SB 1046-1
(LC 4092)
3/14/23 (LHF/ps)

Requested by SENATE COMMITTEE ON HEALTH CARE (at the request of Governor Tina Kotek)

PROPOSED AMENDMENTS TO
SENATE BILL 1046

On page 1 of the printed bill, line 2, after "ORS" insert "743A.058 and".

Delete lines 4 through 31 and delete pages 2 and 3 and insert:

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

"743B.505. (1) [*An insurer*] **A carrier** offering [*a*] **an individual or group** 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*] **use disorder and reproductive health care and treatment**, are accessible**:**

"(A) To **all** enrollees for initial and follow-up appointments [*without unreasonable delay.*]**; and**

"(B) In an appropriate and culturally competent manner to all enrollees, including those with diverse cultural and ethnic backgrounds, varying sexual orientations and gender identities, disabilities or physical or mental health conditions.

"(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 avail-

able, 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*] **carrier** 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**, as prescribed by the department by rule**.

"(c) Annually report to the department [*of Consumer and Business Services*], in the format prescribed by the department, the [*insurer's*] **carrier's** network of providers for each health benefit plan.

"(2)(a) [*An insurer*] **A carrier** 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*] **a carrier** to contract with any health care provider who is willing to abide by the [*insurer's*] **carrier's** terms and conditions for participation established by the [*insurer*]

carrier.

"(c) This subsection does not prevent [*an insurer*] **a carrier** 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*] **subsection** 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.

"(3) The Department of Consumer and Business Services shall [*use one of the following methods in*] **conduct** an annual evaluation of 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)*] **using** a nationally recognized standard adopted by the department and adjusted, as necessary, to reflect the age demographics of the enrollees in the plan.

"**(4)(a) The department shall adopt by rule standards for evaluating, under subsection (3) of this section, the adequacy of a carrier's network of providers in meeting the requirements of subsection (1) of this section and ensuring access by enrollees to initial and follow-up care without unreasonable delay. The standards may include but are not**

limited to:

"(A) Standards for geographic access to ensure that specified providers are located within a reasonable distance of the homes and workplaces of all of the enrollees in the carrier's plans;

"(B) Provider to patient ratios to ensure that a sufficient number of providers are available within the carrier's network to serve all of the enrollees in the carrier's plans; and

"(C) Limits on the amount of time an enrollee must wait to be seen to ensure that enrollees in the carrier's plans are not required to wait longer than a specified interval of time between when they request care and when they receive various forms of care.

"[*(4)*] **(b)** [*In evaluating an insurer's*] **Standards adopted by rule by the department to evaluate a carrier's** network of mental and behavioral health providers under subsection (3) of this section[*, the department shall*] **must** ensure that the network includes[*:*]

"[*(a)*] an adequate number and geographic distribution **in all geographic areas where the carrier offers plans**, as prescribed by the department by rule, of licensed professional counselors, licensed marriage and family therapists, licensed clinical social workers, psychologists and psychiatrists who are accepting new patients, based on the needs of the [*insureds under the policy or certificate*] **enrollees in the carrier's plans**, including but not limited to providers who can address the needs of:

"(A) Children and adults;

"(B) Individuals with limited English proficiency or who are illiterate;

"(C) Individuals with diverse cultural or ethnic backgrounds;

"(D) Individuals with chronic or complex behavioral health conditions; and

"(E) Other groups specified by the department by rule[*; and*]**.**

"[*(b) An adequate number of the providers described in paragraph (a) of this subsection in all geographic areas where the insurer offers plans.*]

"(5) This section does not require [*an insurer*] **a carrier** to contract with an essential community provider that refuses to accept the [*insurer's*] **carrier's** generally applicable payment rates for services covered by the plan.

"(6) This section does not require [*an insurer*] **a carrier** to submit provider contracts to the department for review.

"**(7) As used in this section, 'carrier' and 'small employers' have the meanings given those terms in ORS 743B.005.**

"SECTION 2. ORS 743A.058 is amended to read:

"743A.058. (1) As used in this section:

"(a)(A) 'Audio only' means the use of audio telephone technology, permitting real-time communication between a health care provider and a patient for the purpose of diagnosis, consultation or treatment.

"(B) 'Audio only' does not include:

"(i) The use of facsimile, electronic mail or text messages.

"(ii) The delivery of health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care provider, such as the sharing of laboratory results.

"(b) 'Health benefit plan' has the meaning given that term in ORS 743B.005.

"(c) 'Health professional' means a person licensed, certified or registered in this state to provide health care services or supplies.

"(d) 'Health service' means physical, oral and behavioral health treatment or service provided by a health professional.

"(e) 'Originating site' means the physical location of the patient.

"(f) 'State of emergency' includes:

"(A) A state of emergency declared by the Governor under ORS 401.165; or

"(B) A state of public health emergency declared by the Governor under ORS 433.441.

"(g) 'Telemedicine' means the mode of delivering health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a patient's health care.

"(2) A health benefit plan and a dental-only plan must provide coverage of a health service that is provided using telemedicine if:

"(a) The plan provides coverage of the health service when provided in person by a health professional;

"(b) The health service is medically necessary;

"(c) The health service is determined to be safely and effectively provided using telemedicine according to generally accepted health care practices and standards; and

"(d) The application and technology used to provide the health service meet all standards required by state and federal laws governing the privacy and security of protected health information.

"(3) Except as provided in subsection (4) of this section, permissible telemedicine applications and technologies include:

"(a) Landlines, wireless communications, the Internet and telephone networks; and

"(b) Synchronous or asynchronous transmissions using audio only, video only, audio and video and transmission of data from remote monitoring devices.

"(4) During a state of emergency, a health benefit plan or dental-only plan shall provide coverage of a telemedicine service delivered to an enrollee residing in the geographic area specified in the declaration of the state of emergency, if the telemedicine service is delivered using any commonly available technology, regardless of whether the technology meets all standards required by state and federal laws governing the privacy and security of protected health information.

"(5) A health benefit plan and a dental-only plan may not:

"(a) Distinguish between rural and urban originating sites in providing coverage under subsection (2) of this section or restrict originating sites that qualify for reimbursement.

"(b) Restrict a health care provider to delivering services only in person or only via telemedicine.

"(c) Use telemedicine health care providers to meet network adequacy standards under ORS 743B.505**, except as permitted by the Department of Consumer and Business Services under criteria prescribed by the department by rule**.

"(d) Require an enrollee to have an established patient-provider relationship with a provider to receive telemedicine health services from the provider or require an enrollee to consent to telemedicine services in person.

"(e) Impose additional certification, location or training requirements for telemedicine providers or restrict the scope of services that may be provided using telemedicine to less than a provider's permissible scope of practice.

"(f) Impose more restrictive requirements for telemedicine applications and technologies than those specified in subsection (3) of this section.

"(g) Impose on telemedicine health services different annual dollar maximums or prior authorization requirements than the annual dollar maximums and prior authorization requirements imposed on the services if provided in person.

"(h) Require a medical assistant or other health professional to be present with an enrollee at the originating site.

"(i) Deny an enrollee the choice to receive a health service in person or via telemedicine.

"(j) Reimburse an out-of-network provider at a rate for telemedicine health services that is different than the reimbursement paid to the out-of-network provider for health services delivered in person.

"(k) Restrict a provider from providing telemedicine services across state lines if the services are within the provider's scope of practice and:

"(A) The provider has an established practice within this state;

"(B) The provider's employer operates health clinics or licensed health care facilities in this state;

"(C) The provider has an established relationship with the patient; or

"(D) The patient was referred to the provider by the patient's primary care or specialty provider located in this state.

"(L) Prevent a provider from prescribing, dispensing or administering drugs or medical supplies or otherwise providing treatment recommendations to an enrollee after having performed an appropriate examination of the enrollee in person, through telemedicine or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically.

"(m) Establish standards for determining medical necessity for services delivered using telemedicine that are higher than standards for determining medical necessity for services delivered in person.

"(6) A health benefit plan and a dental-only plan shall:

"(a) Work with contracted providers to ensure meaningful access to telemedicine services by assessing an enrollee's capacity to use telemedicine technologies that comply with accessibility standards, including alternate formats, and providing the optimal quality of care for the enrollee given the enrollee's capacity;

"(b) Ensure access to auxiliary aids and services to ensure that telemedicine services accommodate the needs of enrollees who have difficulty communicating due to a medical condition, who need an accommodation due to disability or advanced age or who have limited English proficiency;

"(c) Ensure access to telemedicine services for enrollees who have limited English proficiency or who are deaf or hard-of-hearing by providing interpreter services reimbursed at the same rate as interpreter services provided in person; and

"(d) Ensure that telemedicine services are culturally and linguistically

appropriate and trauma-informed.

"(7) The coverage under subsection (2) of this section is subject to:

"(a) The terms and conditions of the health benefit plan or dental-only plan; and

"(b) Subject to subsection (8) of this section, the reimbursement specified in the contract between the plan and the health professional.

"(8)(a) A health benefit plan and dental-only plan must pay the same reimbursement for a health service regardless of whether the service is provided in person or using any permissible telemedicine application or technology.

"(b) Paragraph (a) of this subsection does not prohibit the use of value-based payment methods, including capitated, bundled, risk-based or other value-based payment methods, and does not require that any value-based payment method reimburse telemedicine health services based on an equivalent fee-for-service rate.

"(9) This section does not require a health benefit plan or dental-only plan to reimburse a health professional:

"(a) For a health service that is not a covered benefit under the plan;

"(b) Who has not contracted with the plan; or

"(c) For a service that is not included within the Healthcare Procedure Coding System or the American Medical Association's Current Procedural Terminology codes or related modifier codes.

"(10) This section is exempt from ORS 743A.001.".

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