



Regulatory Affairs

Jennifer Baker

(503) 525-6523 Voice

(503) 225-5431 Facsimile

jennifer.baker@cambiahealth.com

Reply to:

P.O. Box 1271 (M/S E12B)

Portland, OR 97207-1271

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Jeannette Holman

Senior Policy Analyst

DCBS/Division of Financial Regulation

350 Winter Street NE

Salem, OR 97301

VIA EMAIL: Jeannette.holman@oregon.gov

RE: Comments on Proposed 2017 Base Benchmark Health Benefit Plan and Essential Health Benefits

Dear Ms. Holman:

I am writing on behalf of Cambia Health Solutions to comment on the Division of Financial Regulation (DFR) proposed permanent rules regarding the Oregon benchmark health plan and required Essential Health Benefits (EHBs). We appreciate the opportunity to work with the Division on this issue and respectfully submit our comments below.

OAR 836-053-0002 Modification of a Health Benefit Plan Subject to Levels of Coverage Requirements

The proposed rule states insurers may make modifications to a group or individual product and those modifications are considered a “uniform modification of coverage” if “the product is continues to cover at least a majority of the same service area.” We request the Division clarify the definition of a “majority” and of a “service area.” It is unclear how the Division measures a service area by square mileage, number of counties listed on the QHP service area template, number of zip codes or some other measurement.

The word “is” should be removed from (2)(c)(B) and (C). This is a typographical error.

OAR 836-053-0012 Essential Health Benefits for 2017

In 836-053-0012(3)(a)(C), the rule states the exclusion of for “age limits on treatments that would otherwise be appropriate for individuals outside of the limited age” are excluded from the benchmark plan. We request the Division clarify in the rule’s language whether hearing aids fall under the treatment limitations and exclusions that are impermissible and if hearing aids are considered a treatment for hearing loss.

The proposed rule does not permit “exclusions for surgeries and procedures related to sex transformations and gender identity disorder or gender dysphoria.” We request the Division provide additional language that clarifies health plans are not required to extend coverage to a

service for gender dysphoria that is excluded for all other diagnoses. This would maintain consistency with the current interpretation of Bulletin 2012-1.

This rule also excludes “any blanket exclusion for a diagnosis made using the diagnostic criteria of the DSM-5.” The rule should also include a reference to diagnostic criteria of the DSM-4.

The rule prohibits health plans from specifying “time limits for treatment of jaw or teeth or orthognathic surgery.” We request the Division provide criteria they are using as the basis for the prohibition of these time limits.

In OAR 836-053-0012(3)(b)(B), the rule states, “wigs following chemotherapy or radiation therapy must be covered up to the actuarial equivalent of \$150 per calendar year.” However, in OAR 836-053-0013(2), the proposed rule states the definition of “coverage” for Standard Bronze and Silver health plans “**does not include** coinsurance, copayments, deductibles, other cost sharing, provider networks, out-of-network coverage, **wigs** or administrative functions related to the provision of coverage, such as eligibility and medical necessity determinations” (emphasis added). These two rules contradict each other regarding whether wigs are mandatory coverage. We request the Division clarify any mandatory coverage of wigs. If wigs are required coverage, please clarify how the coverage limited to chemotherapy and radiation treatments is not discriminatory to other conditions wigs are used for such as alopecia.

The proposed rule requires coverage of diabetes self-management under ORS 743A.184 to be “an additional benefit to what must be supplied under the USPSTF A and B list.” Please clarify the intent of this addition so all carriers implement this benefit correctly.

The original PacificSource benchmark plan states “Osteopathic manipulations are not covered except for treatment of disorders of the musculoskeletal system.” In OAR 836-053-0012(7), the proposed rule states “an insurer may not exclude services provided by a doctor of chiropractic medicine if services are otherwise covered under the plan and the doctor of chiropractic medicine is acting within the scope of the provider’s license.” What do these two statements mean for coverage of Osteopathic and Chiropractic coverage of manipulations? We request clarification on mandatory coverage of manipulations. In our workgroup meetings, the Division stated they would follow up with this inquiry, however, there is no clarification in the proposed rule language.

OAR 836-053-0013 Oregon Standard Bronze and Silver Health Benefit Plans for 2017

The proposed rule states the Standard Silver plan deductible applies to all services except preventive services, office visits, urgent care, and prescription drugs. This conflicts with the draft 2017 Oregon Standard Cost Shares, which indicates deductible is waived for more than just these benefits (e.g. Nutritional Counseling, Diabetic Education). Please clarify if the rule supersedes the Oregon Standard Plan grid.

The proposed rule states the Standard Bronze plan deductible must be integrated applicable to prescription drugs and all services except preventive services. This conflicts with the draft 2017 Oregon Standard Cost Shares, which indicates deductible is waived for more than just preventive (e.g. Nutritional Counseling, Diabetic Education). Please clarify if the rule supersedes the Oregon Standard Plan grid.

The proposed rule contains ICD-9 codes. Please update the rules with ICD-10 so the expectation for coverage is clear to all carriers.

OAR 836-053-0009 Oregon Standard Bronze and Silver Health Benefit Plans for 2014, 2015, and 2016

This rule implies all surgeries are considered “inpatient” under 836-053-0009(3)(a)(A). The rule should state “inpatient surgery” to exclude outpatient surgeries from the definition of “inpatient.”

OAR 836-053-1020 Drug Formularies

The Division added a rule that states a plan formulary does not comply with nondiscrimination requirements “if most or all drugs to treat a specific condition are placed on the highest cost tiers.” This rule is extremely problematic and needs extensive clarification to be implemented in the same manner by all health plan carriers. Please clarify if “most or all drugs” refers to the active ingredient composition, the overall composition, or an alternative definition not stated in the rule. Please clarify the definition of “highest cost tiers” as it is not clear where lower cost tiers end and the highest cost tiers begin. This rule language is likely to be interpreted in a variety of ways by health plan carriers. It is imperative the Division remove this language or provide further clarification.

Cambia met with the Division last October to discuss proposed language regarding drug formulary requirements. We proposed language that states, “A health benefit plan may file a Bronze, Silver or Gold plan that substitutes a different prescription drug benefit from the prescription drug benefit described in the Standard Plans, provided that the health benefit plan demonstrates that its proposed benefit will have a Bronze, Silver or Gold actuarial value and will be of equal or greater actuarial value than the equivalent Standard plan.” We ask the Division to consider implementing this language into the rule to allow carriers flexibility without constraints set forth by the pharmaceutical industry.

EHB Mandatory Cost Share Matrix – No Regulatory Review

The EHB and Cost Share Matrix for Standard Plans was not addressed in this rulemaking process, however, mandatory changes were made to the benefit requirements. We request the Division open this Matrix up for review and comment to discuss discrepancies found.

One particular issue we identified in the changes made from the original SB 91 Matrix to the Current 2016 Matrix deals with biofeedback coverage. The SB 91 grid stated biofeedback must be covered but the cost share varies depending on type and/or place of service. This language allows a carrier to apply an appropriate PCP or Specialist office visit copay for the treatment and apply the deductible and coinsurance as necessary. However, the most recent EHB Cost Share Matrix issued for 2016 states the biofeedback treatment must be “covered with same cost shares as Non-Specialist Visit.” The new language demands carriers must cover biofeedback treatment at the PCP copay and neglects to reference required coverage regarding migraine and urinary incontinence conditions, which implies that such coverage is no longer required.

In the future, we request the Division open the Matrix changes up to the public for review and opportunity to comment before changing requirements. We also request the Division provide explanation for those changes to better understand how coverage is to be implemented into our Standard plans.

We appreciate the time and work by the Division to draft the proposed rules and the opportunity to submit comments. We are available to discuss the above comments at any time.

Sincerely,

Jennifer Baker
Regulatory Affairs
Cambia Health Solutions