Senate Bill 822

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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.** The statement includes a measure digest written in compliance with applicable readability standards.

Digest: Expands network rules for some health benefit plans. Makes DCBS adopt certain rules. Allows some health and dental plans to use remote providers to meet network rules. (Flesch Readability Score: 72.3).

Expands network adequacy requirements to health benefit plans offered to large employers and modifies requirements. Requires the Department of Consumer and Business Services to adopt specified standards for network adequacy.

Permits a health benefit plan and a dental-only plan to use telemedicine health care providers to meet network adequacy standards only as permitted by rule adopted by the department.

A BILL FOR AN ACT

Relating to provider networks; amending ORS 743A.058 and 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*] **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 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*] **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

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.

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*] **2025**.

(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) A*] **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 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 the enrollees in the carrier's plans; and

(C) Specific limits on the amount of time an enrollee must wait to be seen between requesting care and receiving care.

[*(4)*] **(b)** [*In evaluating an insurer's*] **Standards adopted by the department by rule to evalu-**