Oregon
Kate Brown, Governor

Department of Consumer and Business Services
Division of Financial Regulation
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HEARING OFFICER'S REPORT TO AGENCY ON RULEMAKING

DATE: December 10, 2018
TO: Department of Consumer and Business Services
FROM: Alex Cheng, Hearing Officer

Subject: Out-of-Network Reimbursement Rate Rulemaking Hearing

Hearing Date	November 27, 2018
Hearing Location:	Labor & Industries Building, 350 Winter St. NE, Room 260
Comment Period End:	December 4, 2018

Background:

ORS 743B.287, as amended by Senate Bill 1549 (2018), requires an insurer offering a health benefit plan and a health care service contractor to reimburse an out-of-network provider for emergency services or other covered inpatient or outpatient services provided at an in-network health care facility. The statute directs the Department of Consumer and Business Services (DCBS) to promulgate rules for calculating reimbursement rates.

The statute requires that reimbursement be equal to the median allowed amount paid to in-network health care providers by commercial insurers in this state, based on data collected under ORS 442.466 for the 2015 calendar year, adjusted annually using the U.S. City Average Consumer Price Index for All Urban Consumers (All Items) (CPI-U) as published by the Bureau of Labor Statistics (BLS) of the United States Department of Labor. It allows reimbursement to be adjusted based on the differences in allowed amounts paid to health care providers in certain geographic areas of this state.

DCBS convened a rulemaking advisory committee consisting of health care providers, insurance carriers, consumer advocates, and other state agencies to provide input on the rule and its estimated fiscal and economic impacts. The committee met on April 24, May 29, July 16, August 14, and August 29, 2018.

With input from the committee, DCBS filed a notice of proposed rulemaking and statement of need and fiscal impact on October 23, 2018. The documents were published in the Secretary of State's November 2018 Bulletin.

Summary of Oral Comments:

A public hearing was held at 1:30 PM on November 27, 2018, at the Labor and Industries Building located at 350 Winter St NE, Salem, OR 97301. No oral comments were submitted.

Summary of Written Comments:

DCBS received 11 written comments from:

- Dan Caplis, CPA,
- Oregon Society of Anesthesiologists (OSA)
- Oregon Association of Orthopedic Surgeons (OAOS)
- The Oregon Chapter of the American College of Emergency Physicians (OCEP)
- Aetna Life Insurance Company
- Kaiser Foundation Health Plan of the NW
- Providence Health Plans
- Cambia Health Solutions
- MEDNAX Health Solutions Partner
- Moda Health Plan
- America's Health Insurance Plans (AHIP)

The comment letters addressed a number of topics:

Annual Adjustments – ORS 743B.287 directs DCBS to adjust reimbursement rates annually using the CPI-U. The proposed rule designates the adjustment for 2019 to be 107.83%, which represents percentage change from January 2015 to July 2018.

One comment inquired why CPI-U was used as an index. Several comments express concern that the annual adjustment formula does not adequately account for inflation due to the lag in data produced by BLS. A majority of comments supported using the adjustment formula in the proposed rule.

Geographic Adjustments – ORS 743B.287 allows DCBS to make adjustments to the reimbursement rates based on the differences in allowed amounts paid to health care providers in certain geographic areas. The proposed rule would make adjustments based on the seven geographic areas used for rating health benefit plans in Oregon as defined under OAR 836-053-0063.

Several comments supported making geographic adjustments based on the Center for Medicare and Medicaid Services' (CMS) Geographic Price Cost Index (GPCI), which divides Oregon into two localities. Insurance carriers indicated that they currently use GPCI in their billing systems, and that incorporating the seven geographic rating areas into their systems would impose an administrative burden. Several comments supported the geographic adjustments as proposed and indicated that limiting geographic adjustments to only two localities does not adequately account for the cost differences across the entire state.

Base Units – The proposed rule uses the assigned base units in the CMS CY 2018 Physician Fee Schedule for calculating reimbursement for anesthesia-related services. Several comments recommended using the base units assigned in the American Society of Anesthesiologists (ASA), Relative Value Guide 2018, because it more closely reflects the reimbursement rate of commercial claims. One comment supported the rule as proposed.

Obstetric Anesthesiology Services – The proposed rule uses the same reimbursement formula for obstetric anesthesia services as other anesthesia-related services. A majority of comments noted that obstetric anesthesiology services are adequately addressed in the proposed rule and recommended no change. One comment recommended no change to the reimbursement formula, but that language be added to clarify that labor epidurals are included in the anesthesia-related formula. One comment noted that the reimbursement formula in the proposed rule is correct, but that obstetric claims reported to the All Payer All Claims database may have inaccurate time units attached, thus inflating base units for all anesthesia-related rates. One comment suggested calculating a separate reimbursement schedule for obstetric services by calculating a mean epidural rate and a mean cesarean section rate.

Modifiers – For non-anesthesia procedures, the proposed rule allows for adjustments to be made to the base rate for modifiers AS, FX, FY, NU, RR, SA, UE, 22, 23, 25, 47, 50, 51, 52, 53, 54, 55, 56, 62, 66, 73, 78, 80, 81, and 82. For anesthesia-related procedures, the proposed rule allows for adjustments to be made to the base rate for modifiers QK, QX, and QY.

One comment recommended removal of modifiers NU and RR from the list, as they are not typically used in commercial claims. One comment recommended adding AD to the list of anesthesia-related modifiers. Several comments recommended against adding AD. One comment requested clarifying language that claims with modifiers not listed on the fee schedule should be reimbursed at 100% of the base rate.

Other Issues

The proposed rule provides a base rate for services for which a valid median allowed amount could be derived from 2015 claims reported to the All Payer All Claims database. For services that did not have a valid base rate, the proposed rule directs reimbursement to be at a rate agreed upon in good faith by the insurer and the provider. Several comments suggested that the final rule provide more guidance on the reimbursement of claims for which a base rate is not listed. Two comments suggested that a default rate be set as a percentage of Medicare. One comment suggested that a default rate be set using claims from an independent nonprofit database such as FAIR Health.

One comment suggested that implementation of the final rule be delayed for three months.

One comment noted that the proposed rule does not contain any enforcement mechanisms for health care providers that violate the prohibition on balance billing contained in ORS 743B.287.

Discussion:

Based on the comments submitted and input from the rulemaking advisory committee, DCBS concludes that:

- The annual adjustment formula in the proposed rule is the most appropriate and consistent with statutory requirements. Although the final rule will only apply to services provided in Oregon, ORS 743B.287 directs DCBS to adjust reimbursement using CPI-U, which is a national average. DCBS does not have authority to use a different index.
- The annual adjustment amount is appropriate. Because annual average data is not released by BLS until after the year is over, DCBS must rely on month by month CPI-U adjustments. Since 2015 APAC data represents claims reported throughout the 2015 calendar year, the ideal adjustment would be from the midpoint of 2015 (July) to January 2019. This adjustment is also not feasible because January 2019 data is not yet available. The proposed rule approximates the ideal formula by adjusting from January 2015 to July 2018 (the same length of time, but six months earlier).
- The geographic adjustments in the proposed rule are appropriate. The department recognizes the concerns raised by insurance carriers that adjusting based on 7 geographic rating areas would represent greater administrative costs than adjusting based on 2 GPCI localities. However, the 2 GPCI localities (the Portland metropolitan area and the rest of the state) do not adequately account for all of the geographic difference in the state. A more finely tailored geographic adjustment is needed to reflect cost differences, particularly in rural areas.
- Base units from the ASA Relative Value Guide 2018 should be used for anesthesia-related rate calculations. Although the ASA values are largely the same as the CMS fee schedule, DCBS agrees with comments noting that the ASA list more closely reflects the reimbursement rate of commercial claims. Many members of the rulemaking advisory committee also supported the use of the ASA list.
- The reimbursement formula for anesthesia-related services adequately accounts for obstetric anesthesia services. DCBS also agrees that additional language could be added to clarify that obstetric anesthesia services are included in the general anesthesia formula.
- NU and RR should be removed from the list of modifiers for non-anesthesia claims. These modifiers are used by CMS to make adjustments for new or rented durable medical equipment. A majority of rulemaking advisory committee, including insurance carriers and health care providers, indicated that these modifiers are not typically used in commercial claims and that they would not likely be relevant in out-of-network situations covered under the rule.
- AD should not be included in the list of modifiers for anesthesia-related claims. Several comments noted that this modifier is rarely used and most insurers do not make additional adjustments for that modifier.
- Additional language can be added to clarify that claims with modifiers not listed on the fee schedule should be reimbursed at 100% of the base rate.
- Additional guidance would be helpful when a valid median allowed amount can not be derived from 2015 APAC data. Because ORS 743B.287 requires that "reimbursement must be equal to the median allowed amount paid to in-network health care providers by commercial insurers in this state," DCBS may not set rates based on data sets that include Medicare or out-of-state claims.
- DCBS does not have the statutory authority to delay the implementation date nor to enact enforcement mechanisms for health care providers that violate the prohibition on balance billing contained in ORS 743B.287.

Summary:

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

- Base units from ASA Relative Value Guide 2018 be used for calculating anesthesia-related reimbursement;
- Additional language be added to clarify that reimbursement for obstetric anesthesia services be calculated with the formula for anesthesia-related claims;
- The reimbursement formula for non-anesthesia services not make adjustments for NU and RR;
- Additional language be added to clarify that claims with modifiers not listed on the fee schedule should be reimbursed at 100% of the base rate.
- Additional language be added to clarify that out-of-network claims for which the final rule does not provide a specific rate should be reimbursed "at a rate agreed upon in good faith by the insurer and the provider to be usual and customary for in-network commercial claims, using best efforts to establish a rate within a reasonable amount of time;" and
- The remainder of the rule be adopted as proposed.

Alex Cheng
Hearing Officer

This Summary and Recommendation are reviewed and adopted.

Signed this 19th day of December, 2018.

Department of Consumer and Business Services

Andrew Stolfi
Administrator
Division of Financial Regulation