

1 836-010-0155 (NEW)

2  
3 **Gender Specific Contract Language**

4  
5 **(1) As used in this rule, “provider” includes but is not limited to:**

6  
7 **(a) A physician as defined in ORS 677.010.**

8  
9 **(b) A physician group, independent practice association, physician-controlled organization, hospital organization or other provider organization that contracts with a provider for the purpose of facilitating the provider’s participation in a provider network contract.**

10  
11  
12  
13 **(c) A person licensed, certified or otherwise authorized or permitted by the laws of this state to administer medical services or mental health services in the ordinary course of business or practice of a profession.**

14  
15  
16  
17 **(2) If a provider determines that sex-specific recommended preventive service that is required to be covered without cost sharing under section 2713 of the Public Health Service Act and its implementing regulations is medically appropriate for a particular individual is determined by the individual’s attending provider. When an attending provider determines that a recommended service is medically appropriate for an individual and the individual satisfies the criteria for the benefit or treatment the insurer must provide coverage for the recommended service regardless of sex assigned at birth, gender identity, or gender of the individual otherwise recorded by the insurer.**

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25  
26 **(3) This rule is adopted under the general rulemaking authority of the Director of the Department of Consumer and Business Services in ORS 731.244 to comply with guidance received from the United States Department of Labor, Employee Benefits Security Administration on May 11, 2015.**

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30  
31 Stat. Auth.: ORS 731.244

32 Stats Implemented: ORS 743A.066, 743A.080, 743A.100, 743A.104, 743A.105, 743A.108,  
33 743A.110 and 743A.120

34 Hist.:

35  
36 836-053-0002 (Amended)

37  
38 **Modification of a Health Benefit Plan Subject to Levels of Coverage Requirements**

39  
40 (1) A modification of a health benefit plan subject to the levels of coverage defined in 42 U.S.C.  
41 18022(d) is defined in this rule for the purposes of:

42  
43 (a) ORS 743.737, regarding small employer health benefit plans; and

44  
45 (b) ORS 743.766, regarding individual health benefit plans.

1 (2) One or more decreases or increases in the services or benefits covered in a health benefit plan  
2 are a modification and not a discontinuance when the decrease or decreases, or the increase or  
3 increases, or any combination thereof, occur at the time of renewal and the change or changes  
4 together do not alter the level of coverage as defined in 42 U.S.C. 18022(d).

5  
6 (3) One or more decreases or increases in the services or benefits covered in a health benefit plan  
7 are a discontinuance when the decrease or decreases, or the increase or increases, or any  
8 combination thereof, alter the level of coverage as defined in 42 U.S.C. 18022(d).

9  
10 **(4) At the time of coverage renewal insurers may modify the coverage for a product offered**  
11 **to a group health benefit plan or an individual health benefit plan.**

12  
13 **(a) The modification must be consistent with state law and if effective uniformly with that**  
14 **product.**

15  
16 **(b) Modifications made uniformly and solely pursuant to applicable federal or state**  
17 **requirements are considered a uniform modification of coverage if:**

18  
19 **(A) The modification is made within a reasonable time period after the imposition or**  
20 **modification of the federal or state requirement; and**

21  
22 **(B) The modification is directly related to the imposition or modification of the federal or**  
23 **state requirement.**

24  
25 **(c) Other types of modification made uniformly are considered a uniform modification of**  
26 **coverage if the coverage for the product in the individual or small group market meets all of**  
27 **the following criteria:**

28  
29 **(A) The product is offered by the same health insurer;**

30  
31 **(B) The product is offered has the same product network type;**

32  
33 **(C) The product is continues to cover at least a majority of the same service area;**

34  
35 **(D) Within the product, each plan has the same cost sharing structure as before the**  
36 **modification, except for any variation in cost sharing solely related to changes in cost and**  
37 **utilization of medical care, or to maintain the same metal tier level described in 42 U.S.C.**  
38 **18022(d); and**

39  
40 **(E) The product provides the same covered benefits, except for any changes in benefits that**  
41 **cumulatively impact the plan-adjusted index rate for any plan within the product within an**  
42 **allowable variation of the +/- 2 percentage points (not including changes pursuant to**  
43 **applicable federal or state requirements).**

1 **(5) Insurers must use the standardized notice of modification or discontinuance as set forth**  
2 **on website for the Insurance Division of the Department of Consumer and Business**  
3 **Services at [www.insurance.oregon.gov](http://www.insurance.oregon.gov).**  
4

5 Stat. Auth.: ORS 731.244, 743.566 & 743.773  
6 Stats Implemented: ORS 743.737, 743.754 & 743.766  
7 Hist.: ID 12-2013, f. 12-31-13, cert. ef. 1-1-14  
8

9 **835-053-0004 (NEW)**

10  
11 **Compliance with Federal and State Law**  
12

13 **Upon contract issuance or renewal, any insurer offering a health benefit plan must update**  
14 **the plans of the insurer as necessary to comply with state and federal law.**  
15

16 Stat. Auth.: ORS 731.244  
17 Stats Implemented: ORS 742.005  
18 Hist.:

19  
20 836-053-0008 (Amended)  
21

22 **Essential Health Benefits for Plan Years 2014, 2015 and 2016**  
23

24 **(1) This rule applies to plan years beginning January 1, 2014 through December 31, 2016.**  
25

26 **(2)** As used in the Insurance Code:  
27

28 (a) “Base benchmark health benefit plan” means the PacificSource Health Plans Preferred  
29 CoDeduct Value 3000 35 70 small group health benefit plan, including prescription drug  
30 benefits, as set forth on the Insurance Division website of the Department of Consumer and  
31 Business Services at [www.insurance.oregon.gov](http://www.insurance.oregon.gov)[;].  
32

33 (b) “Essential health benefits” means the following coverage provided in compliance with 45  
34 CFR 156:  
35

36 (A) The base-benchmark health benefit plan, excluding the 24-month waiting period for  
37 transplant benefits;  
38

39 (B) Pediatric dental benefits;  
40

41 (C) Pediatric vision benefits; and  
42

43 (D) Habilitative services.  
44

1 (c) “Habilitative benefits” means the rehabilitative services provisions of the base benchmark  
2 when the services are medically necessary for the maintenance, learning or improving skills and  
3 function for daily living.  
4

5 (d) “Pediatric dental benefits” means the benefits described in the children’s dental provisions of  
6 the State Children’s Health Insurance Plan as set forth on the Insurance Division website of the  
7 Department of Consumer and Business Services at [www.insurance.oregon.gov](http://www.insurance.oregon.gov). Pediatric dental  
8 benefits are payable to persons under 19 years of age.  
9

10 (e) “Pediatric vision benefits” means the benefits described in the vision provisions of the  
11 Federal Employee Dental and Vision Insurance Plan Blue Vision High Option as set forth on the  
12 Insurance Division website of the Department of Consumer and Business Services at  
13 [www.insurance.oregon.gov](http://www.insurance.oregon.gov). Pediatric vision benefits are payable to persons under 19 years of  
14 age.  
15

16 [(2)](3) An [issuer of a] **insurer that issues a health benefit** plan offering essential health  
17 benefits may not include as an essential health benefit:  
18

- 19 (a) Routine non-pediatric dental services;
- 20
- 21 (b) Routine non-pediatric eye exam services;
- 22
- 23 (c) Long-term care or custodial nursing home care benefits; or
- 24
- 25 (d) Non-medically necessary orthodontia services.  
26

27 Stat. Auth.: Sec. 2, Ch. 681, OL 2013  
28 Stats. Implemented: Sec. 2, Ch. 681, OL 2013  
29 Hist.: ID 12-2013, f. 12-31-13, cert. ef. 1-1-14  
30

31 **836-053-000x-1 (NEW)**

32  
33 **Essential Health Benefits for Plan Years Beginning on and after January 1, 2017**

34  
35 **(1) This rule applies to plan years beginning on and after January 1, 2017.**

36  
37 **(2) As used in the Insurance Code and OAR Chapter 836:**

38  
39 **(a) “Base benchmark health benefit plan” means the PacificSource Health Plans Preferred**  
40 **CoDeduct Value 3000 35 70 small group health benefit plan, including prescription drug**  
41 **benefits, as set forth on the Insurance Division website of the Department of Consumer and**  
42 **Business Services at [www.insurance.oregon.gov](http://www.insurance.oregon.gov);**  
43

44 **(b) “Essential health benefits” means the following coverage provided in compliance with**  
45 **45 CFR 156:**  
46

1 **(A) The base-benchmark health benefit plan, but with the following exclusions and**  
2 **modifications of provisions of that plan:**

3  
4 **(i) The following treatment limitations and exclusions of coverage currently included in the**  
5 **base-benchmark health benefit plan are excluded:**

6  
7 **(I) The 24-month waiting period for transplant benefits;**

8  
9 **(II) Visit limits for inpatient and outpatient mental health services, including services**  
10 **provided for the treatment of mental health conditions including but not limited to**  
11 **habilitative and rehabilitative benefits;**

12  
13 **(III) Age limits on treatments that would otherwise be appropriate for individuals outside**  
14 **of the limited age, including but not limited to speech, physical and occupational therapy**  
15 **used in the treatment of mental or nervous conditions as defined in OAR 836-053-1404;**

16  
17 **(IV) Exclusions for the treatment of erectile dysfunction or sexual dysfunction as defined**  
18 **in the "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition" (DSM-5);**

19  
20 **(V) Exclusions for surgeries and procedures related to sex transformations and gender**  
21 **identity disorder or gender dysphoria;**

22  
23 **(VI) Any blanket exclusion for a diagnosis made using the diagnostic criteria of the DSM-5;**

24  
25 **(VII) Exclusions for court-order screening interviews or drug or alcohol treatment**  
26 **programs;**

27  
28 **(VII) Any limitations or waiting periods for pre-existing conditions;**

29  
30 **(VIII) Time limits for treatment of jaw or teeth or orthognathic surgery; and**

31  
32 **(IX) Dollar limits for coverage of durable medical equipment must comply with the**  
33 **following:**

34  
35 **(aa) Annual dollar limits must be converted to a non-dollar actuarial equivalent.**

36  
37 **(bb) Lifetime dollar limits must be converted to a non-dollar actuarial equivalent.**

38  
39 **(ii) The following provisions of the base-benchmark plan must be modified:**

40  
41 **(I) Providers and practitioners must include any provider acting within the scope of the**  
42 **provider's Oregon license or as otherwise allowed under Oregon law;**

43  
44 **(II) Any waiting periods must be consistent with limitations imposed by state or federal**  
45 **law;**

1 **(III) Wigs following chemotherapy or radiation therapy must be covered up to the**  
2 **actuarial equivalent of \$150;**

3  
4 **(IV) The coverage of diabetes self-management under ORS 743A.184 must be an additional**  
5 **benefit to what must be supplied under the USPSTF A and B list;**

6  
7 **(V) The limitation on cosmetic or reconstructive surgery to one attempt within 18 months**  
8 **of injury or defect must be modified to remove these limitations in because this limitation**  
9 **violates prohibitions on discriminatory benefit designs under 45 CFR 156.125(a) and**  
10 **discrimination based on health factors under 45 CFR 146.121;**

11  
12 **(VI) Contraceptive coverage must comply with CMS guidance and requirements related to**  
13 **contraception issued by the United States Department of Labor, Employee Benefits**  
14 **Security Administration on May 11, 2015; and**

15  
16 **(VII) Provisions related to telemedical health services must reflect changes made to ORS**  
17 **743A.058 by chapter 340, Oregon Laws 2015 (Enrolled Senate Bill 144);**

18  
19 **(B) Pediatric dental benefits;**

20  
21 **(C) Pediatric vision benefits; and**

22  
23 **(D) Habilitative services and devices.**

24  
25 **(3) An insurer that issues a health benefit plan offering essential health benefits may not**  
26 **include as an essential health benefit:**

27  
28 **(a) Routine non-pediatric dental services;**

29  
30 **(b) Routine non-pediatric eye exam services;**

31  
32 **(c) Long-term care or custodial nursing home care benefits; or**

33  
34 **(d) Non-medically necessary orthodontia services.**

35  
36 **(4) In the administration of essential health benefits and the EHB base benchmark health**  
37 **benefit plan an insurer may not discriminate against a provider acting within the scope of**  
38 **the provider's license.**

39  
40 **(5) Any categorical exclusion for naturopathic treatment or services under the benchmark**  
41 **plan cannot include exclude services provided by a naturopath if the services are otherwise**  
42 **covered under the plan and the naturopathic provider is acting within the scope of the**  
43 **provider's license.**

44  
45 **(6) Any categorical exclusion for chiropractic care under the benchmark plan cannot**  
46 **exclude services provided by a doctor of chiropractic medicine if the services are otherwise**

1 covered under plan and the chiropractor is acting within the scope of the provider’s  
2 license.

3  
4 **(7) As used in the Insurance Code and OAR Chapter 836:**

5  
6 **(a) “Applied behavior analysis” has the meaning given in Section 2, chapter 771, Oregon**  
7 **Laws 2013 as amended by Section 9, chapter 674, Oregon Laws 2015.**

8  
9 **(b) “Habilitative services and devices” means services and devices that help a person keep,**  
10 **learn, or improve skills and functioning for daily living (habilitative services). Examples**  
11 **include therapy for a child who is not walking or talking at the expected age. These services**  
12 **and devices may include physical and occupational therapy, speech-language pathology**  
13 **and other services and devices for people with disabilities in a variety of inpatient or**  
14 **outpatient settings.**

15  
16 **(c) “Mental or nervous condition” has the meaning given in OAR 836-053-1404.**

17  
18 **(d) “Pediatric dental benefits” means the benefits described in the children’s dental**  
19 **provisions of the State Children’s Health Insurance Plan as set forth on the Insurance**  
20 **Division website of the Department of Consumer and Business Services at**  
21 **www.insurance.oregon.gov. Pediatric dental benefits are payable to persons under 19 years**  
22 **of age.**

23  
24 **(e) “Pediatric vision benefits” means the benefits described in the vision provisions of the**  
25 **Federal Employee Dental and Vision Insurance Plan Blue Vision High Option as set forth**  
26 **on the Insurance Division website of the Department of Consumer and Business Services at**  
27 **www.insurance.oregon.gov. Pediatric vision benefits are payable to persons under 19 years**  
28 **of age.**

29  
30 **(f) “Treatment of a mental health condition” includes medical treatments and prescription**  
31 **drugs used to treat a mental or nervous condition.**

32  
33 Stat. Auth.: Sec. 2, Ch. 681, OL 2013

34 Stats. Implemented: Sec. 2, Ch. 681, OL 2013

35 Hist.:

36  
37 836-053-0009 (Amended)

38  
39 Oregon Standard Bronze and Silver Health Benefit Plans **for Plan Years 2014, 2015 and 2016**

40  
41 **(1) This rule applies to plan years beginning January 1, 2014 through December 31, 2016.**

42  
43 **(2) As used in this rule, “coverage” includes medically necessary benefits, services, prescription**  
44 **drugs and medical devices. “Coverage” does not include coinsurance, copayments, deductibles,**  
45 **other cost sharing, provider networks, out-of-network coverage, wigs or administrative functions**  
46 **related to the provision of coverage, such as eligibility and medical necessity determinations.**

1  
2 [(2)](3) For purposes of coverage required under this rule:

3  
4 (a) “Inpatient” includes but is not limited to:

5  
6 (A) Surgery;

7  
8 (B) Intensive care unit, neonatal intensive care unit, maternity and skilled nursing facility  
9 services; and

10  
11 (C) Mental health and substance abuse treatment.

12  
13 (b) “Outpatient” includes but is not limited to services received from ambulatory surgery centers  
14 and physician and anesthesia services and benefits when applicable.

15  
16 (c) “Habilitative benefits” means services and devices that help a person keep, learn, or improve  
17 skills and functioning for daily living (habilitative services). Examples include therapy for a  
18 child who is not walking or talking at the expected age. These services and devices may include  
19 physical and occupational therapy, speech-language pathology and other services and devices for  
20 people with disabilities in a variety of inpatient or outpatient settings.

21  
22 (d) A reference to a specific version of a code or manual, including but not limited to references  
23 to ICD-9, CPT, Diagnostic and Statistical Manual of Mental Disorders, DSM-IV TR, Fourth  
24 Edition; place of service and diagnosis includes a reference to a code with equivalent coverage  
25 under the most recent version of the code or manual.

26  
27 [(3)] (4) When offering a plan required under ORS 743.822, an issuer must use the following  
28 naming convention: “[Name of Issuer] Oregon Standard [Bronze/ Silver] Plan”. For example,  
29 “Acme Oregon Standard Bronze Plan”.

30  
31 [(4)](5) Coverage required under ORS 743.822 must be provided in accordance with the  
32 requirements of sections [(5) to (10)](6 to (11)) of this rule.

33  
34 [(5)] (6) Coverage must be provided in a manner consistent with the requirements of:

35  
36 (a) 45 CFR 156, except that actuarial substitution of coverage within an essential health benefits  
37 category is prohibited;

38  
39 (b) OAR 836-053-1404 and 836-053-1405; and

40  
41 (c) The federal Mental Health Parity and Addiction Equity Act of 2008;

42  
43 [(6)](7) Coverage must provide essential health benefits as defined in OAR 836-053-0008.  
44

1 [(7)](8) Except when a specific benefit exclusion applies, or a claim fails to satisfy the issuer's  
2 definition of medical necessity or fails to meet other issuer requirements the following coverage  
3 must be provided:  
4

5 (a) Ambulatory services based on the following Place of Service Codes:  
6

7 (A) 11 — Office;  
8

9 (B) 12 — Patient's home;  
10

11 (C) 20 — Urgent care facility;  
12

13 (D) 22 — Outpatient hospital;  
14

15 (E) 24 — Ambulatory surgical center;  
16

17 (F) 25 — Birthing center;  
18

19 (G) 49 — Independent clinic;  
20

21 (H) 50 — Federally qualified health center;  
22

23 (I) 71 — State or local public health clinic;  
24

25 (J) 72 — Rural health clinic;  
26

27 (b) Emergency services based on Place of Service Code 23 — Emergency;  
28

29 (c) Hospitalization services based on Place of Service Code 21 — Hospital;  
30

31 (d) Maternity and newborn services based on the following ICD-9 codes:  
32

33 (A) V20 to V20.2;  
34

35 (B) V22 to V39; and  
36

37 (C) 630-677;  
38

39 (e) Rehabilitation and habilitation services based the following ICD-9 or CPT codes:  
40

41 (A) Physical Therapy/Professional: 97001-97002, 97010-97036, 97039, 97110, 97112, 97113-  
42 97116, 97122, 97128, 97139, 97140-97530, 97535, 97542, 97703, 97750, 97760, 97761-97762,  
43 97799, and S9090;  
44

45 (B) Occupational Therapy/Professional: 97003-97004 and G0129 in addition to all physical  
46 therapy codes if performed by an occupational therapist;

1  
2 (C) Speech Therapy/Professional: 92507-92508, 92526, 92609-92610, and 97532 except ICD-9  
3 784.49;

4  
5 (f) Laboratory services in the CPT code range 8XXXX;

6  
7 (g) All grade A and B United States Preventive Services Task Force preventive services, Bright  
8 Futures recommended medical screenings for children, Institute of Medicine recommended  
9 women's guidelines, and Advisory Committee on Immunization Practices recommended  
10 immunizations for children coverage must be provided without cost share; and

11  
12 (h) Prescription drug coverage at the greater of:

13  
14 (A) At least one drug in every United States Pharmacopeia (USP) category and class as the  
15 prescription drug coverage of the plan described in OAR 836-053-0000(1)(a); or

16  
17 (B) The same number of prescription drugs in each category and class as the prescription drug  
18 coverage of the plan described in OAR 836-053-0000(1)(a).

19  
20 [(8)](9) Copays and coinsurance for coverage required under ORS 743.822 must comply with the  
21 following:

22  
23 (a) Non-specialist copays apply to physical therapy, speech therapy, occupational therapy and  
24 vision services when these services are provided in connection with an office visit.

25  
26 (b) Subject to the Mental Health Parity and Addiction Equity Act of 2008, specialist copays  
27 apply to specialty providers including, mental health and substance abuse providers, if and when  
28 such providers act in a specialist capacity as determined under the terms of the health benefit  
29 plan.

30  
31 (c) Coinsurance for emergency room coverage must be waived if a patient is admitted, at which  
32 time the inpatient coinsurance applies.

33  
34 [(9)](10) Deductibles for coverage required under ORS 743.822 must comply with the following:

35  
36 (a) For a bronze plan, in accordance with the coinsurance, copayment and deductible amounts  
37 and coverage requirements for a bronze plan set forth in Exhibit 1 to this rule. The bronze plan  
38 deductible must be integrated applicable to prescription drugs and all services except preventive  
39 services.

40  
41 (b) For a silver plan, in accordance with the coinsurance, copayment and deductible amounts and  
42 coverage requirements for a silver plan set forth in Exhibit 1 to this rule. The silver plan  
43 deductible applies to all services except preventive services, office visits, urgent care, and  
44 prescription drugs.

1 (c) The individual deductible applies to all enrollees, and the family deductible applies when  
2 multiple family members incur claims.

3  
4 [(10)](11) Dollar limits for coverage required under ORS 743.822 must comply with the  
5 following:

6  
7 (a) Annual dollar limits must be converted to a non-dollar actuarial equivalent.

8  
9 (b) Lifetime dollar limits must be converted to a non-dollar actuarial equivalent.

10  
11 Stat. Auth.: ORS 743.822

12 Stats. Implemented: ORS 743.822

13 Hist.: ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

14  
15 **836-053-000x-2 (NEW)**

16  
17 **Oregon Standard Bronze and Silver Health Benefit Plans for Plan Years Beginning on and**  
18 **after January 1, 2017**

19  
20 **(1) This rule applies to plan years beginning on and after January 1, 2017.**

21  
22 **(2) As used in this rule, “coverage” includes medically necessary benefits, services,**  
23 **prescription drugs and medical devices. “Coverage” does not include coinsurance,**  
24 **copayments, deductibles, other cost sharing, provider networks, out-of-network coverage,**  
25 **wigs or administrative functions related to the provision of coverage, such as eligibility and**  
26 **medical necessity determinations.**

27  
28 **(3) For purposes of coverage required under this rule:**

29  
30 **(a) “Inpatient” includes but is not limited to:**

31  
32 **(A) Surgery;**

33  
34 **(B) Intensive care unit, neonatal intensive care unit, maternity and skilled nursing facility**  
35 **services; and**

36  
37 **(C) Mental health and substance abuse treatment.**

38  
39 **(b) “Outpatient” includes but is not limited to services received from ambulatory surgery**  
40 **centers and physician and anesthesia services and benefits when applicable.**

41  
42 **(c) A reference to a specific version of a code or manual, including but not limited to**  
43 **references to ICD-9, CPT, Diagnostic and Statistical Manual of Mental Disorders, DSM-IV**  
44 **TR, Fourth Edition; place of service and diagnosis includes a reference to a code with**  
45 **equivalent coverage under the most recent version of the code or manual.**  
46

1 **(4) When offering a plan required under ORS 743.822, an insurer must:**  
2

3 **(a) Use the following naming convention: “[Name of Insurer] Standard [Bronze/ Silver]**  
4 **Plan”. The name of insurer may be shortened to an easily identifiable acronym that is**  
5 **commonly used by the insurer in consumer facing publications. For example, “Acme**  
6 **Standard Bronze Plan”.**  
7

8 **(b) Include a service area or network identifier if the plan is not offered on a statewide**  
9 **basis with a statewide network.**

10  
11 **(5) Coverage required under ORS 743.822 must be provided in accordance with the**  
12 **requirements of sections (6) to (11) of this rule.**  
13

14 **(6) Coverage must be provided in a manner consistent with the requirements of:**  
15

16 **(a) 45 CFR 156, except that actuarial substitution of coverage within an essential health**  
17 **benefits category is prohibited;**  
18

19 **(b) OAR 836-053-1404, 836-053-1405, 836-053-1407 and 836-053-1408; and**  
20

21 **(c) The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction**  
22 **Equity Act, 29 U.S.C. 1185a (MHPAEA) and implementing regulations at 45 CFR 146.136**  
23 **and 147.160;**  
24

25 **(7) Coverage must provide essential health benefits as defined in OAR 836-053-000x1.**  
26

27 **(8) Except when a specific benefit exclusion applies, or a claim fails to satisfy the insurer’s**  
28 **definition of medical necessity or fails to meet other issuer requirements the following**  
29 **coverage must be provided:**  
30

31 **(a) Ambulatory services based on the Place of Service Codes;**  
32

33 **(b) Emergency services;**  
34

35 **(c) Hospitalization services;**  
36

37 **(d) Maternity and newborn services ;**  
38

39 **(e) Rehabilitation and habilitation services including**  
40

41 **(A) Professional Physical Therapy services;**  
42

43 **(B) Professional Occupational Therapy;**  
44

45 **(C) Physical therapy performed by an occupational therapist; and**  
46

1 **(D) Professional Speech Therapy;**

2  
3 **(f) Laboratory services;**

4  
5 **(g) All grade A and B United States Preventive Services Task Force preventive services,**  
6 **Bright Futures recommended medical screenings for children, Institute of Medicine**  
7 **recommended women's guidelines, and Advisory Committee on Immunization Practices**  
8 **recommended immunizations for children coverage must be provided without cost share;**  
9 **and**

10  
11 **(h) (A) Prescription drug coverage at the greater of:**

12  
13 **(i) At least one drug in every United States Pharmacopeia (USP) category and class as the**  
14 **prescription drug coverage of the plan described in OAR 836-053-000x-1(2) or**

15  
16 **(ii) The same number of prescription drugs in each category and class as the prescription**  
17 **drug coverage of the plan described in OAR 836-053-000x-1(2).**

18  
19 **(B) Insurers must submit the formulary drug list for review and approval.**

20  
21 **(D) For plan years beginning on or after January 1, 2017 insurers must use a pharmacy**  
22 **and therapeutics committee that complies with the standards set forth in 45 CFR 156.122:**

23  
24 **(9) Copays and coinsurance for coverage required under ORS 743.822 must comply with**  
25 **the following:**

26  
27 **(a) Non-specialist copays apply to physical therapy, speech therapy, occupational therapy**  
28 **and vision services when these services are provided in connection with an office visit.**

29  
30 **(b) Subject to the federal Paul Wellstone and Pete Domenici Mental Health Parity and**  
31 **Addiction Equity Act, 29 U.S.C. 1185a, specialist copays apply to specialty providers**  
32 **including mental health and substance abuse providers, if and when such providers act in a**  
33 **specialist capacity as determined under the terms of the health benefit plan.**

34  
35 **(c) Coinsurance for emergency room coverage must be waived if a patient is admitted, at**  
36 **which time the inpatient coinsurance applies.**

37  
38 **(10) Deductibles for coverage required under ORS 743.822 must comply with the**  
39 **following:**

40  
41 **(a) For a bronze plan, in accordance with the coinsurance, copayment and deductible**  
42 **amounts and coverage requirements for a bronze plan set forth in the cost-sharing matrix**  
43 **set forth in Exhibit 1 to this rule. The bronze plan deductible must be integrated applicable**  
44 **to prescription drugs and all services except preventive services.**

1 **(b) For a silver plan, in accordance with the coinsurance, copayment and deductible**  
2 **amounts and coverage requirements for a silver plan set forth in the cost-sharing matrix**  
3 **set forth in Exhibit [I]2 to this rule. The silver plan deductible applies to all services except**  
4 **preventive services, office visits, urgent care, and prescription drugs.**

5  
6 **(c) The individual deductible applies to all enrollees, and the family deductible applies**  
7 **when multiple family members incur claims.**

8  
9 **(11) Dollar limits for coverage required under ORS 743.822 must comply with the**  
10 **following:**

11  
12 **(a) Annual dollar limits must be converted to a non-dollar actuarial equivalent.**

13  
14 **(b) Lifetime dollar limits must be converted to a non-dollar actuarial equivalent.**

15  
16 **Stat. Auth.: ORS 743.822**

17 **Stats. Implemented: ORS 743.822**

18 **Hist.:**

19  
20 836-053-1020 (Amended)

21  
22 Drug Formularies

23  
24 (1) For purposes of OAR 836-053-0000 to 836-053-1200:

25  
26 (a) "Open formulary" means a method used by an insurer to provide prescription drug benefits in  
27 which all prescribed FDA approved prescription drug products are covered except for any drug  
28 product that is excluded by the insurer pursuant to the insurer's policy regarding medical  
29 appropriateness or by the terms of a specific health benefit plan, or except for an entire class of  
30 drug product that is excluded by the insurer.

31  
32 (b) "Closed formulary" means a method used by an insurer to provide prescription drug benefits  
33 in which only specified FDA approved prescription drug products are covered, as determined by  
34 the insurer, but in which medical exceptions are allowed. Maximum benefits or coverage may be  
35 limited to formulary drugs in a health benefit plan with a closed formulary. *[; and]*

36  
37 *[(c) "Mandatory closed formulary" means a method used by an insurer to provide prescription*  
38 *drug benefits in which only specified FDA approved prescription drug products are covered, as*  
39 *determined by the insurer, and in which no exceptions are allowed. ]*

40  
41 (2) An insurer that uses an open formulary must have a written procedure that includes the  
42 written criteria or explains the review process established by the insurer for determining when an  
43 item will be limited or excluded pursuant to the insurer's policy regarding medical  
44 appropriateness.

1 (3) An insurer that uses a closed formulary must have a written procedure stating that FDA  
2 approved prescription drug products are covered only if they are listed in the formulary. The  
3 procedure must also describe how the insurer determines the content of the closed formulary and  
4 how the insurer determines the application of a medical exception. The procedure must describe  
5 how a provider may request inclusion of a new item in the closed formulary and must ensure that  
6 the insurer will issue a timely written response to a provider making such a request.

7  
8 *[(4) An insurer that uses a mandatory closed formulary must have a written procedure stating  
9 that FDA approved prescription drug products are covered only if they are listed in the  
10 formulary and that no exception is allowed. The procedure must describe how the insurer  
11 determines the content of the mandatory closed formulary. The procedure must also describe  
12 how a provider may request inclusion of a new item in the formulary and must ensure that the  
13 insurer will issue a timely written response to a provider making such a request. ]*

14  
15 **(4)** [(5)] An insurer must furnish a copy of the procedures it has adopted under section (2)[, (3)  
16 or (4)] **or (3)** of this rule to a provider with authority to prescribe drugs and medications, upon  
17 the request of the provider.

18  
19 **(5)** [(6)] Except as provided in section [(7)]**(6)** of this rule, a formulary must comply with the  
20 requirements of 45 CFR 156.122 and include the greater of:

21  
22 (a) At least one drug in every United States Pharmacopeia therapeutic category and class; or

23  
24 (b) The same number of drugs in each United States Pharmacopeia category and class as the  
25 prescription drug benefit of the plan described in OAR 836-053-0008(1)(a).

26  
27 **(6)** [(7)] An insurer that issues a small group or individual health benefit plan formulary that does  
28 not comply with the requirements of section [(6)] **(5)** of this rule must file with the Director of  
29 the Department of Consumer and Business Services the form entitled “Formulary-Inadequate  
30 Category/Class Count Justification” as set forth on the website of the Insurance Division of the  
31 Department of Consumer and Business Services at [www.insurance.oregon.gov](http://www.insurance.oregon.gov). The director, **in**  
32 **the director’s discretion**, may **consider** [approve]**approval of** a formulary that does not meet  
33 the requirements of section **(5)** [(6)] of this rule if:

34  
35 (a) Drugs in a category or class have been discontinued by the manufacturer;

36  
37 (b) Drugs in a category or class have been deemed unsafe by the Food and Drug Administration  
38 or removed from market by the manufacturer due to safety concerns;

39  
40 (c) Drugs in a category of class have a Drug Efficacy Study Implementation classification;

41  
42 (d) Drugs in a category or class have become available as generics; or

43  
44 (e) Drugs in a category or class are provided in a medical setting and are covered under the  
45 medical provisions of the plan.

46

1 **(7) An insurer that issues a small group or individual health benefit plan formulary does**  
2 **not comply with the nondiscrimination requirements of OAR 836-053-0001x if most or all**  
3 **drugs to treat a specific condition are placed on the highest cost tiers.**  
4

5 Stat. Auth.: ORS 731.244 & sec. 2, ch.681, OL 2013

6 Stats. Implemented: ORS 743.804 & sec. 2, ch. 681, OL 2013

7 Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

8  
9 **Coverage of Mental or Nervous Conditions; Mental Health Parity (New Heading)**

10  
11 836-053-1404 (Amended)

12  
13 Definitions; Noncontracting Providers; Co-Morbidity Disorders

14  
15 (1) As used in ORS 743A.168[, *this rule and OAR 836-053-1405 to 836-053-1408*] **and OAR**  
16 **Chapter 836:**

17  
18 (a) "Mental or nervous conditions" means any mental disorder covered by diagnostic categories  
19 listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth  
20 Edition" (DSM-IV) or the "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition"  
21 (DSM-5).

22  
23 (b) "Chemical dependency" means an addictive relationship with any drug or alcohol  
24 characterized by a physical or psychological relationship, or both, that interferes on a recurring  
25 basis with an individual's social, psychological or physical adjustment to common problems.

26  
27 (c) "Chemical dependency" does not mean an addiction to, or dependency on:

28  
29 (A) Tobacco;

30  
31 (B) Tobacco products; or

32  
33 (C) Foods.

34  
35 (2) A non-contracting provider must cooperate with a group health insurer's requirements for  
36 review of treatment in ORS 743A.168(10) and (11) to the same extent as a contracting provider  
37 in order to be eligible for reimbursement.

38  
39 (3) The exception of a disorder in the definition of "mental or nervous conditions" or "chemical  
40 dependency" in section (1) of this rule does not include or extend to a co-morbidity disorder  
41 accompanying the excepted disorder.

42  
43 Stat. Auth.: ORS 731.244 & 743A.168

44 Stats. Implemented: ORS 743A.168

1 Hist.: ID 13-2006, f. 7-14-06 cert. ef. 1-1-07; ID 19-2012(Temp), f. & cert. ef. 12-20-12 thru 6-  
2 17-13; ID 3-2013, f. 6-10-13, cert. ef. 6-17-13; ID 19-2014(Temp), f. & cert. ef. 11-14-14 thru 5-  
3 12-15; ID 3-2015, f. & cert. ef. 5-12-15

4  
5 836-053-1405 (Amended)

6  
7 General Requirements for Coverage of Mental or Nervous Conditions and Chemical  
8 Dependency

9  
10 (1) A group health insurance policy issued or renewed in this state shall provide coverage or  
11 reimbursement for medically necessary treatment of mental or nervous conditions and chemical  
12 dependency, including alcoholism, at the same level as, and subject to limitations no more  
13 restrictive than those imposed on coverage or reimbursement for medically necessary treatment  
14 for other medical conditions.

15  
16 (2) For the purposes of ORS 743A.168, the following standards apply in determining whether  
17 coverage for expenses arising from treatment for chemical dependency, including alcoholism,  
18 and for mental or nervous conditions is provided at the same level as, and subject to limitations  
19 no more restrictive than, those imposed on coverage or reimbursement of expenses arising from  
20 treatment for other medical conditions:

21  
22 (a) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not  
23 limited to, deductibles for mental or nervous conditions and chemical dependency, including  
24 alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing,  
25 including, but not limited to, deductibles for medical and surgical services otherwise provided  
26 under the health insurance policy.

27  
28 (b) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not  
29 limited to, deductibles for wellness and preventive services for mental or nervous conditions and  
30 chemical dependency, including alcoholism, may be no more than the co-payment or  
31 coinsurance, or other cost sharing, including, but not limited to, deductibles for wellness and  
32 preventive services otherwise provided under the health insurance policy.

33  
34 (c) **If** annual or lifetime limits for treatment of mental or nervous conditions and chemical  
35 dependency, including alcoholism[, *may be no less than the annual or lifetime limits for medical*  
36 *and surgical services otherwise provided under the health insurance policy*] , **the limits must**  
37 **comply with the predominately equal to and substantially all tests required under the**  
38 **federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act,**  
39 **29 U.S.C. 1185a (MHPAEA) and implementing regulations at 45 CFR 146.136 and 147.160.**

40  
41 [(d)](c) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not  
42 limited to, deductibles expenses for prescription drugs intended to treat mental or nervous  
43 conditions and chemical dependency, including alcoholism, may be no more than the co-  
44 payment or coinsurance, or other cost sharing expenses for prescription drugs prescribed for  
45 other medical services provided under the health insurance policy.

1 [(e)](d) Classification of prescription drugs into open, closed, or tiered drug benefit formularies,  
2 for drugs intended to treat mental or nervous conditions and chemical dependency, including  
3 alcoholism, must be by the same process as drug selection for formulary status applied for drugs  
4 intended to treat other medical conditions, regardless of whether such drugs are intended to treat  
5 mental or nervous conditions, chemical dependency, including alcoholism, or other medical  
6 conditions.

7  
8 (3) A group health insurance policy issued or renewed in this state must contain a single  
9 definition of medical necessity that applies uniformly to all medical, mental or nervous  
10 conditions, and chemical dependency, including alcoholism.

11  
12 (4) A group health insurer that issues or renews a group health insurance policy in this state shall  
13 have policies and procedures in place to ensure uniform application of the policy's definition of  
14 medical necessity to all medical, mental or nervous conditions, and chemical dependency,  
15 including alcoholism.

16  
17 (5) Coverage for expenses arising from treatment for mental or nervous conditions and chemical  
18 dependency, including alcoholism, may be managed through common methods designed to limit  
19 eligible expenses to treatment that is medically necessary only if similar limitations or  
20 requirements are imposed on coverage for expenses arising from other medical condition.  
21 Common methods include, but are not limited to, selectively contracted panels, health policy  
22 benefit differential designs, preadmission screening, prior authorization of services, case  
23 management, utilization review, or other mechanisms designed to limit eligible expenses to  
24 treatment that is medically necessary.

25  
26 [(6) Coverage of mental or nervous conditions and chemical dependency, including alcoholism,  
27 may be limited for in-home services.]

28  
29 (6)[(7)] Nothing in this rule prevents a group health insurance policy from providing coverage  
30 for conditions or disorder excepted under the definition of "mental or nervous condition" in OAR  
31 836-053-1400.

32  
33 (7)[(8)] The Director shall review OAR 836-053-1400 and this rule and any other materials  
34 [within two years of the rules' effective date] **every two years** to determine whether the  
35 requirements set forth in the rules are uniformly applied to all medical, mental or nervous  
36 conditions, and chemical dependency, including alcoholism.

37  
38 Stat. Auth.: ORS 731.244 & 743A.168

39 Stats. Implemented: ORS 743A.168

40 Hist.: ID 13-2006, f. 7-14-06 cert. ef. 1-1-07; ID 19-2012(Temp), f. & cert. ef. 12-20-12 thru 6-  
41 17-13; ID 3-2013, f. 6-10-13, cert. ef. 6-17-13

42  
43 Cost Estimates

44  
45 836-053-1406 (renumber to 836-053-1409 if available)

1 Definitions

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19

(1) As used in ORS 743.874 and 743.876, “provider” means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the practice of a profession.

(2) As used in ORS 743.876, for the purpose of an insurer’s procedure for providing an estimate of an enrollee’s costs for a covered out-of-network procedure or service:

(a) The “allowable charge” for a covered procedure or service is the estimated amount established under the insurance policy, whether expressed as an “allowable charge,” “allowable expense,” “eligible fee” or other term denoting the amount on which the benefit is calculated.

(b) The “billed charge” is the estimated amount charged by a provider for performance of a procedure or service.

Stat. Auth.: ORS 731.244 & 743.893  
Stats. Implemented: ORS 743.874 & 743.876  
Hist.: ID 16-2008, f. & cert. ef. 9-24-08

DRAFT PROPOSED RULES 12/1/15