Seventy-Eighth Oregon Legislative Assembly - 2015 Regular Session **MEASURE: HB 2468 A**
STAFF MEASURE SUMMARY **CARRIER: Rep. Greenlick**
House Committee On Health Care

Fiscal:	Has minimal fiscal impact
Revenue:	No Revenue Impact
Action Date:	03/25/15
Action:	Do Pass As Amended And Be Printed Engrossed.
Meeting Dates:	02/16, 03/25
Vote:	
	Yeas: 9 - Buehler, Clem, Greenlick, Hayden, Kennemer, Keny-Guyer, Lively, Nosse, Weidner
Prepared By:	Sandy Thiele-Cirka, Committee Administrator

WHAT THE MEASURE DOES:
Creates standards for insurers' provider networks. Clarifies that the adequacy requirements apply on a plan-specific basis. Grants Department of Consumer and Business Services (DCBS) rulemaking authority and specifies that rules relating to provider non-discrimination must align with federal requirements. Requires insurers to submit an annual report to DCBS demonstrating how the insurers' provider networks meet requirements. Clarifies that the categories to be used in evaluating network adequacy are to use the factor-based approach, that the categories are to be established in statute and that the factors are to be established by rule. Establishes conditions under which DCBS is allowed to access insurers' provider contracts. Establishes operative date on or after January 1, 2017.

ISSUES DISCUSSED:

- Department of Consumer and Business Services Network Adequacy Workgroup
- Mechanism necessary to monitor sufficient supply of providers
- Affordable Care Act requirements
- Provider network transparency
- Need for network innovation
- Continued improvement in health care transparency
- Proposed amendments
- Amendment review
- Concerns relating to areas with existing provider shortage

EFFECT OF COMMITTEE AMENDMENT:
Clarifies that the adequacy requirements apply on a plan-specific basis. Grants DCBS rulemaking authority. Specifies that rules relating to provider non-discrimination must align with federal requirements. Directs insurers to submit annual report to DCBS demonstrating how the insurers' provider networks meet requirements. Clarifies that the categories to be used in evaluating network adequacy are to use the factor-based approach, that the categories are to be established in statute and that the factors are to be established by rule. Establishes conditions under which DCBS is allowed to access insurers' provider contracts. Deletes language relating to discrimination against enrollees based on health status through provider network design including composition of a drug formulary. Establishes operative date on or after January 1, 2017.

BACKGROUND:
Currently, qualified health plans sold through the insurance exchange are required to meet minimum standards established by the Affordable Care Act (ACA), including required standards for health care network adequacy. These plans are regulated by the Department of Consumer and Business Services (DCBS), Insurance Division. Oregon law does not meet federal minimum requirements under the ACA and does not grant DCBS authority to establish and enforce provisions to ensure consumers have adequate access to appropriate care.

House Bill 2468-A establishes standards applicable to individual and small-group commercial health benefit plans providing coverage through provider networks to ensure consumers have adequate access to care and online or printed access to provider directories.