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SB 1046: Network Adequacy

Network adequacy refers to the ability of a health plan to provide enrollees with timely access to a sufficient number of in-network providers. In Oregon, the Department of Consumer and Business Services (department) regulates network adequacy as it relates to the commercial health insurance market, which includes fully insured employer group plans and individual health benefit plans providing coverage to approximately 25 percent of the state's population.

ORS 743B.505 establishes minimum standards for health benefit plan provider networks. The law requires insurers to contract with or employ a network of providers sufficient in number, geographic distribution, and types of providers to ensure that all covered services, including mental health and substance abuse treatment, are accessible to enrollees without unreasonable delay. The law further requires insurers to report to the department annually on their plan for ensuring that the network of providers for each health benefit plan complies with the law.

SB 1046 expands and strengthens network adequacy protections for Oregonians who receive coverage in the commercial marketplace by:

1. **Applying the network adequacy statute to large group health benefit plans.**

The network adequacy statute (ORS 743B.505) applies to individual and small group health benefit plans. Large group plans insure the majority of those receiving commercial coverage in Oregon, with approximately 635,000 insured in this market. Expanding coverage to include large group insurers would ensure network adequacy protections for the majority of those with commercial insurance in Oregon.

2. **Expanding the network adequacy law to advance health equity in network access**

SB 1046 adds a new subsection that requires carriers to contract with or employ a network of providers sufficient in number, geographic distribution, and types of providers to ensure that all covered services are accessible to all enrollees, including those with diverse cultural and ethnic backgrounds, varying sexual orientations and gender identities, disabilities, and physical or mental health conditions. It also directs carriers to provide appropriate, culturally competent care and resources.

Advancing health equity in provider networks is not solely the responsibility of health insurance carriers, as it is highly dependent on provider availability and the ability and willingness of providers to work with carriers to share information and coordinate around health access issues for diverse populations. There are areas where providers may be reluctant to provide information that may become public about services or populations they serve or represent. The department recognizes these dynamics and will focus implementation efforts on ensuring that carriers make a reasonable effort in this area.

3. **Increased focus on access to reproductive health services**

SB 1046 explicitly adds reproductive health services to the services that must be made accessible to all enrollees to clarify that this will be a focus of the department's network adequacy oversight.

4. **Providing the department with authority to set quantitative network adequacy standards.**

Beginning this year, the federal government is taking a more active role in the review of networks for federally facilitated marketplaces. Under the 2023 rule[1], CMS will review Qualified Health Plan (QHP) networks in all federally facilitated marketplace states, unless the state applies and enforces quantitative network adequacy standards at least as stringent as the federal standards. Beginning this year, state network adequacy laws must include compliance with time and distance standards; starting next year, appointment wait time standards must also be considered.

Current network adequacy statutes and rules in Oregon are not as stringent as the federal standard as they do not contain comparable quantitative standards. SB 1046 will enable Oregon to adopt quantitative standards to ensure the state can retain primary oversight of network adequacy.

Ensuring access to a network of providers that can meet quantitative time, distance and wait time standards is also not the sole responsibility of health insurance carriers, as it is highly dependent on provider availability. Quantitative network adequacy standards typically allow for variation related to population density and other factors that affect provider availability, but there may still be instances where there simply are not enough providers available to meet such standards through no fault of the insurer. The department recognizes these dynamics and will focus implementation efforts on ensuring that carriers make a reasonable effort in this area.

5. **Clarifying that the department will evaluate an insurers network adequacy using a nationally recognized standard adopted by the department.**

ORS 743B.505 allows the department to evaluate network adequacy using either a factor based approach or a nationally recognized standard. In practice, the factor-based approach outlined in the statute has not been utilized by insurance carriers, and is not aligned with the department's objectives in network adequacy oversight. Accordingly, SB 1046 would eliminate this option.

6. **-1 Amendment: Allows consideration of telemedicine in network adequacy**

HB 2508 (2021) added provisions to the Oregon Insurance Code's telemedicine statute, ORS 743A.058, prohibiting the use of telemedicine to meet state network adequacy standards. This blanket prohibition has prevented the department from exercising effective oversight in the area of telehealth access, which has become a critical means of accessing needed services for many Oregonians, especially since the COVID-19 pandemic. The -1 amendment would enable the consideration of telemedicine in network adequacy, but solely to the extent permitted by the department by rule.

The intent of this provision is to ensure adequate access both to needed in-person and telemedicine services, and provide consumers with choice in health care access. This provision is in no way intended to enable substitution of telemedical services for access to needed in-person health care services, or vice versa, or to compromise consumer choice in how to access care. Rulemaking to implement this provision will include robust sideboards to ensure that oversight of telemedicine networks advances consumer access to needed care.

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[1] HHS Notice of Benefit and Payment Parameters 2023, Health and Human Services Department, https://www.govinfo.gov/content/pkg/FR-2022-01-05/pdf/2021-28317.pdf