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Brooke Hall
Senior Policy Analyst
Department of Consumer and Business Services, Division of Financial Regulation
P.O. Box 14480
Salem, OR 97309

SENT VIA EMAIL

RE: Comments on Draft No. 3 - Network Adequacy Reporting Template Beginning in 2027

Dear Ms. Hall:

I am writing on behalf of Cambia Health Solutions (Cambia Health), which operates Regence BlueCross BlueShield of Oregon (Regence) and BridgeSpan Health plans. Cambia Health is a not-for-profit health insurer dedicated to improving the health and well-being of our members and the communities we serve. As the state's largest health insurer, we provide high-value, affordable health care to nearly one million Oregonians across a network of 39,000 providers at 705 sites across the state. In keeping with our values as a tax-paying nonprofit, 90% of every premium dollar goes to pay our members' medical claims and expenses.

We appreciate the opportunity to comment on the third draft of the Network Adequacy Reporting Template that was discussed during the June 12, 2026 Network Adequacy Reporting Template Work Group Meeting. Our comments address the following tabs: **Reporting Information**, **Exceptions – HPSA**, **Exceptions – Low Income Zip**, and **Time Distance Reporting**.

Reporting Information

1. **Network ID:** While there is a Network ID for QHP individual and small group plan filings, there is no equivalent field that exists for large group plans. We request clarification on what carriers should enter for large group, or whether "N/A" (Not Applicable) is the appropriate response given that a Network ID does not exist for large group filings.
2. **Health Benefit Plans that apply to network:** The list of health benefit plans and their associated networks will be extensive across individual, small group, and large group lines of business. To improve both reporting efficiency and DFR review, we recommend that a dedicated tab, tentatively titled *"Health Benefit Plans and Networks"* be added to the template, ideally following the "Instructions and Definitions" tab. This structure would accommodate the reality that multiple benefit plans can be associated with a single network. For example, a network serving the Individual line of business may have 15 associated products/health benefit plans, while a network serving both small and large group may have more than 20. A separate tab would allow carriers to clearly identify the applicable line of business for each product/health benefit plan name.

Exceptions – HPSA and Exceptions – Low Income Zip

1. We would like the DFR to confirm whether the HPSA and Low-Income Zip exception lists are identical. If so, we recommend combining them into a single tab labeled *"Exceptions – HPSA and Low Income Zip"* to reduce redundancy and simplify reporting.
2. In addition, as we understand it, the DFR intends to adopt the 2026 CMS Marketplace Low-Income Zip Code list *"to establish the standard for the 2026 reporting year."* However, since the first annual report under the new rules effective June 29, 2026 will be submitted in 2027, we believe the bulletin should be revised to reference *"the 2027 reporting year"* to accurately reflect the applicable reporting period.

Time Distance Reporting

1. Column G requires carriers to report the *" # of Telemedicine Providers Used to Meet Access Requirements."* We note that when reporting telehealth providers to CMS for Medicare Advantage network audits, the standard approach asks whether a network offers telehealth benefits (Yes/No) by specialty such as Primary Care, Gynecology, OB/GYN, Endocrinology, Psychiatry, etc. We are able to report either:
    - Whether a given specialty within the network offers telehealth services, or
    - The total count of providers within a specialty who offer telehealth

    We are unable to identify the specific number of providers used to meet access requirements, as the DFR has not yet issued guidance on how carriers should determine which telemedicine-only providers count toward network adequacy.

    Currently, providers self-report whether they offer telemedicine services. Given that many "brick and mortar" providers offer both in-person and virtual care, we seek clarification on whether the intent is to count only providers who exclusively offer telemedicine services, or all providers who offer telemedicine as part of their practice.

Conclusion

Thank you again for the opportunity to provide comments. We continue to appreciate and value the Department's collaborative approach to developing a practical and workable reporting template through this stakeholder process and look forward to continued engagement.

Sincerely,

A. Awuakye

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