836-053-0300

Purpose; Statutory Authority; Applicability of Network Adequacy Requirements

(1) OAR 836-053-0300 to 836-053-~~0350~~ xxxx are adopted for the purpose of implementing ORS 743B.505.

(2) ~~The requirements set forth in OAR 836-053-0320 to 836-053-0340 apply to all insurers offering individual or small group health benefit plans in this state that are issued or renewed on or after January 1, 2017.~~ The requirements set forth in OAR 836-053-0310 to 836-053-XXXX apply to all carriers offering individual or group health benefit plans in this state that are issued or renewed on or after January 1, 2026. These requirements apply to the adequacy of networks serving enrollees who reside in Oregon.

~~(3) The requirements set forth in OAR 836-053-0310 and 836-053-0350 apply to all insurers offering individual, or small group health benefit plans in this state that are issued or renewed on or after January 1, 2017.~~

Statutory/Other Authority: ORS 731.244 and 743B.505
Statutes/Other Implemented: 743B.505
History:
ID 10-2016, f. & cert. ef. 9-14-16

836-053-0310
Network Adequacy Definitions for OAR 836-053-0300 to 836-053-0350

(1) As used in these rules:

(a) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible for a group or individual health benefit plan who has enrolled for coverage under the terms of the plan.

~~(b) "Insurer includes a health care service contractor as defined in ORS 750.005.~~" Carrier" has the meaning given that term in ORS 743B.005.

(c) "Health benefit plan" means any:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or

(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

(d) "Network plan" means a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with or employed by the ~~insurer~~carrier.

(e) "Marketplace" means health insurance exchange as defined in OAR 945-001-00002(23~~4~~).

(f) "Low-income zip code" means a ZIP code included in the Centers for Medicare and Medicaid Services (CMS) Marketplace Low-Income ZIP Code list for the applicable plan year, as published by CMS.

(g) "Health professional shortage area" or HPSA means a geographic area, population group, or facility designated as such by the Department of Health and Human Services under 42 U.S.C. § 254e. For purposes of network adequacy, a provider or facility will be considered to be located in or serving an HPSA if it appears on the HPSA ZIP code list published by CMS, updated annually.

(h) "Telemedicine" has the meaning given that term in ORS 743A.058.

(i) Nationally recognized standards" means the federal network adequacy standard for Qualified Health Plans, as set forth in 45 C.F.R. § 156.230, as in effect on January 1, 2025, unless otherwise specified in these rules.

(j) “County" means the designation assigned by the Centers for Medicare & Medicaid Services (CMS) for purposes of applying network adequacy standards for Qualified Health Plans (QHPs). County classifications are defined in the CMS *2025 Letter to Issuers* and include:

(A) Large Metro – Counties with a population size and population density meeting the CMS thresholds for large metropolitan areas;

(B) Metro – Counties with a population size and population density meeting the CMS thresholds for metropolitan areas;

(C) Micro – Counties with a population size and population density meeting the CMS thresholds for micropolitan areas;

(D) Rural – Counties with a population size and population density meeting the CMS thresholds for rural areas; and

(E) Counties with Extreme Access Considerations (CEAC) – Counties with a population density of fewer than 10 persons per square mile, as determined by CMS.

Statutory/Other Authority: ORS 731.244 and 743B.505
Statutes/Other Implemented: 743B.505
History:
ID 10-2016, f. & cert. ef. 9-14-1

~~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) 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, gay, lesbian, bisexual, transgender, and any other minority gender identity or sexual orientation, physical or mental disabilities, and serious, chronic, complex medical or behavioral health 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, if 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 & ORS 743B.505
Statutes/Other Implemented: ORS 743B.505
History:
ID 8-2022, amend filed 12/22/2022, effective 01/01/2023
ID 6-2019, amend filed 06/17/2019, effective 07/01/2019
ID 10-2016, f. & cert. ef. 9-14-16

836-053-0330

Nationally Recognized Standards for Use in Demonstrating Compliance with Network Adequacy Requirements

(1) 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 the federal network adequacy standards applicable to Medicare Advantage plans, adjusted to reflect the age demographics of the enrollees in the plan. An insurer must adjust the Medicare Advantage network adequacy standards to ensure these specialties are included for the age demographics of the population covered by the network plan:

(a) 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 Director no later than March 31 each year for the immediately preceding calendar year as of December 31.

Statutory/Other Authority: ORS 731.244 & ORS 743B.505
Statutes/Other Implemented: ORS 743B.505
History:
ID 6-2019, amend filed 06/17/2019, effective 07/01/2019
ID 10-2016, f. & cert. ef. 9-14-16

836-053-0340

Factor-Based Evidence of Compliance with Network Adequacy Requirements

(1) An insurer electing to demonstrate compliance with network adequacy requirements required under ORS 743.505B via the factor-based approach shall submit evidence of compliance to the Director by March 31 each year.

(2) The evidence must include a narrative description of how the insurer complies with the factor along with the source and methodology, where applicable, for at least one of the factors listed for each of these categories:

(a) Access to Care Consistent with the Needs of the Enrollees Served by the Network category:

(A) Access to Care Factor #1– The insurer's network ensures all covered services under the health benefit plan are accessible to enrollees without unreasonable delay.

(i) Submit median enrollee wait times for preventive care appointments for the prior calendar year.

(ii) Submit median length of time enrollees waited for access to mental health and substance abuse providers for the prior calendar year.

(iii) Submit median length of time enrollees waited to receive care for mental health conditions following intake evaluation.

(iv) Evidence that the network provides 24-hour access to clinical advice.

(v) Urgent care services outside of regular business hours are available in all covered regions or service areas.

(vi) Submit median enrollee wait times for routine care appointments for the prior calendar year.

(vii) Submit median enrollee wait times for specialist appointments for the prior calendar year.

(B) Access to Care Factor #2 – The network meets special needs of specific populations.

(i) The network has the capacity to accept new patients.

(ii) The network includes a full range of pediatric providers including pediatric subspecialists and providers that offer care to children with special needs.

(iii) Services are made available to enrollees residing in medically underserved areas of the state, if the insurer offers coverage in those areas.

~~(iv) All plans served by a network are included when determining whether the network is sufficient.~~

~~(v) The network provides access to culturally and linguistically appropriate services.~~

~~(C) Access to Care Factor #3 – The insurer actively manages the network including oversight of access to care.~~

~~(i) Providers who are not accepting new patients are not included when determining whether an adequate number of providers (including specialists) are in the network.~~

~~(ii) All plans served by a network are included when determining whether the network is sufficient.~~

~~(iii) The network adequacy monitoring process includes specific intervals between formal reviews, reporting of review results to senior management or board of directors, and formal reviews are used to monitor and improve accessibility for enrollees.~~

~~(b) Consumer Satisfaction category:~~

~~(A) Consumer Satisfaction Factor #1 – Insurer maintains accreditation status and can demonstrate consumers are satisfied with the plan.~~

~~(i) Submit insurer accreditation status from either the National Committee for Quality Assurance (NCQA), URAC, or the Accreditation Association for Ambulatory Health Care (AAAHC) including information regarding customer satisfaction rating from accreditation entity; or~~

~~(ii) Either of the following:~~

~~(I)Global rating of health plan (Enrollee Satisfaction Survey Consumer Assessment of Healthcare Providers and Systems) and~~

~~(II) Global rating of health care (Enrollee Satisfaction Survey Consumer Assessment of Healthcare Providers and Systems).~~

~~(B) Consumer Satisfaction Factor #2 – Consumers are able to access care when needed without unreasonable delay.~~

~~(i) Number of enrollee communications the insurer received during the previous calendar year regarding difficulty in obtaining an appointment with a provider, including but not limited to the inability to find a provider with an open practice or an unreasonable length of time to wait for an appointment.~~

~~(ii) Number of consumer complaints the insurer received during the previous calendar year regarding care received out of network due to consumer's inability to receive care in network. Communications under this section include but are not limited to complaints, appeals and grievances from enrollees.~~

~~(iii) Median wait times for members to be seen at time of appointment.~~

~~(c) Transparency:~~

~~(A) Transparency Factor #1 – Insurer maintains an accurate provider directory which is available to the general public.~~

~~(i) Provider locations are transparent to the public.~~

~~(ii) Provide link to website where provider directory is located and explain how frequently the directory is updated and where this information is disclosed on the provider directory.~~

~~(iii) Explain how the insurer keeps information on which providers in the network have open practices and how often this information is updated.~~

~~(iv) Provide position and department of individual responsible for establishing and monitoring the network.~~

~~(B) Transparency Factor #2 – Consumers, enrollees and providers have access to accurate provider information.~~

~~(i) Providers have access to information about other providers in the network.~~

~~(ii) Consumers and enrollees are informed on how to locate in-network providers when scheduling medical services.~~

~~(iii) Explain how frequently enrollees are specifically notified of changes to the provider network and the method the insurer uses to communicate this information.~~

~~(iv) Provider directory discloses which providers are fluent in languages other than English and if so, what languages are available.~~

~~(v) Consumers and enrollees are informed of providers in the network with open practices.~~

~~(d) Quality of Care and Cost Containment:~~

~~(A) Quality of Care and Cost Containment Factor #1 – The insurer engages in provider quality improvement activities.~~

~~(i) Submit provider quality data the insurer uses.~~

~~(ii) Describe the specific quality designations required of specialists in the network.~~

~~(iii) Explain provider accreditation status requirements used by the insurer.~~

~~(iv) Provide the percentage of accredited patient-centered primary care homes in the network.~~

~~(v) Provide a list of all provider types included in the network and identify those who provide telemedicine services.~~

~~(B) Quality of Care and Cost Containment Factor #2 – The insurer is implementing quality improvement activities in addition to provider quality improvement.~~

~~(i) The insurer reports quality improvement strategies to the public.~~

~~(ii) The provider payment structure supports improved health outcomes, reduction of hospital readmissions, improved patient safety and reduction of medical errors, and reduction of health care disparities.~~

~~(iii) The insurer offers health promotion and wellness programs to enrollees.~~

~~(iv) Appointments with high volume specialists are available within the network without unreasonable delay.~~

~~(C) Quality of Care and Cost Containment Factor #3 – The insurer employs network design strategies to reduce cost and improve quality.~~

~~(i) The network design supports improved enrollee health and lower cost.~~

~~(ii) The insurer analyzes relevant information to promote good health outcomes.~~

~~(iii) The network can be considered a high-value network.~~

~~(iv) Electronic health records are used within the network.~~

~~**Statutory/Other Authority:** ORS 731.244 and 743B.505~~
~~**Statutes/Other Implemented:** ORS 743B.505~~
~~**History:**~~
~~ID 10-2016, f. & cert. ef. 9-14-16~~

836-053-XXXX

Nationally Recognized Standard for Annual Network Adequacy Evaluation

(1) For purposes of the annual evaluation of network adequacy required by ORS 743B.505, the department adopts the nationally recognized standard for network adequacy, defined as the federal network adequacy standards for Qualified Health Plans set forth in 45 C.F.R. § 156.230, as in effect on January 1, 2025, and as published in annual CMS network adequacy guidance. ~~The department will adjust these standards as needed to reflect the age demographics and service needs of Oregon enrollees and to address unique access issues, including provider availability in health professional shortage areas and low-income ZIP codes.~~

(2) Carriers must ensure network access for all provider specialties and facility types identified by CMS for Qualified Health Plans, including, at a minimum, primary care, behavioral health care, substance use disorder treatment, and reproductive health care services.

(3) Each carrier must submit all network data and documentation necessary for the department's annual evaluation, using forms, deadlines, and reporting templates prescribed by the department.

(4) Compliance with this rule does not exempt a carrier from meeting any other applicable network adequacy requirements under Oregon or federal law.

Statutory/Other Authority: ORS 731.244 & ORS 743B.505

Statutes/Other Implemented: ORS 743B.505

History:

ID 6-2019, amend filed 06/17/2019, effective 07/01/2019

ID 10-2016, f. & cert. ef. 9-14-16

836-053-XXX

Quantitative Network Adequacy Access Standards

(1) Carriers must meet the following minimum quantitative access benchmarks, consistent with the network adequacy standards for Qualified Health Plans set forth in 45 C.F.R. § 156.230, as in effect on January 1, 2025

(a) Travel time and distance

(A) Carriers must meet the time and distance standards established in 45 C.F.R. § 156.230, as in effect on January 1, 2025, ensuring that at least 90 percent of enrollees have access to in-network providers within the applicable time and distance requirements for each provider type and county as defined in OAR 836-053-0310(1)(j). The applicable federal standards, including specific time and distance benchmarks by provider and county type, are published by the Centers for Medicare & Medicaid Services (CMS) in Appendix E of the Network Adequacy Template for Plan Year 2025, available on the CMS QHP Application Materials website (https://www.qhpcertification.cms.gov/s/QHP%20Application%20Materials)

(B) Each carrier is responsible for conducting the geospatial analysis required to demonstrate compliance with time and distance standards. Carriers must submit the results of their analysis, showing the number and percentage of enrollees meeting each standard for every required provider and facility type, by county classification, in the format and manner prescribed by the Department.

(b) Appointment wait times

(A) For each provider type listed below, carriers must ensure that at least 90 percent of enrollees have access to an in-network appointment within the following timeframes:

(i) Primary care: not more than 15 business days.

(ii) Behavioral health care: not more than 10 business days.

(iii) Specialty care: not more than 30 business days.

(2) In areas designated as health professional shortage areas (HPSAs) by HRSA, or low-income ZIP codes as defined in OAR 836-053-0310, carriers may ~~adjust these quantitative standards, as permitted by federal guidance and as further described in OAR 836-053-XXXX (Network Adequacy Reporting Requirements).~~ satisfy these quantitative standards in this rule through a justification process as described in OAR 836-053-XXXX (**Network Adequacy Reporting Requirements).**

(3) In meeting the quantitative network adequacy standards in this rule, carriers may use telemedicine providers to satisfy up to:

(a) 10 percent of the access requirements for primary care and specialty care services; and

(b) 30 percent of the access requirements for behavioral health care services.

Statutory/Other Authority: ORS 731.244, 743B.505

Statutes Implemented: ORS 743B.505

~~**836-053-XXX**~~

~~**Culturally and Linguistically Responsive Care**~~

~~(1) Each carrier must maintain a network sufficient to provide appropriate, culturally, and linguistically responsive care for all enrollees, including those with diverse cultural and ethnic backgrounds, varying sexual orientations and gender identities, disabilities or physical or mental health conditions, and limited English proficiency.~~

~~(2) Carriers must:~~
~~(a) Contract with providers who reflect the language and cultural needs of the enrollee population;~~
~~(b) Support provider training in culturally responsive or trauma-informed care;~~
~~(c) Ensure provider directories accurately identify provider language skills and relevant experience, training, or capacity to serve the enrollee population, including those with limited English proficiency or disabilities.~~

~~(3) Carriers must annually report on actions taken under this section, including, but not limited to, data on language access and cultural competence among network providers, as required by OAR-053-XXXX (Network Adequacy Reporting Requirements).~~

~~Statutory/Other Authority: ORS 731.244, 743B.505~~

~~Statutes Implemented: ORS 743B.505~~

836-053-XXXX
Network Adequacy Reporting Requirements

(1) By March 31 of each year, a carrier must submit a network adequacy report for each health benefit plan offered or renewed in this state, demonstrating compliance with the requirements of OAR 836-053-0300 through 836-053-XXXX.

(2) The annual report must include, at a minimum, the following information for each network and health benefit plan:

(a) Identification of the carrier's network and the health benefit plans to which the network applies, including a description of how telemedicine or other technology is used to meet network access standards. The report must indicate the percentage of network adequacy standards met through telemedicine for each provider or service line, consistent with the limits adopted by the department;

(b) Evidence of compliance with the network adequacy standard (OAR 836-053-XXXX) and quantitative access standards (OAR 836-053-XXXX), including travel distance, time, and appointment wait times for each provider and facility type;

(c) For each required provider type and service line, including but not limited to behavioral health, substance use disorder, reproductive health, the report must include:

(A) The number, geographic distribution, and appointment availability of each provider and facility.

(B) Provider or facility name, specialty/type, location, and contact information.

(C) Whether the provider is accepting new patients.

(D) Whether the provider or facility is located in, or serves, a low-income ZIP code or health professional shortage area (HPSA).

(E) Network affiliations and tier level, if applicable

~~(d) For any area designated as an HPSA by HRSA or as a low-income ZIP code (as defined in OAR 836-053-0310), carriers must submit:~~

~~(A) Documentation identifying the HPSA designation or low-income ZIP code.~~

~~(B) A detailed justification for any adjustment made to the quantitative standards, referencing relevant HRSA or CMS guidance.~~

(d) For any network plan that fails to meet a quantitative time and distance or appointment wait time standard established by the department in a HPSA or low-income ZIP code (as

defined in OAR 836-053-0310), the carrier must submit a written justification demonstrating how the plan's provider network ensures that all covered services will be accessible to enrollees without unreasonable delay, consistent with 45 C.F.R. 156.230(a)(2)(ii). The written justification must include, at a minimum, the following mandatory elements for each unmet standard:

(A) Identify the specific network inadequacy and the required quantitative standard (e.g., maximum travel distance/time or wait time) that was not met.

(B) Provide a clear and concise explanation of the primary reason the network failed to meet the standard, such as a lack of available providers, a lack of providers willing to contract, or the recent departure or closure of a key provider or facility.

(C) Documentation of specific, recent, good-faith contracting efforts undertaken by the carrier to address the network gap.

(D) A description of mitigating measures that ensure enrollees in the affected area have access to care without unreasonable delay. This must detail the plan's specific strategy for providing timely access, including:

(i) The use of telemedicine (consistent with OAR 836-053-XXX(3)).

(ii) Identification of contracted providers in adjacent counties or service areas who regularly serve the affected population, including the volume or capacity dedicated to serving enrollees in the gap area.

(iii) Documentation of established case management, referral, or transportation protocols to ensure enrollees are able to access the required services outside the standard time/distance parameters.

(e) A description of the carrier's procedures for:

(A) Making and authorizing referrals within and outside its network, if applicable.

(B) Ongoing monitoring and assuring the sufficiency of the network to meet enrollee health care needs, including how the network is built, reviewed, and modified.

(C) Enabling enrollees to change primary care professionals, if applicable.

(f) The factors used by the carrier to build and maintain its provider network, including provider selection, tiering, and efforts to include essential community providers, when appropriate.

(g) The carrier's plan for providing continuity of care in the event of contract termination with a participating provider, insolvency, or other inability to continue operations, as

required by ORS 743B.225. The plan must explain how enrollees will be notified and transitioned to other providers in a timely manner.

(h) Methods for assessing the health care needs of enrollees and their satisfaction with network services.

(i) The carrier's methods for informing enrollees about:

(A) Covered services and plan features;

(B) Grievance and appeals procedures;

(C) Choosing and changing providers;

(D) Emergency, urgent, and specialty care access and approval processes;

(E) Its process for updating provider directories for each of its network plans.

(j) ~~The carrier's efforts to address the needs of enrollees, including but not limited to providing access in an appropriate and culturally competent manner to all enrollees, including those with diverse cultural and ethnic backgrounds, varying sexual orientations and gender identities, disabilities or physical or mental health conditions. The carrier must also describe efforts, when appropriate, to include various types of essential community providers in its network, and actions taken to ensure culturally and linguistically responsive care, including data on language access and cultural competency among network providers, consistent with OAR 836-053-XXXX.~~ Baseline information on culturally and linguistically responsive care: Each carrier must provide information on actions taken to ensure culturally and linguistically responsive care including:

(A) The availability of interpreter services across provider types.

(B) Number or percentage of network providers who self-report as being able to deliver services one or more languages other than English.

(C) Number or percentage of providers that self-report cultural competency training or continuing education.

(D) Any carrier initiatives, incentives, or programs designed to improve enrollee access to culturally and linguistically responsive care.

(k) A description of the process for ensuring that networks for plans sold outside of the marketplace provide enrollees who reside in low-income ZIP codes or HPSAs with adequate access to care without delay, including documentation and justification for any adjustment to quantitative standards as permitted under OAR 836-053-XXXX.

(l) A description of the process for monitoring access to provider specialist services in emergency room care, anesthesiology, radiology, hospitalist care, and pathology or laboratory services at participating hospitals.

(m) A description of the system for ensuring coordination and continuity of care for:

(A) Enrollees referred to specialty providers;

(B) Enrollees using ancillary services, including social services and other community resources;

(C) Enrollees needing appropriate discharge planning.

(n) Any other information or supporting documentation required by the department to verify compliance, as set forth in reporting templates and instructions published by the department.

Statutory/Other Authority: ORS 731.244, 743B.505
Statutes Implemented: ORS 743B.505

836-053-0350
Provider Directory Requirements for Network Adequacy

(1)(a) A~~n insurer~~ carrier 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 section (2) of this rule.

(b) In making the directory available electronically, the ~~insurer~~carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(c)(A) A~~n insurer~~carrier shall update each network plan provider directory at least monthly. The provider directory shall disclose the frequency with which it is updated.

(B) The ~~insurer~~carrier shall include a disclosure in the directory that the information included in the directory is accurate as of the date posted to the web or printed and that enrollees or prospective enrollees should consult the ~~insurer~~carrier to obtain current provider directory information.

(d) A~~n insurer~~carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described in section (2) of this rule upon request of an enrollee or a prospective enrollee.

(e) For each network plan, a~~n insurer~~carrier shall include in plain language in both the electronic and print directory, the following general information:

(A) A description of the criteria the ~~insurer~~carrier has used to build its provider network;

(B) If applicable, a description of the criteria the ~~insurer~~carrier has used to tier providers;

(C) If applicable, information about how the ~~insurer~~carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital, or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for an enrollee or a prospective enrollee to be able to identify the provider tier; and

(D) If applicable, note that authorization or referral may be required to access some providers.

(f)(A) A~~n insurer~~carrier shall make it clear in both its electronic and print directories which provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

(B) The ~~insurer~~carrier shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that enrollees or the general public may use to notify the ~~insurer~~carrier of inaccurate provider directory information.

(g) For the pieces of information required under this section in a provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the ~~insurer~~carrier shall make available through the directory a general explanation of the source of the information and any limitations, if applicable.

(h) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(2) The ~~insurer~~carrier shall make available through an electronic provider directory that includes search functions, for each network plan, all of the following information:

(a) For health care professionals:

(A) Name;

(B) Gender;

(C) Participating office locations;

(D) Specialty, if applicable;

(E) Participating facility affiliations, if applicable;

(F) Languages spoken by provider other than English, if applicable;

(G) Whether accepting new patients;

(H) Network affiliations;

(I) Tier level, if applicable;

(J) Contact information; and

(K) Board certifications.

(b) For hospitals:

(A) Hospital name;

(B) Participating hospital location;

(C) Hospital accreditation status;

(D) Network affiliations;

(E) Tier level, if applicable; and

(F) Telephone number.

(c) For facilities, other than hospitals, by type:

(A) Facility name;

(B) Facility type;

(C) Participating facility locations;

(D) Network affiliations;

(E) Tier level, if applicable; and

(F) Telephone number.

Statutory/Other Authority: ORS 731.244~~, and~~ ORS 743B.505. and ORS 743B.250
Statutes/Other Implemented: ~~ORS 743B.505~~ORS 743B.250
History:
ID 10-2016, f. & cert. ef. 9-14-16