836-053-0320
Annual Report Requirements for Network Adequacy

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

(2) Beginning March 31, 2020, the annual report shall include at least the following information for networks associated with health benefit plans currently in force and networks associated with health benefit plans being marketed at the time the report is submitted:

(a) Identification of the insurer's network, including plans to which the network applies, how the use of telemedicine or telehealth or other technology may be used to meet network access standards;

(b) The insurer's procedures for making and authorizing referrals within and outside its network, if applicable;

(c) The insurer's procedures for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;

(d) The factors used by the insurer to build its provider network, including a description of the network and the criteria used to select or tier providers;

(e) The insurer's efforts to address the needs of enrollees, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, gay, lesbian, bisexual, transgender, and any other minority gender identity or sexual orientation, physical or mental disabilities, and serious, chronic, ~~or~~ complex medical or behavioral health conditions. This information must include the insurer's efforts, when appropriate, to include various types of essential community providers in its network;

(f) The insurer's process for ensuring networks for plans sold outside of the marketplace provide enrollees who reside in low-income zip code areas or who reside in health professional shortage areas with adequate access to care without delay;

(g) The insurer's methods for assessing the health care needs of enrollees and their satisfaction with services;

(h) The insurer's method of informing enrollees of the plan's covered services and features, including but not limited to:

(A) The plan's grievance and appeals procedures;

(B) Its process for choosing and changing providers;

(C) Its process for updating its provider directories for each of its network plans;

(D) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and

(E) Its procedures for covering and approving emergency, urgent and specialty care, if applicable.

(i) The insurer's system for ensuring the coordination and continuity of care:

(A) For enrollees referred to specialty physicians; and

(B) For enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.

(j) The insurer's process for enabling enrollees to change primary care professionals, if applicable;

(k) The insurer's proposed plan for providing continuity of care in the event of contract termination between the insurer and any of its participating providers, or in the event of the insurer's insolvency or other inability to continue operations. The description shall explain how enrollees will be notified of the contract termination, or the insurer's insolvency or other cessation of operations, and transitioned to other providers in a timely manner; and

(l) The insurer's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals.

Statutory/Other Authority: ORS 731.244 & ORS 743B.505
Statutes/Other Implemented: ORS 743B.505
History:
ID 6-2019, amend filed 06/17/2019, effective 07/01/2019
ID 10-2016, f. & cert. ef. 9-14-16