Reporting Requirements
Network Adequacy Report

DUE March 31, 2022

ORS 743B.505 and OAR 836-053-0300 to 836-053-0350 set minimum requirements for health benefit plan networks. They also require insurers to report on their compliance efforts to the Division of Financial Regulation on an annual basis. An analysis of the 2020 report identified the need to establish specific report elements and clarify expectations with insurers. The resulting 2021 reports were more uniform, respond to rule requirements, and allow easier analysis of responses.

In 2021 the Division continued to monitor network deficiencies through consumer and provider complaints, including any issues related to the ongoing COVID-19 pandemic impacting access to services. The 2021 Legislative Session resulted in changes to network requirements for the commercial market which are identified in this reporting guide. The Division will continue to monitor emerging network issues and ongoing barriers to expanding network access including provider availability through 2022.

This document outlines reporting guidelines for annual reports due on March 31, 2022.

Approximate Timeline for Implementation

February 2022	Call with division to answer remaining questions, if needed
March 31, 2022	Network adequacy reports due
April – June 2022	Division staff review reports
July 2022	Feedback to insurers

Reporting guidelines for annual report due March 31, 2022

Elements listed below are necessary for demonstrating compliance with annual network adequacy reporting requirements. In some situations, one document may satisfy multiple criteria. Unless otherwise indicated all "non-data documents" must be submitted in the .pdf file type.

OAR 836-053-0320(1) - *An insurer offering individual or small group health benefits plans must submit its annual report for each network.*

OAR 836-053-0320(2) – *The annual report includes at least the 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.*

Reporting minimum	Helpful hints

☐ The report provides information on *each network* operated by the insurer and the company's general process for determining network adequacy.	Insurers with more than one network in the individual and small group market must provide network specific information on each network for required reporting elements found in OAR 836-053-0320. Network information of interest to the Division: • Number of members in each network. • If large group plans rely on the same network or panel of providers. • When the Network was introduced. • Any significant network changes from previous report. Insurers offering small group coverage should consider multiple plan years in their reports because small group plans renew quarterly and may be marketed on different schedules.

OAR 836-053-0320(2)(a) - *Identification of the insurer's network(s), including plans to which the network applies.*

Reporting minimum	Helpful hints
☐ The report includes a "crosswalk" or "key" that identifies each of the insurer's networks and all associated plans	The insurers file yearly binders which include network information for each individual and small group plan offered in the state. Information included in the report will be compared to the previously filed and approved binders to ensure consistency. Insurers should also report on networks for which there is not enrollment but the plan is approved and actively marketed.

OAR 836-053-0320(2)(a) – …*how the use of telemedicine or telehealth or other technology may be used to meet network access standards.*

Reporting minimum	Helpful hints
☐ The report clearly indicates the insurer **does not** use telemedicine or telehealth to meet network access standards. ☐ The report identifies any state or national telehealth provider under	HB 2508 (2021) updated Oregon's telemedicine mandate found in ORS 743A.058. Insurers are now prohibited from using telemedicine to meet network adequacy requirements.

contract or agreement to perform services. ☐ The report explains any efforts to address lack of diversity, equity, and inclusion through telemedicine.	HB 2508 expanded telemedicine requirements to include dental services. If plans include dental coverage insurers should explain efforts to include dental telemedicine.
☐ The report covers the insurer's use of medical/surgical *and* mental health/substance use of telemedicine, telehealth, or other technology.	Mental health and substance use disorder services should be accessible via telemedicine, telehealth, or other technology.

OAR 836-053-0320(2)(b) - The insurer's procedures for making and authorizing referrals within and outside its network, if applicable.

Reporting minimum	Helpful hints
☐ The report includes the insurer's procedures for making referrals in and out-of-network. ☐ The report includes the insurer's procedures for approving an out-of-network referral. ☐ The report specifically includes any company procedures for approving an out-of-network referrals for mental health or substance abuse treatment that are more restrictive or substantially different than other procedures.	Insurers who use "confirmation statements" do not meet the regulatory requirement of reporting on the procedures for referral and authorization of out-of-network care. Insurers may use out-of-network referrals and single case agreements to enable treatment and care otherwise not available in-network. *Note:* Frequent out-of-network referrals for services may be an indicator additional providers need to be added to the panel.

OAR 836-053-0320(2)(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.*

Reporting minimum	Helpful hints

☐ The report includes the insurer's procedures for monitoring network sufficiency on an *ongoing* basis. ☐ The report includes the criteria, metrics, and thresholds the insurer uses to determine network sufficiency. ☐ The report includes a description of the process by which the insurer selected the data elements and how they are reviewed. ☐ The schedule for ongoing monitoring (if not otherwise included in the procedures document).	Best Practice: The Division believes that insurers should review network sufficiency at least quarterly. Summaries or descriptions of processes are not sufficient for the division to determine if the company procedures include ongoing monitoring of network sufficiency. All procedures should be provided as an attachment in their entirety. If the company uses nationally recognized standards for evaluation, provide the complete standards as an attachment to the report. Avoid vague references, for example the following response would be considered incomplete: "The company reviews networks against nationally recognized standards on an ongoing basis." Don't focus on *annual* network adequacy review. This portion of the report should address ongoing monitoring of network sufficiency occurring throughout the plan year. Ongoing monitoring includes gathering data, internal information sharing, and creating processes for adjusting network size if gaps (inadequacies) are identified. HB 3046 (2021) expanded network adequacy requirements for mental health and substance use. The Division has necessary rulemaking underway and will not have the rule finalized in time for the 2022 Network Adequacy Report. The requirements under the new law are summarized here for your convenience when drafting a response to this reporting requirement.

OAR 836-053-0320(2)(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.*

Reporting minimum	Helpful hints

☐ The report provides the factors used by the insurer to build the provider network. ☐ The report explains any criteria given priority or weight over other criteria. If the company does not weigh or prioritize evaluation criteria please also note this. ☐ The report explains why the company selected each network factor, geographic area, and criteria applied when creating a provider network, and to select or tier providers. ☐ The report explains any additions or changes in factors used to build provider network since the last report.	Explanations on the use of weighting (or prioritizing) criteria may help the division understand the methodology used to support the companies evaluation of network adequacy. When explaining changes in factors used to build networks consider: ☐ 2021 Legislation, specifically HB 2508 and HB 3046. ☐ Known impacts of the COVID surges on provider availability and member need. ☐ Other network changes related to COVID. ☐ Any changes specific to diversity, equity, and inclusion.
☐ The report includes a description of the network, including the network type and if policies offer nonemergency out-of-network coverage.	HB 3046 (2021) expanded network adequacy requirements for mental health and substance use. The Division has necessary rulemaking underway and will not have the rule finalized in time for the 2022 Network Adequacy Report. The requirements under the new law are summarized here for your convenience when drafting a response to this reporting requirement. Under the law the coverage of behavioral health treatment may not limit coverage for treatment of pervasive or chronic behavioral health conditions to short-term or acute behavioral health treatment at any level of care or placement. Insurers offering group or individual health benefit plans are required to have a network of providers of behavioral health treatment sufficient to meet the standards described in ORS 743B.505. If there is no in-network provider qualified to timely deliver, as defined by rule, medically necessary behavioral treatment to an insured in a geographic area, the insurer is required to provide coverage of out-of-network medically necessary behavioral health treatment without any additional out-of-pocket costs if provided by an available out-of-network provider that

	enters into an agreement with the insurer to be reimbursed at in-network rates. Insurers often limit the network description to counties or rating areas. Reporting on geographic barriers provides important insight about member's ability to access care during inclement weather or other nature events (e.g. wildfires). The network type (e.g. EPO, PPO, etc.) provides information about access to benefits, but insurers should also clarify if their policies offer out-of-network care for non-emergency services.
The report provides evidence that the following information is available in both print and electronic directories"[1] ☐ The criteria the insurer used to build the network. ☐ The criteria the insurer uses to tier providers. ☐ Information on how the insurer designates different provider tiers or network levels. (If applicable.)	Online directories should contain required information without requiring a call to customer service or log-in to an account. See also: OAR 836-053-0350(1)(e)(A), (B) and (C).
	Best practice for providing information on the designating providers by tiers or network level. 1. Answer yes/no: Does your network have provider tiers? For example, preferred in-network, nonpreferred in-network, out-of-network? 2. If the networks are tiered, explain how providers are assigned a tier. The explanation should include information on how a provider moves from preferred to nonpreferred.
☐ The report includes a criteria review schedule for ongoing relevancy review.	Continuous review of network criteria is essential for ensuring networks keep pace with changes in membership, social values, benefit mandates, etc.

[1] OAR 836-053-0350(1)(e)(A), (B) and (C)

OAR 836-053-0320(2)(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.*

Reporting minimum	Helpful Hints
The report explains the insurer's efforts to address the needs of enrollees, including specific information on: ☐ Children and adults ☐ Enrollees with limited English proficiency or illiteracy. ☐ Diverse cultural or ethnic backgrounds. ☐ Physical or mental disabilities. ☐ Serious, chronic or complex medical condition.	See also OAR 836-053-0320(2)(c) and OAR 836-053-0320(2)(g).
☐ The report includes the insurer's efforts to include various types of essential community providers in its network, when appropriate.	

OAR 836-053-0320(2)(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.*

Reporting minimum	Helpful hints
☐ (If applicable) The report discloses the role of a third-party administrator in finalizing the list of low-income zip code areas and/or administering the network in those areas. ☐ The report explains process and frequency of re-evaluation of all Oregon zip codes against the definition of "low-income zip code areas." ☐ A list of the zip codes identified by the insurer. (.xls file)	

☐ The report includes the criteria, metrics, and thresholds used by the company to assess whether enrollees have adequate access to care. ☐ The report explains how the definition of adequate access to care was developed, including external sources such as third-party administrators. ☐ The report explains how the company seeks feedback from members and providers on the insurer's adherence to "adequate access to care."	The company is responsible for adhering to internal controls related to adequate access to care. Members may have a different assessment of adequate access to care and network complaints may result from lack of clarity about this definition. Adequate access to care is defined by the Office of Disease Prevent and Health Promotion as "the timely use of personal health services to achieve the best health outcomes." The following are identified measures of Timeliness: ☐ Availability of appointments and care for illness or injury when it is needed. This is also stated as the delay in time between identifying a need for a specific test or treatment and actually receiving those services. ☐ Time spent waiting in doctors' offices and emergency departments (EDs).
☐ (If applicable) The report discloses the role of a third-party administrator in finalizing the list of health professional shortage areas and/or administering the network in those areas. ☐ A list of the zip codes identified by the insurer. (.xls file)	
☐ The report includes the criteria, metrics, and thresholds used by the company to determine that enrollees have access to care without delay. ☐ The report explains how the criteria were developed, including resources used to monitor care delays.	Companies should monitor any reports of care delays against the definition of "access to care without delay."

OAR 836-053-0320(2)(g) - *The insurer's methods for assessing the health care needs of enrollees and their satisfaction with services.*

Reporting minimum	Helpful Hints

☐ The insurer has a method for assessing the health care needs of enrollees. ☐ The insurer has a method for assessing enrollees' satisfaction with services. ☐ The report includes specific information about the insurer's methods for making these assessments, and a link or other instruction for providing feedback on their satisfaction with services.	See also OAR 836-053-0320(2)(c) and OAR 836-053-0320(2)(e). See also ORS 743B.202. Avoid vague statements and compliance confirmation statements. For example: "the company collects consumer complaints and reviews them for suggestions on network changes" and "we monitor complaints and inquiries". These statements are vague and confirm compliance without providing the required information or supporting documentation.
☐ The report includes samples of recurring reports used to monitor network adequacy complaints and inquiries about a provider's network status, and the frequency of single case agreements. ☐ The report provides detailed information on how the company compiles network feedback from members and providers and incorporates it into network updates.	Avoid vague statements and *compliance confirmation statements*. For example: "the company collects consumer complaints and reviews them for suggestions on network changes" and "we monitor complaints and inquiries" are vague and confirm compliance without providing the required information.

OAR 836-053-0320(2)(h)(A) - *The insurer's method of informing enrollees of the plan's covered services and features, including the plan's grievance and appeals procedures.*

Reporting minimum	Helpful Hints
☐ The report explains how enrollees are informed of the grievance and appeals procedures.	The grievance and appeals process is outlined in the member handbook but may also appear in online sources.

OAR 836-053-0320(2)(h)(B) - *The insurer's method of informing enrollees of the plan's covered services and features, including the process for choosing and changing providers.*

Reporting minimum	Helpful Hints

☐ The report includes a list of places where the member may access the list of services, features. ☐ The report includes disclosure language used to inform/instruct members of how to choose and change providers. ☐ The report includes a description of the plan's outreach efforts for pushing service and feature information to members.	

OAR 836-053-0320(2)(h)(C) – *The insurer's process for updating its provider directories for each of its network plans.*

Reporting minimum	Helpful Hints
☐ The report includes the internal process document for updating the provider directories for each network. ☐ The report includes an explanation of where the provider directories are located or a link to the directories. ☐ If not included in the process document, the report provides a description of how the company keeps the information current.	If the process is the same for each network the report should include a statement clarifying this change. Provider directories may not be placed exclusively on member only pages. Provider directories should be updated at least monthly to reflect any new or updated providers. See also OAR 836-053-0350.

OAR 836-053-0320(2)(h)(D) – *A statement of health care services offered, including those services offered through the preventive care benefit, if applicable.*

Reporting minimum	Helpful hints
☐ The report provides the binder filing number, also known as the SERFF filing number, for all approved plans and forms. ☐ The report identifies the services offered through the preventive care benefit, at no cost the consumer.	Benefits are captured in binder filings for small group and individual plans and may alleviate the need for additional explanation in this area. If insurers advertise or offer value added benefits the report describes the interaction between value added benefits and other benefits covered under the insurance policy.

OAR 836-053-0320(2)(h)(E) – *"Its procedures for covering and approving emergency, urgent and specialty care, if applicable."*

Reporting minimum	Helpful hints

☐ The report explains the insurer's process for determining that care did not meet the definition of an emergency.	There are state and federal laws that specify coverage requirements for emergency care, including in and out – of-network care. Insurers should consider Oregon's Balance Billing law and the No Surprises Act when developing procedures for covering and approving emergency care. Prior authorization for Emergency Services is not permissible.
☐ The report includes the company's procedures for approving urgent care.	The report identifies where there are gaps in the availability of urgent care. Insurers should consider applicable utilization review guidelines for urgent and concurrent care when developing internal procedures for approving urgent care.
☐ The report includes procedures for approving specialty care. ☐ The report includes company policies for approving out-of-network specialty care when in-network providers are unavailable, including if consumers are subject to increased cost-sharing.	Insurers should consider the applicability of HB 3046 (2021) when responding to this reporting requirement.

OAR 836-053-0320(2)(i)(A) - *The insurer's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians.*

Reporting minimum	Helpful hints
☐ The report explains the insurer's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians.	

OAR 836-053-0320(2)(i)(B) - *The insurer's system for ensuring the coordination and continuity of care for enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.*

Reporting minimum	Helpful hints
☐ The report explains the insurer's system for ensuring the coordination and continuity of care for enrollees *using ancillary services*.	See also ORS 743B.225.

OAR 836-053-0320(2)(j) - *The insurer's process for enabling enrollees to change primary care professionals, if applicable.*

Reporting minimum	Helpful Hints
☐ The report includes the insurer's process for an enrollee changing primary care providers.	See also OAR 836-053-0320(2)(H)(B). See also ORS 743B.220, ORS 743B.222,

OAR 836-053-0320(2)(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.*"

Reporting minimum	Helpful hints
☐ The report includes the proposed plan for providing continuity of care in the event of contract termination between the company and any of its participating providers, including facilities.	Reports should describe the following elements: ☐ Member communication. ☐ Transportation to nearby in-network providers or facilities. ☐ Protecting members from balance billing and higher out-of-network costs. ☐ A description of how the insurer will continue to cover previously approved prior authorizations with the out-of-network provider. ☐ Communication to the Division, elected officials, and unions. ☐ Adding new in-network providers or facilities. ☐ An explanation of how the company will ensure continuity of care with the same provider or transitions to a new provider in-network. ☐ The timeline for notification to regulators, members, and elected officials, etc.

OAR 836-053-0320(2)(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.*

Reporting minimum	Helpful Hints

The report includes the process for monitoring access to the following services at participating hospitals: ☐ Physician specialist services in emergency room care ☐ Anesthesiology ☐ Radiology	
☐ Hospitalist care ☐ Pathology and laboratory services.	

OAR 836-053-0350 - *An insurer shall post electronically a current, accurate and complete provider directory for each of its network plans with the information and search functions, as described in this rule.*

Reporting minimum	Helpful Hints
☐ The insurer has an electronic provider directory that is current, accurate, and complete for each network.	Provider directories may not be placed exclusively on member only pages.

FAQs regarding the 2022 Annual Report

FAQ No. 1 **Are there changes to the network adequacy rules for the 2022 report?**

Response No, Oregon's network adequacy rules were last changed in 2019 and changes under HB 3046 are not in place for the 2022 report. The key change for the 2022 reports center on telemedicine.

FAQ No. 2 **What will insurers need to do to comply with network adequacy requirements in 2022?**

Response To satisfy reporting requirements for 2022, insurers will be required to provide the information outlined in OAR 836-053-0320 and all reporting components for the preferred reporting method in OAR 836-053-0330 or 0340.

FAQ No. 3 ***If the division determines the report is inadequate, what are the next steps?***

Response The division will review and analyze insurer reports for consistency with reporting requirements. division staff will work cooperatively with the insurer in identifying supplemental information the insurer can provide to complete its reporting requirements. We may also provide general feedback on the network.

FAQ No. 4 **We currently have unmet reporting requirements. How should we report?**

Response If your company has an unmet reporting requirement it should be reflected in the report as being unmet.

<u>Best practice for reporting on unmet reporting requirements</u>.
If your company encounters an unmet reporting requirement the best practice is to provide the following information to the division:

1. An explanation of the unmet requirement (e.g. the rule citation).
2. How the requirement is unmet. For example, if the reporting requirement is to provide a process that hasn't been developed the company should state the requirement is unmet because the company hasn't developed the required process.
3. Any steps the company has taken to comply with the law, including implementation of an undocumented process.
4. How the company plans to be compliant by the 2023 reporting deadline.