HB 2942-1
(LC 2907)
3/4/25 (EKJ/ps)

Requested by Representative NELSON

PROPOSED AMENDMENTS TO
HOUSE BILL 2942

In line 2 of the printed bill, after the first semicolon delete the rest of the line and insert "amending ORS 414.609, 414.764 and 743B.505; and prescribing an effective".

After line 24 insert:

"SECTION 2. ORS 414.609, as amended by section 10, chapter 70, Oregon Laws 2024, is amended to read:

"414.609. (1) A coordinated care organization that contracts with the Oregon Health Authority must maintain a network of providers, including but not limited to addiction treatment providers, sufficient in numbers and areas of practice and geographically distributed in a manner to ensure that the health services provided under the contract are reasonably accessible to members.

"(2) A member may transfer from one organization to another organization no more than once during each enrollment period.

"**(3) The participation of pharmacies in the coordinated care organization's network drug benefits does not satisfy the network adequacy requirement described in this section for networks to include a sufficient number of pharmacists to provide covered medical services that can be provided within the lawful scope of practice of a pharmacist.**

"SECTION 3. 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 for initial and follow-up appointments 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.

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

"(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 that are in effect on January 1, 2017.

"**(3) The participation of pharmacies in the health benefit plan's network drug benefits does not satisfy the network adequacy requirement described in this section for plans to include a sufficient number of pharmacists to provide covered medical services that can be provided within the lawful scope of practice of a pharmacist.**

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

"[*(4)*] **(5)** In evaluating an insurer's network of mental and behavioral health providers under subsection (3) of this section, the department shall ensure that the network includes:

"(a) An adequate number and geographic distribution, 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, 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)*] **(6)** 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.

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

In line 25, delete “2.” and insert “4.”.