisfies the current federal minimum requirements and requires those minimum requirements to apply to all plans, both on and off the exchange. The current version of the draft bill would become effective for plans issued or renewed on and after Jan. 1, 2017.

DCBS worked with an advisory committee composed of insurers, consumer representatives, medical providers, and rural health experts to develop this proposed legislation. We carefully balanced the need for clear standards for insurers with the need for continued innovation that benefits consumers.

Concept: Insurers will be required to submit an annual report to DCBS demonstrating that its provider networks are adequate using one of two methods:

- Factor-based approach: insurers will demonstrate adequacy through compliance with a selection of factors to be established by rule; or
- Nationally-recognized approach: insurers will demonstrate adequacy through compliance with a nationally-recognized standard (such as the existing Medicare standard) to be identified by rule.

The bill also requires insurers to publish an online version of their provider directories and, upon request, a printed format. DCBS will establish by rule specific requirements regarding frequency and content of the provider directory updates. In general, directories will need to be updated periodically and display a date to ensure consumers know how recent the information is. Directories also will include a disclosure advising consumers to confirm network coverage with insurers and providers.

The advisory committee provided feedback on several elements of the concept after the original bill language was drafted. The department has requested amendments addressing this feedback, listed on the reverse side of this document.

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Proposed Amendments to HB 2468

The department has requested amendments to address feedback provided by the advisory committee on several elements of the concept after the original bill language was drafted.

The amendments:

- Require insurers to demonstrate how they ensure their networks include an adequate number of providers offering care to populations residing in low-income or Health Professional Shortage Areas for plans sold outside of the exchange.

- Clarify the scope of rulemaking associated with provider non-discrimination to align future Oregon rules with federal requirements.

- Remove the prescription drug formulary non-discrimination language and associated references to it. This issue is not necessarily related to provider networks and requires further discussion.

- Change the description of the factor-based approach to more clearly describe how this method of compliance will work.

- Change the description of the nationally-recognized approach to specify that the nationally-recognized standard will be adjusted as needed to reflect the age demographics of the covered population.

- Change the language related to submission of provider contracts to clarify the department's intent not to require submission of provider contracts in conjunction with an insurer's demonstration of network adequacy.

- Clarify the scope of rulemaking associated with the definition of Essential Community Provider to align future Oregon rules with federal requirements.

- Restrict the applicability of the bill to the large group market by only requiring coverage offered to large groups to comply with the provider directory requirements. The department is concerned that persons enrolled in large group health benefit plans should enjoy the same level of consumer protection provided for persons insured under individual and small group plans; however, there are unique aspects of the large group market that have not yet been fully discussed by the advisory committee. The department plans to continue discussion of the applicability to the large group market for consideration in future legislative sessions.