2015 ORS 743B.505¹ Provider networks

rules

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(1)An insurer offering a health benefit plan in this state that provides coverage to individuals or to small employers, as defined in ORS **743B.005** (Definitions), through a specified network of health care providers shall:

(a)Contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers to ensure that all covered services under the health benefit plan, including mental health and substance abuse treatment, are accessible to enrollees without unreasonable delay.

(b)(A) With respect to health benefit plans offered through the health insurance exchange under ORS 741.310 (Requirements for purchase of insurance through exchange and for participation of insurers in exchange), contract with a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of essential community providers for low-income, medically underserved individuals in the plan's service area in accordance with the network adequacy

standards established by the Department of Consumer and Business Services;

(B)If the health benefit plan offered through the health insurance exchange offers a majority of the covered services through physicians employed by the insurer or through a single contracted medical group, have a sufficient number and geographic distribution of employed or contracted providers and hospital facilities to ensure reasonable and timely access for low-income, medically underserved enrollees in the plan's service area, in accordance with network adequacy standards adopted by the Department of Consumer and Business Services; **or**

(C)With respect to health benefit plans offered outside of the health insurance exchange, contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers to ensure access to care by enrollees who reside in locations within the health benefit plan's service area that are designated by the Health Resources and Services Administration of the United States Department of Health and Human Services as health professional shortage areas or low-income zip codes.

(c)Annually report to the Department of Consumer and Business Services, in the format prescribed by the department, the insurer's plan for ensuring that the network of providers for each health benefit plan meets the requirements of this section.

(2)(a) An insurer may not discriminate with respect to participation under a health benefit plan or coverage under the plan against any health care provider who is acting within the scope of the provider's license or certification in this state.

(b)This subsection does not require an insurer to contract with any health care provider who is willing to abide by the insurer's terms and conditions for participation established by the insurer.

(c)This subsection does not prevent an insurer from establishing varying reimbursement rates based on quality or performance measures.

(d)Rules adopted by the Department of Consumer and Business Services to implement this section shall be consistent with the provisions of 42 U.S.C. 300gg-5 and the rules adopted by the United States Department of Health and

Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 300gg-5.

(3) The Department of Consumer and Business Services shall use one of the following methods in evaluating whether the network of providers available to enrollees in a health benefit plan meets the requirements of this section:

(a)An approach by which an insurer submits evidence that the insurer is complying with at least one of the factors prescribed by the department by rule from each of the following categories:

(A)Access to care consistent with the needs of the enrollees served by the network;

(B)Consumer satisfaction;

(C)Transparency; and

(D)Quality of care and cost containment; or

(b)A nationally recognized standard adopted by the department and adjusted, as necessary, to reflect the age demographics of the enrollees in the plan.

(4) This section does not require an insurer to contract with an essential community provider that refuses to accept the insurer's generally applicable payment rates for services covered by the plan.

(5) This section does not require an insurer to submit provider contracts to the department for review. [2015 c.59 §2]

Note: **743B.505 (Provider networks)** becomes operative January 1, 2017. See section 11, chapter 59, Oregon Laws 2015.

Note: **743B.505 (Provider networks)** was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743B or any series therein. See Preface to Oregon Revised Statutes for further explanation. v Coward banchi, limit noted - NC Wild a covered battefit - *** Assumed, not specifically stated

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