



April 22, 2026

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Department of Consumer and Business Services
Division of Financial Regulation
350 Winter St NE
Salem, OR 97309

Delivered via email: dfr.rules@dcbs.oregon.gov

Re: PacificSource Health Plan Comments on Rules Implementing House Bill 3243 (2025)

Dear Lisa:

The PacificSource companies are independent, not-for-profit health insurance providers based in Oregon. We serve over 500,000 commercial, Medicaid, and Medicare Advantage members in three states. PacificSource Community Solutions is the contracted coordinated care organization (CCO) in Central Oregon, the Columbia River Gorge, and Marion & Polk Counties. Our mission is to provide better health, better care, and better value to the people and communities we serve.

We appreciate the opportunity to provide comment on the adoption of the permanent version of temporary rules currently in place to implement 2025 House Bill 3243 ("Act"), found in OAR chapter 836, division 53. While we appreciate all the public process that went into the adoption of the temporary rule, commenting on permanent versions of laws already in place puts interested parties with legitimate issues with the proposed rules at an unfair disadvantage. We would urge the department to be more proactive with the Legislative Assembly in its need for time to implement complex pieces of legislation such as the Act.

Our specific comments on the rules include:

- In proposed rule -0454, section (1)(c) states that in the absence of an established local rate or a contract between health plan and ground ambulance service organization, the default reimbursement amount equals 325% of Medicare as set on January 1, 2026. We agree with this approach and think it meets constitutional nondelegation requirements. But the text in the subsection goes on to state that the department will annually update the Medicare rate by self-publishing a bulletin.

Traditionally, the Insurance Commissioner publishes bulletins to remind regulated entities of existing legal standards and how to comply with those standards. Bulletins themselves do not have any legal force. Instead, this update will have to be done via administrative rule to meet non-delegation concerns. Since this language appears in

section (2)(b) as well, we recommend removing the language in all instances and adopting a new rule that isolates the rate into a separate rule. A separate rule that only exists to adopt updated Medicare standards would limit the ability for interested parties – like health plans – to make suggestions in future rulemaking processes.

- In proposed rule -0454, section (3) establishes the department’s policy that “established local rates are reported to the department by ground ambulance service organizations for transparency purposes.” This misreads the problem that the catalog described in section 2(5) of House Bill 3243 sought to solve. With hundreds of established local rates possible, how would the public or health plans know what local jurisdictions analyze and establish as rates? To solve this problem, the Assembly stated that ground ambulance service organizations “shall” submit established local rates annually and within five calendar days of a change to the rates. Clearly, the Assembly meant for the department to be the catchment point of rates and the analysis that went into determining those rates. If the Assembly meant for the catalog just to be about transparency purposes, it would have said so in the Act.

More troubling, the rule proposes that, for billing purposes, “the health benefit plan and the ground ambulance service organizations will determine the payment amount based on the allowed amount at the time and place of the service[.]” Unless there is a different read of the rule, this proposal ignores the Assembly’s policy that rates should be published and updated as soon as possible and instead requires health plans to check with hundreds of local jurisdictions to determine the rate at the time of service, which may have shifted many times since local jurisdictions are not limited on the number of times they may update established local rates.

In our view, there are only three ways health plans reimburse ground ambulance service organizations after passage of the Act: (1) a contracted rate, (2) 325% of Medicare, kept up to date by DCBS by rule, or (3) the established local rate submitted to DCBS by the ground ambulance service organizations within five days of any change, and once a year. Thus, we believe the text of the Act necessitates the complete removal of section (3).

- In proposed rule -0457, section (2), for reasons stated above we would reiterate that the section be struck in its entirety.
- In proposed rule -0457, section (3) requires the submission of superficial information by ground ambulance service organizations. Even though the department’s own proposed rule (OAR 836-053-0447) defines “established local rate” to mean a rate “that includes an *analysis* of the cost to provide the ground ambulance services,” [emphasis added] there is no requirement in -0457(3) to require the submission of any documentation that would indicate how the ground ambulance service organizations established a local rate. Rule -0457(3) does not even specify what documentation would suffice as “analysis” under -0447. We believe that the department should re-convene the rulemaking advisory committee and finish this incomplete and lax transparency requirement.

We also have comments on the statement of need and fiscal impact form:

- In the cost of compliance statement, the department estimates that the proposed rules do not have a fiscal impact on local governments, even though later on in the statement the department is able to estimate that 135 ground ambulance service organizations are local government entities.
- The changes for which we have provided public comment would likely increase reimbursement to ground ambulance service organizations and result in more

administrative burden to health plans, who likely need to proactively search for hundreds of local rates if these rules are enacted. This particular fiscal impact is separate and apart from the underlying Act, which as we have detailed above did not require health plans to actively search for every ground ambulance rate in Oregon.

- Under the Administrative Procedures Act, rulemaking advisory committees must give state agencies feedback on the proposed fiscal impact of proposed rules. The rulemaking advisory committee should have spent more time gathering information from the participants on the fiscal impacts these rules may have had on interested parties.

Thank you in advance for fully considering our comments.

Sincerely,

/s

Richard Blackwell
Director, Oregon Government Relations