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MEMORANDUM
FOR PUBLIC RELEASE

Date: May 21, 2020

TO: TK Keen, Deputy Administrator
Division of Financial Regulation
Department of Consumer and Business Services (DCBS)

FROM: Pramela Reddi, Assistant Attorney General
Health and Human Services Section

Re: Oregon Provider Non-Discrimination Provisions

The Division of Financial Regulation has asked for this legal analysis. Although publicly released, this memo is intended for reliance by state officers only.[1]

Question

What is the legislative intent of ORS 743B.505, specifically subsections (2) (a) and (b) that refer to "participation" and "coverage?"

Short Answer

Legislative intent is defined as "the ends sought to be achieved by a legislature in an enactment."[2] The legislative intent of ORS 743B.505(2) can be determined by evaluating the text in context and its pertinent legislative history. Under this analysis, this provision prohibits an insurer from discriminating against a health care provider for performing a covered service[3] the provider is licensed to perform. Non-discrimination does not require an insurer to contract with every provider who is qualified and willing to contract with an insurer.

[1] ORS 180.060(3)
[2] Legislative intent. 2020. In *Merriam-Webster.com*. Retrieved April 24, 2020, from https://www.merriam-webster.com/legal/legislative%20intent.
[3] A covered service is a service or benefit eligible for payment under the insurance plan.

Background

Oregon House Bill 2468 (2015) added "provider non-discrimination provisions" to the Insurance Code. These provisions align with similar federal requirements in the Patient Protection and Affordable Care Act (ACA), specifically section 2706(a) of the Public Health Service (PHS) Act.[4]

PHS Act Section 2706(a)

Section 2706 of the PHS Act was one of many provisions enacted by the ACA in 2010 as part of federal comprehensive health reform. There has been controversy over section 2706(a) since the Center for Consumer Information and Insurance Oversight (CCIIO) of the Centers for Medicare & Medicaid Services (CMS) issued informal guidance in the form of Frequently Asked Questions (FAQs) in April 2013.[5] This guidance elicited commentary and complaints by providers and provider organizations who were concerned about the exclusion of provider types and reimbursement rates. Members of Congress stated the guidance did not reflect the provision's legislative intent and directed the federal departments responsible for implementing the law to issue new revised guidance. In 2014, the Departments of Labor, Health and Human Services (HHS), and the Treasury published a Request for Information (RFI) to solicit "comments on all aspects of the interpretation of section 2706(a) of the PHS Act."[6]

Following a formal directive to provide a corrected FAQ,[7] the CCIIO posted the current guidance on May 26, 2015.[8] The current guidance includes the same introductory background as the 2013 guidance, provides additional background on why new guidance is being issued, and answers two new FAQs. The first question (Q4) addresses the "Departments' approach to PHS Act section 2706(a)" with this statement:

> "In light of the breadth of issues identified in the comments to the RFI, the Departments are restating their current enforcement approach to PHS Act section 2706(a). Until further guidance is issued, the Departments will not take any enforcement action against a group health plan, or health insurance issuer offering group or individual coverage, with respect to implementing the requirements of PHS Act section 2706(a) as long as the plan or issuer is using a good faith, reasonable interpretation of the statutory provision ***."

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[4] Section 1201 of the ACA, amended the Public Health Service Act by inserting, among other things, a new section 2706(a), codified as 42 USC § 300gg-5.
[5] FAQs about Affordable Care Act Implementation available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html.
[6] 79 FR 14051, 14052 (March 12, 2014) available at https://www.govinfo.gov/content/pkg/FR-2014-03-12/pdf/2014-05348.pdf.
[7] 160 Cong. Rec. H9837 (daily ed. Dec. 11, 2014) available at https://www.govinfo.gov/content/pkg/CREC-2014-12-11/pdf/CREC-2014-12-11-pt2-PgH9307-2.pdf
[8] Revised FAQs About Affordable Care Act Implementation (Part XXVII) available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQs-Part-XXVII-MOOP-2706-FINAL.pdf.

The second question (Q5) confirms that the current FAQs supersede the previous guidance and states, "[t]he Departments will continue to work together with employers, plans, issuers, states, providers and other stakeholders to help them comply ***."

Oregon law

The Oregon Legislature passed HB 2468 in 2015, which established provider network standards that aligned with the federal requirements in the ACA. The legislation included provisions, commonly referred to as "provider non-discrimination provisions," that explicitly align with section 2706(a). This direct linkage is indicated in the provision that states, "[r]ules adopted *** to implement this section shall be consistent with [section 2706] and the rules adopted by the [US HHS], the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 300gg-5 that are in effect on January 1, 2017."[9]

Rulemaking

To date, no rules have been adopted to implement section 2706(a) or the Oregon provider non-discrimination provisions.

Legislative Intent

The process of determining the legislative intent of a statute involves three steps. First, consideration is given to the statutory text in context. Next, pertinent legislative history may be reviewed. Finally, if the legislative intent is still not clear, then "general maxims of statutory construction" should be applied.[10] However, statutory construction is generally applied using state law. As discussed below, ORS 7432B.505(2) is best interpreted in the context of federal law. Further complicating the analysis is that the federal guidance on the ACA provision has been reduced to a "good faith" and "discretionary" interpretation of the statute, signaling the lack of clarity and lack of consensus as to the interpretation of the federal provision.

Text and Context

The text is the primary source for meaning of a statute.[11] The Oregon Supreme Court emphasized this in *State v. Gaines*: "Only the text of a statute receives the consideration and approval of a majority of the members of the legislature, as required to have the effect of law."[12] Courts have held that rules of statutory construction, mandated by statute or case law, will determine how to read the text. The general context of the statute, also considered at the

[9] ORS 743B.505(2)(d).
[10] *State v Gaines*, 346 Or. 160 at 171-172.
[11] *PGE v. BOLI*, 317 Or. 606, 610 (1993).
[12] *State v Gaines*, 346 Or. 160 at 171.

outset, follows similar interpretation methods as text. [13] For legislative history, its evaluative weight should be considered to determine legislative intent.[14]

The context for ORS 743B.505(2) is important to interpreting the statute's text. HB 2468 was enacted to establish provider network standards that require insurers to "contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers" and to "ensure reasonable and timely access."[15] The legislation was also enacted to give Oregon authority to enforce minimum access standards established by the ACA and specifically, ORS 743B.505(2) is based on section 2706(a) in the ACA.

The text related to "participation" and "coverage" in ORS 743B.505 is:

> "(2)(a) An insurer may not discriminate with respect to participation under a health benefit plan or coverage under the plan against any health care provider who is acting within the scope of the provider's license or certification in this state.
> (b) This subsection does not require an insurer to contract with any health care provider who is willing to abide by the insurer's terms and conditions for participation established by the insurer."

And, the related text in section 2706(a) is:

> "PROVIDERS. - A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. ***"

As the source for ORS 743B.505(2), first I will review the text in section 2706(a). This provision states that both "*group health plans* and *health insurance issuers offering group or individual health insurance coverage* shall not discriminate with respect to participation under the plan or coverage" against a health care provider. (Emphasis added.) This language states that two types of insurers (1. group health plans and 2. issuers of group/individual health insurance coverage) may not discriminate with respect to participation under these two types of insurance. These types of insurance are also referred to as a "plan" and "coverage" respectively. Therefore, section 2706(a) means that group health plans may not discriminate with respect to participation under the group health plan and, likewise, health insurance issuers offering group or individual health insurance coverage may not discriminate with respect to participation under the health insurance coverage.

The reference in section 2706(a) to two types of health insurance signals that the provision governs both federally regulated plans, as defined in the Employee Retirement Income

[13] *PGE v. BOLI*, 317 Or. 606 at 611.
[14] *State v Gaines*, 346 Or. 160 at 171-172.
[15] See ORS 743B.505(1).

and Security Act of 1974 (ERISA), and health insurance regulated by states. The definitions for these types of insurance are found in federal law. "Group health plan" is an ERISA "employee welfare benefit plan" and "health insurance issuer" means: "*** an insurance company *** which is licensed to engage in the business of insurance *** and which is subject to State law which regulates insurance ***."[16]

The text in ORS 743B.505(2) is based on the text in section 2706(a). Subsection (2)(d) makes explicit this alignment with the federal law by requiring that rules adopted by DCBS to implement this section be consistent with section 2706 and the federal rules to implement section 2706.[17] As rules are derived from their statutory authority, this alignment would be predicated on alignment in the underlying statutes.

The similarities in the text of the two laws also emphasize their alignment. The text of ORS 743B.505(2)(a) refers to a "health benefit plan" – the term used generally for state-regulated health insurance plans.[18] This subsection states, "An insurer may not discriminate with respect to participation under a health benefit plan or coverage under the plan" against any health care provider. Read in alignment with section 2706(a), this provision means an insurer may not discriminate with respect to participation under a health benefit plan against any health care provider.

As well, the text of subsection (2)(b) is very similar to the text in section 2706(a). The Oregon provision states, "This subsection does not require an insurer to contract with any health care provider who is willing ***." The federal provision, again referring to both types of insurance, states "This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing ***."

Legislative history

In addition to the text and context of a statute, pertinent legislative history may be examined to determine the legislature's intent for the statute.[19] Whether the legislative history is of assistance in "determining legislative intent will depend on the substance and probative quality of the legislative history itself."[20] As ORS 743B.505(2) is based on a similar provision in PHS Act section 2706, its legislative history is relevant and may also be evaluated.[21]

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[16] 42 USC § 3000gg-91 (a)(1) and (b)(1).
[17] ORS 743B.505(2)(d) states: "Rules adopted by the Department of Consumer and Business Services to implement this section shall be consistent with the provisions of 42 U.S.C. 300gg-5 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 300gg-5 that are in effect on January 1, 2017."
[18] See ORS 743B.005(16).
[19] *State v Gaines*, 346 Or. 160, 171-172 (2009).
[20] *Id.* at 172 n.9.
[21] See *State v. Cooper*, 319 Or 162, 168 (1994), which states: "*** the Oregon legislature *** knew of the significant role played by Congress in adopting the federal rules. Thus, we give weight to a pre-existing interpretation by Congress of the language adopted by the Oregon legislature and look to the legislative history of FRE 615 for guidance in determining Oregon legislative intent concerning OEC 615(2)."

ORS 743B.505

The legislative history for ORS 743B.505(2) consists of a statement by the Insurance Commissioner from DCBS, the agency that sponsored the legislation, written testimony by stakeholders, and written staff summaries. No legislator testimony was found in the record. Where there is no testimony from legislators available, other types of legislative history may be give appropriate consideration. Statements about the legislation made "post-enactment" are generally not considered by courts to carry any weight. That the statute is already in effect makes subsequent statements by legislators irrelevant.[22]

The legislative record for ORS 743B.505(2) includes remarks by Insurance Commissioner Laura Cali recorded at the House Committee on Health Care hearing on March 25, 2015.[23] In response to a question from Representative Knute Buehler about subsection (2) she states:

> "This language is very similar to federal language that does the same thing. It basically says that an insurer can't discriminate based on the type of licensure that a provider has and say, 'well, you may be licensed to do a certain procedure or the scope of your license allows you to do that, but, as a general rule, I'm not going to reimburse a chiropractor who performs the service.' There are some different elements and some different things that insurers can do to structure their program and their reimbursement. But it is making it really clear that they can't just say, 'I don't contract ever with any chiropractors or I don't ever reimburse chiropractors for this.' It's intended to make sure that we reference that important piece of the federal law in building an adequate network."

Commissioner Cali represented DCBS, the agency that was a "principal proponent" of the bill. As such, "greater weight" to this non-legislator testimony may be given.[24] However, some case law cautions against relying on a single legislator or witness in determining the legislature's intent. [25] Commissioner Cali's remarks would likely be given significant weight based on her position and DCBS' support of the legislation.

In Commissioner Cali's remarks, she states the provision in subsection (2) is similar and "does the same thing" as the federal law. She then states that the provision "basically says that an insurer can't discriminate based on the type of licensure that a provider has and say, 'well, you may be licensed to do a certain procedure or the scope of your license allows you to do that, but, as a general rule, I'm not going to reimburse a chiropractor who performs the *service*.'" She further clarifies by stating, "*** it is making it really clear that [insurers] can't just say, 'I don't contract ever with any chiropractors or I don't ever reimburse chiropractors *for this*.'" (Emphasis

[22] *Tektronix, Inc. v. Dep't. of Revenue*, 354 Or. 531, 546 (2014); *United Tel. Emps. PAC v. Sec'y of State*, 138 Or. App. 135, 139 (1995).
[23] House Committee on Health Care, March 25, 2015, at 49:25.
[24] *Kohring v. Ballard*, 355 Or. 297, 312-313 (2014).
[25] *Patton v. Target Corp*., 349 Or. 230, 242 (2010).

added.) Her remarks indicate "service" in this context means a covered service. If the service was not a covered benefit under the insurance plan, an insurer could deny reimbursement based on the service not being a covered benefit. For the provider type to be relevant in this context, the service must be a covered service and eligible for reimbursement. As such, "for this" refers to a covered service. Therefore, Commissioner Cali appears to state at this hearing that the provision does not allow insurers to refuse to reimburse providers for a covered service based on their provider type.

Written testimony from two persons also addressed subsection (2). Jeff Clark of the Oregon Association of Naturopathic Physicians submitted two letters dated February 16, 2015 and April 22, 2015.[26] In the second letter, he supplements his earlier remarks and states:

> "This language mirrored language already codified in the Affordable Care Act so that our federal and state laws would reflect and reinforce each other. We began working with the Oregon Insurance Division in the summer of 2013 about issues relating to implementation of the Affordable Care Act. Specifically, we were focused on implementing what has become known colloquially as Section 2706 of the ACA – a clause that prohibits insurance companies from discriminating against provider types in either coverage or participation in a plan. That office immediately understood the importance of including provider non-discrimination language in Oregon's own state-level network adequacy discussions in order to keep consistency in networks and insurance coverage for patients moving between Medicaid, the Exchange, and individual or group plans. Subsequently Commissioner Cali invited us to the network adequacy discussion and included provider non-discrimination language in HB 2468 that will make all parts of Oregon's insurance market accountable to the same standard. Including the provider non-discrimination language in HB 2468 will provide Oregon's own agencies (regulating both CCOs and, with this bill Oregon's commercial insurance market) with the legal tools they need to educate, implement and enforce laws designed to hold insurers accountable for providing health plans that can actually provide access to healthcare and ensure that Oregonians have access to all the state licensed provider types that can provide covered services."

The written testimony of Laura Jenson from the Oregon Affiliate of the American College of Nurse-Midwives also addresses subsection (2). In her April 22, 2015 letter[27] she states:

> "Furthermore, this bill would prohibit a health care service plan or health insurer from discriminating against any health care provider working within the scope of the provider's license or certification. *** One plan pays CNMs at a lower rate than they pay physicians for the same service, a practice that is not based on outcomes or performance but simply a result of licensure, clearly a discriminatory

[26] Jeff Clark, Senate Committee on Health Care, April 22, 2015, available at https://olis.leg.state.or.us/liz/2015R1/Downloads/CommitteeMeetingDocument/67961.
[27] Laura Jenson, Senate Committee on Health Care, April 22, 2015, available at https://olis.leg.state.or.us/liz/2015R1/Downloads/CommitteeMeetingDocument/67840.

> approach to reimbursement. Two plans indicate they do not cover home birth services rendered by CNMs, even though this is a legal part of CNM practice within the state. *** Although the picture we have for Oregon, based on limited data, is relatively positive, we support HB 2468 because the national picture painted by our survey is very different. We are concerned that large insurers may seek to implement practices in Oregon they have used in other states, limiting access to midwifery services, to the detriment of the women and children we serve. *** It is a serious matter that a major provider of maternity and newborn care is being systematically excluded or discriminated against by plans participating in the exchanges."

Stakeholder testimony may be considered but is often not considered relevant by courts.[28] For HB 2468, the written testimony by stakeholders discussed the alignment with the ACA provision, network adequacy, and reimbursement issues. These statements may certainly reflect the aspirations of the stakeholders, but it is less clear whether they are dispositive of the legislature's intent.

Lastly, there are two Staff Measure Summaries[29] for HB 2468. Regarding subsection (2), both summaries state:

> "Grants Department of Consumer and Business Services (DCBS) rulemaking authority and specifies that rules relating to provider non-discrimination must align with federal requirements."

These summaries support the text of the statute, which under subsection (2)(d) require that rules adopted to implement subsection (2) must be consistent with PHS Act section 2706(a).

Section 2706(a)

The legislative record for section 2706(a) is limited to remarks recorded in the Congressional Record by Representative Bill Pascrell, Jr. in his role as co-chair of the Congressional Brain Injury Task Force.[30] His remarks emphasize network adequacy, continuum of treatment, and treatment settings. His remarks specifically addressing section 2706(a) do not add any further context for this provision. Those remarks are the following:

> "In addition, the bill [H.R. 3590] specifies that a group health plan and a health insurance issuer shall not discriminate with respect to participation in the group or individual health insurance plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. The bill also specifies that health plans to be considered ''qualified'' by the Secretary must ensure ''a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section

[28] *Qwest Corp. v. City of Portland*, 275 Or. App. 874, 893-894 (2015).
[29] Staff Measure Summaries for Senate Committee on Health Care, March 25, 2015 and April 22, 2015, available at https://olis.leg.state.or.us/liz/2015R1/Measures/Analysis/HB2468.
[30] Cong. Rec. E463 (111th Cong., daily ed. March 23, 2010) available at https://www.congress.gov/111/crec/2010/03/23/CREC-2010-03-23.pdf

> 2702(c) of the Public Health Services Act) and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers'' in order to ensure enrollee access to covered benefits, treatments and services under a qualified health benefits plan. Thus, rehabilitative and habilitative services and chronic disease management services must be available from a full continuum of accredited programs and treatment settings at a level of intensity that is consistent with the needs of the patient."

Conclusion

The legislative intent of ORS 743B.505(2), evaluating its text in context and its pertinent legislative history, can be determined. The text of subsections (2) (a) and (b) together provide that 1) a health insurer may not discriminate against a health care provider who is acting within the scope of the provider's license or certification and 2) an insurer is not required to contract with any health care provider who is willing to participate in the health benefit plan. The first part states the prohibited discrimination is discrimination based on acting within the scope of a provider's license. In other words, an insurer may not discriminate against a provider for performing a service they are licensed to perform. The second part adds that an insurer is not required to contract with every provider. Read in the context of the previous discrimination language, this text indicates that it is not discriminatory per se if an insurer decides not to contract with a provider.

Commissioner Cali's remarks in the legislative record describe the discrimination issue as one involving reimbursement for a covered service (i.e., the service is eligible for payment under the insurance plan). Her remarks indicate that ORS 743B.505(2) means that if a provider performs a covered service that is within the scope of their license, then an insurer cannot object to reimbursing the provider based on their provider type. In summary, ORS 743B.505(2) provides that an insurer cannot refuse to pay the provider for a covered service based on the provider's license or certification type, but the insurer is not required to contract with every provider qualified and willing to contract with an insurer.