OFFICE OF THE SECRETARY OF STATE
TOBIAS READ
SECRETARY OF STATE

MICHAEL KAPLAN
DEPUTY SECRETARY OF STATE

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

PERMANENT ADMINISTRATIVE ORDER

OHP 6-2026

CHAPTER 409
OREGON HEALTH AUTHORITY
HEALTH POLICY AND ANALYTICS

FILED: 10/21/2026 8:27 AM
ARCHIVES DIVISION SECRETARY OF STATE & LEGISLATIVE COUNSEL

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

EFFECTIVE DATE: 12/01/2026

AGENCY APPROVED DATE: 10/19/2026

CONTACT:
Grace Paiva
971-283-5279
APAC.Admin@odhsoha.oregon.gov
800 NE Oregon St. Ste 730
Portland, OR 97232

Filed By:
Melanie White
Rules Coordinator

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

AMEND: 409-025-0110

RULE TITLE: General Reporting Requirements

NOTICE FILED DATE: 08/26/2026

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.

RULE TEXT:
(1) Determination of “mandatory reporter”: The Authority shall identify mandatory reporters for carriers, dental carriers, and third party administrators using information collected by DCBS including, but not limited to, data from the Health Insurance Member Enrollment Report.
(a) The Authority shall aggregate the most recent four quarters of data.
(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:
(A) Large group;
(B) Small group;
(C) Individual market;
(D) dental;
(E) Medicare Advantage; and
(F) Self-insured.
(2) Mandatory reporters:
(a) All carriers, dental carriers and licensed third-party administrators with calculated mean total lives of 5,000 or higher are mandatory reporters.
(b) All carriers with Medicare Advantage members totaling 2,000 or more covered lives are mandatory reporters.
(c) All PBMs with calculated mean total of lives of 2,000 or higher are mandatory reporters, except PBMs with OEBB and PEBB lines of business.
(d) All CCOs are mandatory reporters.
(e) All reporting entities with Dual Eligible Special Needs Plans with calculated mean total lives of 2,000 or higher in Oregon are mandatory reporters.
(f) All insurers providing coverage funded under Part D of Medicare are mandatory reporters.
(g) All insurers offering a health benefits plan in Oregon's health insurance exchange are mandatory reporters.
(h) All insurers providing group health insurance plans to PEBB and OEBB members are mandatory reporters.
(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.
(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.
(5) An organization may elect to participate as a voluntary reporter by notifying the Authority in writing.
(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.
(7) Mandatory and voluntary reporters shall comply with data file layout, format, and coding requirements in OAR 409-025-0120.
(8) Mandatory and voluntary reporters shall comply with data submission requirements in OAR 409-025-0130.
(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.
(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.
(11) New mandatory reporters submitting for the first time, or mandatory reporters that did not submit data in the previous year, shall submit test files. The mandatory reporter shall submit test files no later than 60 days before the first quarter of the reporting year following the data submission schedule.

STATUTORY/OTHER AUTHORITY: ORS 442.466

STATUTES/OTHER IMPLEMENTED: ORS 442.464, 442.466

AMEND: 409-025-0120

RULE TITLE: Data File Layout, Format, and Coding Requirements

NOTICE FILED DATE: 08/26/2026

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.

RULE TEXT:
(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

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=339802