836-053-0300

Purpose; Statutory Authority; Applicability of Network Adequacy Requirements

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

(2) The requirements set forth in OAR 836-053-0310 to 836-053-0350 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 provider networks used to deliver services in a health benefit plan's service area.

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 **OAR 836-053-0300 to 836-053-0350**:

(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) "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 carrier.

(e) "Marketplace" means health insurance exchange as defined in OAR 945-001-0002(23).

(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 as of January 1, 2025 and thereafter as published by the department in a bulletin made available on the Division's website at https://dfr.oregon.gov/laws-rules/Pages/bulletins.aspx, or its successor.

(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 as of January 1, 2025 and thereafter as published by the department in a bulletin made available on the Division's website at https://dfr.oregon.gov/laws-rules/Pages/bulletins.aspx, or its successor.

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

(i) “Nationally recognized standard” 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). The following County classifications are defined in 42 C.F.R § 156.230, as in effect on January 1, 2025, unless otherwise specified in these rules.

(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

836-053-0335

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 Centers for Medicare and Medicaid Services (CMS) network adequacy guidance.

(2) For purposes of this rule, the department adopts as the default quantitative benchmark the Baseline Time and Distance Standards published by CMS for Plan Year 2025, which are available on the division's website at https://dfr.oregon.gov/business/reg/health/Pages/annual-network-adequacy.aspx.

(3) When CMS publishes Alternative Time and Distance Standards for specific provider types or counties in any plan year, carriers may rely on those alternative benchmarks in their Oregon filings for that year, but only for the provider types and geographic areas identified in the applicable CMS guidance. (4) 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.

(5) 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.

(6) 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, and 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

836-053-0345

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: Carriers must meet the travel time and distance standards to ensure 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, which are available on the division's website at https://dfr.oregon.gov/business/reg/health/Pages/annual-network-adequacy.aspx.

(b) Each carrier is responsible for conducting the geospatial analysis required to demonstrate compliance with travel 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.

(c) Appointment wait times: 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:

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

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

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

(2) In areas designated as health professional shortage areas (HPSAs), or low-income ZIP codes as defined in OAR 836-053-0310, carriers may satisfy the quantitative standards in this rule through a justification process as described in OAR 836-053-0025 (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, and 743B.505

Statutes Implemented: ORS 743B.505

836-053-0325
Network Adequacy Reporting Requirements

(1) By March 31 of each year, a carrier must submit a network adequacy report for each provider network used in connection with a health benefit plan offered or renewed in this state, demonstrating compliance with the requirements of OAR 836-053-0300 through 836-053-0350. When a single provider network is associated with multiple health benefit plans, the carrier must report once for that network and include all health benefit plans and enrollees for that network.

(2) For each provider network, the network adequacy report must include:

(a) Identification of the carrier's provider network and the health benefit plans to which the network applies;

(b) A description of how telemedicine or other technology is used to meet network access standards, including a breakdown of the percentage of telemedicine delivered by Oregon-based providers who also provide in-person care versus the percentage delivered by telemedicine-only providers. The report must indicate the percentage of network adequacy standards met through telemedicine for each provider, consistent with the limits in OAR 836-053-0345(3) (Quantitative Network Adequacy Access Standards);

(c) Evidence of compliance with quantitative access standards in (OAR 836-053-0345;

(d) For each required provider in the network , including but not limited to behavioral health, substance use disorder, and reproductive health, the report must include the following information:

(A) Provider and facility name and unique identifier, if assigned;

(B) Specialty or provider type, consistent with department assigned categories;

(C) Street address and zip code of the provider or facility location;

(D) County served;

(j) A description of the process for ensuring that provider networks for health benefit 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 836-053-0345.

(k) 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.

(l) 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.

(m) 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.

(3) For any provider network that fails to meet a quantitative travel 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 annual network adequacy report must include a written justification demonstrating how the carrier 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 provider 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 carrier's specific strategy for providing timely access, including:

(i) The use of telemedicine (consistent with OAR 836-053-0345(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.

(4) A carrier may request a waiver from the detailed reporting requirements of this rule for any provider network that has zero enrolled lives in Oregon as of the reporting date. The waiver request must be submitted in writing and certify that the network is not currently marketed or used for any active health benefit plan.

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

836-053-0355Behavioral Health Network Composition and Reporting

(1) For the purposes of evaluating the sufficiency of a carrier's network of behavioral health providers under ORS 743B.505(4)(b), the carrier must annually submit, as part of its network adequacy report, a behavioral health access and capacity analysis that includes the following;

(a) A list of all in-network behavioral health providers, by provider type, including:

(A) Licensed professional counselors;

(B) Licensed marriage and family therapists;

(C) Licensed clinical social workers;

(D) Psychologists; and

(E) Psychiatrists.

(b) For each provider listed in (a), the report must identify:

(A) Whether the provider is accepting new patients;

(B) Whether the provider serves children, adults, or both;

(C) Whether the provider has self-identified as able to serve:

(i) individuals with limited English proficiency, without the use of an interpreter, or those who are illiterate;

(ii) Individuals with diverse cultural or ethnic backgrounds;

(iii) individuals with chronic or complex behavioral health conditions;

(iv) Individuals who identify as LGBTQIA+ or with diverse gender identities or sexual orientations.

(D) The geographic location (county, zip code) where services are delivered;

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

836-053-0350
Provider Directory Requirements for Network Adequacy

(1)(a) A 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 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 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 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 carrier to obtain current provider directory information.

(d) A 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 carrier shall include in plain language in both the electronic and print directory, the following general information:

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

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

(C) If applicable, information about how the 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 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 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 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 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 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 interpreter services (spoken or signed) are available at the provider's practice location, and the types of access supported (e.g., in-person, telephonic, video remote).

(H) Whether the provider self-identifies as having clinical focus in serving one or more of the following populations:

(i) Individuals from diverse cultural or ethnic backgrounds;

(ii) Individuals with disabilities;

(iii) Individuals with specified physical or behavioral health conditions;

(iv) Individuals who identify as LGBTQIA+ or with diverse gender identities or sexual orientations.

(I) Whether accepting new patients;

(J) Network affiliations;

(K) Tier level, if applicable;

(JL Contact information; and

(M) 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,ORS 743B.505, and ORS 743B.250
Statutes/Other Implemented: ORS 743B.505, and ORS 743B.250
History:
ID 10-2016, f. & cert. ef. 9-14-16