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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
09/25/2025 2:27 PM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILING CAPTION: HB 3134 (2025) Prior Authorization Insurer Data Reporting Updates

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 10/29/2025 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT: Karen Winkel
503-947-7694
dfr.rules@dcbs.oregon.gov

Labor and Industries Building
350 Winter St. NE
Salem,OR 97301

Filed By:
Karen Winkel
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 10/22/2025
TIME: 1:30 PM
OFFICER: Lisa Emerson

IN-PERSON HEARING DETAILS
ADDRESS: Labor and Industries Building, 350 Winter St. NE, Basement, Conf Rm E, Salem, OR 97301

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 503-446-4951
CONFERENCE ID: 839053451
SPECIAL INSTRUCTIONS:
This is a hybrid meeting conducted in-person and virtually via Microsoft Teams:
Meeting ID: 215 446 891 609 4
Passcode: ME6vj7vG

NOTE: PUBLIC COMMENTS ARE PUBLIC RECORDS AND WILL BE POSTED ON THE DFR RULEMAKING WEBPAGE.

NEED FOR THE RULE(S)

House Bill 3134 (2025) amends ORS 743B.250 by updating the prior authorization data insurers are required to report to DCBS on an annual basis. Effective January 1, 2026, and no later than March 1 of each calendar year, DCBS must publish on its website prior authorization aggregate data reported by insurers in a format that does not identify the insurer.

Amending OAR 836-053-1070 (Reporting of Grievances and Prior Authorization; Format and Contents) is necessary to align the rule with the new prior authorization data reporting requirements in HB 3134 and provide a submission due date.

The rulemaking amends the prior authorization data metrics currently contained in the rule and amends the due date for insurers to report the prior authorization aggregate data from "on or before June 30" to "on or before January 31" in OAR 836-053-1070(1). This change in due dates will allow adequate time for insurers to report the required data to DCBS and for DCBS to analyze and post the data on the department's website by March 1, 2026, and annually thereafter. The grievance and appeals aggregate data that insures have been reporting annually to DCBS will remain due "on or before June 30" and is not required to be posted on the department's website. The rulemaking will also update the statutory citations to include Or Laws 2025, chapter 388.

To inform the rulemaking process, DCBS convened a Rulemaking Advisory Committee (RAC) that included representatives of health care providers, commercial health insurers, and consumer advocates. The RAC provided feedback on draft rule language, data collection practices, and potential impacts on equity and administrative burden, helping to ensure that the final rule is both practical and responsive to stakeholder needs.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

Draft rules are available from Karen Winkel, Rules Coordinator, Division of Financial Regulation located at 350 Winter St. NE, Salem, OR 97301 and are available on the division's website: https://dfr.oregon.gov/laws-rules/Pages/proposed-rules.aspx.

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

The bill's consumer protections apply equally to enrollees of health benefit plans regulated by DCBS and are not expected to have a disproportionate impact on any specific community. The amendments to the prior authorization data metrics insurers are required to report to DCBS primarily affect commercial health insurers. However, the amendments to the prior authorization data insurers are required to report to DCBS may also improve the transparency of insurer prior authorization processes for health care providers and consumers. This transparency may be of disproportionate benefit for groups and communities most likely to experience difficulties related to prior authorization, including individuals with serious health conditions. It may also disproportionately benefit groups with fewer resources to navigate the prior authorization process, including historically underserved groups such as communities of color, rural residents, and low-income individuals.

FISCAL AND ECONOMIC IMPACT:

The rules could result in a small increase in administrative costs resulting from insurers needing to report additional prior authorization data earlier in the year, by January 31 annually starting in 2026. Any fiscal impact is not solely resulting from amending this rule, but rather the legislature's amendments to ORS 743B.250 by HB 3134 (2025). The division will provide data reporting instructions to insurers on the prior authorization data reporting template, which may help offset any increased administrative costs.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Based on information currently available to DCBS, the proposed rule would not have a fiscal or economic impact on

state agencies, local government units, nor members of the public. Members of the public that are health care providers and patients may be positively affected indirectly by increased transparency of health insurers' prior authorization processes.

(2)(a) The rule applies to health insurance carriers. Based on financial filings made to DFR, no insurers meet the definition of a small business under ORS 183.310, because no insurer is independently owned and operated.

(2)(b) The expected costs are minimal for the proposed rules as they apply to commercial payers only and would require minimal administrative activities or costs to comply with the requirements of the proposed rules. The insurers have already been reporting prior authorization data metrics to the division for several years. The division will provide data reporting instructions to insurers on the prior authorization data reporting template, which may help offset any increased administrative costs.

(2)(c) The expected costs are minimal for the proposed rules as they apply to commercial payers only and would require minimal administrative activities or costs to comply with the requirements of the proposed rules. The insurers have already been reporting prior authorization data metrics to the division for several years. The division will provide data reporting instructions to insurers on the prior authorization data reporting template, which may help offset any increased administrative costs.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Representatives of small businesses were invited to provide comment on the rule. RAC members with the Oregon Medical Association and the Oregon Academy of Family Physicians represented the interests of health care providers, many of whom are small businesses.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

AMEND: 836-053-1070

RULE SUMMARY: Updates the rule to align with the prior authorization data reporting requirements in HB 3134 (2025), including:

- Amends the prior authorization aggregate data metrics to be reported to DCBS.
- Amends the prior authorization aggregate data reporting due date from "on or before June 30" to "on or before January 31".
- Adds statutory definitions of standard and expedited prior authorization requests.
- Updates statutory citations.

CHANGES TO RULE:

836-053-1070
Reporting of Grievances and Prior Authorization; Format and Contents ¶

(1)(a) To comply with the requirements in ORS 743B.250, on or before June 30 of each calendar year, an insurer must submit information pertaining to grievances and appeals in the previous calendar year ending December 31. ¶
(b) To comply with the requirements in OR Laws 2025, chapter 388, on or before January 31 of each calendar year, an insurer must submit information pertaining to prior authorizations in the previous calendar year ending December 31.¶
(c) The data must be reported in the format prescribed by the director of the Department of Consumer and Business Services as set forth on the website of the Division of Financial Regulation of the Department of Consumer and Business Services at dfr.oregon.gov. Filing and reporting requirements in this rule apply to:¶

(~~a~~A) A domestic insurer; and¶
(~~b~~B) A foreign insurer transacting $2 million or more in health benefit plan premium in Oregon during the calendar year immediately preceding the due date of a required report.¶
(2) For purposes of this rule, a grievance is "closed" if:¶
(a) The grievance has been appealed through all available grievance appeal levels; or¶
(b) The insurer determines that the complainant is no longer pursuing the grievance.¶
(3) The grievance data to be included in the annual summary required by section 1 of this rule are as follows:¶
(a) The total number of grievances closed in the reporting year;¶
(b) The number of grievances closed in each of the categories listed in section 4 of this rule;¶
(c) The number and percentage of grievances in each of the categories listed in section 4 of this rule in which the insurer's initial decision is upheld and the number and percentage in which the initial decision is reversed at closure of the grievance;¶
(d) The number and percentage of all grievances that are closed at the conclusion of the first level of appeal;¶
(e) The number and percentage of all grievances that are closed at the conclusion of the second level of appeal;¶
(f) The number and percentage of all grievances that result in applications for external review; and¶
(g) For each level of appeal listed in subsections d and e of this section, the average length of time between the date an enrollee files the appeal and the date an insurer sends written notice of the insurer's determination for that appeal to the enrollee, or person filing the appeal on behalf of the enrollee.¶
(4) An insurer must report each grievance according to the nature of the grievance. The nature of the grievance shall be determined according to the categories listed in this section. The insurer must report each grievance in one category only and must have a system that allows the insurer to report accurately in the specified categories. If a grievance could fit in more than one category, an insurer shall report the grievance in the category established in this section that the insurer determines to be most appropriate for the grievance. The categories of grievances are as follows:¶
(a) Adverse benefit determinations based on medical necessity under ORS 743.857;¶
(b) Adverse benefit determinations based on an insurer's determination that a plan or course of treatment is experimental or investigational under ORS 743.857;¶
(c) Continuity of care as defined in ORS 743.854;¶
(d) Access and referral problems including timelines and availability of a provider and quality of clinical care;¶
(e) Whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care;¶
(f) Adverse benefit determinations of otherwise covered benefits due to imposition of a source-of-injury exclusion, out-of-network or out-of-plan exclusion, annual benefit limits or other limitations of otherwise covered benefits, or imposition of a preexisting condition exclusion in a grandfathered health plan;¶
(g) Adverse benefit determinations based on general exclusions, not a covered benefit or other coverage issues not listed in this section;¶
(h) Eligibility for, or termination of enrollment, rescission or cancelation of a policy or certificate;¶
(i) Quality of plan services, not including the quality of clinical care as provided in subsection d of this section;¶
(j) Emergency services; and¶
(k) Administrative issues and issues other than those otherwise listed in this section.¶
(5) Nothing in this rule prohibits an insurer from creating or using its own system to categorize the nature of grievances in order to collect data if the system allows the insurer to report grievances accurately according to the categories in section 4 of this rule and if the system enables the director to track the grievances accurately.¶
(6) For the purposes of this rule, the definitions for "standard" and "expedited" prior authorizations are: ¶
(a) "Standard prior authorization" means a prior authorization request that is not an expedited prior authorization request.¶
(b) "Expedited prior authorization" means a prior authorization that must be expedited in order to avoid jeopardizing the enrollee's life, health or ability to maintain or regain maximum function.¶
(7) The prior authorization data to be included in the annual summary required by section 1 of this rule are as follows:¶
(a) The percentage and number of standard prior authorization requests ~~received;¶~~
~~(b) The number of~~that were approved;¶
(b) The percentage and number of standard prior authorization requests that were ~~initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or failure to provide additional clinical information requested by the insurer~~denied;¶
(c) The percentage and number of standard prior authorization requests that were approved after appeal;¶
(d) The percentage and number of all prior authorization requests for which the time frame for review was extended and the request was approved;¶
(~~c~~e) The ~~number of~~percentage and number of expedited prior authorization requests that were ~~initially~~ approved;

¶
(df) The ~~number of denials that were reversed by internal appeals or external reviews; and¶~~
~~(e) The number of requests for which the entire requested item or service was not approv~~percentage and number of expedited prior authorization requests that were denied;¶
(g) The average and median times that elapsed between the submission of a request and a determination by the insurer for standard prior authorization; and¶
(h) The average and median times that elapsed~~, but a specified portetween~~ the submission of ~~thea~~ request~~ed item or service or a specified alternative item or service was approved~~ and a decision by the insurer for expedited prior authorization.
Statutory/Other Authority: ORS 743B.250, ORS 743B.420, ORS 743B.422, ORS 743B.423, ORS 746.233, Or Laws 202~~1~~5, ch ~~154~~388
Statutes/Other Implemented: ORS 743B.250, ORS 743B.420, ORS 743B.422, ORS 743B.423, ORS 746.233, Or Laws 202~~1~~5, ch ~~154~~388