



## **Hearing Officer's Report to Agency on Rulemaking Hearing**

Date: August 24, 2016

To: Department of Consumer and Business Services

From: Gayle Woods, Hearing Officer

Subject: In the matter of the adoption of OAR 836-053-0300, 836-53-0310, 836-053-0320, 836-053-0340 and 836-053-0350 relating to health benefit plans providing coverage through a specified network of providers

Hearing Date: June 28, 2016  
Hearing Location: Conference Room F, Labor & Industries Building,  
350 Winter Street NE, Salem, OR  
Comment Period End: July 7, 2016

### **Background**

In 2015, the Oregon Legislature enacted House Bill 2468. The bill instructs the Director of the Department of Consumer and Business Services to adopt rules pertaining to an insurer's network of health care providers.

On May 13, 2016, the director filed with the Secretary of State a notice of proposed rulemaking hearing (Notice), giving notice that the director proposed to adopt rules establishing standards for the adequacy of an insurer's network of health care providers.

The Notice announced that a rulemaking hearing would be held on June 28, 2016, and that interested persons could submit comments through July 7, 2016. A copy of the Notice was published in the Secretary of State's Oregon Bulletin of June 2016. Copies of the Statement of Need and Fiscal Impact and the Notice of Proposed Rulemaking were delivered or mailed or otherwise distributed to persons on the department of Financial Regulation's mailing list established under the Administrative Procedures Act, to those members of the Legislative Assembly to whom notice is required to be given and to other interested persons. Copies were also made available to interested persons through the department's e-notify system and were posted on the department's web site.

These proposed rules prescribe annual network reporting requirements, define nationally-recognized standards to be used in demonstrating networks are adequate, and establish factors to be used when insurers demonstrate compliance with network adequacy requirements via the "factor-based" approach. The rules also establish provider directory requirements and apply to health benefit plans in effect on or after January 1, 2017.

## Summary of Oral Comments

No oral comments were received during the hearing.

## Summary of Written Comments

Subsequent to the hearing, the department received written comments from Jennifer Baker representing Cambia Health Solutions; Wendy Funk Shrag, LMSW, ACSW representing Fresenius Kidney Care; Dave Nesseler-Cass representing Moda Health; Mark A. Bonanno, JD, MPH representing Oregon Medical Association (OMA); Patrick Mooney, Ph.D., John Milnes, LCSW, Anne Emmett, LCSW, Nick Dietlein, Psy.D., Larry Venaska, LCSW, Marc Andrews, LCSW, J.L. Wilson, Public Affairs Counsel and Justen Rainey, Public Affairs Counsel representing Oregon Independent Mental Health Professionals; and Brian Hunter representing Kaiser Foundation Health Plan of the Northwest.

Moda Health and Fresenius Kidney Care wrote to express their support for the proposed rules. Kaiser also expressed support for the proposed rules but asked the department to issue additional guidance regarding the required format of the annual report and the dates insurers must use when extracting data for their submissions in 2017.

The OMA encouraged the director to publish guidance to clarify the applicability of the rules to large groups, small groups, and individual plans, the legislative background and intent of the law as well as practical guidance for plans and providers.

The OMA also recommended the rules be amended to remove the phrase “to meet network access standards” from the requirement for insurers to disclose in the annual report how they are using telemedicine or telehealth or other technology to meet network access standards. The OMA expressed concern that insurers could fulfill network access requirements solely via telemedicine.

The OMA expressed concern that insurers are being given the option of demonstrating compliance with Oregon’s network adequacy requirements through use of either the Medicare Advantage or Qualified Health Plan nationally-recognized standards. The concern is that from a physician provider perspective, confusion about which standards apply creates more administrative burden. The OMA asked that the director keep in mind the effect of the standards on downstream providers and not just how they impact insurers.

The OMA recommended the department remove “access to care” factors that would burden a medical office. The OMA also recommended the phrase “unreasonable delay” be removed and replaced with a more objective standard.

Representatives from the Oregon Independent Mental Health Professionals proposed multiple quantitative measures be added to the rules for use in determining whether appropriate provider ratios for treatment of mental health conditions are met. This organization also recommended that when a network’s number of mental health specialists or professional licensed groups in a region is insufficient, plans using that network should be required to process out-of-network claims on the same basis as in-network claims and that the level of reimbursement for the out-of-

network services be paid at the reasonable and customary value for those services and not at the in-network discounted rate.

Cambia recommended the rules be revised to include the review standards established by the Centers for Medicare and Medicaid Services (CMS) as outlined in the 2017 Letter to Issuers in the Federally-Facilitated Marketplaces. Cambia is concerned that Oregon use a consistent review standard for all network adequacy enforcement actions.

The hearing officer recommends a definition of the term "Marketplace" be added to the proposed rules. The hearing officer also recommends modifying proposed rule 836-053-0340 to clarify that a narrative description of how the insurer complies with factors is required when using the factor-based approach.

### **Discussion**

The hearing was held as scheduled. Gayle Woods, Senior Policy Advisor was the hearing officer. There were no members of the public attending or testifying at the hearing and no written comments were submitted at that time. The department did receive written comments subsequent to the hearing and those are included in the Summary of Written Comments above.

The hearing officer agrees with Kaiser's request for the department to issue additional guidance regarding the required format of the annual report and the dates insurers must use when extracting data for their submissions in 2017.

The OMA encouraged the director to publish guidance to clarify the applicability of the rules to large groups, small groups, and individual plans, the legislative background and intent of the law as well as practical guidance for plans and providers. The hearing officer disagrees with the recommendation. The department will monitor the effectiveness of the rules to determine whether publication of guidance to clarify the applicability of the rules and to provide practical guidance for plans and providers is necessary. Information about legislative intent or other legislative background information is readily available via the Oregon Legislative Information System (OLIS).

The OMA stated in their comments that they support the development of appropriate use of telemedicine and telehealth services, but also stated they prefer that these methods of health care delivery not be solely relied upon by an insurer for meeting network access standards. While the hearing officer agrees with the reasoning, a revision to the proposed rules is not necessary to ensure that telemedicine becomes a loophole that overtakes the rule. The proposed rules require the disclosure of the extent to which use of telemedicine or telehealth may be used to meet network access standards as part of the annual report requirements. In addition to the annual report, carriers will be required to provide evidence of compliance to network adequacy standards through either the nationally-recognized standard or factor-based approach. Neither of these options allows for compliance with network access standards exclusively through the use of telehealth or telemedicine. Indeed, disclosure of tele-health information in the annual report provides information the department can use to determine whether a disproportionate level of service is being furnished via this method.

The OMA asked the regulators to be mindful of the effect the standards could have on downstream providers and not just how they impact insurers. However, the OMA did not recommend a change to the proposed rules related to this comment. The hearing officer agrees with the idea that insurers will need to provide clear direction to their contracted providers if additional provider recordkeeping or reporting is needed in order to be compliant with the nationally-recognized standard being used by the insurer. However, without concrete recommendations, the hearing officer does not recommend amendments to the rule at this time.

The OMA recommended the department remove “access to care” factors that would burden a medical office. The OMA also recommended the phrase “unreasonable delay” be removed and replaced with a more objective standard. The hearing officer disagrees that factors need to be removed at this time, for several reasons.

First, access to care consistent with the needs of the enrollees served by the network is one of the factor categories specified in HB 2468. It would be impossible not to consider these factors, given the clear statutory requirement. While the OMA stated the standards seem to do little to ensure the insurer is maintaining an adequate network, it is our understanding that lengthy wait times to receive care can be indicative of insufficient networks. Insurers are directly responsible for ensuring enrollees have appropriate access to the care they need for services offered under the health benefit plan. It appears an insurer should have knowledge regarding the amount of time enrollees are required to wait for care when certifying its networks meet this requirement.

Next, HB 2468 requires the network to be sufficient to ensure all covered services under the plan, including mental health and substance abuse treatment, are accessible to enrollees without unreasonable delay. Defining “unreasonable delay” is problematic in that what is reasonable for one region within the state might not be reasonable for other Oregon regions. Provider capacity issues as well as geographic challenges within the state contribute to the challenge in setting a single objective standard. The hearing officer notes that defining “unreasonable delay” would take away flexibility to respond to unique conditions in the state, and so recommends not amending the term at this time. Finally, the term “unreasonable delay” is also used in federal law and to date the federal government has similarly declined to define the term.

Oregon Independent Mental Health Professionals proposed multiple provider ratio requirements be added to the rules for professional license groups that treat mental health conditions. They also recommended that when a network’s number of mental health specialists or professional licensed groups in a region is insufficient, plans using that network should be required to process out-of-network claims on the same basis as in-network claims and that the level of reimbursement for the out-of-network services be paid at the reasonable and customary value for those services and not at the in-network discounted rate.

The hearing officer disagrees with these recommendations. HB 2468 did not grant to the department the ability to modify nationally-recognized standard as has been recommended. The bill only provided for adjustment of the nationally-recognized standard to reflect the age demographics of the enrollees in the plan. Provider ratio requirements for provider license categories were not developed for use as part of the factor-based approach for demonstrating compliance with network adequacy standards. The Network Adequacy Rulemaking Advisory Committee comprised of representatives from providers, insurers, producers, consumers, the

Oregon Health Authority and Oregon Health Insurance Marketplace developed the factors to be used in measuring compliance under the factor-based approach as part of a collaborative public process. Relatedly, HB 2468 did not grant the department authority to prescribe by rule provider compensation requirements. Additional legislation may be necessary to address how out of network claims are processed at a “reasonable and customary” rate.

Cambia recommended the rules be revised to include the review standards established by the Centers for Medicare and Medicaid Services (CMS) as outlined in the 2017 Letter to Issuers in the Federally-Facilitated Marketplaces. For plan year 2017, CMS indicated it would continue to use the reasonable access standard. Cambia raised concerns that Oregon should use one consistent review standard for all network adequacy enforcement actions. The hearing officer cannot put forward this recommendation due to the structure of HB 2468. The act provides that multiple methods can be used to demonstrate compliance with network adequacy requirements. Because insurers may elect to use one of the nationally-recognized standards or choose to use the factor-based approach, the department could not rely on a single method for evaluating compliance. All carriers electing to use the federal network adequacy standards applicable to Qualified Health Plans would be subject to the federal review standards noted in Cambia’s comments.

Adding the definition of “marketplace” is necessary to distinguish that when the term is used in the proposed rules, reference is being made to Oregon Health Insurance Marketplace and not the general insurance marketplace in Oregon.

Amending proposed rule 836-053-0340 is necessary to clarify that a narrative description of how the insurer complies with factors is required when using the factor-based approach. This change should assist insurers when preparing to submit the required evidence of compliance.

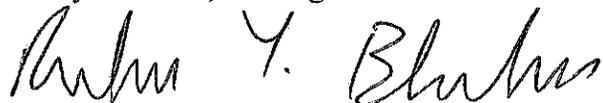
### Summary

Having considered fully all written and oral submissions, the hearing officer recommends the following:

Adopt the proposed rules with the following changes to the rules:

1. Revise *proposed* OAR 836-053-0340 to number the second sentence in section (1) as (2) and clarifying what the insurer is required to submit under section (1).
2. Add definition of “Marketplace” under *proposed* OAR 836-053-0310.
3. Adopt additional guidance for use by insurers and providers once the rules are adopted.

For Gayle Woods, Hearing Officer



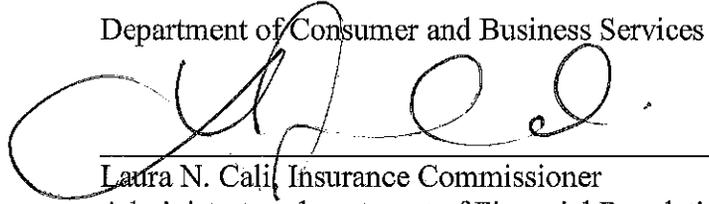
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Richard Y. Blackwell  
Policy Manager

This Summary and Recommendation are reviewed and adopted.

Signed this 31 day of August, 2016.

Department of Consumer and Business Services

A handwritten signature in black ink, appearing to read 'Laura N. Cali', is written over a horizontal line. The signature is stylized and cursive.

Laura N. Cali, Insurance Commissioner  
Administrator, department of Financial Regulation