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ARCHIVES DIVISION
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# NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

**FILED**
04/05/2019 10:40 AM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Network Adequacy Compliance Requirements.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 05/31/2019 5:00 PM

*The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.*

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350 Winter St. NE
Salem,OR 97301

Filed By:
Karen Winkel
Rules Coordinator

HEARING(S)

*Auxilary aids for persons with disabilities are available upon advance request. Notify the contact listed above.*

DATE: 05/23/2019
TIME: 10:00 AM
OFFICER: Gayle Woods
ADDRESS: Labor & Industries Building
350 Winter St. NE
Conference Room E
Salem, OR 97301
SPECIAL INSTRUCTIONS:
Conference phone information:
Call 888-808-6929
Access code 4969117

NEED FOR THE RULE(S):

Oregon adopted its network adequacy requirements through House Bill 2468 in 2015 and adoption of related administrative rules in 2016. The Oregon process allows insurers to demonstrate its networks are adequate by submitting to the department evidence of compliance with a nationally-recognized standard. Acceptable nationally-recognized standards were established in administrative rule and included federal network adequacy standards applicable to Medicare Advantage plans, adjusted to reflect the age demographics of the enrollees in the plan or federal network adequacy standards applicable to Qualified Health Benefit Plans as outlined in the Final United States Department of Health and Human Services Notice of Benefit and Payment Parameters and Letter to Issuers in the Federally-facilitated Marketplaces.

The Centers for Medicare and Medicaid Services (CMS) no longer conducts network adequacy compliance reviews for Qualified Health Plans (QHPs) and now defers to state processes to determine compliance. CMS relies on insurers'

accreditation with an HHS-recognized accrediting entity for states without authority and means to conduct network adequacy reviews.

At the time Oregon's current network adequacy rules were adopted, the rulemaking advisory committee considered whether accreditation with an HHS-recognized accrediting entity would be an acceptable nationally-recognized standard and determined the accreditation process would not provide sufficient evidence that networks are adequate. The proposed amendments to the rules remove the federal network adequacy standards applicable to QHPs as an acceptable nationally-recognized standard to use in demonstrating network adequacy.

The proposed rules also provide clarification requested by the external rulemaking advisory committee on:
1. The applicability of the annual report required in OAR 836-053-0320 to networks associated with health benefit plans currently in force and to those health benefit plans currently being sold.
2. The evidence of compliance with a nationally- recognized standard should be based on compliance as of December 31 of the calendar year immediately preceding the March 31 reporting date.
3. How the Medicare Advantage network adequacy standards must be adjusted to reflect the age demographics of the enrollees in the plan.

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DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Draft rules are available from Karen Winkel located at 350 Winter St. NE, Salem, OR 97301 and are available on the division's Web site at:
http://dfr.oregon.gov/laws-rules/Pages/proposed-rules.aspx.

CMS 2019 Letter to Issuers:
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf.

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FISCAL AND ECONOMIC IMPACT:

These rules clarify existing annual network adequacy reporting requirements insurers must submit and any fiscal or economic impact related to this clarification is a result of the underlying legislation. The rules also remove the federal network adequacy standards applicable to QHPs as an acceptable nationally-recognized standard to use in demonstrating compliance with Oregon's network adequacy requirements. This change will require insurers who previously relied on federal QHP standards as evidence of compliance to submit new evidence of compliance based on the remaining options in the administrative rules. This change could result in a minor fiscal impact on insurers to which these rules apply.

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COST OF COMPLIANCE:

*(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).*

(1) The proposed rules do not add any new requirements on public entities, but instead amend and clarify the network adequacy evidence of compliance filing requirements. Other state agencies and local governments are not involved in enforcing these network adequacy standards and are not expected to incur any fiscal impact. The department is not expected to incur any fiscal impact as a result of the proposed rules since the rules simply clarify for insurers the existing

requirements for reporting evidence of compliance and modify the nationally-recognized standard available for insurers to use as evidence of compliance.

It is unlikely that these changes to the evidence of compliance reporting requirements would have any impact on the general public.

(2)(a) The department does not have information as to the number of employees employed by insurers authorized to transact insurance in Oregon. It is unlikely that any insurer subject to this rule is a small business (i.e., 50 or fewer employees).

(2)(b) None. It is unlikely that any insurer subject to this rule is a small business (i.e., 50 or fewer employees).

(2)(c) None. It is unlikely that any insurer subject to this rule is a small business (i.e., 50 or fewer employees).

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DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

A small business health care provider was a member of the rulemaking advisory committee.

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WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

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RULES PROPOSED:
836-053-0320, 836-053-0330

AMEND: 836-053-0320

RULE SUMMARY: To clarify period to which annual report applies.

CHANGES TO RULE:

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) ~~T~~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, physical or

mental disabilities, and serious, chronic or complex medical 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, it 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 ~~and~~, ORS 743B.505
Statutes/Other Implemented: ORS 743B.505

AMEND: 836-053-0330

RULE SUMMARY: To clarify period to which evidence of compliance applies. To explain how Medicare Advantage network adequacy standards must be adjusted for the age demographics of the plan's enrollees. To remove the federal network adequacy standards applicable to Qualified Health Plans as an acceptable nationally-recognized standard to use in demonstrating compliance with Oregon's network adequacy requirements.

CHANGES TO RULE:

836-053-0330
Nationally Recognized Standards for Use in Demonstrating Compliance with Network Adequacy Requirements ¶

(1) ~~A~~Beginning with plan year 2020, an insurer electing to demonstrate compliance with network adequacy requirements established in ORS 743B.505 by submitting for each network evidence of compliance with a nationally recognized standard may use ~~either of the following two standards with modifications that the Director of the Department of Co~~ federal network adequacy standards applicable to Medicare Advantage plans, adjusted to reflect the age demographics of the enrollees in the plan. An insu~~m~~rer ~~and Business Services has specified by order or bulletin:¶~~
~~(a) Federal~~must adjust the Medicare Advantage network adequacy standards ~~applicable to Medicare Advantage plans, adjusted to reflect the age demographics of the enrollees in the~~to ensure these specialties are included for the age demographics of the population covered by the network plan~~; or~~: ¶
(~~b~~a) ~~Federal network adequacy standards applicable to Qualified Health Plans as outlined in the Final United States Department of Health and Human Services Notice of Benefit and Payment Parameters and Letter to Issuers in the Federally-facilitated Marketplaces~~Primary Care, including pediatrics - aggregate Medicare Advantage HSD Reference Codes 001 through 006;¶
(b) Endocrinology - Medicare Advantage HSD Reference Code 012;¶
(c) Gynecology (OB/GYN) - Medicare Advantage HSD Reference Code 016;¶
(d) Infectious Diseases - Medicare Advantage HSD Reference Code 017;¶
(e) Oncology - Medical/Surgical -Medicare Advantage HSD Reference Code 021;¶
(f) Oncology - Radiation/Radiology -Medicare Advantage HSD Reference Code 022;¶
(g) Psychiatric - Medicare Advantage HSD Reference Code 029;¶
(h) Cardiology - Medicare Advantage HSD Reference Code 008;¶
(i) Rheumatology - Medicare Advantage HSD Reference Code 031;¶
(j) Hospitals - Medicare Advantage HSD Reference Code 040;¶
(k) Outpatient Dialysis - Medicare Advantage HSD Reference Code 044; and¶
(l) Inpatient Psychiatric Facility Services - Medicare Advantage HSD Reference Code 052.¶
(2) The evidence of compliance with a nationally recognized standard must be submitted to the ~~D~~director no later than March 31 each year for the immediately preceding calendar year as of December 31.
Statutory/Other Authority: ORS 7~~31.244 and 743B.505~~43B.505, ORS 731.244
Statutes/Other Implemented: ORS 743B.505