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2 **Network Adequacy**
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4 **836-053-0300 (NEW)**

5 **Purpose; Statutory Authority; Applicability of Network Adequacy Requirements**
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7 (1) OAR 836-053-0300 to 836-053-0350 are adopted for the purpose of implementing ORS
8 743B.505.

9 (2) The requirements set forth in OAR 836-053-0320 to 836-053-0340 apply to all insurers
10 offering individual or small group health benefit plans in this state that are issued or renewed on
11 or after January 1, 2017.

12 (3) The requirements set forth in OAR 836-053-0310 and 836-053-0350 apply to all insurers
13 offering individual, large group, or small group health benefit plans in this state that are issued or
14 renewed on or after January 1, 2017.

15 Stat. Auth: ORS 731.244 and 743B.505

16 Stats. Implemented: 743B.505
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19 **836-053-0310 (NEW)**

20 **Network Adequacy Definitions for OAR 836-053-0300 to 836-053-0350**
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22 (1) As used in these rules:

23 (a) "Enrollee" means an employee, dependent of the employee or an individual otherwise
24 eligible for a group or individual health benefit plan who has enrolled for coverage under the
25 terms of the plan.

26 (b) "Insurer includes a health care service contractor as defined in ORS 750.005.

27 (c) "Health benefit plan" means any:

28 (A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

29 (B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or

30 (C) Plan provided by a multiple employer welfare arrangement or by another benefit
31 arrangement defined in the federal Employee Retirement Income Security Act of 1974, as
32 amended, to the extent that the plan is subject to state regulation.

33 (d) "Network plan" means a health benefit plan that either requires an enrollee to use, or creates
34 incentives, including financial incentives, for an enrollee to use health care providers managed,
35 owned, under contract with or employed by the insurer.

36 [\(e\) "Marketplace" means health insurance exchange as defined in OAR 945-001-002\(21\).](#)

37 Stat. Auth: ORS 731.244 and 743B.505

38 Stats. Implemented: 743B.505
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41 **836-053-0320 (NEW)**

42 **Annual Report Requirements for Network Adequacy**
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44 (1) An insurer offering individual or small group health benefits plans must submit its annual
45 report for each network required under ORS 743B.505 no later than March 31 of each year.

46 (2) The annual report shall include at least the following information:

- 1 (a) Identification of the insurer's network, including plans to which the network applies, how the
2 use of telemedicine or telehealth or other technology may be used to meet network access
3 standards;
- 4 (b) The insurer's procedures for making and authorizing referrals within and outside its network,
5 if applicable;
- 6 (c) The insurer's procedures for monitoring and assuring on an ongoing basis the sufficiency of
7 the network to meet the health care needs of populations that enroll in network plans;
- 8 (d) The factors used by the insurer to build its provider network, including a description of the
9 network and the criteria used to select or tier providers;
- 10 (e) The insurer's efforts to address the needs of enrollees, including, but not limited to children
11 and adults, including those with limited English proficiency or illiteracy, diverse cultural or
12 ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical
13 conditions. This information must include the insurer's efforts, when appropriate, to include
14 various types of essential community providers in its network;
- 15 (f) The insurer's process for ensuring networks for plans sold outside of the marketplace provide
16 enrollees who reside in low-income zip code areas or who reside in health professional shortage
17 areas with adequate access to care without delay;
- 18 (g) The insurer's methods for assessing the health care needs of enrollees and their satisfaction
19 with services;
- 20 (h) The insurer's method of informing enrollees of the plan's covered services and features,
21 including but not limited to:
- 22 (A) The plan's grievance and appeals procedures;
- 23 (B) Its process for choosing and changing providers;
- 24 (C) Its process for updating its provider directories for each of its network plans;
- 25 (D) A statement of health care services offered, including those services offered through the
26 preventive care benefit, if applicable; and
- 27 (E) Its procedures for covering and approving emergency, urgent and specialty care, if
28 applicable.
- 29 (i) The insurer's system for ensuring the coordination and continuity of care:
- 30 (A) For enrollees referred to specialty physicians; and
- 31 (B) For enrollees using ancillary services, including social services and other community
32 resources, and for ensuring appropriate discharge planning.
- 33 (j) The insurer's process for enabling enrollees to change primary care professionals, if
34 applicable;
- 35 (k) The insurer's proposed plan for providing continuity of care in the event of contract
36 termination between the insurer and any of its participating providers, or in the event of the
37 insurer's insolvency or other inability to continue operations. The description shall explain how
38 enrollees will be notified of the contract termination, or the insurer's insolvency or other
39 cessation of operations, and transitioned to other providers in a timely manner; and
- 40 (l) The insurer's process for monitoring access to physician specialist services in emergency
41 room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their
42 participating hospitals.

43 Stat. Auth: ORS 731.244 and 743B.505

44 Stats. Implemented: 743B.505

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1 **836-053-0330 (NEW)**

2 **Nationally Recognized Standards for Use in Demonstrating Compliance with Network**
3 **Adequacy Requirements**

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5 (1) An insurer electing to demonstrate compliance with network adequacy requirements
6 established in ORS 743B.505 by submitting for each network evidence of compliance with a
7 nationally recognized standard may use either of the following two standards with modifications
8 that the Director of the Department of Consumer and Business Services has specified by order or
9 bulletin:

10 (a) Federal network adequacy standards applicable to Medicare Advantage plans, adjusted to
11 reflect the age demographics of the enrollees in the plan; or

12 (b) Federal network adequacy standards applicable to Qualified Health Plans as outlined in the
13 Final United States Department of Health and Human Services Notice of Benefit and Payment
14 Parameters and Letter to Issuers in the Federally-facilitated Marketplaces.

15 (2) The evidence of compliance with a nationally recognized standard must be submitted to the
16 Director no later than March 31 each year.

17 Stat. Auth: ORS 731.244 and 743B.505

18 Stats. Implemented: 743B.505
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21 **836-053-0340 (NEW)**

22 **Factor-Based Evidence of Compliance with Network Adequacy Requirements**

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24 ~~(1) (4)~~ An insurer electing to demonstrate compliance with network adequacy requirements
25 required under ORS 743.505B via the factor-based approach shall submit by submitting evidence
26 of compliance with factors shall submit the evidence of compliance to the Director by March 31
27 each year.

28 (2) The evidence must include a narrative description of how the insurer complies with the factor
29 along with the source and methodology, where applicable, for at least one of the factors listed for
30 each of these categories:

31 (a) Access to Care Consistent with the Needs of the Enrollees Served by the Network category:

32 (A) Access to Care Factor #1– The insurer’s network ensures all covered services under the
33 health benefit plan are accessible to enrollees without unreasonable delay.

34 (i) Submit median enrollee wait times for preventive care appointments for the prior calendar
35 year.

36 (ii) Submit median length of time enrollees waited for access to mental health and substance
37 abuse providers for the prior calendar year.

38 (iii) Submit median length of time enrollees waited to receive care for mental health conditions
39 following intake evaluation.

40 (iv) Evidence that the network provides 24-hour access to clinical advice.

41 (v) Urgent care services outside of regular business hours are available in all covered regions or
42 service areas.

43 (vi) Submit median enrollee wait times for routine care appointments for the prior calendar year.

44 (vii) Submit median enrollee wait times for specialist appointments for the prior calendar year.

45 (B) Access to Care Factor #2 – The network meets special needs of specific populations.

46 (i) The network has the capacity to accept new patients.

- 1 (ii) The network includes a full range of pediatric providers including pediatric subspecialists
2 and providers that offer care to children with special needs.
- 3 (iii) Services are made available to enrollees residing in medically underserved areas of the state,
4 if the insurer offers coverage in those areas.
- 5 (iv) All plans served by a network are included when determining whether the network is
6 sufficient.
- 7 (v) The network provides access to culturally and linguistically appropriate services.
- 8 (C) Access to Care Factor #3 – The insurer actively manages the network including oversight of
9 access to care.
- 10 (i) Providers who are not accepting new patients are not included when determining whether an
11 adequate number of providers (including specialists) are in the network.
- 12 (ii) All plans served by a network are included when determining whether the network is
13 sufficient.
- 14 (iii) The network adequacy monitoring process includes specific intervals between formal
15 reviews, reporting of review results to senior management or board of directors, and formal
16 reviews are used to monitor and improve accessibility for enrollees.
- 17 (b) Consumer Satisfaction category:
- 18 (A) Consumer Satisfaction Factor #1 – Insurer maintains accreditation status and can
19 demonstrate consumers are satisfied with the plan.
- 20 (i) Submit insurer accreditation status from either the National Committee for Quality Assurance
21 (NCQA), URAC, or the Accreditation Association for Ambulatory Health Care (AAAHC)
22 including information regarding customer satisfaction rating from accreditation entity ; or
- 23 (ii) Either of the following:
- 24 (I) Global rating of health plan (Enrollee Satisfaction Survey Consumer Assessment of
25 Healthcare Providers and Systems) and
- 26 (II) Global rating of health care (Enrollee Satisfaction Survey Consumer Assessment of
27 Healthcare Providers and Systems).
- 28 (B) Consumer Satisfaction Factor #2 – Consumers are able to access care when needed without
29 unreasonable delay.
- 30 (i) Number of enrollee communications the insurer received during the previous calendar year
31 regarding difficulty in obtaining an appointment with a provider, including but not limited to the
32 inability to find a provider with an open practice or an unreasonable length of time to wait for an
33 appointment.
- 34 (ii) Number of consumer complaints the insurer received during the previous calendar year
35 regarding care received out of network due to consumer’s inability to receive care in network.
36 Communications under this section include but are not limited to complaints, appeals and
37 grievances from enrollees.
- 38 (iii) Median wait times for members to be seen at time of appointment.
- 39 (c) Transparency:
- 40 (A) Transparency Factor #1 – Insurer maintains an accurate provider directory which is available
41 to the general public.
- 42 (i) Provider locations are transparent to the public.
- 43 (ii) Provide link to website where provider directory is located and explain how frequently the
44 directory is updated and where this information is disclosed on the provider directory.
- 45 (iii) Explain how the insurer keeps information on which providers in the network have open
46 practices and how often this information is updated.

- 1 (iv) Provide position and department of individual responsible for establishing and monitoring
2 the network.
- 3 (B) Transparency Factor #2 – Consumers, enrollees and providers have access to accurate
4 provider information.
- 5 (i) Providers have access to information about other providers in the network.
6 (ii) Consumers and enrollees are informed on how to locate in-network providers when
7 scheduling medical services.
8 (iii) Explain how frequently enrollees are specifically notified of changes to the provider network
9 and the method the insurer uses to communicate this information.
- 10 (iv) Provider directory discloses which providers are fluent in languages other than English and
11 if so, what languages are available.
- 12 (v) Consumers and enrollees are informed of providers in the network with open practices.
- 13 (d) Quality of Care and Cost Containment:
- 14 (A) Quality of Care and Cost Containment Factor #1 – The insurer engages in provider quality
15 improvement activities.
- 16 (i) Submit provider quality data the insurer uses.
17 (ii) Describe the specific quality designations required of specialists in the network.
18 (iii) Explain provider accreditation status requirements used by the insurer.
19 (iv) Provide the percentage of accredited patient-centered primary care homes in the network.
20 (v) Provide a list of all provider types included in the network and identify those who provide
21 telemedicine services.
- 22 (B) Quality of Care and Cost Containment Factor #2 – The insurer is implementing quality
23 improvement activities in addition to provider quality improvement.
- 24 (i) The insurer reports quality improvement strategies to the public.
25 (ii) The provider payment structure supports improved health outcomes, reduction of hospital
26 readmissions, improved patient safety and reduction of medical errors, and reduction of health
27 care disparities.
28 (iii) The insurer offers health promotion and wellness programs to enrollees.
29 (iv) Appointments with high volume specialists are available within the network without
30 unreasonable delay.
- 31 (C) Quality of Care and Cost Containment Factor #3 – The insurer employs network design
32 strategies to reduce cost and improve quality.
- 33 (i) The network design supports improved enrollee health and lower cost.
34 (ii) The insurer analyzes relevant information to promote good health outcomes.
35 (iii) The network can be considered a high-value network.
36 (iv) Electronic health records are used within the network.
- 37 Stat. Auth: ORS 731.244 and 743B.505
38 Stats. Implemented: ORS 743B.505
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43 **836-053-0350 (NEW)**

44 **Provider Directory Requirements for Network Adequacy**
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1 (1) (a) An insurer shall post electronically a current, accurate and complete provider directory for
2 each of its network plans with the information and search functions, as described in section (2) of
3 this rule.

4 (b) In making the directory available electronically, the insurer shall ensure that the general
5 public is able to view all of the current providers for a plan through a clearly identifiable link or
6 tab and without creating or accessing an account or entering a policy or contract number.

7 (c) (A) An insurer shall update each network plan provider directory at least monthly. The
8 provider directory shall disclose the frequency with which it is updated.

9 (B) The insurer shall include a disclosure in the directory that the information included in the
10 directory is accurate as of the date posted to the web or printed and that enrollees or prospective
11 enrollees should consult the insurer to obtain current provider directory information.

12 (d) An insurer shall provide a print copy, or a print copy of the requested directory information,
13 of a current provider directory with the information described in section (2) of this rule upon
14 request of an enrollee or a prospective enrollee.

15 (e) For each network plan, an insurer shall include in plain language in both the electronic and
16 print directory, the following general information:

17 (A) A description of the criteria the insurer has used to build its provider network;
18 (B) If applicable, a description of the criteria the insurer has used to tier providers;
19 (C) If applicable, information about how the insurer designates the different provider tiers or
20 levels in the network and identifies for each specific provider, hospital, or other type of facility in
21 the network which tier each is placed, for example by name, symbols or grouping, in order for an
22 enrollee or a prospective enrollee to be able to identify the provider tier; and
23 (D) If applicable, note that authorization or referral may be required to access some providers.

24 (f) (A) An insurer shall make it clear in both its electronic and print directories which provider
25 directory applies to which network plan, such as including the specific name of the network plan
26 as marketed and issued in this state.

27 (B) The insurer shall include in both its electronic and print directories a customer service email
28 address and telephone number or electronic link that enrollees or the general public may use to
29 notify the insurer of inaccurate provider directory information.

30 (g) For the pieces of information required under this section in a provider directory pertaining to
31 a health care professional, a hospital or a facility other than a hospital, the insurer shall make
32 available through the directory a general explanation of the source of the information and any
33 limitations, if applicable.

34 (h) A provider directory, whether in electronic or print format, shall accommodate the
35 communication needs of individuals with disabilities, and include a link to or information
36 regarding available assistance for persons with limited English proficiency.

37 (2) The insurer shall make available through an electronic provider directory that includes search
38 functions, for each network plan, all of the following information:

39 (a) For health care professionals:

40 (A) Name;
41 (B) Gender;
42 (C) Participating office locations;
43 (D) Specialty, if applicable;
44 (E) Participating facility affiliations, if applicable;
45 (F) Languages spoken by provider other than English, if applicable;
46 (G) Whether accepting new patients;

- 1 (H) Network affiliations;
- 2 (I) Tier level, if applicable;
- 3 (J) Contact information; and
- 4 (K) Board certifications.
- 5 (b) For hospitals:
- 6 (A) Hospital name;
- 7 (B) Participating hospital location;
- 8 (C) Hospital accreditation status;
- 9 (D) Network affiliations;
- 10 (E) Tier level, if applicable; and
- 11 (F) Telephone number.
- 12 (c) For facilities, other than hospitals, by type:
- 13 (A) Facility name;
- 14 (B) Facility type;
- 15 (C) Participating facility locations;
- 16 (D) Network affiliations;
- 17 (E) Tier level, if applicable; and
- 18 (F) Telephone number.
- 19 Stat. Auth: ORS 731.244 and ORS 743B.505
- 20 Stats. Implemented: ORS 743B.505
- 21 History:

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