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**Sent:** Tuesday, December 22, 2015 1:31 PM  
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**Subject:** OAR 836-053-0002

Should we have included a notification requirement in OAR 836-053-0002 similar to the highlighted one in OAR 836-053-0001?

836-053-0002

#### Modification of a Health Benefit

##### Plan Subject to Levels of Coverage Requirements

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

- (a) ORS 743.737, regarding small employer health benefit plans; and
- (b) ORS 743.766, regarding individual health benefit plans.

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

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

Stat. Auth.: ORS 731.244, 743.566 & 743.773

Stats Implemented: ORS 743.737, 743.754 & 743.766

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

836-053-0001

#### Modification of Health Benefit Plan Not Subject to Level of Coverage Requirements

(1) A modification of a health benefit plan not subject to the levels of coverage defined in 42 U.S.C. 18022(d) is defined in this rule for the purposes of:

- (a) ORS 743.737 and 743.754, regarding group health benefit plans; and
- (b) ORS 743.766, regarding individual health benefit plans.

(2) One or more decreases or increases described in this section in the services or benefits covered in a health benefit plan are a modification and not a discontinuance when the decrease or decreases, or the increase or increases, or any combination thereof, occur at the time of renewal and the change or changes together alter the actuarial valuation of the health benefit plan by less than ten percent in the aggregate to the policyholder. This section applies to a decrease or increase that:

- (a) Eliminates or adds benefits payable under the plan;

(b) Decreases or increases benefits payable under the plan, including a decrease or increase that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations;

(c) Increases or decreases deductibles, copayments or other amounts to be paid by an enrollee; or

(d) Establishes new conditions or requirements, such as prior authorization requirements, to obtaining services or benefits under the plan, or eliminates such conditions or requirements.

(3) A carrier must give the policyholder notice of a modification to which this rule applies not later than the 30th day before the date of renewal of the plan to which the modification applies.

(4) A change in a requirement for eligibility is not a modification for purposes of this rule but instead is a discontinuance if the change will result in the exclusion of a class or category of enrollees covered under the current plan.

(5) A decrease or increase described in this section in the services or benefits covered in a health benefit plan is a modification and not a discontinuance, but the decrease or increase is not subject to section (2) of this rule. This section applies to the following:

(a) A carrier's normal and customary administrative changes that do not have an actuarial impact, such as the following:

(A) Formulary changes.

(B) Utilization management protocols.

(C) Changes to pharmacy prior authorization requirements if, at least 48 hours before a change, the insurer prominently posts:

(i) A description of any pharmacy prior authorization requirement change to a page of the insurer's website that an enrollee or provider can easily locate and access; and

(ii) A link to the website page described in subparagraph (i) of this paragraph on the home page of the insurer's website.

(D) Changes to non-pharmacy prior authorization requirements that are made other than at renewal only when an insurer does all of the following:

(i) Makes a reasonable and good faith effort to identify all enrollees affected by the changes.

(ii) Makes a reasonable and good faith effort to identify providers who provide a service or treatment affected by the changes.

(iii) Notifies all enrollees and providers identified in subparagraphs (i) and (ii) of this paragraph at least 60 days in advance of the effective date of the change.

(iv) Posts a description of any change to the non-pharmacy prior authorization requirements to a page of the insurer's website that an enrollee or provider can easily locate and access.

(v) Posts a link to the website page described in subparagraph (iv) of this paragraph on the home page of the insurer's website.

(vi) Covers to the extent otherwise payable under the terms of the contract, and without penalty, any claim for services or treatment affected by changes to prior authorization requirements of an enrollee to whom the insurer fails to provide notice of the change.

(b) A decrease or increase required by state or federal law.

Stat. Auth.: ORS 731.244, 743.566 & 743.773

Stats Implemented: ORS 743.737, 743.754 & 743.766

Hist.: ID 7-2002, f. & cert. ef. 2-15-02; ID 18-2010, f. 9-14-10, cert. ef. 1-1-11; ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

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