



July 7, 2016

**Via email [karen.j.winkel@oregon.gov](mailto:karen.j.winkel@oregon.gov)**

Karen Winkel, Rules Coordinator  
Department of Consumer and Business Services, Insurance Regulation  
350 Winter Street, NE  
Salem, OR 97301

**Re: Public Comment on Network Adequacy Proposed Rules**

Dear Ms. Winkel,

The Oregon Medical Association (OMA) appreciates the opportunity to comment on the draft proposed rules regarding network adequacy filed with the Secretary of State on May 13, 2016.

We are respectfully submitting the following comments on the following sections of the proposed rules. We would be glad to supplement our comments with continued discussion with Department of Consumer and Business Services (DCBS) staff assigned to these rules.

**1. OAR 836-053-0300 (1) and (2): Purpose; Statutory Authority; Applicability of Network Adequacy Requirements**

**Comment:** The OMA supports and encourages DCBS to adopt network adequacy rules consistent with HB 2468 (2015). The one comment OMA has here is with the likely confusion for plans determining which rules are applicable to individual, small or large group benefit plans, Medicare Advantage plans, and Qualified Health Plans. We believe the rules should be consistent with the statute, but given the complexity of both the statute and the rules, OMA would encourage DCBS to explain in either a frequently asked question (FAQ) manner or through other communications such as bulletins, the legislative background and intent of the law as well as practical guidance for plans and providers.

**2. OAR 836-053-0320 (2)(a): Annual Report Requirements for Network Adequacy**

**Comment:** The OMA also supports the development of appropriate use of telemedicine and telehealth services. However, the OMA is concerned that an insurer may rely too heavily or even exclusively on the use of telehealth services particularly in rural areas of the state to meet network access standards. Again, the OMA supports the use of telehealth services but would prefer that they not be solely relied upon by an insurer for meeting network access standards.

**Suggested revision:**

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

**3. OAR 386-053-0330 (1): Nationally Recognized Standards for Use in Demonstrating Compliance with Network**

**Comment:** Similar to the comments above about confusion of which standards apply to which insurers, here DCBS is proposing to allow some insurers the option to demonstrate state regulatory compliance by reference to federal network adequacy standards for Medicare Advantage plans or Qualified Health Plans, whichever is applicable. From the physician provider perspective, as downstream providers in network plans, the varying standards in play likely will create significant administrative burden on medical practices already struggling to keep up with the myriad of health care reform changes and day-to-day compliance obligations. Confusion about which standards apply creates more administrative burden, not less. OMA urges DCBS to be mindful of the effect of these standards on downstream providers, not just how they impact insurers.

**4. OAR 836-053-0340: Factor-Based Evidence of Compliance with Network Adequacy Requirements.**

**Comment:** Again, the OMA values the work DCBS has undertaken to develop detailed factors to support more adequate provider networks in the state. Some of the factors listed, however, should be reviewed carefully and reconsidered by DCBS for how they might be implemented and enforced. For example, under Access to Care category, there is a proposed standard that the insurer would have to submit median enrollee wait times for routine care appointments. See OAR 836-053-0340(1)(a)(A)(vi). Further, under the Consumer Satisfaction category, there is a proposed standard that the insurer report on median wait times for members to be seen at the time of appointment. See OAR 836-053-0340(1)(b)(B)(iii). Respectfully, those sorts of standards ultimately will have to rely on provider collection activities versus the insurer collecting the data. That type of work, for example, in attempting to track the time of when a patient enters a medical office and then enters an exam room would be challenging and an administrative burden on the medical office. Further, those standards seem to do little to ensure the insurer, not the provider, is maintaining an adequate network. The OMA urges DCBS to reconsider any standard that would burden a medical office and remove those standards from these proposed rules for future consideration. In addition, in at least two places, DCBS refers to the term “unreasonable” as a standard. See OAR 836-053-0340(1)(b)(B)(i)(“unreasonable length of time”) and OAR 836-053-0340(1)(d)(B)(iv)(“unreasonable delay”). Use of the word unreasonable in a regulatory standard is subject to interpretation, and we suggest that it be removed and replaced with a more objective standard.

Thank you for your consideration of our comments and suggested revisions.

Sincerely,



Mark A. Bonanno, JD, MPH  
General Counsel and  
Director of Health Policy