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PERMANENT ADMINISTRATIVE ORDER

ID 6-2026

CHAPTER 836

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE REGULATION

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ARCHIVES DIVISION SECRETARY OF STATE & LEGISLATIVE COUNSEL

FILING CAPTION: Network Adequacy Standards for Health Benefit Plans – Implementation of SB 822

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RULES:
836-053-0300, 836-053-0310, 836-053-0320, 836-053-0325, 836-053-0330, 836-053-0335, 836-053-0340, 836-053-0345, 836-053-0350, 836-053-0355

AMEND: 836-053-0300

REPEAL: Temporary 836-053-0300 from ID 14-2025

NOTICE FILED DATE: 04/27/2026

RULE SUMMARY: Establishes the purpose and statutory authority for the rules and expands applicability to all individual and group health benefit plans beginning January 1, 2026.

CHANGES TO RULE:

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

(1) OAR 836-053-0300 to 836-053-035~~0~~5 are adopted for the purpose of implementing ORS 743B.505.¶
(2) The requirements set forth in OAR 836-053-03~~2~~10 to 836-053-034~~0~~55 apply to all ~~insur~~carriers offering individual or ~~small~~ group health benefit plans in this state that are issued or renewed on or after January 1, 20~~17.¶~~

~~(3)~~26. These requirements ~~set forth in OAR 836-053-0310 and 836-053-0350 apply to all insurers offering individual, large group, or small group~~apply to the adequacy of provider networks used to deliver services in a health benefit plan's ~~in this state that are issued or renewed on or after January 1, 2017~~service area.
Statutory/Other Authority: ORS 731.244~~ and~~, ORS 743B.505
Statutes/Other Implemented: ORS 743B.505

AMEND: 836-053-0310

REPEAL: Temporary 836-053-0310 from ID 14-2025

NOTICE FILED DATE: 04/27/2026

RULE SUMMARY: Provides definitions used throughout the network adequacy rules, including enrollee, carrier, health benefit plan, low-income ZIP code, health professional shortage area (HPSA), telemedicine, nationally recognized standard, and county classifications.

CHANGES TO RULE:

836-053-0310
Network Adequacy Definitions for OAR 836-053-0300 to 836-053-035~~0~~5 ¶

~~(1)~~ As used in ~~these rules~~OAR 836-053-0300 to 836-053-0355:¶
(~~a~~1) "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~~2) "~~Insurer includes a health care service contractor as defined~~Carrier" has the meaning given that term in ORS 7~~50~~43B.005.¶
(~~c~~3) "Health benefit plan" means any:¶
(~~A~~a) Hospital expense, medical expense or hospital or medical expense policy or certificate;¶
(~~B~~b) Subscriber contract of a health care service contractor as defined in ORS 750.005; or¶
(~~C~~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~~4) "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 ~~insur~~carrier.¶
(~~e~~5) "Marketplace" means health insurance exchange as defined in OAR 945-001-0002(2~~1)~~3).¶
(6) "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.¶
(7) "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 is located in, or serves a population group designated as an HPSA by the Health Resources and Services Administration (HRSA), 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.¶
(8) "Telemedicine" has the meaning given that term in ORS 743A.058.¶
(9) "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.¶
(10) "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~~, ORS 743B.505
Statutes/Other Implemented: ORS 743B.505

REPEAL: 836-053-0320

NOTICE FILED DATE: 04/27/2026

RULE SUMMARY: This rule is repealed and replaced by updated network adequacy reporting requirements in OAR 836-053-0325.

CHANGES TO RULE:

~~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~~

ADOPT: 836-053-0325

NOTICE FILED DATE: 04/27/2026

RULE SUMMARY: Establishes reporting requirements carriers must submit to demonstrate compliance with quantitative network adequacy standards, including provider-level data and justifications for network gaps.

CHANGES TO RULE:

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 to 836-053-0355. 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);¶
(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) Contact phone number;¶
(E) Whether the provider is accepting new patients;¶
(F) Whether the provider or facility is located in, or serves, a low-income ZIP code or federally designated health professional shortage area (HPSA); and¶
(G) Network affiliation(s) and tier level, if applicable.¶
(e) 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:¶
(A) The use of telemedicine (consistent with OAR 836-053-0345(3)).¶
(B) 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.¶
(C) 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 department for 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, ORS 743B.505
Statutes/Other Implemented: ORS 743B.505

REPEAL: 836-053-0330

NOTICE FILED DATE: 04/27/2026

RULE SUMMARY: This rule is repealed and replaced by the new nationally recognized standard established in OAR 836-053-0335.

CHANGES TO RULE:

~~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~~

ADOPT: 836-053-0335

NOTICE FILED DATE: 04/27/2026

RULE SUMMARY: Adopts federal network adequacy standards for Qualified Health Plans (45 CFR §156.230) as the baseline standard for evaluating network adequacy in Oregon.

CHANGES TO RULE:

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, ORS 743B.505
Statutes/Other Implemented: ORS 743B.505

REPEAL: 836-053-0340

NOTICE FILED DATE: 04/27/2026

RULE SUMMARY: This rule is repealed. The qualitative, factor-based compliance approach is eliminated and replaced with quantitative network adequacy standards under SB 822.

CHANGES TO RULE:

~~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~~

ADOPT: 836-053-0345

REPEAL: Temporary 836-053-0345 from ID 14-2025

NOTICE FILED DATE: 04/27/2026

RULE SUMMARY: Establishes minimum quantitative standards for travel time and distance and appointment wait times and specifies how telemedicine may be used to meet access standards.

CHANGES TO RULE:

836-053-0345
Quantitative Network Adequacy Access Standards
(1) Carriers must meet the following minimum quantitative access benchmarks as adopted in OAR 836-053-0335, 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(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 provider 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 836-053-0325.¶
(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, ORS 743B.505
Statutes/Other Implemented: ORS 743B.505

AMEND: 836-053-0350

NOTICE FILED DATE: 04/27/2026

RULE SUMMARY: Establishes requirements for provider directories, including information that must be displayed, directory accuracy, update frequency, and accessibility.

CHANGES TO RULE:

836-053-0350
Provider Directory Requirements for Network Adequacy ¶

(1)(a) A~~n insur~~ 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 ~~insur~~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 insur~~ 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 ~~insur~~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 ~~insur~~carrier to obtain current provider directory information.¶
(d) A~~n insur~~ 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 insur~~ carrier shall include in plain language in both the electronic and print directory, the following general information:¶
(A) A description of the criteria the ~~insur~~carrier has used to build its provider network;¶
(B) If applicable, a description of the criteria the ~~insur~~carrier has used to tier providers;¶
(C) If applicable, information about how the ~~insur~~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 insur~~ 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 ~~insur~~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 ~~insur~~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 ~~insur~~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 ~~insur~~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~~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;¶
(IK) Tier level, if applicable;¶
(JL) Contact information; and¶
(KM) 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.25055
Statutes/Other Implemented: ORS 743B.505, ORS 743B.250

ADOPT: 836-053-0355

NOTICE FILED DATE: 04/27/2026

RULE SUMMARY: Establishes behavioral health network reporting requirements and provider-level data elements necessary to evaluate behavioral health access.

CHANGES TO RULE:

836-053-0355
Behavioral Health Network Composition and Reporting
For the purpose 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:¶
(1) 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.¶
(2) 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:¶
(A) Individuals with limited English proficiency, without the use of an interpreter, or those who are illiterate;¶
(B) Individuals with diverse cultural or ethnic backgrounds;¶
(C) Individuals with chronic or complex behavioral health conditions; and¶
(D) 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, ORS 743B.505
Statutes/Other Implemented: ORS 743B.505