

# House Bill 2694

Sponsored by Representative NOSSE, Senator BEYER; Representative SCHOUTEN (Presession filed.)

## 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**.

Requires insurer that credentials one primary care provider who is part of medical group to credential all primary care providers in same medical group if they are licensed or certified and in good standing with their licensing boards. Requires insurer to reimburse all primary care providers within medical group at same rate unless variance is based on published performance standards. Defines "primary care" and "primary care provider."

## A BILL FOR AN ACT

1  
2 Relating to primary care providers; creating new provisions; and amending ORS 743B.005 and  
3 743B.505.

4 Whereas statewide access to affordable primary care will be expanded by removing barriers to  
5 the credentialing of qualified primary care providers by health insurers; now, therefore,

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

7 **SECTION 1. Section 2 of this 2019 Act is added to and made a part of the Insurance Code.**

8 **SECTION 2. (1) As used in this section:**

9 (a) "Medical group" means an association, partnership, limited liability company, corpo-  
10 ration or other business entity organized for the purpose of providing primary care.

11 (b) "Primary care" means family medicine, general internal medicine, obstetrics and gy-  
12 necology or pediatrics.

13 (c) "Primary care provider" means a physician licensed under ORS 677.100 to 677.228,  
14 naturopath, nurse practitioner or physician assistant, whose clinical practice is in the area  
15 of primary care.

16 (2) If an insurer credentials a primary care provider to be reimbursed by the insurer for  
17 care provided to enrollees in a health benefit plan offered by the insurer and the provider is  
18 part of or employed by a medical group, the insurer shall credential all of the primary care  
19 providers in the medical group who are in good standing with their health licensing boards.

20 (3)(a) Except as provided in paragraph (b) of this subsection, an insurer shall reimburse  
21 the cost of services provided by primary care providers within a medical group at the same  
22 rate.

23 (b) An insurer may vary the rate of reimbursement paid to primary care providers in a  
24 medical group based only on published clinical performance standards.

25 **SECTION 3. ORS 743B.005 is amended to read:**

26 743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and  
27 743B.128 **and section 2 of this 2019 Act:**

28 (1) "Actuarial certification" means a written statement by a member of the American Academy  
29 of Actuaries or other individual acceptable to the Director of the Department of Consumer and  
30 Business Services that a carrier is in compliance with the provisions of ORS 743B.012 based upon

**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.

1 the person's examination, including a review of the appropriate records and of the actuarial as-  
 2 sumptions and methods used by the carrier in establishing premium rates for small employer health  
 3 benefit plans.

4 (2) "Affiliate" of, or person "affiliated" with, a specified person means any carrier who, directly  
 5 or indirectly through one or more intermediaries, controls or is controlled by or is under common  
 6 control with a specified person. For purposes of this definition, "control" has the meaning given that  
 7 term in ORS 732.548.

8 (3) "Affiliation period" means, under the terms of a group health benefit plan issued by a health  
 9 care service contractor, a period:

10 (a) That is applied uniformly and without regard to any health status related factors to an  
 11 enrollee or late enrollee;

12 (b) That must expire before any coverage becomes effective under the plan for the enrollee or  
 13 late enrollee;

14 (c) During which no premium shall be charged to the enrollee or late enrollee; and

15 (d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs  
 16 concurrently with any eligibility waiting period under the plan.

17 (4) "Bona fide association" means an association that:

18 (a) Has been in active existence for at least five years;

19 (b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

20 (c) Does not condition membership in the association on any factor relating to the health status  
 21 of an individual or the individual's dependent or employee;

22 (d) Makes health insurance coverage that is offered through the association available to all  
 23 members of the association regardless of the health status of the member or individuals who are  
 24 eligible for coverage through the member;

25 (e) Does not make health insurance coverage that is offered through the association available  
 26 other than in connection with a member of the association;

27 (f) Has a constitution and bylaws; and

28 (g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

29 (5) "Carrier" means any person who provides health benefit plans in this state, including:

30 (a) A licensed insurance company;

31 (b) A health care service contractor;

32 (c) A health maintenance organization;

33 (d) An association or group of employers that provides benefits by means of a multiple employer  
 34 welfare arrangement and that:

35 (A) Is subject to ORS 750.301 to 750.341; or

36 (B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by  
 37 ORS 743B.010 to 743B.013; or

38 (e) Any other person or corporation responsible for the payment of benefits or provision of ser-  
 39 vices.

40 (6) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms  
 41 of the health benefit plan covering the employee.

42 (7) "Eligible employee" means an employee who is eligible for coverage under a group health  
 43 benefit plan.

44 (8) "Employee" means any individual employed by an employer.

45 (9) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible

1 for a group or individual health benefit plan who has enrolled for coverage under the terms of the  
 2 plan.

3 (10) "Exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031,  
 4 18032, 18033 and 18041.

5 (11) "Exclusion period" means a period during which specified treatments or services are ex-  
 6 cluded from coverage.

7 (12) "Financial impairment" means that a carrier is not insolvent and is:

8 (a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

9 (b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

10 (13)(a) "Geographic average rate" means the arithmetical average of the lowest premium and the  
 11 corresponding highest premium to be charged by a carrier in a geographic area established by the  
 12 director for the carrier's:

13 (A) Group health benefit plans offered to small employers; or

14 (B) Individual health benefit plans.

15 (b) "Geographic average rate" does not include premium differences that are due to differences  
 16 in benefit design, age, tobacco use or family composition.

17 (14) "Grandfathered health plan" has the meaning prescribed by rule by the United States Sec-  
 18 retaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e) that  
 19 is in effect on January 1, 2017.

20 (15) "Group eligibility waiting period" means, with respect to a group health benefit plan, the  
 21 period of employment or membership with the group that a prospective enrollee must complete be-  
 22 fore plan coverage begins.

23 (16)(a) "Health benefit plan" means any:

24 (A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

25 (B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or

26 (C) Plan provided by a multiple employer welfare arrangement or by another benefit arrange-  
 27 ment defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the  
 28 extent that the plan is subject to state regulation.

29 (b) "Health benefit plan" does not include:

30 (A) Coverage for accident only, specific disease or condition only, credit or disability income;

31 (B) Coverage of Medicare services pursuant to contracts with the federal government;

32 (C) Medicare supplement insurance policies;

33 (D) Coverage of TRICARE services pursuant to contracts with the federal government;

34 (E) Benefits delivered through a flexible spending arrangement established pursuant to section  
 35 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition  
 36 to a group health benefit plan;

37 (F) Separately offered long term care insurance, including, but not limited to, coverage of nurs-  
 38 ing home care, home health care and community-based care;

39 (G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity in-  
 40 surance;

41 (H) Short term health insurance policies that are in effect for periods of three months or less,  
 42 including the term of a renewal of the policy;

43 (I) Dental only coverage;

44 (J) Vision only coverage;

45 (K) Stop-loss coverage that meets the requirements of ORS 742.065;

1 (L) Coverage issued as a supplement to liability insurance;

2 (M) Insurance arising out of a workers' compensation or similar law;

3 (N) Automobile medical payment insurance or insurance under which benefits are payable with  
4 or without regard to fault and that is statutorily required to be contained in any liability insurance  
5 policy or equivalent self-insurance; or

6 (O) Any employee welfare benefit plan that is exempt from state regulation because of the fed-  
7 eral Employee Retirement Income Security Act of 1974, as amended.

8 (c) For purposes of this subsection, renewal of a short term health insurance policy includes the  
9 issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days  
10 after the expiration of a policy previously issued by the insurer to the policyholder.

11 (17) "Individual health benefit plan" means a health benefit plan:

12 (a) That is issued to an individual policyholder; or

13 (b) That provides individual coverage through a trust, association or similar group, regardless  
14 of the situs of the policy or contract.

15 (18) "Initial enrollment period" means a period of at least 30 days following commencement of  
16 the first eligibility period for an individual.

17 (19) "Late enrollee" means an individual who enrolls in a group health benefit plan subsequent  
18 to the initial enrollment period during which the individual was eligible for coverage but declined  
19 to enroll. However, an eligible individual shall not be considered a late enrollee if:

20 (a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg  
21 or as prescribed by rule by the Department of Consumer and Business Services;

22 (b) The individual applies for coverage during an open enrollment period;

23 (c) A court issues an order that coverage be provided for a spouse or minor child under an  
24 employee's employer sponsored health benefit plan and request for enrollment is made within 30  
25 days after issuance of the court order;

26 (d) The individual is employed by an employer that offers multiple health benefit plans and the  
27 individual elects a different health benefit plan during an open enrollment period; or

28 (e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a  
29 publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance  
30 program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for  
31 coverage in a group health benefit plan.

32 (20) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement  
33 as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended,  
34 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

35 (21) "Preexisting condition exclusion" means:

36 (a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of  
37 coverage based on a medical condition being present before the effective date of coverage or before  
38 the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was  
39 recommended or received for the condition before the date of coverage or denial of coverage.

40 (b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late  
41 enrollee that excludes coverage for services, charges or expenses incurred during a specified period  
42 immediately following enrollment for a condition for which medical advice, diagnosis, care or treat-  
43 ment was recommended or received during a specified period immediately preceding enrollment. For  
44 purposes of this paragraph pregnancy and genetic information do not constitute preexisting condi-  
45 tions.

1 (22) "Premium" includes insurance premiums or other fees charged for a health benefit plan,  
2 including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by  
3 the plan.

4 (23) "Rating period" means the 12-month calendar period for which premium rates established  
5 by a carrier are in effect, as determined by the carrier.

6 (24) "Representative" does not include an insurance producer or an employee or authorized  
7 representative of an insurance producer or carrier.

8 (25) "Small employer" means an employer who employed an average of at least one but not more  
9 than 50 full-time equivalent employees on business days during the preceding calendar year and who  
10 employs at least one full-time equivalent employee on the first day of the plan year, determined in  
11 accordance with a methodology prescribed by the Department of Consumer and Business Services  
12 by rule.

13 **SECTION 4.** ORS 743B.505 is amended to read:

14 743B.505. (1) An insurer offering a health benefit plan in this state that provides coverage to  
15 individuals or to small employers, as defined in ORS 743B.005, through a specified network of health  
16 care providers shall:

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

21 (b)(A) With respect to health benefit plans offered through the health insurance exchange under  
22 ORS 741.310, contract with a sufficient number and geographic distribution of essential community  
23 providers, where available, to ensure reasonable and timely access to a broad range of essential  
24 community providers for low-income, medically underserved individuals in the plan's service area in  
25 accordance with the network adequacy standards established by the Department of Consumer and  
26 Business Services;

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

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

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

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

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

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

5 (d) Rules adopted by the Department of Consumer and Business Services to implement this sec-  
6 tion shall be consistent with the provisions of 42 U.S.C. 300gg-5 and the rules adopted by the United  
7 States Department of Health and Human Services, the United States Department of the Treasury  
8 or the United States Department of Labor to carry out 42 U.S.C. 300gg-5 that are in effect on Jan-  
9 uary 1, 2017.

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

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

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

16 (B) Consumer satisfaction;

17 (C) Transparency; and

18 (D) Quality of care and cost containment; or

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

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

24 (5) This section does not require an insurer to submit provider contracts to the department for  
25 review.

26