Senate Bill 1046
Sponsored by Senator WAGNER (at the request of Governor Tina Kotek)

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.

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

A BILL FOR AN ACT
Relating to provider networks; amending ORS 743B.505.

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

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

ORS 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, or large employers 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:

(B) In a manner that meets the needs of enrollees who face unique challenges in accessing health care, including but not limited to enrollees with diverse cultural and ethnic backgrounds, sexual orientations and gender identities and enrollees with physical and mental disabilities.

(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 standards adopted by the department of Consumer and Business Services;

(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

NOTE: Matter in boldfaced type in an amended section is new; matter in italic and bracketed is existing law to be omitted. New sections are in boldfaced type.

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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.