# House Bill 2186

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of House Interim Committee on Health Care for former Representative A. Richard Vial)

**SUMMARY**

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Adds further specification to prohibition on discrimination against health care providers by insurers in participation in or coverage under health benefit plan. Requires Department of Consumer and Business Services to adopt rules and report to interim committees of Legislative Assembly related to health regarding adoption of rules.

**A BILL FOR AN ACT**

Relating to discrimination against health care providers; creating new provisions; and amending ORS 743B.505.

**Be It Enacted by the People of the State of Oregon:**

**SECTION 1.** ORS 743B.505 is amended to read:

743B.505. (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, 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, 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.

**NOTE:** Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(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*] **in** a health benefit plan or coverage under the plan against any **licensed or certified** 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*] **all** health care [*provider who is*] **providers who are** willing to abide by the [*insurer's*] terms and conditions [*for participation*] established by the insurer **for participation in a health benefit plan**.

(c) This subsection does not prevent an insurer from establishing varying reimbursement rates based on quality or performance measures **so long as the rates apply uniformly to all types of licensed or certified health care providers**.

[*(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 that are in effect on January 1, 2017.*]

**(d) An insurer discriminates against a health care provider with respect to participation in a health benefit plan or coverage under a health benefit plan if the insurer:**

**(A) Denies reimbursement for a covered service based on the licensure or certification of the provider and the service is within the scope of practice authorized by the provider's licensing or certifying entity; or**

**(B) Offers a health benefit plan in this state that effectively denies reimbursement for a covered service based on the licensure or certification of the provider through the use of exclusions, utilization reviews or other terms or conditions.**

(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.

**SECTION 2. No later than July 1, 2020, the Department of Consumer and Business Services shall adopt rules to carry out the provisions of ORS 743B.505.**

**SECTION 3. (1) The Director of the Department of Consumer and Business Services shall report to the interim committees of the Legislative Assembly related to health on the adoption of the rules described in section 2 of this 2019 Act.**

**(2) The report under subsection (1) of this section shall be submitted as provided in ORS 192.245 no later than July 5, 2020.**

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