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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 409
OREGON HEALTH AUTHORITY
HEALTH POLICY AND ANALYTICS

FILED: 08/26/2026 10:53 AM
ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Update All Payer All Claims existing rule language and data submission file layouts.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 09/21/2026 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.

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Filed By:
Melanie White
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HEARING(S)
Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 09/16/2026
TIME: 10:00 AM - 11:00 AM
OFFICER: Mel White

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 971-277-2343
CONFERENCE ID: 271138473
SPECIAL INSTRUCTIONS:
Attendees will need to join the meeting by Microsoft Teams or phone. If you wish to provide comment, please be signed in or call in by no later than 15 minutes after the start time. Join by Microsoft Teams: Meeting ID: 236 892 954 924 594 Passcode: Mu2bx79j or call in: +1 971-277-2343 Phone Conference ID: 271 138 473# Everyone has a right to know about and use OHA's programs and services. OHA provides assistance such as sign language and spoken language interpreters, written materials in other languages, braille, large print, audio and other formats. If you need assistance or have questions, please contact HPA-Rules@oha.oregon.gov at least 5 days before the meeting.

NEED FOR THE RULE(S):

The All Payer All Claims (APAC) program is updating OAR 409□025□0110 and OAR 409□025□0160, and revising the Appendices A–G Data Submission File Layouts referenced in OAR 409□025□0120.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None.

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

The program does not directly interact with individuals, providers, or community groups. The All Payer All Claims (APAC) program does not establish eligibility for coverage, determine services to be provided, or establish the cost or payment for any services.

FISCAL AND ECONOMIC IMPACT:

No fiscal or economic impact is expected as these updates intend to provide clarity in submission requirements for mandatory reporters and data submitters.

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) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). None
(2) Effect on Small Businesses: None known.
(a) Estimate the number and type of small businesses subject to the rule(s); zero
(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); None expected.
(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s). None expected.

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

These rules were developed without the input of small businesses due to the program's inability to identify such businesses that would be affected, as employee count and annual revenue are not reported to APAC. Most mandatory reporters are national organizations, and they have yet to identify themselves as small businesses.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? NO IF NOT, WHY NOT?

No. Under an exemption, the program consulted with the Technical Advisory Group consisting of mandatory reporters and data requesters in lieu of a Rule Advisory Committee that includes public members. Members of the public are welcome to attend any Technical Advisory Group every other month meeting. However, the current attendees do not include members of the public.

RULES PROPOSED:
409-025-0110, 409-025-0120, 409-025-0160

AMEND: 409-025-0110

RULE SUMMARY: Clarifies how mandatory reporters are identified, sets a 2,000 covered lives threshold for PBMs, Medicare Advantage, and DSNPs, reorganizes the rules, and clarifies test file requirements for new or returning reporters.

CHANGES TO RULE:

409-025-0110
General Reporting Requirements ¶

(1) Determination of "mandatory reporter":~~¶~~
~~(a) F~~ The Authority shall identify mandatory reporters for carriers, dental carriers, and ~~licensed~~ third~~-~~ party administrators~~, the Authority shall identify mandatory reporters~~ using information collected by DCBS including, but not limited to, data from the Health Insurance Member Enrollment Report.¶
(~~A~~a) The Authority shall aggregate the most recent four quarters of data.¶
(~~B~~b) The Authority shall calculate the mean total lives for each carrier and licensed third-party administrator. Mean total lives shall be calculated by using the total covered lives in the following lines of business for each carrier, dental carrier and licensed third-party administrator:¶
(~~i~~A) Large group;¶
(~~ii~~B) Small group;¶
(~~iii~~C) Individual market;¶
(~~iv~~D) dental;¶
(~~v~~E) Medicare Advantage; and¶
(~~vi~~F) Self-insured.¶
(~~C~~2) Mandatory reporters: ¶
(a) All carriers, dental carriers and licensed third-party administrators with calculated mean total lives of 5,000 or higher ~~shall b~~are mandatory reporters.¶
(b) All carriers with Medicare Advantage members totaling 2,000 or more covered lives are mandatory reporters.¶
(~~b~~c) All PBMs ~~shall be mandatory reporter~~with calculated mean total of lives of 2,000 or higher are mandatory reporters, except PBMs with OEBB and PEBB lines of business.¶
(~~c~~d) All CCOs ~~shall b~~are mandatory reporters.¶
(~~d~~e) All reporting entities with Dual Eligible Special Needs Plans with calculated mean total lives of 2,000 or higher in Oregon ~~shall b~~are mandatory reporters.¶
(~~e~~f) All insurers providing coverage funded under Part D of Medicare ~~shall b~~are mandatory reporters.¶
(~~f~~g) All insurers offering a health benefits plan in Oregon's health insurance exchange ~~shall b~~are mandatory reporters.¶
(~~g~~h) All insurers providing group health insurance plans to PEBB and OEBB members ~~shall b~~are mandatory reporters.¶
(~~2~~3) If an organization believes a determination by the Authority of its mandatory status to be in error, the organization must contact the Authority to contest the determination as described in the notice no later than 90 days prior to the first scheduled date of submission of production files.¶
(~~3~~4) Any carrier or licensed third-party administrator who has been identified as a mandatory reporter and believes their entity has fewer than 5,000 mean total lives due to ERISA self-insured shall notify the Authority by filing a request for waiver under OAR 409-025-0140.¶
(~~4~~5) An organization may elect to participate as a voluntary reporter by notifying the Authority in writing.¶
(~~5~~6) Mandatory and voluntary reporters shall submit data files for all required lines of business. They may submit data files for the voluntary lines of business and may not submit data files for any excluded lines of business.¶
(a) Required lines of business include:¶
(A) Medicare Advantage Part C and Medicare Part D;¶
(B) Medicaid;¶
(C) Individual;¶
(D) Small employer health insurance;¶
(E) Large group;¶
(F) Associations and trusts;¶
(G) PEBB and OEBB group health insurance plans;¶
(H) Self-insured plans not subject to ERISA; and¶
(I) Dental insurance.¶
(b) Voluntary lines of business include self-insured plans subject to ERISA.¶
(c) Excluded lines of business include:¶
(A) Accident policy;¶

(B) Disability policy;¶
(C) Hospital indemnity policy;¶
(D) Long-term care insurance;¶
(E) Medicare supplemental insurance;¶
(F) Specific disease policy;¶
(G) Stop-loss plans;¶
(H) Student health policy;¶
(I) Supplemental insurance that pays deductibles, copays or coinsurance;¶
(J) Vision-only insurance; and¶
(K) Workers compensation.¶
(d) A mandatory reporter that contracts with another entity remains responsible for reporting all required lines of business. If the mandatory reporter elects to have the data reported by a contracted entity, the mandatory reporter shall notify the Authority and provide contact information for the contracted entity.¶
(~~6~~7) Mandatory and voluntary reporters shall comply with data file layout, format, and coding requirements in OAR 409-025-0120.¶
(~~7~~8) Mandatory and voluntary reporters shall comply with data submission requirements in OAR 409-025-0130.¶
(~~8~~9) A mandatory reporter who plans to withhold data must submit a waiver of reporting in compliance with OAR 409-025-0140. If the mandatory reporter believes that the data are prohibited from disclosure under state or federal statutes, regulations or rules, then the waiver request must state the data prohibited from disclosure and the statute, regulation or rule that requires withholding the data.¶
(~~9~~10) The Authority shall provide written notification by July 1 of each year to all mandatory reporter's subject to the reporting requirements of OAR 409-025-0100 to 409-025-0150 for the following calendar year.¶
(1~~0~~1) New mandatory reporters submitting for the first time, or mandatory reporters that did not submit data in the previous year, shall submit test files ~~before production files are due~~. The mandatory reporter~~s~~ shall submit test files no later than 60 days before the first ~~scheduled date of submission of production fi~~quarter of the reporting year following the data submission schedul~~es~~.
Statutory/Other Authority: ORS 442.466
Statutes/Other Implemented: ORS 442.464, 442.466

AMEND: 409-025-0120

RULE SUMMARY: Updates Appendices A–G file layouts cited in rule to improve formatting and clarify reporting requirements, creates standalone files for each appendix and a separate lookup table file.

CHANGES TO RULE:

409-025-0120
Data File Layout, Format, and Coding Requirements ¶

(1) All mandatory reporters shall submit claims-based data for all claims where the subscriber's residence is in Oregon or the subscriber is enrolled in a plan for which the State of Oregon is the payer.¶
(2) Claims-based data files shall include:¶
(a) Enrollment;¶
(b) Medical claims;¶
(c) Pharmacy claims;¶
(d) Dental claims;¶
(e) Provider;¶
(f) Subscriber-billed premiums; and¶
(g) Control totals files.¶
(3) Mandatory reporters must include plan-specific identifiers for members, subscribers, providers and contracts in required files. Mandatory reporters authorized by the Centers for Medicare and Medicaid Services or contracted through an insurer must provide the member's identifier for those organizations in addition to the mandatory reporters' member specific identifier. All identifiers must be:¶
(a) Sufficient length to be unique within the mandatory reporters' solution;¶
(b) Assigned to a single individual, entity or contract;¶
(c) Consistent across all files for the submission; and¶
(d) Persistent over time unless change in identifier is required due to change in coverage or contract.¶
(4) The enrollment file shall be submitted by all mandatory reporters using the approved layout, format, and coding described in Appendix A, Enrollment.¶
(a) Mandatory reporters shall report race and ethnicity data as outlined in Appendix A, Enrollment. This layout aligns with the Office of Management and Budget's (OMB) Federal Register Notice of October 30, 1997 (62 FR 58782-58790).¶
(b) Mandatory reporters shall report primary language in accordance with ANSI/NISO guidance using the three-character string outlined in Codes for the Representation of Languages for Information Interchange.¶
(c) Race, ethnicity and primary language data shall be collected in a manner that aligns with the following principles:¶
(A) To the greatest extent practicable, race, ethnicity, and preferred language shall be self-reported.¶
(i) Collectors of race, ethnicity and primary language data may not assume or judge ethnic and racial identity or preferred signed, written and spoken language, without asking the individual.¶
(ii) If an individual is unable to self-report and a family member, advocate, or authorized representative is unable to report on his or her behalf, the information shall be recorded as unknown.¶
(B) When an individual declines to identify race, ethnicity or preferred language, the information shall be reported as refused.¶
(5) The membership total and claims control files shall be submitted by all mandatory reporters using the approved layout, format, and coding described in Appendix G, Membership Total and Claims Control.¶
(6) The subscriber-billed premium file shall be submitted by all mandatory reporters except CCOs using the approved layout, format, and coding described in Appendix F, Subscriber-Billed Premium.¶
(7) The provider file shall be submitted by all mandatory reporters except PBMs using the approved layout, format, and coding described in Appendix E, Provider.¶
(8) The medical claims file shall be submitted by all mandatory reporters except PBMs and dental carriers using the approved layout, format, and coding described in Appendix B, Medical Claims.¶
(9) The pharmacy claims file shall be submitted by PBMs, carriers and third party administrators using the approved layout, format, and coding described in Appendix C, Pharmacy Claims.¶
(10) The dental claims file shall be submitted by all mandatory reporters other than PBMs who provide dental coverage using the approved layout, format, and coding described in Appendix D, Dental Claims.¶
(11) All data elements are required unless specified as optional or situational within the file layout.¶
(12) All data files shall be submitted as tab-delimited files which have been encrypted and zipped prior to submission.¶

(13) Numeric data are positive integers unless otherwise specified.¶
(a) Negative values are allowed for quantities, charges, payment, co-payment, co-insurance, deductible, and prepaid amount.¶
(b) Negative values shall be preceded by a minus sign.¶
(14) All data files shall pass edit checks and validations implemented by the Authority or the Authority's data vendor.¶
(a) Data vendors may perform quality and edit checks on data file submissions. If data files do not pass data vendor edit checks or validation, mandatory reporters must make corrections and resubmit data. Mandatory reporters must submit corrected data that passes all quality and edit checks or receive an approved exemption within 14 calendar days of notification by the Authority or the Authority's data vendor of the error.¶
(b) Mandatory reporters must participate in efforts to validate and check the quality of current and historic APAC data, as prescribed and requested by the Authority.¶
(A) The Authority may request from mandatory reporter's information from their internal records that is reasonably necessary to validate and check the quality of APAC data. This information may include, but is not limited to, aggregated number of enrolled members, number of claims and claim lines, charges, allowed amounts, paid amounts, co-insurance, co-payments, premiums, number of visits to primary care, emergency department, inpatient, and other health care treatment settings, and number of prescriptions.¶
(B) Mandatory reporters shall provide the aggregated information within 30 days of the Authority's request.¶
(C) If the Authority finds errors through edit checks or validation, mandatory reporters must make corrections and resubmit data or receive an approved extension or exemption within 30 days or at the next regularly scheduled submission due date.
Statutory/Other Authority: ORS 442.373
Statutes/Other Implemented: ORS 442.373, ORS 442.372

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 409-025-0120.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=339002

AMEND: 409-025-0160

RULE SUMMARY: Removes public use files as an available data set for request, reorganizes the rules, strengthens HIPAA and privacy compliance for limited data set releases, clarifies approval and denial criteria including IRB requirements, reintroduces conditions for denying requests, and updates processes for state agency data requests.

CHANGES TO RULE:

409-025-0160
Data Access and Release ¶

(1) ~~T~~When releasing data as part of a limited data set request, the Authority shall comply with all ~~relevant~~applicable state and federal data privacy~~,~~ and security laws, and antitrust ~~regulation~~laws, including The Health Insurance Portability and Accountability Act (HIPAA), when ~~sharing APAC data.¶~~
~~(2) The Authority may collect payment to recoup costs when APAC data requests are fulfilled.¶~~
~~(3) The Authority shall provide a public use data set, which shall include de-identified member health information, in~~determining whether it can release APAC data and what APAC data is permissible to release.¶
(2) The Authority may disclose limited data sets if the requestor is eligible to receive a limited data set under state and federal law, including but not limited to 45 CFR 164.514 and the application otherwise compli~~ance~~s with ~~applicable Authority policies and state and federal rules, regulations, and statutes~~these rules. Limited data sets may include limited protected health information.¶
(~~a~~3) The Authority shall maintain a list of data elements that may be included in APAC ~~public use data sets~~limited data sets if approved for a specific request.¶
(~~b~~4) Request~~ors seeking access to an APAC public use data set shall complete a Public Use Data File Application (APAC-2). Payment is required as follows:¶~~
~~(A) Actual cost with a maximum cost of $500 per data year for Medical Claims;¶~~
~~(B) Actual cost with a maximum cost of $500 per data year for Pharmacy Claims;¶~~
~~(C) Actual cost with a maximum cost of $500 per data year for Dental Claims; and¶~~
~~(D) Enrollment file requested in conjunction with Medical, Pharmacy or Dental Claims will be provided without additional charge.~~s for limited data sets must be made in the form and manner prescribed by the Authority as described on the agency's website. The requestor must include sufficient information to evaluate any request for APAC data, including identification of each data element requested and explaining the use of the data element within the description of activity in the application. ¶
(~~c~~a) ~~The Authority may approve or deny the completed request and provide written notification to the requestor within 30 calendar days of receipt of the request.¶~~
~~(d) The Authority shall deny the completed request for reasons which include, but are not limited to:¶~~
~~(A) Requestor or any person who will have access to~~Prior to requesting a limited data set for research, a requestor must have obtained a determination from an Institutional Review Board (IRB) that the request is exempt from review or approved and submit the full IRB application to APAC for review. ¶
(b) Completed limited data set applications will be posted on the ~~d~~Data ~~has previously violated a data use agreement with the Authority.¶~~
~~(B) The Authority finds that the specific details of the request do not sufficiently explain the proposed~~Review Committee website for a minimum of two weeks prior to a Data Review Committee meeting to support transparency in data use.¶
(~~C~~5) ~~The Authority finds that the specific details of the request violate any state or federal rule, regulation, or statute.¶~~
~~(D) Full payment is not included with~~Once an application is complete, the Authority's Data Review Committee will review the application ~~or received within thirty (30) days of invoicing.~~and any additional materials in accordance with OAR 409-025-0190. ¶
(~~e~~6) ~~If t~~The Authority ~~denies the Public Us~~may approve or deny a complete ~~A~~application ~~(APAC-2):¶~~
~~(A) The Authority sha~~and will provide written notification ~~stating the reason for the denial and process return of payment; and~~to the requestor of its decision.¶
(7) If approved, the Authority shall:¶
(~~B~~a) ~~The requestor may appeal the denial by requesting a contested case hearing. The appeal must be filed within 30 business days of the denial. The appeal process is conducted pursua~~Require the requestor to sign a data use agreement that complies with 45 CFR 164.514(e)(4).¶
(b) Maintain a list of approved data elements t~~o ORS chapter 183 and the Attorney General's Uniform and Model Rules of Procedure, OAR 137-003-0501 to 137-003-0700. The requestor shall have the burden to prove that the Authority unreasonably denied the application.¶~~

(f) The public use data sets may not be used to identify any individual, including members or subscribers. That were included in an approved limited data set request.¶
(c) Determine the hours required to complete the data request and inform the requestoer may not use outside information to attempt to ascertain the identity of individuals who are the subject of public use data sets.¶
(g) Provider information will be reviewed for information that may be considered personally identifiable informationof the cost of the resulting data set. Payment of the costs of producing the data set must be received by the Authority prior to the data set being provided to the requestor. ¶
(A8) If a taxpayer identification number is determined to be a social security number, such information shall not be released. ¶
(B) Information already available to the publThe Authority may deny a request for a limited data set for reasons which including published licensing data or public-facing data from the National Plan & Provider Enumeration System shall not be considered personally identifiable information.¶
(4) The Authority shall provide limited data sets, in compliance with applicable Authority policies and state and federal rules, regulations, and statutes. Limie, but are not limited to:¶
(a) The requestor is not authorized to receive a limited data set under applicable law.¶
(b) The requestor has previously violated a data usets may include protected health information agreement with the Authority.¶
(ac) The Authority shall maintain a list of data elements that may be included in APAC limited data sets if approved for a specific request.¶
(b) APAC limited data sets may be disclosed for purposes allowed by state and federal regulations, including research, public health, and health care operationsrequestor has not sufficiently explained the proposed use of the data.¶
(d) Disclosure of the requested limited data set would violate an applicable state or federal law.¶
(e9) Requestors seeking access to APAC limited data sets shall complete the Application for APAC Data Files (APAC-3).¶
(d) Requestors must identify each data element requested and explain the use of the data element within the description of activity in the application. The Authority will determine which data elements will be released after review under HIPAA and other applicable laws, regulations, and rules,who receive a limited data set for research must maintain Institutional Review Board (IRB) approval, if required for the data use agreement, throughout the span of authorized use of the data and until the data is destroyed. Requestors must submit updated IRB approval authorizing continued activity prior to the expiration of the previous authorization.¶
(e10) The Authority shall determine the hours required to complete the data requprovide data to Oregon state agencies and inform the requestor of the cost of the resulting data set.¶
(5) The Authority shall provide datalocal public health authorities, in compliance with applicable Authority policies and state and federal rules, regulations and statutes, to Oregon state agencies and local public health authorities. Use is limited to activities required to meet the agency's duties as authorized by Oregon law.¶
(a) Agency-use data sets may include protected health information if allowed by state and federal law.¶
(b) Requestors seeking access to APAC agency data sets shall complete the Application for Agency Data Files and must explain use of each data elementan APAC Agency Application. ¶
(c) The Authority shall maintain a list of approved data elements that were included in an approved Agency requested.¶
(ed) Agency requests will be posted toon the Data Review Committee webpage for a minimum of two weeks to support transparency in data use.¶
(6) Requests for public use data set or limited data sets must be made using the form and manner prescribed by the Authority that is available on the agency's website. The form shall collect sufficient information to evaluate any request for APAC data.¶
(7) Requestors who receive a limited data set must maintain Institutional Review Board (IRB) approval, ife) A signed data sharing agreement between the Authority and the data recipient is required befor the data use agreement, throughout the span of authorized use of the data and until the data is destroyed. Requestors must submit updated documentation authorizing continued activity prior to the expiration of the previous authorization.¶
(8) Requesters who receive a limited data sete sharing an APAC agency data set.¶
(11) Requestors who have received APAC data must submit an amendment to the Authority when there is a change in the proposed use of the data within the scope of the original data request.¶
(a) Requestors shall file such an amendment when any of the following is anticipated:¶
(A) A change in persons accessing the data;¶
(B) Additional data elements are requested;¶
(C) Additional years of data are requested;¶
(D) Any change in the use of the data including linking or the addition of research questions; or¶

(E) Any change in research protocol, regardless of approval by an IRB.¶
(b) Changes or additions to use that are outside of the scope of the original data request will not be approved.¶
(c) Requestors may not implement any change related to access or use of data prior to receiving approval from the Authority.¶
(d) Changes in data elements, data use or research protocol must be reviewed by the Data Review Committee (DRC) described in OAR 409-025-0190. In addition, a recommendation by the DRC may be sought for additional years of data or new project staff for limited data sets the Authority determines to include vulnerable populations.¶
~~(e) The Authority shall review for completeness all applications and provide requestors written notification of completeness within 30 calendar days of receipt of the request. If the Authority determines that the application is incomplete, the requestor shall have 30 calendar days from notification of incompleteness to complete the application. Incomplete applications that are not completed shall be discarded without further notification to the requestor.~~
Statutory/Other Authority: ORS 442.373
Statutes/Other Implemented: ORS 442.373, ORS 442.372