

1 **836-010-0013 (Amended)**

2 **Additional Filing Requirements for Transitional Health Benefit Plans**

3 (1) Under section 5, chapter 80, Oregon Laws 2014, a transitional health benefit plan must comply with  
4 the Insurance Code as of December 31, 2013.

5 (2) In addition to the requirements of OAR 836-010-0000, 836-010-0011, and 836-010-0021 when  
6 submitting a filing for a rate change to a transitional health benefit plan, the insurer shall comply with the  
7 guidance **for the applicable plan year as** provided in Exhibits 1, [and] 2 **and 3** of this rule.

8 (3) The additional filing requirements set forth in this section apply only to 2015, **2016 and 2017**  
9 transitional plans.

10 [ED. NOTE: Exhibits referenced are not included in rule text. [Click here for PDF copy exhibits.](#)]

11 Stat. Auth: ORS 731.244, 743.018

12 Stats. Implementing: Section 5, chapter 80, Oregon Laws 2014 (Enrolled Senate Bill 1582)

13 Hist.: ID 8-2014(Temp), f. & cert. ef. 4-24-14 thru 10-20-14; ID 17-2014, f. & cert. ef. 10-6-14

14 **Mandated Benefits**

15  
16 **836-052-1000 (Amended)**

17 **Prosthetic and Orthotic Devices**

18  
19 (1) This rule is adopted under the authority of ORS 731.244 [*and 743A.144,*] for the purpose of  
20 [*implementing 743A.144*] **clarifying position of the Department of Consumer and Business Services**  
21 **regarding the status and enforcement of ORS 743A.144.**

22 (2) [*The list of prosthetic and orthotic devices and supplies in the Medicare fee schedule for Durable*  
23 *Medical Equipment, Prosthetics, Orthotics and Supplies is adopted for the purpose of listing the*  
24 *prosthetic and orthotic devices and supplies for which coverage is required by ORS 743A.144, insofar as*  
25 *the list is consistent with 743A.144. The list is limited to those rigid or semi rigid devices used for*  
26 *supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in*  
27 *a diseased or injured leg, foot, arm, hand, back or neck or an artificial limb device or appliance designed*  
28 *to replace in whole or in part an arm or a leg that the Centers for Medicare and Medicaid Services*  
29 *(CMS) has designated in the 4-digit L Codes of Healthcare Common Procedure Coding System (HCPC)*  
30 *Level II, which is accessible by selecting the link for the 2012 Alpha-Numeric HCPCS File at:*  
31 *https://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp.*] **Because the Oregon Legislative**  
32 **Assembly has not updated ORS 743A.144, the provisions of that statute are subject to the automatic**  
33 **repeal found in ORS 743A.001. Therefore, the department will not actively update the list of**  
34 **prosthetic and orthotic devices and supplies subject to the mandated provisions. However, many of**  
35 **these devices and supplies may be required under other state or federal law and the department**  
36 **will continue to review provisions in plans and policies for compliance with other applicable state**  
37 **and federal laws related to prosthetic or orthotic devices.**

38 [(3) Under ORS 743A.144(4), benefits payable under a policy may not be subject to internal or separate  
39 limits or caps other than the policy lifetime maximum benefits as they apply to the coverage for prosthetic  
40 and orthotic devices required by ORS 743A.144. ]

41 [(4) A managed care plan to which ORS 743A.144(6) applies is a health insurance policy that requires an  
42 enrollee to use a closed network of providers managed, owned, under contract with or employed by the  
43 insurer in order to receive benefits under the plan. ]

44  
45 Stat. Auth: ORS 731.244 & 743A.144

1 Stats. Implemented: ORS 743A.144  
2 Hist.: ID 12-2007, f. 12-18-07, cert. ef. 1-1-08; ID 12-2009, f. & cert. ef. 12-18-09; ID 8-2011, f. & cert.  
3 ef. 2-23-11; ID 8-2012, f. & cert. ef. 4-5-12  
4  
5

6 **836-053-0015 (NEW – Replacing Temporary Rule)**  
7 **Definition of Small Employer**  
8

9 **(1) This rule is adopted for the purpose of modifying the definition of small employer as authorized**  
10 **in ORS 743B.005.**

11 **(2) This rule establishes the definition of small employer to be used in any instance in which the**  
12 **definition set forth in ORS 743B.005 would apply and in rules of the Department of Consumer and**  
13 **Business Services implementing the Insurance Code, for the period beginning on January 1, 2016**  
14 **and ending on December 31, 2017.**

15 **(3) As used in ORS 743B.005 and rules of the Department of Consumer and Business Services**  
16 **implementing the Insurance Code, “small employer” means, in connection with a group health**  
17 **benefit plan with respect to a calendar year and a plan year, an employer who employed an average**  
18 **of at least one but not more than 50 employees on business days during the preceding calendar year**  
19 **and who employs at least one employee on the first day of the plan year.**

20 **(4) For purposes of determining the number of employees in a group health benefit plan, insurers**  
21 **and producers should follow the guidance entitled, “Revised Counting Methodology for**  
22 **Determining Small or Large Group,” as set forth in Exhibit A of this rule.**  
23

24 **Stat. Auth.: ORS 731.244 & 743B.005**

25 **Stats. Implemented: ORS 743B.005**

26 **Hist.:**  
27  
28

29 836-053-0010 (Amended)  
30 Purpose; Statutory Authority; Enforcement  
31

32 (1) OAR 836-053-0010 to 836-053-0070 are adopted for the purpose of implementing ORS [743.730 to  
33 743.745] **743B.003 to 743B.020 and 743B.100**, pursuant to the authority of ORS 731.244 and [743.730  
34 to 743.745] **743B.003 to 743B.020 and 743B.100**.

35 (2) Violation of any provision of OAR 836-053-0021 to 836-053-0065 is an unfair trade practice under  
36 ORS 746.240.  
37

38 Stat. Auth.: ORS 731.244, [743.731(4)] **743B.003** & 746.240

39 Stats. Implemented: ORS **743B.003 to 743B.020 and 743B.100**.

40 Hist.: ID 17-1992, f. 12-3-92, cert. ef. 12-7-92; ID 12-1996, f. & cert. e.f 9-23-96; ID 5-1998, f. & cert. ef.  
41 3-9-98  
42  
43

44 836-053-0021 (Amended)  
45 Plans Offered to Oregon Small Employers  
46

47 (1) A small employer carrier shall issue a plan to a small employer if the employee eligibility criteria  
48 established by the small employer meet the requirements of this section. [Except when coverage is  
49 obtained through the Oregon Health Insurance Exchange Corporation,] A carrier must [use the form  
50 entitled “Oregon Standardized Group Profile Form”] **follow the methodology and address the issues**  
51 **included in the “Revised Counting Methodology for Determining Small or Large Group,” as** set

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1 forth [on the website of the Insurance Division of the Department of Consumer and Business Services] **in**  
2 **Exhibit A of OAR 836-053-0015** to collect data to determine the applicable type of group coverage for  
3 an employer and to provide disclosure notices as required for small employers. The eligibility criteria  
4 must be based solely on [weekly work hours and] **the criteria set forth in Exhibit A and** completion of a  
5 group eligibility waiting period, if applicable, and those criteria must meet the following standards:]  
6 [(a) The work hours requirement may range from 17.5 to 40 hours per week, but a single, uniform  
7 requirement must apply to all employees of the employer; and]  
8 [(b) A waiting period requirement may not exceed 90 days and a single, uniform requirement must apply  
9 to all employees of the employer.]  
10 [(2) For purposes of determining whether an employer is a small employer a carrier may not count as an  
11 employee:]  
12 [(a) A sole proprietor;]  
13 [(b) A partner of a partnership;]  
14 [(c) The owner of more than two percent of the shares of:]  
15 [(A) An S corporation; or]  
16 [(B) Limited liability company;]  
17 [(d) The owner of a corporation wholly owned by the individual or the individual and the individual's  
18 spouse; or]  
19 [(e) The spouse of a person described in subsections (a) to (d) of this section.]  
20 [(3)] **(2) Impermissible** employee eligibility criteria [must be limited to those described in section (1) of  
21 this rule. Impermissible criteria] include:

- 22 (a) Health status;
  - 23 (b) Disability; and
  - 24 (c) A requirement that an employee be actively at work when coverage would otherwise begin.
- 25 [(4)] **(3)** A small employer carrier may provide different health benefit plans to different categories of  
26 employees of an employer, as determined by the employer only if based on bona fide employment-based  
27 classifications that are consistent with the employer's usual business practice. The categories may not  
28 relate to the actual or expected health status of the employees or their dependents

29 Stat. Auth.: ORS 731.244, **743B.020** & **743B.003**

30 Stats. Implemented: ORS **743B.003** to **743B.020** and **743B.100**.

31 Hist.: ID 5-1998, f. & cert. ef. 3-9-98; ID 23-2002, f. & cert. ef. 11-27-02; ID 5-2007(Temp), f. 8-17-07,  
32 cert. ef. 8-20-07 thru 2-15-08; ID 2-2008, f. & cert. ef. 2-11-08; ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

33 836-053-0030 (Amended)

### 34 35 36 37 Marketing of a Health Benefit Plan to Small Employers

38  
39 (1) A carrier may offer different small employer health benefit plans in different geographic areas. The  
40 bronze and silver plan required to be offered under ORS [743.822] **743B.130** and a point-of-service plan  
41 required under ORS [743.808] **743B.220** must be offered in every geographic area in which the carrier  
42 offers or renews its small employer health benefit plans. A carrier may not cease offering or renewing, or  
43 offering and renewing, the bronze or silver small group health benefit plan required to be offered under  
44 ORS [743.822] **743B.130** or a point-of -service plan required under ORS [743.808] **743B.130** in a  
45 geographic area unless the carrier discontinues all plans in the geographic area as provided in  
46 [743.737(3)(e)] **ORS 743B.013**.

47 (2) A carrier must offer all of its approved nongrandfathered small employer health benefit plans and plan  
48 options, [including small employer health benefit plans offered through an association,] to all small  
49 employers on a guaranteed issue basis without regard to health status, claims experience or industry  
50 except that a carrier may limit enrollment to the period from November 15 to December 15 of each  
51 calendar year for small employers that fail to meet the carrier's reasonable participation or contribution

1 requirements. A carrier may not serve only a portion of the small employer market, such as employers  
2 with more than 25 employees, and a carrier may not establish or maintain a closed plan or plan option or a  
3 closed book of business in the small employer market. For purposes of this section, a "closed"  
4 arrangement is one in which coverage is maintained and renewed for currently enrolled small employers,  
5 but the coverage is not offered or issued to other small employers.

6 (3) A carrier may not require a small employer to purchase or maintain other lines of coverage, such as  
7 group life insurance, in order to purchase or maintain a small employer health benefit plan. However, a  
8 small group carrier may require reasonable assurance of pediatric dental coverage consistent with  
9 Essential Health Benefits, Final Rule, 78 Fed. Reg. 12853 (February 25, 2013).

10 (4) A carrier must market fairly all of its small employer health benefit plans and plan options and shall  
11 not engage in any practice that:

12 (a) Restricts a small employer's choice of such plans and plan options; or

13 (b) Has the effect or is intended to influence a small employer's choice of such plans and plan options for  
14 reasons of risk selection.

15 (5) A carrier shall not provide to any insurance producer any financial or other incentive that conflicts  
16 with the requirements of section (4) of this rule.

17 (6) A carrier must use the same sales compensation methodology for all small employer health benefit  
18 plans offered by the carrier.

19 (7) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of  
20 representation with an insurance producer for any reason related to the following: the health status, claims  
21 experience, occupation, geographic location of small employer groups, or the type of small employer  
22 plans placed by the insurance producer with the carrier.

23  
24 Stat. Auth.: ORS 731.244 & **743B.003**

25 Stats. Implemented: ORS **743B.003, 743B.012, 743B.013, 743B.130**, 746.650

26 Hist.: ID 17-1992, f. 12-3-92, cert. ef. 12-7-92; ID 12-1996, f. & cert. e.f 9-23-96; ID 5-1998, f. & cert. ef.  
27 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 5-2007(Temp), f. 8-  
28 17-07, cert. ef. 8-20-07 thru 2-15-08; ID 2-2008, f. & cert. ef. 2-11-08; ID 12-2013, f. 12-31-13, cert. ef.  
29 1-1-14

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31  
32 836-053-0050 (Amended)

33 Trade Practices Relating to Small Employer Health Benefit Plans

34  
35 (1) When offering plans to small employers, a carrier must briefly describe the variety of small employer  
36 plans and plan options that are available from the carrier and must specify that:

37 (a) Nongrandfathered plans and plan options are available without regard to health status, claims  
38 experience or industry and are offered on a guaranteed issue basis; and

39 (b) Grandfathered plans and plan options are available under limited circumstances to a small employer  
40 that has existing grandfathered coverage.

41 (2) Subject to requirements established by the [*Oregon Health Insurance Exchange Corporation*]  
42 **Department of Consumer and Business Services** pursuant to 45 CFR 155.720(b) for small employer  
43 health benefit plans offered through the [*Oregon Health Insurance Exchange Corporation*]**health**  
44 **insurance exchange**, a small employer health benefit plan must be issued with an effective date no later  
45 than 31 days after the carrier actually receives the application, and if required by the carrier, the premium.

46 (3) Neither a carrier nor an insurance producer may encourage or direct a small employer to seek  
47 coverage from another carrier because of the small employer's health status, claims experience, industry  
48 occupation or geographic location, if within the carrier's service area.

49 (4) Neither a carrier nor an insurance producer may induce or otherwise encourage a small employer to  
50 separate or otherwise exclude an eligible employee from employment or from health coverage or benefits  
51 provided in connection with the employee's employment.

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1 (5) A small employer health benefit plan may specify that an enrolled small employer may replace its  
2 current coverage with another small employer plan offered by the carrier only on the anniversary date of  
3 the current coverage. This limitation also applies to a small employer that discontinues coverage with a  
4 carrier, or forfeits coverage because of non-payment of premiums and then requests new coverage with  
5 the same carrier.

6 (6) A small employer carrier that also issues individual health benefit plans may not include with an  
7 invoice for small employer coverage, individual health benefit plan premiums for employees of the  
8 employer or otherwise bill a small employer for such premiums.

9  
10 Stat. Auth.: ORS 731.244 & 746.240

11 Stats. Implemented: ORS **743B.003, 743B.011, 743B.012, 743B.013** & 746.240

12 Hist.: ID 17-1992, f. 12-3-92, cert. ef. 12-7-92; ID 12-1996, f. & cert. e.f 9-23-96; ID 5-1998, f. & cert. ef.  
13 3-9-98; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 5-2007(Temp), f. 8-17-07, cert. ef. 8-20-07 thru 2-15-  
14 08; ID 2-2008, f. & cert. ef. 2-11-08; ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

15  
16 836-053-0066 (Amended)

17 Rating for Transitional Health Benefit Plans **Offered to Small Employers**

18  
19 *[The following provisions relating to rating apply to transitional health benefit plans offered to*  
20 *individuals or small employers:]*

21 *[(1)] **For purposes of rating**, a transitional health benefit plan offered to small employers:*

22 *[(a)] **(1)** Is subject to the requirements of OAR 836-053-0065 that apply to grandfathered health benefit*  
23 *plans offered to small employers; and*

24 *[(b)] **(2)** Must be pooled with all of the carrier's grandfathered business in the small employer market to*  
25 *determine its geographic average rate.*

26 *[(2) An individual transitional health benefit plan:]*

27 *[(a) Is subject to the requirements of OAR 836-053-0465(4)(a) and 836-053-0465(4)(c)(A); and]*

28 *[(b) Must be pooled with all of the carrier's grandfathered business in the individual market to determine*  
29 *its geographic average rate.]*

30  
31 Stat. Auth.: ORS 731.244, **743B.003, 743B.013** & 2014 OL Ch. 80, Sec. 5

32 Stats. Implemented: ORS **743B.003, 743B.013** & 746.737 & 2014 OL Ch. 80, Sec. 5

33 Hist.: ID 6-2014(Temp), f. & cert. ef. 4-11-14 thru 10-8-14; ID 17-2014, f. & cert. ef. 10-6-14

34  
35  
36 836-053-0230 (Amended)

37 Underwriting

38  
39 (1) Every group health benefit plan issued by a carrier must specify all of the participation, contribution  
40 and eligibility requirements that have been agreed upon by the carrier and the covered group, and the  
41 carrier must apply those requirements uniformly within each category of eligible members.

42 (2) A carrier offering a group health benefit plan shall not use health statements, except *[for late*  
43 *enrollees]* as provided in ORS *[743.751]***743B.103**. A health statement *[used for a late enrollee]* **for a**  
44 **group health benefit plan also** must comply with the requirements of OAR 836-053-0510. After  
45 enrollment, health statements or other information may be used by a carrier for the purpose of providing  
46 services or arranging for the provision of services under a group health benefit plan.

47 (3) A carrier offering a group health benefit plan shall not use health statements or other information  
48 revealing individual health status to determine the acceptance or rejection of a group that has applied for  
49 coverage. Impermissible other information includes claim records that identify individual claimants.

50 *[Permissible criteria for the declination of a group include such factors as:]*

51 *[(a) The risk status or claims experience of the group as a whole; and]*

1 [(b) *The financial condition of the group as a whole.*]  
2 [(4) *When a group health benefit plan is issued to a collection of eligible subgroups or individuals, as*  
3 *may occur with an association, trust or fully insured multiple employer welfare arrangement, a carrier*  
4 *may determine the acceptance or rejection of coverage for each eligible subgroup or individual. The*  
5 *determination of the carrier, however, must be made in accordance with section (3) of this rule.*]  
6 (4)(5) If a carrier accepts a group for coverage, the carrier shall not:  
7 (a) Decline to offer coverage to any eligible member;  
8 (b) Impose any terms or conditions on the coverage of an eligible member that are based on the actual or  
9 expected health status of the member, except as provided in ORS[743.754]**743B.105**; or  
10 (c) Delay enrollment for an otherwise eligible employee or dependent who is disabled when enrollment  
11 would normally occur.  
12 [(6) *The crediting of prior coverage, as specified in ORS 743.754, shall be applied in either of the*  
13 *following cases:*]  
14 [(a) *If creditable coverage remains in effect on the enrollment date, as specified in ORS 743.754(1); or*]  
15 [(b) *If creditable coverage terminated no more than 62 days prior to the enrollment date, as specified in*  
16 *ORS 743.754(1).*]  
17 [(7) *All policy forms and enrollee summaries for group health benefit plans that contain a preexisting*  
18 *conditions provision must clearly disclose how prior creditable coverage will be applied. A carrier may*  
19 *use the following statement, or other similar disclosure, for this purpose:*]  
20 [*The duration of the preexisting conditions provision in this policy will be reduced by the amount of your*  
21 *prior “creditable coverage” if:*]  
22 [(a) *Your creditable coverage is still in effect on your date of enrollment in this policy; or*]  
23 [(b) *Your creditable coverage ended no more than 62 days before your date of enrollment in this policy.*]  
24 *Creditable coverage means any of the following coverages: Group coverage (including FEHBP and*  
25 *Peace Corps); Individual coverage (including student health plans); Medicaid; Medicare; CHAMPUS;*  
26 *Indian Health Service or tribal organization coverage; state high risk pool coverage; and public health*  
27 *plans. Creditable coverage does not include coverage only for a specified disease or illness or hospital*  
28 *indemnity (income) insurance.*]  
29 [(8) *To expedite the accurate crediting of prior coverage, in accordance with section (6) of this rule, a*  
30 *carrier shall:*]  
31 [(a) *Include a question about potential creditable coverage in all enrollment forms that are used in*  
32 *conjunction with any group health benefit plan containing a preexisting conditions provision; and*]  
33 [(b) *Include a notice about potential creditable coverage whenever the carrier notifies an enrollee that a*  
34 *claim has been denied because of a preexisting conditions provision. The notice of claim denial shall also*  
35 *include a telephone number at the carrier that the enrollee may use for additional information regarding*  
36 *the denied claim.*]  
37 [(9)] (5) A late enrollee, as defined in ORS [743.730]**743B.005**, must be accepted for coverage in a group  
38 health benefit plan, but may be subject to the coverage limitations specified in **ORS 743B.105** [743.754].  
39 A health statement may be used to determine a late enrollee’s preexisting conditions, but not to determine  
40 a late enrollee’s eligibility to enroll or enrollment date. If a late enrollee is subject to a preexisting  
41 conditions provision, credit for prior creditable coverage must be applied to the preexisting condition  
42 period applicable to the enrollee.]  
43 [(10)] (6) An enrollee who qualifies under a special enrollment period, as specified in ORS  
44 [743.754]**743B.105**, must be accepted for coverage in a group health benefit plan and shall not be  
45 considered a late enrollee. [Such an enrollee, however, is subject to the preexisting conditions provision,  
46 if any, and the creditable coverage requirements that apply to regular enrollees.]  
47 [(11)] (7) A modification to an existing group health benefit plan that is required by ORS [743.751 to  
48 743.754]**743B.103 to 743B.105** or by OAR 836-053-0210 to 836-053-0250 shall be implemented for  
49 each policyholder on the next renewal date. For the purposes of this subsection, the next renewal date  
50 means the first renewal date of the policy issued to the policyholder that occurs on or after the operative

1 date of the governing statutory provision (i.e., October 1, 1996, for SB 152 (1995); August 1, 1997, for  
2 SB 98 (1997)).[ *In addition:*]  
3 [(a) Any existing rider or endorsement in effect for a certificate holder or dependent that was based on  
4 the actual or expected health status of the certificate holder or dependent and that excludes coverage for  
5 a disease or medical condition otherwise covered by the plan shall be eliminated and deemed ineffective  
6 as of the next renewal date;]  
7 [(b) A person who was previously eligible to enroll in a plan, but who was denied enrollment on the basis  
8 of the actual or expected health status of the person, shall be offered enrollment in the plan as of the next  
9 renewal date, if the person is still eligible as of that date; and]  
10 [(c) If a certificate holder or dependent has limited coverage because of late enrollment in a plan, credit  
11 shall be granted for the time so enrolled against the maximum exclusion or limitation specified in ORS  
12 743.754 and such crediting of time shall be effective as of the next renewal date.]  
13 [(12)] **(8)** A group health benefit plan shall be renewable at the option of the policyholder and shall not be  
14 discontinued by the carrier during or at the termination of the contract period except in the circumstances  
15 specified in ORS [743.754] **743B.105** and consistent with the requirements of HIPAA (42 U.S.C. 300gg-  
16 12).

17  
18 Stat. Auth.: ORS 731.244

19 Stats. Implemented: ORS 743.522 & [743.751 - 743.754] **743B.103 to 743B.105**

20 Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98

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22  
23 Individual Health Benefit Plans

24  
25 836-053-0410 (Amended)

26 Purpose; Statutory Authority; Enforcement

27  
28 (1) OAR 836-053-0410 to 836-053-0465 are adopted under the authority of ORS [743.499, 743.769 and  
29 743.894]**743B.330, 743B.126 and 743B.310** for the purpose of implementing ORS [743.766 to  
30 743.769 and 743.894]**743B.022, 743B.125, 743B.126 and 743B.310** relating to individual health benefit  
31 plans.

32 (2) Violation of any provision of OAR [836-053-0430]**836-053-0431** to 836-053-0465 is an unfair trade  
33 practice under ORS 746.240.

34  
35 Stat. Auth.: ORS [743.499, 743.769 & 743.894] **743B.330, 743B.126 and 743B.310**

36 Stats. Implemented: ORS [743.499, 743.766–743.769 & 743.894] **743B.330, 743B.126 and 743B.310**

37 Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98; ID 23-2011, f. & cert. ef. 12-19-  
38 11; ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

39  
40  
41 836-053-0431 (Amended)

42 Underwriting, Enrollment and Benefit Design

43  
44 (1) A carrier must offer all of its approved nongrandfathered individual health benefit plans and plan  
45 options, including individual plans offered through associations, to all individuals eligible for such plans  
46 on a guaranteed issue basis without regard to health status, age, immigration status or lawful presence in  
47 the United States. Except as provided in section (2) of this rule:

48 (a) For individual health benefit plans approved by October 1 of each calendar year for sale in the  
49 following calendar year, a carrier may limit enrollment to[:

50 [(A) *October 1, 2013 to March 31, 2014 for coverage effective in 2014;*]

51 [(B) *November 15, 2014 through January 15, 2015 for coverage effective in 2015; and*]

1 [(C)] October 15 to December 7 of each preceding calendar year for coverage effective on or after  
2 January 1, 2016; and  
3 (b) Coverage must be effective consistent with the dates described in 45 CFR 155.410(c) and (f).  
4 (2)(a) Notwithstanding section (1) of this rule, a carrier must deny enrollment under the following  
5 circumstances:  
6 (A) To an individual who is not lawfully present in the United States in a plan provided through the  
7 [Oregon Health Insurance Exchange Corporation] **health insurance exchange**.  
8 (B) To an individual entitled to benefits under a Medicare plan under part A or B or a Medicare Choice or  
9 Medicare Advantage plan described in 42 USC 1395W–21, if and only if the individual is enrolled in  
10 such a plan.  
11 (b) A carrier must enroll an individual who, within 60 days before application for coverage with the  
12 carrier:  
13 (A) Loses minimum essential coverage. Loss of minimum essential coverage does not include termination  
14 or loss due to failure to pay premiums or rescission as specified in 45 CFR 147.128. The effective date of  
15 coverage for the loss of minimum essential must be consistent with the requirements of 45 CFR  
16 155.420(b)(1).  
17 (B) Gains a dependent or becomes a dependent through marriage, birth, adoption or placement for  
18 adoption or foster care. The effective date for coverage for enrollment under this paragraph must be:  
19 (i) In the case of marriage, no later than the first day of the first calendar month following the date the  
20 carrier receives the request for special enrollment.  
21 (ii) In the case of birth, on the date of birth.  
22 (iii) In the case of adoption or placement for adoption or foster care, no later than the date of adoption or  
23 placement for adoption or foster care.  
24 (C) Experiences a qualifying event as defined under section 603 of the Employee Retirement Income  
25 Security Act of 1974, as amended.  
26 (D) Experiences an event described in 45 CFR 155.420(d)(4), (5), (6), or (7). The effective date of  
27 coverage for enrollment under this paragraph must be:  
28 (i) For 45 CFR 155.420(d)(4) or (d)(5), consistent with the requirements of 45 CFR 155.420(b)(2)(iii).  
29 (ii) For 45 CFR 155.420(d)(6) or (d)(7), consistent with the requirements of 45 CFR 155.420(b)(1).  
30 (E) Loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a  
31 state child health plan under title XXI of the Social Security Act. The effective date of coverage for  
32 enrollment under this paragraph must be consistent with the requirements of 45 CFR 155.420(b)(1).  
33 *[(c) During the month of April 2014, a carrier must allow special enrollment on the basis that an*  
34 *individual who applies during April 2014 has experienced an event described in 45 CFR 155.420(d)(9), if*  
35 *no other basis for special enrollment exists. The effective date of coverage for enrollment under this*  
36 *paragraph must be no less restrictive than those described in 45 CFR 155.420(b)(2)(iii)(B).]*  
37 *[(3) Notwithstanding section (1)(a)(A) of this rule, a carrier must enroll an individual who is enrolled in*  
38 *an individual health benefit plan with a policy year that terminates after March 31, 2014 if the individual*  
39 *applies for coverage within 30 calendar days before the end of the individual's individual health benefit*  
40 *plan policy year. This subsection does not require a carrier to enroll an individual enrolled in an*  
41 *individual health benefit plan with a policy year that ends after December 31, 2014 if enrollment is not*  
42 *otherwise required under section (1) or (2) of this rule. The effective date of coverage for enrollment*  
43 *under this subsection must be effective consistent with the requirements of 45 CFR 155.420(b)(1).]*  
44 [(4)](3) Except as permitted under a preexisting condition provision of a grandfathered individual plan, a  
45 carrier may not modify the benefit provisions of an individual health benefit plan for any enrollee by  
46 means of a rider, endorsement or otherwise for the purpose of restricting or excluding coverage for  
47 medical services or conditions that are otherwise covered by the plan.  
48 [(5)](4) A carrier may offer wrap-around occupational coverage to an accepted individual health benefit  
49 plan applicant.  
50 [(6)](5) A carrier may impose an individual coverage waiting period on the coverage of certain new  
51 enrollees in a grandfathered individual health benefit plan in accordance with ORS [743.766] **743B.125**.

1 The terms of the waiting period must be specified in the policy form and enrollee summary. The waiting  
2 period may apply only when the carrier has determined that the enrollee has a preexisting health condition  
3 warranting the application of a waiting period through evaluation of the form entitled “Oregon Individual  
4 Standard Health Statement” as set forth on the website of the [*Insurance Division of the*] Department of  
5 Consumer and Business Services at [www.insurance.oregon.gov](http://www.insurance.oregon.gov).

6 [(7)](6) A carrier may treat a request by an enrollee in an individual health benefit plan to enroll in  
7 another individual plan as a new application for coverage.

8 [(8)](7) Unless otherwise required by law and except as provided in section [(9)](8) of this rule, a carrier  
9 must implement a modification of a nongrandfathered individual health benefit plan required by statute on  
10 the next anniversary or fixed renewal date of the plan that occurs on or after the operative date of the  
11 statutory provision requiring the modification.

12 [(9)](8) For a grandfathered individual health benefit plan:

13 (a) Unless otherwise required by law, a carrier must implement a modification required by statute on the  
14 first day of the calendar year that occurs on or after the operative date of the statutory provision requiring  
15 the modification.

16 (b) A carrier must eliminate and deem ineffective a rider or endorsement in effect for an enrollee based on  
17 the actual or expected health status of the enrollee and that excludes coverage for diseases or medical  
18 conditions otherwise covered by the plan as of the next renewal date;

19 (c) If an enrollee who is subject to a preexisting condition provision has a rider or endorsement eliminated  
20 in accordance with subsection (a) of this section, the enrollee's medical condition that is subject to the  
21 rider or endorsement may be subject to the preexisting conditions provision of the plan, including the  
22 prior coverage credit provisions;

23 [(10)](9) In accordance with applicable federal law, a carrier may not deny continuation or renewal of an  
24 individual health benefit plan based on Medicare eligibility of an individual but an individual health  
25 benefit plan may contain a Medicare non-duplication provision.

26 [(11)](10) Violation of this rule is an unfair trade practice under ORS 746.240.

27  
28 Stat. Auth.: ORS 731.244, [743.745 & 743.769] **743B.100 & 743B.126**

29 Stats. Implemented: ORS [743.745 & 743.766 - 743.769] **743.022, 743B.100, 743B.125 and 743B.126**

30 Hist.: ID 12-2013, f. 12-31-13, cert. ef. 1-1-14; ID 2-2014(Temp), f. & cert. ef. 2-4-14 thru 7-31-14; ID 5-  
31 2014(Temp), f. & cert. ef. 4-2-14 thru 9-24-14; ID 7-2014(Temp), f. & cert. ef. 4-16-14 thru 9-24-14; ID  
32 14-2014, f. & cert. ef. 7-30-14; ID 17-2014, f. & cert. ef. 10-6-14

33  
34  
35 836-053-0465 (Amended)

36 Rating for Individual Health Benefit Plans

37  
38 (1) Individual health benefit plans must be rated in accordance with the geographic areas specified in  
39 OAR 836-053-0065. A carrier must file a single geographic average rate for each health benefit plan that  
40 is offered to individuals within a geographic area. The geographic average rate must be determined on a  
41 pooled basis, and the pool shall include all of the carrier's business in the Oregon individual health benefit  
42 plan market, except for grandfathered health benefit plans[,] **and** student health benefit plans [*and*  
43 *transitional health benefit plans*].

44 (2) The variation in geographic average rates among different individual health benefit plans offered by a  
45 carrier must be based solely on objective differences in plan design or coverage. The variation shall not  
46 include differences based on the risk characteristics or claims experience of the actual or expected  
47 enrollees in a particular plan.

48 (3) A carrier may use the same geographic average rate for multiple rating areas.

49 (4) For a nongrandfathered health benefit plan:

1 (a) A carrier must implement premium rate increases on a fixed schedule that applies concurrently to all  
2 enrollees in a plan. A carrier may adjust an enrollee's premium during the rating period if the enrollee has  
3 a change in family composition.

4 (b) Premium rates must total the sum of the product of the applicable factors in subsection (c) of this  
5 section for each enrollee and dependent 21 years of age and older and the sum of the product of the  
6 applicable factors in section (7) of this rule for each of the three oldest dependent children under the age  
7 of 21.

8 (c) As determined by a carrier, variations in rates may be based on one or both of the following factors:

9 (A) The ages of enrollees and their dependents according to Exhibit 1 to this rule. Variations in rates  
10 based on age may not exceed a ratio of three to one; or

11 (B) A tobacco use factor of no more than one and one-half times the non-tobacco use rate for persons 18  
12 years of age or older except that the factor may not be applied when the person is enrolled in a tobacco  
13 cessation program.

14 (5) For a grandfathered health benefit plan, a carrier must implement premium rate increases in a  
15 consistent manner for all enrollees in a plan. A carrier may use either of the following methods to  
16 schedule premium rate increases for all enrollees in a grandfathered health benefit plan:

17 (a) A rolling schedule that is based on the anniversary of the date of coverage issued to each enrollee or  
18 on another anniversary date established by the carrier; or

19 (b) A fixed schedule that applies concurrently to all enrollees in a plan. If a fixed schedule is used, a  
20 carrier may adjust the premium of an enrollee during the rating period if the enrollee moves into a higher  
21 age bracket or has a change in family composition.

22 (6) In addition to other bases offered by a carrier, an enrollee of an individual health benefit plan must be  
23 offered the opportunity to pay premium on a monthly basis.

24  
25 Stat. Auth.: ORS 731.244, 743.019, 743.020, 743.769 & 2014 OL Ch. 80, Sec. 5

26 Stats. Implemented: ORS 743.766 - 743.769, 746.015, 746.240 & 2014 OL Ch. 80, Sec. 5

27 Hist.: ID 12-1996, f. & cert. ef. 9-23-96; Renumbered from 836-053-0420, ID 5-1998, f. & cert. ef. 3-9-  
28 98; ID 5-2000, f. & cert. ef. 5-11-00; ID 7-2001(Temp), f. 5-30-01, cert. ef. 5-31-01 thru 11-16-01; ID 14-  
29 2001, f. & cert. ef. 11-20-01; ID 5-2010, f. & cert. ef. 2-16-10; ID 12-2013, f. 12-31-13, cert. ef. 1-1-14;  
30 ID 6-2014(Temp), f. & cert. ef. 4-11-14 thru 10-8-14; ID 17-2014, f. & cert. ef. 10-6-14

31  
32 836-053-0472 (Amended)

33  
34 Statutory Authority and Implementation

35  
36 (1) OAR 836-053-0473 and 836-053-0475 are adopted under the authority of ORS 731.244, 743.018,  
37 743.019, and 743.020 to aid in giving effect to provisions of ORS Chapters 742[ and ], **743 and 743B**  
38 relating to the filing of rates and policy forms with the Director. The requirements of OAR 836-053-0473  
39 and 836-053-0475 are in addition to any other requirements established by statute or by rule or bulletin of  
40 the Department.

41 (2) OAR 836-053-0473 and 836-053-0475 apply to the following rate filings submitted or resubmitted to  
42 the Director on or after April 1, 2010:

43 (a) Health benefit plans for small employers;

44 (b) Individual health benefit plans.

45  
46 Stat. Auth.: ORS 743.018, 743.019 & 743.020

47 Stats. Implemented: ORS 742.003, 742.005, 742.007, 743.018, 743.019, 743.020, **743.022 & 743B.005**  
48 [743.730 & 743.767 ]

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

50  
51 836-053-0510 (Amended)

1 Evaluating the Health Status of an Applicant for Individual Health Benefit Plan Coverage

2  
3 (1) A carrier may [not] use [any health statement except] the health statement entitled, "Oregon Standard  
4 Health Statement" set forth on the website [for the Insurance Division] of the Department of Consumer  
5 and Business Services at [www.insurance.oregon.gov](http://www.insurance.oregon.gov). to evaluate the health status of an applicant for  
6 coverage in a grandfathered individual health benefit plan. In all instances in which a carrier uses the  
7 Oregon Standard Health Statement, the carrier must pay for the costs associated with its use or the  
8 collection of information described in section (2) of this rule.

9 (2) In evaluating an Oregon Standard Health Statement, a carrier may request the applicant's medical  
10 records or a statement from the applicant's attending physician, but such a request may be made only for  
11 questions marked "Yes" by the applicant in the numbered questionnaire portion of the statement.  
12 Although a carrier's request for additional medical information is limited to the specific questions marked  
13 "Yes," a carrier may use all of the information received in response to such a request in evaluating the  
14 applicant's health statement.

15 (3) A carrier may [require an applicant for] **use the information obtained in the "Oregon Standard**  
16 **Health Statement from an individual enrolled in** a nongrandfathered individual health benefit plan [to  
17 provide health-related information] for the sole purpose of health care management, including providing  
18 or arranging for the provision of services under the plan.

19 **(4)(a)** A carrier that chooses to collect health-related information from an applicant **for individual**  
20 **grandfathered coverage** before enrollment must:

21 (A) Prominently state immediately before, and on the same page as, any health-related questions that:

22 (i) Health-related information provided by the applicant will be used solely for health care management  
23 purposes.

24 (ii) The applicant's coverage cannot and will not be denied, terminated, delayed, limited or rescinded  
25 based on the applicant's responses or failure to respond to the questions.

26 (iii) The premium charged for the insurance policy cannot and will not change based on the applicant's  
27 responses or failure to respond to questions.

28 (B) Limit pre-enrollment health-related questions to whether an applicant:

29 (i) Has a disability or a chronic health condition

30 (ii) Has been advised by a licensed medical professional in the twelve months before application that  
31 hospitalization, surgery or treatment is necessary or pending.

32 (iii) Is pregnant.

33 (b) A carrier that chooses to ask questions described in paragraph [(3)](4)(a)(B) of this section[,] may  
34 include the following as examples of a disability or chronic health condition:

35 (A) Asthma,

36 (B) Lung disease,

37 (C) Depression,

38 (D) Diabetes,

39 (E) Heart disease,

40 (F) Chronic back pain,

41 (G) Chronic joint pain,

42 (H) Obesity.

43 (c) A carrier may not delay or refuse to issue nongrandfathered individual coverage to an applicant  
44 because the applicant has failed to respond or failed to respond completely to the questions allowed under  
45 paragraph (3)(a)(B) of this section.

46 (d) For purposes of ORS [743.751]**743B.103** and this section, "applicant" includes a prospective enrollee  
47 or dependent of a prospective enrollee.

48 [(4)](5) Violation of any provision of this rule is an unfair trade practice under ORS 746.240.

49  
50 Stat. Auth.: ORS 731.244 & [743.751] **743B.103**

51 Stats. Implemented: ORS [743.751] **743B.103**

1 Hist.: ID 12-1996, f. & cert. ef. 9-23-96; Renumbered from 836-053-0470, ID 5-1998, f. & cert. ef. 3-9-  
2 98; ID 5-2000, f. & cert. ef. 5-11-00; ID 9-2004, f. & cert. ef. 11-19-04; ID 9-2011, f. & cert. ef. 2-23-11;  
3 ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

4  
5  
6 Rescission of Health Benefit Plan

7  
8 836-053-0825 (Amended)  
9 Rescission of a Group Health Benefit Plan

10  
11 (1) For purposes of ORS [743.737 and 743.754]**743B.013 and 743B.105**, “representative” means a  
12 person who, with specific authority from the employer or plan sponsor to do so, binds the employer or  
13 plan sponsor to a contract for health benefit plan coverage.

14 (2) The notice required by ORS [743.737]**743B.013**(6), [743.754]**743B.105**(8) and [743.894]**743B.310**(3)  
15 to each plan enrollee affected by the rescission must be in writing and include all of the following:

16 (a) Clear identification of the alleged fraudulent act, practice or omission or the intentional  
17 misrepresentation of material fact underlying the rescission.

18 (b) An explanation of why the act, practice or omission was fraudulent or was an intentional  
19 misrepresentation of a material fact.

20 (c) A statement explaining an enrollee’s right to file a grievance or request a review of the decision to  
21 rescind coverage.

22 (d) A description of the health carrier’s applicable grievance procedures, including any time limits  
23 applicable to those procedures.

24 (e) A statement explaining that complaints relating to the notice of rescission required under ORS  
25 [743.737] **743B.013** (6), [743.754] **743B.105** (8) and [743.894] **743B.310** (3) may be made with the  
26 [Insurance Division of the] Department of Consumer and Business Services by writing to the [Insurance  
27 Division]**department** at PO Box 14480, Salem, OR 97309-0405; by calling (503) 947-7984 or (888) 877-  
28 4894; online at <http://www.insurance.oregon.gov>; or by electronic mail to [cp.ins@state.or.us](mailto:cp.ins@state.or.us). The  
29 statement shall also explain that complaints to the [Insurance Division] **Department of Consumer and**  
30 **Business Services** do not constitute grievances under the health benefit plan and may not preserve an  
31 enrollee’s rights under the plan.

32 (f) The toll-free customer service number of the insurer.

33 (g) The effective date of the rescission and the date back to which the coverage will be rescinded.

34 (3) Subject to ORS [743.777]**743.023**(3), a health carrier may provide the required notice for small  
35 employer group health insurance either by first class mail or electronically.

36 (4)(a) On or before June 30 of each calendar year, an insurer must submit an electronic notice for the  
37 preceding calendar year in the format prescribed by the Director of the Department of Consumer and  
38 Business Services and in accordance with instructions accessed through the website of the [Insurance  
39 Division] **department** at <http://www.insurance.oregon.gov>. The notice required by ORS  
40 [743.737]**743B.013** (6)(c), [743.754] **743B.105**(8)(c) and [743.894]**743B.310**(4) must include information  
41 related to group health benefit plan rescissions including but not limited to the total number of:

42 (A) Fully rescinded group health benefit plans;

43 (B) Partially rescinded group health benefit plans;

44 (C) Group health benefit plans in force on December 31 of the report year;

45 (D) Enrollees affected by a fully rescinded group health benefit plan; and

46 (E) Enrollees affected by a partially rescinded group health benefit plan.

47 (b) The notice required under this section may be combined with the notice required under OAR 836-053-  
48 0830 and 836-053-0835.

49 **(5) An insurer may not rescind coverage for fraud if a representative fails to accurately comply**  
50 **with the requirement to provide reasonable assurance that pediatric dental coverage is separately**  
51 **provided.**

1  
2 Stat. Auth.: ORS 743.018, 743.019, 743.020 & [743.894]743B.310  
3 Stats. Implemented: ORS 742.003, 742.005, 742.007, 743.018, 743.019, 743.020,[743.730] 743.022,  
4 **743B.005**, [743.737, 743.754 & 743.767 & 743.894] **743B.013, 743B.105 & 743B.310**  
5 Hist.: ID 23-2011, f. & cert. ef. 12-19-11; ID 12-2013, f. 12-31-13, cert. ef. 1-1-14  
6  
7

8 836-053-0830 (Amended)  
9 Rescission of an Individual Health Benefit Plan or Individual Health Insurance Policy  
10

11 (1) The notice required by ORS [743.894]743B.310(2) to the individual whose coverage is rescinded  
12 must be in writing and include all of the following:

13 (a) Clear identification of the alleged fraudulent act, practice or omission or the intentional  
14 misrepresentation of material fact underlying the rescission.

15 (b) An explanation as to why the act, practice or omission was fraudulent or was an intentional  
16 misrepresentation of a material fact.

17 (c) A statement informing the individual of any right the individual has to file a grievance or to request a  
18 review of the decision to rescind coverage.

19 (d) A description of the health carrier's grievance procedures, including any time limits applicable to  
20 those procedures if such procedures are available to the individual.

21 (e) A statement explaining that complaints relating to the notice of rescission required by ORS  
22 [743.894]743B.310 (2) may be made with the [*Oregon Insurance Division*] **Department of Consumer**  
23 **and Business Services** by writing to PO Box 14480, Salem, OR 97309-0405; by calling (503) 947-7984  
24 or (888) 877-4894; online at <http://www.insurance.oregon.gov>; or by electronic mail to  
25 [cp.ins@state.or.us](mailto:cp.ins@state.or.us). The statement shall also explain that such complaints do not constitute grievances  
26 under the health benefit plan or health insurance policy and may not preserve an enrollee's rights under  
27 the plan or policy.

28 (f) The toll-free customer service number of the insurer.

29 (g) The effective date of the rescission and the date back to which the coverage will be rescinded.

30 (2) Subject to ORS 743.777, a health carrier may provide the notice required under ORS  
31 [743.894]743B.310 (2) for individual health insurance either by first class mail or electronically.

32 (3)(a) On or before June 30 of each calendar year, an insurer must submit an electronic notice for the  
33 preceding calendar year in the format prescribed by the Director of the Department of Consumer and  
34 Business Services and in accordance with instructions set forth on the website [*of the Insurance Division*]  
35 of the Department of Consumer and Business Services at <http://www.insurance.oregon.gov>. The notice  
36 required by ORS [743.894]743B.310 (4) must include information related to rescission of individual  
37 health benefit plans and individual health insurance policies including but not limited to the total number  
38 of:

39 (A) Fully rescinded individual health benefit plans and individual health insurance policies;

40 (B) Partially rescinded individual health benefit plans and health insurance policies;

41 (C) Individual health benefit plans and individual health insurance policies in force on December 31 of  
42 the report year; and

43 (D) Enrollees affected by full or partial rescission of an individual health benefit plan or individual health  
44 insurance policy.

45 (b) The notice required under this section may be combined with the notice required under OAR 836-053-  
46 0825 and 836-053-0835.

47 **(4) A health carrier may not rescind coverage for fraud if an individual fails to accurately comply**  
48 **with the requirement to provide reasonable assurance that pediatric dental coverage is separately**  
49 **provided.**  
50

51 Stat. Auth.: ORS 731.244 & [743.894]743B.310

1 Stats. Implemented: ORS [743.731]**743B.003** & [743.894]**743B.310**  
2 Hist.: ID 23-2011, f. & cert. ef. 12-19-11; ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

3  
4  
5 836-053-0835 (Amended)

6 Rescission of an Individual's Coverage under a Group Health Benefit Plan or Group Health Insurance  
7 Policy

8  
9 (1) Subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, P.L. 99-272,  
10 April 7, 1986, and ORS 743.601 and 743.610, for purposes of rescission of an individual's coverage  
11 under a group health insurance policy, including a group health benefit plan under ORS [743.737,  
12 743.754, and 743.894]**743B.013, 743B.105 and 743B.310**, "rescission" does not include retroactive  
13 cancellation or discontinuance of coverage of an enrollee if:

14 (a) The enrollee is no longer eligible for such coverage;

15 (b) The enrollee has not paid required premiums or contributed to coverage or any premiums paid have  
16 been refunded; and

17 (c) The insurer is not notified of the enrollee's change in eligibility when the change occurs.

18 (2) The notice required by ORS [743.737(5), 743.754(7) and 743.894(2)] **743B.013(5), 743B.105(7) and**  
19 **743B.310(2)** to each plan enrollee affected by rescission of coverage under a group health benefit plan or  
20 group health insurance policy must be in writing and include all of the following:

21 (a) Clear identification of the alleged fraudulent act, practice or omission or the intentional  
22 misrepresentation of material fact underlying the rescission.

23 (b) An explanation of why the act, practice or omission was fraudulent or was an intentional  
24 misrepresentation of a material fact.

25 (c) A statement explaining an enrollee's right to file a grievance or request a review of the decision to  
26 rescind coverage.

27 (d) A description of the health carrier's applicable grievance procedures, including any time limits  
28 applicable to those procedures.

29 (e) A statement explaining that complaints relating to the notice of rescission required under ORS  
30 [743.737(5), 743.754(7) and 743.894(2)] **743B.013(5), 743B.105(7) and 743B.310(2)** may be made with  
31 the [*Insurance Division of the*] Department of Consumer and Business Services by writing to the  
32 [*Insurance Division*]**department** at PO Box 14480, Salem, OR 97309-0405; by calling (503) 947-7984 or  
33 (888) 877-4894; online at <http://www.insurance.oregon.gov>; or by electronic mail to [cp.ins@state.or.us](mailto:cp.ins@state.or.us).  
34 The statement shall also explain that complaints to the [*Insurance Division*] **Department of Consumer**  
35 **and Business Services** do not constitute grievances under the group health benefit plan or group health  
36 insurance policy and may not preserve an enrollee's rights under the plan or policy.

37 (f) The toll-free customer service number of the insurer.

38 (g) The effective date of the rescission and the date back to which the coverage will be rescinded.

39 (3) Subject to ORS [743.777]**743.023**, a health carrier may provide the required notice for small employer  
40 group health insurance either by first class mail or electronically.

41 (4)(a) On or before June 30 of each calendar year, an insurer must submit an electronic notice for the  
42 preceding calendar year in the format prescribed by the Director of the Department of Consumer and  
43 Business Services and in accordance with instructions set forth on the website [*of the Insurance Division*]  
44 of the Department of Consumer and Business Services at <http://www.insurance.oregon.gov>. The notice  
45 required by ORS [743.737(5), 743.754(7) and 743.894(2)] **743B.013(5), 743B.105(7) and 743B.310(2)**  
46 must include information related to rescissions of enrollee coverage under a group health benefit plan or  
47 group health insurance policy including but not limited to the total number of enrollees affected by full or  
48 partial rescission of coverage under a group health benefit plan or group health insurance policy.

49 (b) The notice required under this section may be combined with the notice required under OAR 836-053-  
50 0825 and 836-053-0830.

1 **(5) An insurer may not rescind coverage for fraud if an enrollee fails to accurately comply with the**  
2 **requirement to provide reasonable assurance that pediatric dental coverage is separately provided.**

3  
4 Stat. Auth.: ORS 743.244, [743.737, 743.754 and 743.894] **743B.013, 743B.105 and 743B.310**  
5 Stats. Implemented: ORS [743.737, 743.754 and 743.894] **743B.013, 743B.105 and 743B.310**  
6 Hist.: ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

7  
8  
9 **Primary Care Services Reporting**

10  
11 **836-053-1500 (NEW- Replaces Temporary Rule)**

12 **Purpose; Statutory Authority; Applicability**

13  
14 **(1) OAR 836-053-1500 to 836-053-1510 are adopted for the purpose of implementing**  
15 **sections 1 to 4, chapter 575, Oregon Laws 2015 and section 7, chapter 26, Oregon Laws**  
16 **2016.**

17 **(2) The requirements set forth in OAR 836-053-1500 to 836-053-1510 apply to prominent**  
18 **carriers.**

19  
20 **Stat. Auth: ORS 731.244; section 1 to 4, chapter 575, Oregon Laws 2015; and section 7,**  
21 **chapter 26, Oregon Laws 2016**

22 **Stats. Implemented: Sections 1 & 3, chapter 575, Oregon Laws 2015 and section 7, chapter**  
23 **26, Oregon Laws 2016**

24 **History:**

25  
26  
27 **836-053-1505 (NEW- Replaces Temporary Rule)**

28 **Definitions for OAR 836-053-1500 to 836-053-1510**

29  
30 **As used in OAR 836-053-1500 to 836-053-1510:**

31 **(1) The definitions set forth in Section 2, chapter 575, Oregon Laws 2015 apply to the use of**  
32 **those terms in these rules.**

33 **(2) “Prominent carrier” means:**

34 **(a) A carrier with annual premium income of \$200 million or more in direct health**  
35 **premiums written in Oregon and is not also licensed as a Coordinated Care Organization;**

36 **(b) The Public Employees’ Benefit Board; and**

37 **(c) The Oregon Educators Benefit Board.**

38 **(3) “Non-claims based primary care expenditures” means resources given to a primary**  
39 **care provider or practice for the following services or arrangements:**

40 **(a) Capitation or salaried arrangements with primary care providers or practices not billed**  
41 **or captured through claims;**

42 **(b) Risk-based reconciliation for arrangements with primary care providers or practices**  
43 **not billed or captured through claims;**

44 **(c) Payments to Patient-Centered Primary Care Homes or Patient-Centered Medical**  
45 **Homes based upon that recognition or payments for participation in proprietary or other**  
46 **multi-payer medical home initiatives;**

- 1 **(d) Retrospective incentive payments to primary care providers or practices based on**  
2 **performance aimed at decreasing cost or improving value for a defined population of**  
3 **patients;**
- 4 **(e) Prospective incentive payments to primary care providers or practices aimed at**  
5 **developing capacity for improving care for a defined population of patients;**
- 6 **(f) Payments for Health Information Technology structural changes at a primary care**  
7 **practice such as electronic records and data reporting capacity from those records; or**  
8 **(g) Workforce expenses including payments or expenses for supplemental staff or**  
9 **supplemental activities integrated into the primary care practice (i.e. practice coaches,**  
10 **patient educators, patient navigators, nurse care managers, etc.).**
- 11 **(4) “Non-claims based total health care expenditures” means resources given to a provider**  
12 **or practice for the following services or arrangements:**
- 13 **(a) Capitation or salaried arrangements with providers or practices not billed or captured**  
14 **through claims;**
- 15 **(b) Risk-based reconciliation for arrangements with providers or practices not billed or**  
16 **captured through claims;**
- 17 **(c) Payments to Patient-Centered Primary Care Homes, Patient-Centered Medical Homes,**  
18 **or Patient-Centered Specialty Practices based upon that recognition or payments for**  
19 **participation in proprietary or other multi-payer medical home or specialty care**  
20 **initiatives;**
- 21 **(d) Retrospective incentive payments to providers or practices based on performance**  
22 **aimed at decreasing cost or improving value for a defined population of patients;**
- 23 **(e) Prospective incentive payments to providers or practices aimed at developing capacity**  
24 **for improving care for a defined population of patients;**
- 25 **(f) Payments for Health Information Technology structural changes at a practice such as**  
26 **electronic records and data reporting capacity from those records; or**  
27 **(g) Workforce expenses including payments or expenses for supplemental staff or**  
28 **supplemental activities integrated into the practice (i.e. practice coaches, patient educators,**  
29 **patient navigators, nurse care managers, etc.).**
- 30 **(5) “Patient-Centered Medical Home” means a practice or provider who has been**  
31 **recognized as such by the National Committee for Quality Assurance.**
- 32 **(6) “Patient-Centered Primary Care Home” means a health care team or clinic as defined**  
33 **in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been**  
34 **recognized through the process pursuant to OAR 409-055-0040.**
- 35 **(7) “Patient-Centered Specialty Practice” means a practice or provider who has been**  
36 **recognized as such by the National Committee for Quality Assurance.**
- 37 **(8) “Practice” means an individual, facility, institution, corporate entity, or other**  
38 **organization which provides direct health care services or items, also termed a performing**  
39 **provider, or bills, obligates and receives reimbursement on behalf of a performing provider**  
40 **of services, also termed a billing provider. The term provider refers to both performing**  
41 **providers and billing providers unless otherwise specified.**
- 42 **(9) “Primary care” means family medicine, general internal medicine, naturopathic**  
43 **medicine, obstetrics and gynecology, pediatrics or general psychiatry.**
- 44 **(10) “Primary care provider” means:**

1 **(a) A physician, naturopath, nurse practitioner, physician assistant or other health**  
2 **professional licensed or certified in this state, whose clinical practice is in the area of**  
3 **primary care.**

4 **(b) A health care team or clinic that has been certified by the Oregon Health Authority as a**  
5 **Patient-Centered Primary Care Home.**

6  
7 **Stat. Auth: ORS 731.244 and section 1, chapter 575, Oregon Laws 2015**

8 **Stats. Implemented: Sections 1 & 3, chapter 575, Oregon Laws 2015 as amended by section**  
9 **7, chapter 26, Oregon Laws 2016**

10 **History:**

11  
12  
13 **836-053-1510 (NEW- Replaces Temporary Rule)**  
14 **Prominent Carrier Reporting Requirements**

15  
16 **(1) Not later than October 1 of each year from 2016 through 2018, each prominent carrier**  
17 **shall submit to the Department of Consumer and Business Services all non-claims based**  
18 **primary care expenditures for the prior calendar year using the approved file layout and**  
19 **format set forth on the website of the Department of Consumer and Business Services at**  
20 **[www.insurance.oregon.gov](http://www.insurance.oregon.gov).**

21 **(2) Each prominent carrier shall submit to Department all non-claims based total health**  
22 **care expenditures for the prior calendar year using the approved file layout and format set**  
23 **forth on the website of the Department of Consumer and Business Services at**  
24 **[www.insurance.oregon.gov](http://www.insurance.oregon.gov).**

25 **(3) Each category included in the approved file format is mutually exclusive; therefore,**  
26 **expenditures shall only be accounted for in one category.**

27 **(4) All data shall be submitted to the department no later than October 1 of each year that**  
28 **the prominent carrier is required to report under section (1) of this rule.**

29 **(5) Claims-based primary care and total health care expenditures will be calculated for**  
30 **each prominent carrier by the Oregon Health Authority using data from the All-Payer All-**  
31 **Claims Database.**

32 **(6) Expenditures for services or activities outside the primary care setting, regardless of a**  
33 **primary care capacity building intent, are not considered primary care expenditures for**  
34 **purposes of this report.**

35  
36 **Stat. Auth: ORS 731.244 and sections 1 to 3, chapter 575, Oregon Laws 2015 and section 7,**  
37 **chapter 26, Oregon Laws 2016**

38 **Stats. Implemented: Sections 1 to 3, chapter 575, Oregon Laws 2015 and section 7, chapter**  
39 **26, Oregon Laws 2016**

40 **History:**

41  
42  
43 **Repeal of Rules Imposing 1% Assessment on Health Insurance Premiums (Enrolled House Bill**  
44 **2913, 2015 Legislative Session)**

45  
46 **836-009-0020 (Repealed)**

47 **Definitions**

- 1
- 2 *836-009-0025 (Repealed)*
- 3 *Verified Assessment Reporting and Form*
- 4
- 5 *836-009-0030 (Repealed)*
- 6 *One-Time Increase in Existing, Approved Premium Rates*
- 7
- 8 *836-009-0035(Repealed)*
- 9 *Inclusion of Assessment in Future Rate Filings*
- 10
- 11 *836-009-0040 (Repealed)*
- 12 *Assessment Derived from Premiums Derived From Contracts not Subject to Rate Approval*