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Reply to:
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December 9, 2025

Brooke Hall
Senior Policy Analyst
Department of Consumer and Business Services, Division of Financial Regulation
P.O. Box 14480
Salem, OR 97309

SENT VIA EMAIL

RE: Comments on Draft Rule Dated 11-12-25 Implementing SB 822 (2025) – Network Adequacy

Dear Ms. Hall:

I am providing comments on behalf of Cambia Health Solutions (Cambia Health), which operates Regence BlueCross BlueShield of Oregon (Regence) and BridgeSpan Health plans. Cambia Health is a not-for-profit health insurer dedicated to improving the health and well-being of our members and the communities we serve. As the state's largest health insurer, we provide high-value, affordable health care to nearly one million Oregonians across a network of 39,000 providers at 705 sites across the state. In keeping with our values as a tax-paying nonprofit, 90% of every premium dollar goes to pay our members' medical claims and expenses.

Thank you for the opportunity to provide comments on the draft rules dated 11-12-2025 implementing SB 822 (2025) and reviewed and discussed at the November 12, 2025 Rule Advisory Committee (RAC) meeting.

Comments on Draft Rules

OAR 836-053-0300 – Purpose; Statutory Authority; Applicability of Network Adequacy Requirements

While we appreciate the inclusion of language in subsection (2) clarifying that "These requirements apply to the adequacy of networks serving enrollees who reside in Oregon," we have concerns about the additional phrase ", and to the provider networks used to deliver services to enrollees covered under those plans."

This added language inadvertently expands the scope of Oregon networks beyond state borders. During the RAC meeting, the DFR clarified that the intent is to report on networks located in and providing services within Oregon but also capture members who work in other states but maintain Oregon health plans.

The DFR also indicated openness to receiving language that better reflects this intent. As such, we propose replacing the problematic phrase with: "and its provider networks used to deliver services in the health benefit plan's service area." The complete revised subsection (2) would read:

> "These requirements apply to the adequacy of networks serving enrollees who reside in Oregon, and its provider networks used to deliver services in the health benefit plan's service area."

We believe this revision aligns with the DFR's stated intent while maintaining appropriate geographic boundaries.

OAR 836-053-XXXX – Quantitative Network Adequacy Access Standards

Subsection (3) currently provides that carriers may use telemedicine providers to satisfy up to:

(a) 10 percent of the access requirement for primary care and specialty care services; and
(b) 30 percent of the access requirements for behavioral health care services.

We would like to emphasize again our recommendation from our previous comment letter to increase these percentages thresholds. The healthcare landscape has evolved with nationally recognized virtual care providers now licensed in Oregon helping address critical specialty care shortages. Virtual care has proven particularly effective for behavioral health early intervention and specialty consultations in underserved areas, often providing faster access than traditional inpatient visit care while maintaining quality outcomes. These higher thresholds better reflect current healthcare delivery capabilities and patient needs. As such, we recommend:

(a) Primary/Specialty care increase from 10% to 30%
(b) Behavioral Health increase from 30% to 50%

OAR 836-053-XXXX – Network Adequacy Reporting Requirements

At the RAC meeting, the DFR clarified that networks with no enrollment must still be reported, though without the required details. We support the carrier suggestion to submit a confidential waiver instead of reporting networks with zero enrollment.

With respect to subsection (2):

1. In (d)(D), we request that the DFR clarify that "County served" refers to the county where the provider is physically located. We recommend changing the language from "County served" to "County where provider is located" to eliminate ambiguity.

2. In (j)(A), it requires insurers to report on actions taken to ensure culturally and linguistically responsive care, including the number or percentage of networks providers that self-report specialized experience or clinical focus in serving “individuals with disabilities” and “Individuals with physical or mental health conditions.” We respectfully request that the DFR remove these two categories for the following reasons:

First, the terms “individuals with disabilities” and “individuals with physical or mental health conditions” are overly broad without further definition. Second, without a legal definition provided in this regulation, providers are left to exercise individual discretion in determining what qualifies as a disability or physical/mental health condition; and third, this ambiguity will likely result in inconsistent self-reporting across the provider network, undermining the utility of the data collected.

If the DFR intends to collect data for these two categories, we suggest specifying particular disabilities or conditions of regulatory interest, which would enable consistent reporting.

OAR 836-053-XXXX – Behavioral Health Network Composition and Reporting

While most requirements under SB 699 are reflected in the draft rules, subsection (1)(E) introduces a new provision not found in the underlying legislation. This provision requires carriers to submit, as part of their annual network adequacy report, a behavioral health assessment and capacity analysis that includes “The number of enrollees in each area who are assigned to, or attributed to receive care from, the specific provider, if applicable.”

This provision would require insurers to provide a comprehensive list of all enrollees assigned to or attributed to **each** individual provider in every area served. This represents a significant operation burden that: (1) exceeds the scope of SB 699’s statutory requirements; and (2) goes substantially beyond current reporting capabilities and practices. For these reasons, we request that the DFR remove subsection (1)(E) from the draft rules as it is not mandated by the underlying legislation, imposes disproportionate administrative burden relative to regulatory burden, and extends beyond established reporting frameworks.

Conclusion

Thank you for the opportunity to provide additional comments. We appreciate the Department’s collaborative approach and look forward to participating in the RAC in 2026 to make the rules permanent

Thank you for your consideration of our comments.

Sincerely,

A. Awuakye

Antoinette Awuakye
Sr. Public and Regulatory Affairs Specialist