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November 24, 2021

Pat Allen, Director, Oregon Health Authority
500 Summer Street NE, E-20
Salem, OR 97301

Delivered electronically to: hcmo.info@dhsoha.state.or.us

RE: Rules Advisory Committee for the Health Care Market Oversight Program

Dear Director Allen,

We continue to appreciate the Authority's thoughtful leadership and efforts invested into building the Health Care Market Oversight Program.

On the whole, we think the third draft of the rules is much simpler and clearer. Combined with the table of examples, there is much greater clarity about which transactions and entities must file for review, as well as how the Authority will manage exclusions. In addition, we appreciate the revised fee schedule, which seems more appropriate especially for less complex transactions.

However, we think further edits are required to ensure the draft rules align with the statute or serve the best interest of the program. We provide specific suggestions below.

Thank you for your ongoing efforts to make this important program successful; we look forward to reviewing the final rules.

Sincerely,

Kirsten Isaacson
Research Director

# FEEDBACK ON 11.10.21 DRAFT RULES FOR HEALTH CARE MARKET OVERSIGHT PROGRAM

**OAR 409-070-0010: Covered Transactions**

- **(2)(h)** In general, we are very supportive of the thoughtful definition of reduction of essential services. It is well drafted and reflective of the need to serve a variety of populations, especially those currently underserved.

  We have one suggested edit that, while small, is critical. "Prenatal care" should be updated to "Pregnancy care" to encompass the full array of maternity care services, from conception through birth. These services are essential by all definitions.

  *(h) A reduction in the availability of any specific type of care such as primary care, behavioral health care, oral health care, specialty care, ~~prenatal~~ pregnancy care, inpatient care, outpatient care, or emergent care.*

**OAR 409-070-0022: Emergency**

- **(1)** Statute clearly dictates that the emergency exemption not be used for solvency issues alone. The failure to complete the transaction must also have a negative impact on consumers. To conform with Section (2)(8)(a) of the statute, "or" must be changed to an "and" in the following situations:
  - *(1) Pursuant to Section 2(8)(a) of the 2021 Act, the Authority, for good cause shown, may exempt an otherwise covered transaction from review if the Authority finds that (i) there is an emergency situation which immediately threatens health care services and (ii) the transaction is urgently needed to protect the interest of consumers ~~or~~ and to preserve the solvency of an entity other than a domestic health insurer.*
  - *(2) If a proposed transaction would otherwise be subject to review because it involves a change in control of a domestic health insurer, the Department, in consultation with the Authority, for good cause shown, may exempt the transaction from review if the Department finds that (i) there is an emergency situation which immediately threatens health care services and (ii) the transaction is urgently needed to protect the interest of consumers ~~or~~ and to preserve the solvency of the domestic health insurer.*

  This necessary change is informed by two areas of the statute:
  - Section (2)(8)(a): *"Criteria to exempt an entity from the requirements of subsection (4) of this section if there is an emergency situation that threatens immediate care services **and** the transaction is urgently needed to protect the interest of consumers..."*
  - Section (2)(6)(a): *"If the transaction is in the interest of consumers **and** is urgently necessary to maintain the solvency of an entity involved in the transaction..."*

- **(4)** We appreciate that the Authority has created space where confidentiality and urgency may be prioritized when necessary. However, this flexibility should be balanced with transparency, even if retroactively. It should be made clear in the rules that all transaction applications will be made public within 30 days of approval (given the emergency situation we assume this will also mean post transaction closing).
- **Addition:** We believe that transparency around emergency exemptions and when they are used will be informative to the public and health policymakers. Therefore, we request that the Authority disclose on an annual basis the frequency with which transactions are exempted under each emergency category.
- **Addition:** We believe that if there is the unfortunate situation of entities creating the conditions for an emergency or purposefully delaying until urgent to avoid review, the pattern should be noted and there be consequences. Therefore we suggest the following addition: *Repeat, excessive use of the emergency exemption by related entities will result in stricter application of the standard.*

**OAR 409-070-0045: Form and Contents of Notice of Material Change Transaction**

- **(8)** We remain concerned about the Analytic Framework. What is most important in the framework is that the standards be strongly reflective of the statute. While ensuring the process is "clear, fair, predictable and consistent" is an important and laudable goal, any additional standards established in rule must not supersede those explicitly outlined in the statute.
- **(8)(b)** Looking deeper into the language around the framework, we are concerned that as written, measures of quality and access must be compared across Oregon or to other states, and over time. This could be an impossibly high bar to meet. The core of the legislation is centered around protecting essential services, controlling consumer healthcare prices, and addressing contributors to health inequities. There just aren't HEDIS-like measures for all of these. Oregon is often leading the way on such measures. Setting a standard that prioritizes cross-state metrics could overly narrow the scope of vision and perpetuate problematic and short-sighted rubrics this program seeks to update.

**OAR 409-070-0050: Retention of Outside Advisors**

- We believe the ability to retain outside advisors is critical to ensuring the Authority, Agency, or any applicable review body not only has the capacity to move the review forward in a timely manner, but also the correct expertise. We believe this is in the interest of both applicants and impacted communities. However, we also understand concerns that were raised about unknown and uncapped fees. We suggest a clarifying addition, such as, "*Expenses shall be reasonably incurred and scoped to the size and complexity of the transaction."*

**OAR 409-070-0060: Comprehensive Review of a Notice of a Material Change Transaction**

- **(8)(a)** We believe that "commitment" is ill-defined and more reflective of intentions on paper than a demonstrable track record in that area. We suggest deleting reference to "commitment" and instead add that assessing if a transaction will reduce health disparities can be informed by *"a) the purpose and plan of the transaction itself and b)*

*entities' track records."* That said, we understand this is the language adopted by the Oregon Health Policy Board.

- **(8)(d)(B) and (8)(e)** It has already been established in other sections of the rules that assessing impact on a statewide basis is not always appropriate. Just as "improving health" will not be measured across the whole state in earlier sections, access and competition should also not be measured this way. Therefore, we suggest that *"or a region of the state"* be added for clarity in two areas:
    - *(8)(d)(B) Access to and quality of health care for people in this state, including access to essential services, or would substantially increase the cost of health care for people in this state <u>or a region of the state</u>; or*
    - *(8)(e) There is a substantial likelihood that the transaction would result in material anticompetitive effects in this state, <u>or a region of the state,</u> that would not be outweighed by an increase or maintenance of services to the underserved populations.*
- **Addition**: We remain concerned that this section, while addressing some very important points, fails to reflect a key aspect of the statute. Section (2)(9) of the law specifies that transactions must benefit the public good.

  Section 2.9 of the statute states:
    - *A health care entity may engage in a material change transaction if, following a comprehensive review conducted by the authority and recommendations by a review board appointed under subsection (7) of this section, the authority determines that the transaction meets the criteria adopted by the department by rule under subsection (2) of this section and: (a)(A) The parties to the transaction demonstrate that the transaction will benefit the public good and communities…*

  We propose the following edits to reflect the statute requirement:

    - *(8) The Authority shall approve, or approve with conditions as provided in OAR 409-070-0065, a material change transaction, or, in the case of a material change transaction involving a domestic health insurer, recommend to the Department that the transaction be approved <u>if the conditions under [NEW SECTION] are met</u> and, unless the Authority makes any one or more of the following findings and conclusions:*

  *<u>(NEW SECTION #) In order to approve a transaction after a comprehensive review, the Authority must conclude that either:</u>*

  *(a) <u>The transaction will, on balance, benefit the public good and impacted communities by:</u>*

  *(A) <u>Reducing the growth in patient costs in accordance with the health care cost growth targets established under ORS 442.386 or maintain a rate of cost growth that exceeds the target that the entity demonstrates is the best interest of the public; or</u>*

*(B) Increasing access to services in medically underserved areas; or*

*(C) Rectifying historical and contemporary factors contributing to a lack of health equities or access to services; or*

*(b) The transaction is likely to improve health outcomes for residents of the state and there is no substantial likelihood of anticompetitive effects from the transaction that outweigh the benefits of the transaction in increasing or maintaining services to underserved populations.*

**Regarding the Proposed Forms:**
We respectfully offer the following suggestion in an effort to simplify the proposed forms.

We suggest collapsing the cover sheet into Exhibit 2. Both forms are public and must be completed by everyone. By moving the contact information questions into Form 2, we believe you could simplify the process by having one initial form for all applicants.

We understand and share the concerns raised by some parties about the relevancy of some questions and requirements present in Exhibit 1 (e.g., background checks). We also recognize that Exhibit 1 is a near duplicate of DCBS's Form A that is currently in use. There is value to aligning the forms. However, we suggest that OHA collect the in-depth information included in Exhibit 1 only once a comprehensive review is deemed necessary. The rules could also accommodate using the cover sheet/Exhibit 2 as the initial filing form and allow the Agency to request additional information if needed to make an initial determination.

If the program requires entities to file a revised Exhibit 2 (including necessary cover sheet information), along with the term sheet and recent financials, it would be simpler and more similar to the initial form used in Massachusetts' program. We hope the initial review could proceed with that level of information.