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.

~~(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 945-001-002(21).

(f) "Low-income zip code" means a zip code in which a specified percentage of residents have household incomes below the federal poverty level, as defined by the Centers for Medicare and Medicaid Services (CMS) or the U.S. Department of Health and Human Services (HHS) for the purpose of network adequacy reviews.

(g) "Health professional shortage area" has the meaning given that term in 42 U.S.C. 254e.

(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.

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-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 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.

(2) 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.

(3) 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.

(4) 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.

(5) 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 distance and Time

(A) Urban counties**:** At least 90 percent of enrollees must have access to an in-network provider or facility within 30 miles or 30 minutes.

(B) Rural counties**:** At least 90 percent of enrollees must have access to an in-network provider or facility within 60 miles or 60 minutes.

(C) In suburban or large rural counties, or for provider or facility types where 45 C.F.R. § 156.230 establishes different time and distance standards, the carrier must meet the applicable federal benchmark, ensuring at least 90 percent of enrollees meet the published standard.

(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).

(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 national 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.

(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.

(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 physician 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 physicians;

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