

**STATE OF OREGON
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
DIVISION OF FINANCIAL REGULATION**

Before the Insurance Commissioner
Department of Consumer and Business Services

In the Matter of Adopting OAR 836-010-0155,)
836-053-0004, 836-053-0012, 836-053-0013;)
Amending OAR 836-053-0002, 836-053-0008,)
836-053-0009, 836-053-1020, 836-053-1404,)
836-053-1405; Repealing 836-053-0004(T))
836-053-0012(T), 836-053-0013(T);)
and Renumbering 836-053-0010 to 836-053-0019,)
and 836-053-1406 to 836-053-1409)
related to adopting the 2017 base benchmark)
health benefit plan and essential health benefits)

SUMMARY OF TESTIMONY
AND HEARING OFFICER'S
RECOMMENDATION,

Procedures Followed

On December 15, 2015, the Director of the Department of Consumer and Business Services (DCBS) filed with the Secretary of State a Notice of Proposed Rulemaking Hearing, giving notice that the Director proposed to adopt rules necessary to establish the Oregon benchmark health benefit plan and standard plans for plan years beginning on and after January 1, 2017. The proposed rules also supplement the selected plans as necessary to conform to existing state and federal requirements adopted since 2014 and make conforming amendments to rules related to coverage of mental or nervous conditions.

The notice announced that a public hearing would be held on January 26, 2016, and that interested persons could submit written comments until 5:00 PM on February 3, 2016. A copy of the notice was published in the Secretary of State's Oregon Bulletin of January 2016.

On March 8, 2016 the division extended the comment period to March 28, 2016 to allow additional time for the public to submit written testimony due to necessary standard plan changes. The proposed standard bronze plan did not meet the actuarial value threshold using the federal 2017 Actuarial Value calculator and plan changes were significant. The division provided notice of the extended comment period to the same persons that received the original notice of rulemaking hearing. Comments received were fully considered in the same manner as comments received during the initial comment period.

These proposed rules adopt a new benchmark plan for 2017 as required by federal law. In addition to identifying the 2017 plans, the rules also include changes to the benchmark plan and related rules necessary to reflect current state and federal law because changes since 2014 are not included in the base benchmark plan. These changes include addressing gender specific contract

language; revising modification and discontinuation requirements; defining “habilitative services and devices;” and clarifying mental health parity requirements.

These rules are necessary to implement requirements of the 2016 Notice of Benefit and Payment Parameters¹ and ORS 743B.130(2) to establish the benchmark plan and standard plans. The rules adopt the 2014 PacificSource Codeduct Value 3000+35/70% as the base benchmark plan. The Oregon Health Plan Children’s Health Insurance Plan and the Federal Employee Dental and Vision Insurance Plan Blue Vision High Option will supplement the base benchmark plan for pediatric dental and vision coverage. These documents have been added as exhibits to OAR 836-053-0012. Finally, the rules adopt a definition of “habilitative services and devices” to supplement the base benchmark plan.

The division is adopting a permanent rule clarifying insurers must cover services and treatments regardless of gender assigned at birth if a licensed providers determine whether sex-specific preventative services are medically appropriate for an individual. The rule complies with regulatory guidance prepared by the United States Departments of Labor, Health and Human Services, and U.S. Department of the Treasury.

Finally, the rules clarify the benchmark plan by conforming specific provisions of the base benchmark plan to current state and federal regulations including provider non-discrimination, prescription drug access, age limits, and annual and lifetime dollar limitations.

This rulemaking adopts permanent rules that were in large part previously adopted as temporary rules. Temporary rules were necessary to implement provisions of the benchmark and standard plans to coincide with federal rate, form, and binder filing deadlines.

The proposed rules and the fiscal impact were reviewed by members of the external rulemaking advisory committee that included insurers, producers and consumer representatives.

Fiscal impact: The advisory committee reviewed the proposed rule and the proposed fiscal impact statement for the rule. Generally, these proposed rules do not have a financial impact on state agencies or local governments. The impact on insurers, the general public and small businesses is unknown based on available information. The fiscal impacts to insurers and the public generally will be in potential increased administrative costs resulting from insurers needing to update plan language.

However, the insurers would be required to adjust plan language to conform to current requirements even without these rules, so this cost is not solely resulting from adoption of these rules. Inclusion of clearer language providing guidance to insurers may help to counter any increased administrative costs. The plan selected by the rulemaking advisory committee is an updated version of the current Oregon benchmark plan. One reason the committee recommended this plan is to minimize the disruption and changes that would result from selection of an entirely new plan.

Testimony Received and Hearing Officer Recommendation

The hearing was held as scheduled. Two members of the public attended and presented testimony. Ms. Jennifer Baker, representing Cambia, presented oral testimony reiterating written

¹ <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>

comments provided. Ms. Lisa Trussell, representing Health Net Health Plan, presented verbal testimony and followed up with written comments. The hearing officer also received written testimony from Michael Schopf, representing Providence Health Plan; Anthony Behrens, representing the Oregon Health Insurance Marketplace; Sue Ober, representing Sue Ober & Associates; Betsy Earls, representing Associated Oregon Industries; and Kate Murphy, representing Regence.

One commenter noted that language in 836-010-0155(1)(c) was overly broad and suggested removal of “or otherwise authorized or permitted.” The commenter also suggested removal of OAR 836-010-0155(3) because they felt it was unusual and unnecessary to reference sub-regulatory guidance. The hearing officer agrees with both suggestions and has revised the proposed rule as suggested. Although, the rule no longer directly references the May 11, 2015 United States Departments of Labor, Health and Human Services, and U.S. Department of the Treasury guidance on gender specific services the hearing officer understands that insurers must comply with the guidance.

One commenter requested that the hearing officer not permanently adopt OAR 836-053-0004, which requires insurers to comply with all state and federal law, because the requirement already exists under state law. While the hearing officer agrees that this is an existing requirement the hearing officer proposes that the division adopt the rule without modification.

Several commenters suggested changes to OAR 836-053-0002 relating to Modification and Discontinuance of a health benefit plan. One comment suggested removal of the words “health benefit plan” in section 2 for clarification and consistency. The hearing officer agrees and has revised the section to state: “At the time of coverage renewal insurers may modify the coverage for a product offered to a group or an individual.” Two commenters requested clarification about use of model notices offered by Centers for Medicare and Medicaid Services (CMS) or the division and one requested clarification on the timing of the notices. The final rule clarifies both the timing of the notices and that insurers may use either the state or federal notice.

The hearing officer received two comments related to age limits on essential health benefits, including hearing aids. One commenter asked the division to clarify that insurers may apply reasonable age limits to the established hearing aid mandate under ORS 743A.141. The other commenter asked the division to clarify whether hearing aids fall under the impermissible treatment limitations and exclusions and if hearing aids are considered a treatment for hearing loss. The hearing officer notes that in the 2017 Notice of Benefit and Payment Parameters, the Center for Consumer Information and Insurance Oversight (CCIIO) clarified that insurers do not provide essential health benefits if the plan benefit design, or implementation of the benefit design, discriminates based on an “individuals age, expected length of life, present or predicted disability...” Our understanding of federal regulations is that if age limits are used they must be supported by medical evidence. In the final rule the division has clarified that age limits are not allowed for hearing aids. Insurers are expected to remove impermissible age limits on treatments and services that would otherwise be appropriate for individuals outside the limited age.

One commenter requested clarification on sexual dysfunction exclusions and the language found in OAR 836-053-0012(3)(a)(D). The PacificSource benchmark plan includes an exclusion for “[s]ervices or supplies to diagnose, prevent, or treat sterility, infertility, erectile dysfunction, frigidity, or sexual dysfunction.” The application of mental health parity makes this exclusion impermissible when applied to a mental health condition. The rule removes the exclusion in the benchmark plan and reminds insurers that plans must cover diagnosis and all medically

necessary and clinically appropriate treatment of sexual dysfunction as a mental health condition. Medically necessary and clinically appropriate treatment includes prescription drugs.

The division received two comments on rule language relating to coverage of surgeries and procedures related to sex transformations and gender identity disorder or gender dysphoria. Both commenters requested clarification related to surgical treatment of gender dysphoria, including gender affirming surgeries. One commenter referenced Insurance Division Bulletin ID 2012-1, and requested consistency between the rule and the bulletin². The division would like to clarify that all medically necessary and clinically appropriate surgeries, medications, and services must be covered for individuals diagnosed with gender dysphoria. This requirement is consistent with division bulletin 2014-1 and application of mental health parity generally. Insurers may not limit or exclude gender affirming services and treatments by categorizing them as cosmetic procedures, treatments, or services. Such an exclusion would be considered a categorical exclusion and impermissible under mental health parity statutes as explained in ID 2014-1. The proposed rule clarifies that exclusions for *medically necessary* surgeries and procedures related to sex transformation and gender identity disorder or gender dysphoria are impermissible.

One commenter inquired about the division's criteria for prohibiting time limits for treatment of jaw or teeth or orthognathic surgery. The criteria for prohibiting time limits on treatment of essential health benefits may be found in federal regulations (45 CFR 146.121 and 45 CFR 156.125(a)). 45 CFR 146.121 prohibits insurers from discriminating based on health factors. Health factors are defined as health status, medical conditions, physical illness, mental illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. Imposing a waiting period or exclusion period on treatment of jaw or teeth conditions or orthognathic surgery would be considered discrimination on the basis of a health condition and as such, is not allowed.

One commenter suggested renumbering the Durable Medical Equipment language found in OAR 836-053-0012(3)(a)(J) for clarity. The hearing officer agrees; OAR 836-053-0012(3)(a)(J) is proposed to be included as OAR 836-053-0012(3)(b). The remainder of the rule will be renumbered accordingly.

Two commenters requested clarification on the proposed wig benefit. One commenter asked for either a reference to a wig benefit or for the benefit to be removed. To that point, wigs are an essential health benefit found in the base benchmark plan (see page 22 of the benchmark policy form). The other commenter pointed out that language in OAR 836-053-0012 and OAR 836-053-0013 contradicted coverage requirements for wigs as an EHB and requested clarification. The hearing officer agrees that this language is contradictory, wigs are an EHB found in the base benchmark plan. To clarify the requirement the hearing officer proposed to remove the word wigs from OAR 836-053-0013(2). Oregon Standard Bronze and Silver plans are required to cover wigs as an EHB.

Three commenters requested clarification regarding coverage of diabetes self management under ORS 743A.184 and the USPSTF A and B list. The rule clarifies the division's position that coverage of one required diabetic benefit does not supplant requirements under a different mandate or preventive services. Insurers should review each mandate and preventive service requirement for distinct elements and ensure full compliance with each benefit. To reduce

² OID Bulletin 2012-1 is currently being revised and any inconsistencies between this rule and the new bulletin will be resolved in the new bulletin.

confusion in the permanent rules the hearing officer proposes to remove removed OAR 836-053-0012(3)(c) and add section (5) to specifically address this requirement on a broad scale. The remainder of the rule will be renumbered accordingly.

One commenter requested clarification on coverage of osteopathic manipulations for treatment of disorders of the musculoskeletal system, as found in the benchmark plan, and application of OAR 836-053-0012 relating to coverage of chiropractic services. Follow-up conversations with Pacificsource, the benchmark plan insurer, indicate that chiropractic manipulation is different from osteopathic manipulation. Pacificsource clarified that the benchmark plan does not provide benefits for chiropractic manipulations, regardless of the medical provider. However, the plan covers a medical provider, including chiropractor, providing osteopathic manipulation for treatment of disorders of the musculoskeletal system. The hearing officer recommends no change to the proposed rules related to osteopathic manipulations.

One commenter requested clarification of OAR 836-053-0012(5), renumbered in the final rule to OAR 836-053-0012(6), which prohibits insurers from discriminating against a provider acting within the scope of the providers license. The commenter noted that the language appears to reference the federal ‘anti-discrimination’ language while indicating an ‘any willing provider requirement’. The language in OAR 836-053-0012 is consistent with language in Public Health Service Act section 2706(a), which specifies that the regulation does not require that a group health plan or health insurance issuer contract with any willing provider.

The division received one comment regarding prescription drug coverage requirements found in OAR 836-053-0012. Language adopted in OAR 836-053-0012, relating to formulary construction and exceptions process, is consistent with language found in 45 CFR 156.122. The hearing officer recommends no changes to this requirement.

One commenter requested clarification on whether division’s collection of a ‘‘formulary drug list’’ codified the requirement that carriers must submit a completed CMS ‘‘QHP Application Prescription Drug Template – Drug List Worksheet.’’ The division added reference to filing requirements posted on the DCBS website to OAR 836-053-0013(8)(h)(B), which, at this time requires completion and submission of a Prescription Drug Template. The hearing officer recommends against providing more specificity in the rule at this time due to evolving CMS requirements.

One commenter noted differences in rule text found in OAR 836-053-0013(10) and the draft cost share matrix for both the Standard Silver and Standard Bronze plan. To resolve the discrepancy the hearing officer recommends removing the following language from OAR 836-053-0013(10)(a): ‘‘The Bronze plan deductible must be integrated applicable to prescription drugs and all services except preventive services.’’ Additionally, the hearing officer also recommends removing the following language from OAR 836-053-0013(10)(b) ‘‘The Silver plan deductible applies to all services except preventive services, office visits, urgent care and prescription drugs.’’

The rulemaking advisory committee proposed the following for both the standard bronze and Standard Silver plan:

- Deductible and coinsurance will continue to apply to maternity services (with the exception of those services considered preventive for which cost sharing is prohibited by the ACA);

- Cost sharing for pediatric vision should remain the same as the 2014-2016 standard plans;
- No cost sharing should apply for the following services
 - Diabetes Education
 - Nutritional counseling (for certain medical conditions only)
 - Diabetic supplies
- Cost sharing for biofeedback and cardiac rehabilitation services should be consistent with other outpatient rehabilitation services;
- Habilitative services are assumed to have the same cost sharing as rehabilitative services; and
- Mental health services are assumed to have the same cost sharing as other medical services based on type and place of service.

The proposed rules adopt these recommendations within the final Standard Bronze and Silver plans as indicated in Exhibits 1 and 2 to OAR 836-053-0013, without change.

The division received one request to revise the rules to reflect the ICD-10 coding requirements. Due to the complexity of ICD-10 coding, the hearing officer proposes to remove specific codes from OAR 836-053-0013 with the expectation that insurers will apply the appropriate code for each EHB service.

One commenter requested clarification in OAR 836-053-0009(3) relating to inpatient services, specifically services. The proposed rule reflects the addition of the word “inpatient” before surgery in both OAR 836-053-0009 and OAR 836-053-0013.

One commenter proposed a number of suggestions to prescription drug formulary requirements found OAR 836-053-1020. The commenter requested that the division remove proposed language regarding formulary non-discrimination and access requirements. The hearing officer notes that the proposed language is consistent with statements provided by CMS in the 2016 Notice of Benefit and Payment Parameters. The hearing officer does not recommend adjusting the language to remain consistent with federal formulary and non-discrimination requirements. The commenter also proposed additional language allowing health benefit plans to substitute prescription drugs in the standard plan. The hearing officer finds this proposal acceptable, and recommends adding section (10) to OAR 836-053-1020.

In February 2016 the division received a revised version of the Actuarial Value calculator prompting revisions of the proposed Bronze Standard plan. The division extended the comment period and provided four options meeting the actuarial value requirement. Two of the three comments received on the proposed Bronze Standard Plan preferred option 1. The third commenter preferred option 3. Based on the information received, the hearing officer recommends the adoption of Option 1, as indicated in the attachment to this report. The division is adopting the Standard Silver plan as proposed by the EHB committee.

A number of non-substantive technical spelling and grammar corrections were made with the finalization of the rules. One commenter requested substantial revision of the rules to place all definitions in a single location. Although the hearing officer agrees this revision would be advantageous, the need to adopt these rules to provide guidance to insurers currently developing and filing 2017 plans is of the highest importance. Finally, references to CMS guidance issued by the United States Department of Labor, Employee Benefits Security Administration were

revised to accurately represent the guidance as jointly issued by the Departments of Labor, Health and Human Services, and the U.S. Department of the Treasury.

In summary, the hearing officer recommends that the proposed rules be adopted with the following changes to the rules:

1. Revise OAR 836-010-0155(1)(c) to remove "or otherwise authorized or permitted" and the entire subsection (3);
2. Revise OAR 836-053-0002 to clarify requirement related to Modification and discontinuations;
3. Revise OAR 836-053-0012(3)(a)(C) to include hearing aids under the restriction on age limits;
4. Revise OAR 836-053-0012(3)(E) to clarify that treatment of gender dysphoria is limited to medically necessary surgeries and procedures;
5. Remove OAR 836-053-0012(3)(C) and add OAR 836-053-0012(5) to clarify coverage of overlapping benefits, including mandates and preventive services;
6. Remove benefit specific information from OAR 053-0013(10)(a) and OAR 836-053-0013(10)(b);
7. Adopt OAR 836-053-1020(10) which permits insurers to substitute prescription drugs in the standard plans;
8. Adopt standard Bronze Plan Option 1 as the 2017 Standard Bronze Plan;
9. Include the 2014 PacificSource Codeduct Value 3000+35/70 policy as Exhibit 1 to OAR 836-053-0012;
10. Include the Dental Plan of the Oregon Health Plan Children's' Health Insurance Plan documents as Exhibit 2 to OAR 836-053-0012;
11. Include the Federal Employee Dental and Vision Insurance Plan Blue Vision High Option as Exhibit 3 to OAR 836-053-0012;
12. Include the final Standard Bronze plan matrix as Exhibit 1 to OAR 836-053-0013;
13. Include the final Standard Silver plan matrix as Exhibit 2 to OAR 836-053-0013; and
14. Make any technical changes necessary to reflect the merger of two DCBS divisions (Insurance and Finance and Corporate Securities Divisions) into the Division of Financial Regulation.
15. Correct internal references to reflect statutory renumbering during the ORS codification process.

The rulemaking was reviewed again for its economic effect on businesses, including small businesses, and there is no need for further change. The rulemaking is within the Director's rulemaking authority, and applicable rulemaking procedures were complied with.

Signed this 25th day of April 2016.

Department of Consumer and Business Services


Tashia Sample, Hearing Officer

This Summary and Recommendation are reviewed and adopted.

Signed this 25 day of April 2016.

Department of Consumer and Business Services



Laura N. Cali, Insurance Commissioner

Benefit 2017 Federal AV	Proposed 2017 Standard	Revised Proposed 2017 Standard	Option #1
	63.51%	61.97%	61.96%
Deductible	Combined Medical and Drug \$6,850	Combined Medical and Drug \$7,150	Combined Medical and Drug \$6,850
Maximum OOP	Combined Medical and Drug \$6,850	Combined Medical and Drug \$7,150	Combined Medical and Drug \$6,850
Family multiplier	2x Individual; Embedded Approach	2x Individual; Embedded Approach	2x Individual; Embedded Approach
Primary Care Visit to Treat an Injury or Illness	\$60	\$70	\$90
Specialist Visit	\$100	\$115	\$160
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0% After Deductible	0% After Deductible	0% After Deductible
Outpatient Surgery Physician/Surgical Services	0% After Deductible	0% After Deductible	0% After Deductible
Emergency Room Services	0% After Deductible	0% After Deductible	0% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	0% After Deductible	0% After Deductible	0% After Deductible
Inpatient Physician and Surgical Services	0% After Deductible	0% After Deductible	0% After Deductible
Generic Drugs	\$30	\$35	\$35
Preferred Brand Drugs	0% After Deductible	0% After Deductible	0% After Deductible
Non-Preferred Brand Drugs	0% After Deductible	0% After Deductible	0% After Deductible
Specialty Drugs	0% After Deductible	0% After Deductible	0% After Deductible
Outpatient Rehabilitation Services	0% After Deductible	0% After Deductible	0% After Deductible
Imaging (CT/PET Scans, MRIs)	0% After Deductible	0% After Deductible	0% After Deductible
Laboratory Outpatient and Professional Services	0% After Deductible	0% After Deductible	0% After Deductible
X-rays and Diagnostic Imaging	0% After Deductible	0% After Deductible	0% After Deductible

