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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

ID 14-2025
CHAPTER 836

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

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ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Adoption of Quantitative Network Adequacy Standards for 2026 Health Benefit Plans

EFFECTIVE DATE: 01/01/2026 THROUGH 06/29/2026

AGENCY APPROVED DATE: 12/11/2025

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Filed By:
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Rules Coordinator

NEED FOR THE RULE(S):

These rules are necessary to implement Senate Bill 822 (2025), which mandates that the division adopt standards regulating carrier network adequacy to ensure access to initial and follow-up care without unreasonable delay. Specifically, these rules define “unreasonable delay” by adopting minimum quantitative access benchmarks, including geographic distribution and appointment wait times. In addition to implementing the requirements of SB 822, these definitions are critical for operationalizing consumer protections in House Bill 2002 (2023) regarding gender affirming treatment and Senate Bill 1137 (2025) regarding autologous breast reconstruction. Without these defined standards, the network adequacy protections in those statutes cannot be effectively enforced.

JUSTIFICATION OF TEMPORARY FILING:

(1) Failure to immediately adopt these rules results in lack of defined metrics for what constitutes “unreasonable delay” in network access. This leaves consumers enrolled in health benefit plans in Oregon without enforceable standards to ensure timely and geographically accessible health care, preventing the division from enforcing the statutory mandate for adequate provider networks under the statute.

Furthermore, the lack of standards creates greater risk to specific populations. Both House Bill 2002 (2023) and Senate Bill 1137 (2025) contain provisions allowing enrollees to access out-of-network care without penalty if in-network services are not available without unreasonable delay. Without these temporary rules establishing quantitative standards (e.g. appointment wait times and geographic access standards), carriers lack a regulatory baseline to approve these requests, potentially resulting in the denial of coverage for out-of-network gender affirming treatment and breast reconstruction services, or subjecting enrollees to improper cost sharing.

(2) All consumers enrolled in health benefit plans regulated by the division would be affected if the rules were not immediately adopted. Every enrollee relies on the quantitative network adequacy standards to ensure they can access primary care, behavioral health care, and specialty care services within a reasonable timeframe and distance. Without clear standards, consumers may face inconsistent carrier decisions and longer wait times.

The consequences would be particularly severe for individuals seeking gender-affirming treatment or breast reconstruction services protected under House Bill 2002 and Senate Bill 1137. These statutes entitle enrollees to access out-of-network providers without additional cost-sharing when in-network care cannot be provided in a timely manner. However, without the quantitative benchmarks established in these rules, carriers lack a regulatory basis to determine when these protections are triggered. Consequently, these individuals face a heightened risk of delayed care, denial of medically necessary services, or improper cost-sharing. The absence of clear standards disproportionately impacts these groups because their ability to access medically necessary treatment depends directly on the existence of enforceable network adequacy standards.

(3) The temporary rules are necessary to establish the immediate quantitative standards required by law. Without this temporary action there would be regulatory gaps where the statute is in effect but unenforceable while the rulemaking and technical reporting details are being finalized.

The division has already convened a Rulemaking Advisory Committee (RAC) and is in the process of drafting permanent rules. However, the permanent rulemaking process will not conclude before the January 1, 2026 effective date. This is due to the lengthy and technical nature of the rules, and the new reporting requirements, which require extensive coordination between the division and carriers to ensure feasibility.

(4) This temporary action mitigates harm by defining the statutory concept of "unreasonable delay" with concrete, measurable standards for all commercial health plans. Currently, without specific metrics, there is no objective way to determine when a network has failed to provide timely access to care, leaving a regulatory gap that renders network adequacy unenforceable. By adopting the federal quantitative benchmarks in 45 C.F.R. 156.230, the rules create clear, universal and baseline standards for access to care. This protects health benefit plan enrollees from excessive wait times and delayed care, and specifically for the populations protected by HB 2002 and SB 1137, ensures that out-of-network requests are approved without financial penalty when in-network care is unavailable.

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:

dfr.oregon.gov/laws-rules/Pages/proposed-rules.aspx.

RULES:
836-053-0300, 836-053-0310, 836-053-0345

AMEND: 836-053-0300

RULE SUMMARY: Updates the purpose and applicability of network adequacy rules to include health benefit plans issued or renewed on or after January 1, 2026.

CHANGES TO RULE:

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

(1) OAR 836-053-0300 to 836-053-0350 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~~5~~0 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.¶~~
~~(3) The requirements set forth in OAR 836-053-0310 and 836-053-0350 apply to all insurers offering individual, large group, or small~~carriers offering individual or group health benefit plans in this state that are issued or

renewed on or after January 1, 20~~17~~26.
Statutory/Other Authority: ORS 731.244 ~~and~~, ORS 743B.505, Or/Laws/2025,/ ch 541
Statutes/Other Implemented: ORS 743B.505, Or/Laws/2025,/ ch 541

AMEND: 836-053-0310

RULE SUMMARY: Updates definitions to include terms necessary for the implementation of network adequacy standards, including "Nationally recognized standard," "Telemedicine," and county classifications.

CHANGES TO RULE:

836-053-0310
Network Adequacy Definitions for OAR 836-053-0300 to 836-053-0350 ¶

~~(1)~~ As used in ~~these rules~~OAR 836-053-0300 to 836-053-0350:¶
(~~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 945-001-00~~0~~2(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, as published by CMS as of January 1, 2025, and thereafter as published by the department in a bulletin and 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 appears on the HPSA ZIP code list published by CMS as of January 1, 2025, and thereafter as published by the department in a bulletin and 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 CFR § 422.116, as of January 1, 2025, and thereafter as published by the department in a bulletin and made available on the division's website at https://dfr.oregon.gov/laws-rules/Pages/bulletins.aspx, or its successor. ¶
(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, Or/Laws/2025,/ch 541
Statutes/Other Implemented: ORS 743B.505, Or/Laws/2025,/ch 541

ADOPT: 836-053-0345

RULE SUMMARY: Adopts quantitative network adequacy access standards for health benefit plans, establishing specific appointment wait time limits and travel time and distance benchmarks consistent with federal standards for Qualified Health Plans.

CHANGES TO RULE:

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.¶
(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, Or/Laws/2025,/ch/541
Statutes/Other Implemented: ORS 743B.505, Or/Laws/2025,/ch/541