

1 **836-010-0155 (NEW)**

2  
3 **Gender Specific Contract Language**

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

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

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

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12  
13 **(c) A person licensed or certified by the laws of this state to administer medical services or mental health services in the ordinary course of business or practice of a profession. A person grandfathered under the provisions of Section 3, chapter 674, Oregon Laws 2015 (Enrolled Senate Bill 696) shall be considered licensed or certified under this section.**

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

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27 **Stat. Auth.: ORS 731.244**

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

29 **Hist.: New.**

30  
31  
32 836-053-0002 (Amended)

33  
34 **Modification of a Health Benefit Plan Subject to Levels of Coverage Requirements**

35  
36 (1) A modification of a health benefit plan subject to the levels of coverage defined in 42 U.S.C. 18022(d) is defined in this rule for the purposes of:

37  
38  
39 (a) ORS [743.737]**743B.013**, regarding small employer health benefit plans; and

40  
41 (b) ORS [743.766]**743B.125**, regarding individual health benefit plans.

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

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1 [(3) One or more decreases or increases in the services or benefits covered in a health benefit  
2 plan are a discontinuance when the decrease or decreases, or the increase or increases, or any  
3 combination thereof, alter the level of coverage as defined in 42 U.S.C. 18022(d).]  
4

5 **(2) At the time of coverage renewal insurers may modify the coverage for a product**  
6 **offered to a group or an individual.**  
7

8 **(a) The modification must be consistent with state law and effective uniformly with that**  
9 **product.**

10 **(b) Modifications made uniformly and solely under applicable federal or state**  
11 **requirements are considered a uniform modification of coverage if:**

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

14 **(B) The modification is directly related to the imposition or modification of the federal or**  
15 **state requirement.**

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

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

20 **(B) The product offered has the same product network type;**

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

22 **(D) Within the product, each plan has the same cost sharing structure as before the**  
23 **modification, except for any variation in cost sharing solely related to changes in cost and**  
24 **utilization of medical care, or to maintain the same metal tier level described in 42 U.S.C.**  
25 **18022(d); and**

26 **(E) The product provides the same covered benefits, except for any changes in benefits that**  
27 **cumulatively impact the plan-adjusted index rate for any plan within the product within an**  
28 **allowable variation of the plus or minus two percentage points (not including changes**  
29 **required under applicable federal or state law).**

30 **(3) Insurers must:**

31 **(a) Give the individual notice of a modification to which this rule applies not later than 30**  
32 **days before the date of renewal of the plan to which the modification applies.**

33 **(b) Use either the standard notice created by Centers for Medicare and Medicaid Services**  
34 **or the standardized notice of modification or discontinuance as set forth on website for the**  
35 **Department of Consumer and Business Services at [www.insurance.oregon.gov](http://www.insurance.oregon.gov) .**  
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1  
2 Stat. Auth.: ORS 731.244, [743.566 & 743.773] 743B.127 & 743B.324  
3 Stats Implemented: ORS [743.737, 743.754 & 743.766 ]743B.013, 743B.105 and 743B.125  
4 Hist.: ID 12-2013, f. 12-31-13, cert. ef. 1-1-14  
5

6 **836-053-0004 (NEW)**

7  
8 **Compliance with Federal and State Law**

9  
10 **Upon contract issuance or renewal, any insurer offering a health benefit plan must update**  
11 **the plans of the insurer as necessary to comply with state and federal law.**

12  
13 **Stat. Auth.: ORS 731.244**

14 **Stats Implemented: ORS 742.005**

15 **Hist.:**

16  
17 836-053-0008 (Amended)

18  
19 Essential Health Benefits **for Plan Years 2014, 2015 and 2016**

20  
21 **(1) This rule applies to plan years beginning January 1, 2014 through December 31, 2016.**

22  
23 **(2) As used in the Insurance Code for plan years beginning January 1, 2014 through**  
24 **December 31, 2016 only:**

25  
26 (a) “Base benchmark health benefit plan” means the PacificSource Health Plans Preferred  
27 CoDeduct Value 3000 35 70 small group health benefit plan, including prescription drug  
28 benefits, as set forth on the [*Insurance Division*] website of the Department of Consumer and  
29 Business Services at [www.insurance.oregon.gov](http://www.insurance.oregon.gov)[;].

30  
31 (b) “Essential health benefits” means the following coverage provided in compliance with 45  
32 CFR 156:

33  
34 (A) The base-benchmark health benefit plan, excluding the 24-month waiting period for  
35 transplant benefits;

36  
37 (B) Pediatric dental benefits;

38  
39 (C) Pediatric vision benefits; and

40  
41 (D) Habilitative services.

42  
43 (c) “Habilitative benefits” means the rehabilitative services provisions of the base benchmark  
44 when the services are medically necessary for the maintenance, learning or improving skills and  
45 function for daily living.  
46

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

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

12 [(2)](3) An [*issuer of a*] **insurer that issues a health benefit** plan offering essential health  
13 benefits may not include as an essential health benefit:  
14

- 15 (a) Routine non-pediatric dental services;
- 16
- 17 (b) Routine non-pediatric eye exam services;
- 18
- 19 (c) Long-term care or custodial nursing home care benefits; or
- 20
- 21 (d) Non-medically necessary orthodontia services.  
22

23 Stat. Auth.: [*Sec. 2, Ch. 681, OL 2013*] **ORS 731.097**

24 Stats. Implemented: [*Sec. 2, Ch. 681, OL 2013*] **ORS 731.097**

25 Hist.: ID 12-2013, f. 12-31-13, cert. ef. 1-1-14  
26

27 **836-053-0012 (NEW)**  
28

29 **Essential Health Benefits for Plan Years Beginning on and after January 1, 2017**  
30

31 **(1) This rule applies to plan years beginning on and after January 1, 2017.**  
32

33 **(2) As used in the Insurance Code and OAR Chapter 836:**  
34

35 **(a) “Applied behavior analysis” has that meaning given in Section 2, chapter 771, Oregon**  
36 **Laws 2013 as amended by Section 9, chapter 674, Oregon Laws 2015.**  
37

38 **(b) “Base benchmark health benefit plan” means the PacificSource Health Plans Preferred**  
39 **CoDeduct Value 3000 35 70 small group health benefit plan, including prescription drug**  
40 **benefits, as provided in Exhibit 1 to this rule;**  
41

42 **(c) “Essential health benefits” or “EHB” means the following coverage provided in**  
43 **compliance with 45 CFR 156:**  
44

45 **(A) The base-benchmark health benefit plan with the exclusions and modifications of**  
46 **provisions of that plan as set forth in section (3) to (7) of this rule.**

1  
2 **(B) Pediatric dental benefits;**

3  
4 **(C) Pediatric vision benefits; and**

5  
6 **(D) Habilitative services and devices.**

7  
8 **(d) “Habilitative services and devices” means services and devices that help a person keep,**  
9 **learn, or improve skills and functioning for daily living (habilitative services). Examples**  
10 **include therapy for a child who is not walking or talking at the expected age. These services**  
11 **and devices must include physical and occupational therapy, speech-language pathology**  
12 **and other services and devices for people with disabilities in a variety of inpatient or**  
13 **outpatient settings.**

14  
15 **(e) “Mental or nervous condition” has that meaning given in OAR 836-053-1404.**

16  
17 **(f) “Pediatric dental benefits” means the benefits described in the Dental Plan of the**  
18 **Oregon Health Plan Children’s’ Health Insurance Plan as provided in Exhibit 2 of this**  
19 **rule. Pediatric dental benefits are payable to persons under 19 years of age.**

20  
21 **(g) “Pediatric vision benefits” means the benefits described in the vision provisions of the**  
22 **Federal Employee Dental and Vision Insurance Plan Blue Vision High Option as provided**  
23 **in Exhibit 3 of this rule. Pediatric vision benefits are payable to persons under 19 years of**  
24 **age.**

25  
26 **(h) “Treatment of a mental health condition” includes medical treatments and prescription**  
27 **drugs used to treat a mental or nervous condition.**

28  
29 **(3) The following exclusions and modifications are required supplementation to the base-**  
30 **benchmark health benefit plan:**

31  
32 **(a) The following treatment limitations and exclusions of coverage currently included in the**  
33 **base-benchmark health benefit plan are excluded:**

34  
35 **(A) The 24-month waiting period for transplant benefits;**

36  
37 **(B) Visit limits for inpatient and outpatient mental health services, including but not**  
38 **limited to habilitative and rehabilitative benefits;**

39  
40 **(C) Age limits on treatments that would otherwise be appropriate for individuals outside of**  
41 **the limited age, including but not limited to hearing aids, speech, physical and occupational**  
42 **therapy used in the treatment of mental or nervous conditions as defined in OAR 836-053-**  
43 **1404;**

1 (D) Exclusions for the treatment of erectile dysfunction or sexual dysfunction as defined in  
2 the "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition" (DSM-5) or the  
3 "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition" (DSM-IV);  
4

5 (E) Exclusions for medically necessary surgeries and procedures related to sex  
6 transformations and gender identity disorder or gender dysphoria;  
7

8 (F) Any blanket exclusion for a diagnosis made using the diagnostic criteria of the DSM-5  
9 or the DSM-IV;

10  
11 (G) Exclusions for court-order screening interviews or drug or alcohol treatment  
12 programs;

13  
14 (H) Any limitations or waiting periods for pre-existing conditions;  
15

16 (I) Time limits for treatment of jaw or teeth or orthognathic surgery; and  
17

18 (b) Dollar limits for coverage of durable medical equipment must comply with the  
19 following:

20  
21 (A) Annual dollar limits must be converted to a non-dollar actuarial equivalent.  
22

23 (B) Lifetime dollar limits must be converted to a non-dollar actuarial equivalent.  
24

25 (c) The following provisions of the base-benchmark plan must be modified:  
26

27 (A) Any waiting periods must be consistent with limitations imposed by state or federal  
28 law;

29  
30 (B) Wigs following chemotherapy or radiation therapy must be covered up to the actuarial  
31 equivalent of \$150 per calendar year;  
32

33 (C) The limitation on cosmetic or reconstructive surgery to one attempt within 18 months  
34 of injury or defect must be modified to remove these limitations in cases of medical  
35 necessity in accordance with 45 CFR 156.125(a) and to avoid discrimination based on  
36 health factors under 45 CFR 146.121;  
37

38 (D) Contraceptive coverage must comply with Centers for Medicare and Medicaid Services  
39 guidance and requirements related to contraception issued jointly by the United States  
40 Departments of Labor, Health and Human Services, and Treasury on May 11, 2015;  
41

42 (E) Provisions related to telemedical health services must reflect changes made to ORS  
43 743A.058 by chapter 340, Oregon Laws 2015 (Enrolled Senate Bill 144); and  
44

45 (F) Housing and travel expenses for transplant services are not considered essential health  
46 benefits;

1  
2 **(4) An insurer that issues a health benefit plan offering essential health benefits may not**  
3 **include as an essential health benefit:**

4  
5 **(a) Routine non-pediatric dental services;**

6  
7 **(b) Routine non-pediatric eye exam services;**

8  
9 **(c) Long-term care or custodial nursing home care benefits; or**

10  
11 **(d) Non-medically necessary orthodontia services.**

12  
13 **(5) If both a state law and federal law require coverage of the same or similar service, the**  
14 **insurer must assure that all elements of both laws are met and provide the coverage in the**  
15 **manner most beneficial to the consumer.**

16  
17 **(6) In the administration of essential health benefits and the EHB base benchmark health**  
18 **benefit plan, an insurer may not discriminate against a provider acting within the scope of**  
19 **the provider's license.**

20  
21 **(7) In the administration of essential health benefits and the EHB base benchmark health**  
22 **benefit plan an insurer may not exclude services provided by a naturopathic physician if**  
23 **the services are otherwise covered under the plan and the naturopathic physician is acting**  
24 **within the scope of the provider's license.**

25  
26 **(8) In the administration of essential health benefits and the EHB base benchmark health**  
27 **benefit plan an insurer may not exclude services provided by a doctor of chiropractic**  
28 **medicine if the services are otherwise covered under the plan and the doctor of chiropractic**  
29 **medicine is acting within the scope of the provider's license.**

30  
31 Stat. Auth.: **ORS 731.097**

32 Stats. Implemented: **ORS 731.097**

33 Hist.:

34  
35 836-053-0009 (Amended)

36  
37 Oregon Standard Bronze and Silver Health Benefit Plans **for Plan Years 2014, 2015 and 2016**

38  
39 **(1) This rule applies to plan years beginning January 1, 2014 through December 31, 2016.**

40  
41 **(2) As used in this rule, "coverage" includes medically necessary benefits, services, prescription**  
42 **drugs and medical devices. "Coverage" does not include coinsurance, copayments, deductibles,**  
43 **other cost sharing, provider networks, out-of-network coverage, wigs or administrative functions**  
44 **related to the provision of coverage, such as eligibility and medical necessity determinations.**

45  
46 **[(2)](3) For purposes of coverage required under this rule:**

1  
2 (a) “Inpatient” includes but is not limited to:

3  
4 (A) **Inpatient** surgery;

5  
6 (B) Intensive care unit, neonatal intensive care unit, maternity and skilled nursing facility  
7 services; and

8  
9 (C) Mental health and substance abuse treatment.

10  
11 (b) “Outpatient” includes but is not limited to services received from ambulatory surgery centers  
12 and physician and anesthesia services and benefits when applicable.

13  
14 (c) [*“Habilitation services” are medically necessary services for maintenance, learning or*  
15 *improving skills and function for daily living and are subject to the same cost sharing as*  
16 *rehabilitation services.*] **“Habilitative benefits” means services and devices that help a**  
17 **person keep, learn, or improve skills and functioning for daily living (habilitative services).**  
18 **Examples include therapy for a child who is not walking or talking at the expected age.**  
19 **These services and devices must include physical and occupational therapy, speech-**  
20 **language pathology and other services and devices for people with disabilities in a variety**  
21 **of inpatient or outpatient settings.**

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

27  
28 [(3)] **(4)** When offering a plan required under ORS [743.822] **743B.130**, an issuer must use the  
29 following naming convention: “[Name of Issuer] Oregon Standard [Bronze/ Silver] Plan”. *For*  
30 *example, “Acme Oregon Standard Bronze Plan”.*

31  
32 [(4)] **(5)** Coverage required under ORS [743.822] **743B.130** must be provided in accordance with  
33 the requirements of sections [(5) to (10)] **(6) to (11)** of this rule.

34  
35 [(5)] **(6)** Coverage must be provided in a manner consistent with the requirements of:

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

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

41  
42 (c) The federal **Paul Wellstone and Pete Domenici** Mental Health Parity and Addiction Equity  
43 Act of 2008;

44  
45 [(6)] **(7)** Coverage must provide essential health benefits as defined in OAR 836-053-0008.

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

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

7 (A) 11 — Office;  
8

9 (B) 12 — Patient's home;  
10

11 (C) 20 — Urgent care facility;  
12

13 (D) 22 — Outpatient hospital;  
14

15 (E) 24 — Ambulatory surgical center;  
16

17 (F) 25 — Birthing center;  
18

19 (G) 49 — Independent clinic;  
20

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

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

25 (J) 72 — Rural health clinic;  
26

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

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

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

33 (A) V20 to V20.2;  
34

35 (B) V22 to V39; and  
36

37 (C) 630-677;  
38

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

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

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

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

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

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

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

13  
14 (A) At least one drug in every United States Pharmacopeia (USP) category and class as the  
15 prescription drug coverage of the plan described in OAR [836-053-0000(1)(a)]**836-053-**  
16 **0008(1)(a)**; or

17  
18 (B) The same number of prescription drugs in each category and class as the prescription drug  
19 coverage of the plan described in OAR [836-053-0000(1)(a)]**836-053-0008(1)(a)**.

20  
21 [(8)]**(9)** Copays and coinsurance for coverage required under ORS [743.822]**743B.130** must  
22 comply with the following:

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

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

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

34  
35 [(9)]**(10)** Deductibles for coverage required under ORS [743.822]**743B.130** must comply with  
36 the following:

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

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

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

4  
5 [(10)](11) Dollar limits for coverage required under ORS [743.822] **743B.130** must comply with  
6 the following:

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

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

11  
12 Stat. Auth.: ORS [743.822] **743B.130**

13 Stats. Implemented: ORS [743.822] **743B.130**

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

15  
16 **836-053-0013 (NEW)**

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

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

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

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

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

32  
33 **(A) Inpatient surgery;**

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

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

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

42  
43 **(c) A reference to a specific version of a code or manual, including but not limited to**  
44 **references to ICD-10, CPT, Diagnostic and Statistical Manual of Mental Disorders, (DSM-**  
45 **5), Fifth Edition; place of service and diagnosis includes a reference to a code with**  
46 **equivalent coverage under the most recent version of the code or manual.**

1  
2 **(4) When offering a plan required under ORS 743B.130, an insurer must:**

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

5  
6  
7  
8 **(b) Include a service area or network identifier in the plan name if the plan is not offered on a statewide basis with a statewide network.**

9  
10  
11 **(5) Coverage required under ORS 743B.130 must be provided in accordance with the requirements of sections (6) to (11) of this rule.**

12  
13  
14 **(6) Coverage must be provided in a manner consistent with the requirements of:**

15  
16 **(a) 45 CFR 156, except that actuarial substitution of coverage within an essential health benefits category is prohibited;**

17  
18  
19 **(b) OAR 836-053-1404, 836-053-1405, 836-053-1407 and 836-053-1408; and**

20  
21 **(c) The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. 1185a and implementing regulations at 45 CFR 146.136 and 147.160;**

22  
23  
24 **(7) Coverage must provide essential health benefits as defined in OAR 836-053-0012.**

25  
26 **(8) Except when a specific benefit exclusion applies, or a claim fails to satisfy the insurer’s definition of medical necessity or fails to meet other issuer requirements the following coverage must be provided:**

27  
28  
29  
30 **(a) Ambulatory services;**

31  
32 **(b) Emergency services;**

33  
34 **(c) Hospitalization services;**

35  
36 **(d) Maternity and newborn services;**

37  
38 **(e) Rehabilitation and habilitation services including:**

39  
40 **(A) Professional physical therapy services;**

41  
42 **(B) Professional occupational therapy;**

43  
44 **(C) Physical therapy performed by an occupational therapist; and**

45  
46 **(D) Professional speech therapy;**

1  
2 **(f) Laboratory services;**

3  
4 **(g) All grade A and B United States Preventive Services Task Force preventive services,**  
5 **Bright Futures recommended medical screenings for children, Institute of Medicine**  
6 **recommended women's guidelines, and Advisory Committee on Immunization Practices**  
7 **recommended immunizations for children coverage must be provided without cost share;**  
8 **and**

9  
10 **(h) (A) Prescription drug coverage at the greater of:**

11  
12 **(i) At least one drug in every United States Pharmacopeia (USP) category and class as the**  
13 **prescription drug coverage of the plan described in OAR 836-053-0012(2); or**

14  
15 **(ii) The same number of prescription drugs in each category and class as the prescription**  
16 **drug coverage of the plan described in OAR 836-053-0012(2).**

17  
18 **(B) Insurers must submit the formulary drug list for review and approval. The formulary**  
19 **drug list must comply with filing requirements posted on the Department of Consumer and**  
20 **Business Services website.**

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

24  
25 **(9) Copays and coinsurance for coverage required under ORS 743B.130 must comply with**  
26 **the following:**

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

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

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

38  
39 **(10) Deductibles for coverage required under ORS 743B.130 must comply with the**  
40 **following:**

41  
42 **(a) For a bronze plan, in accordance with the coinsurance, copayment and deductible**  
43 **amounts and coverage requirements for a bronze plan set forth in the cost-sharing matrix**  
44 **as provided in Exhibit 1 to this rule.**

1 **(b) For a silver plan, in accordance with the coinsurance, copayment and deductible**  
2 **amounts and coverage requirements for a silver plan set forth in the cost-sharing matrix as**  
3 **provided in Exhibit 2 to this rule.**

4  
5 **(c) The individual deductible applies to all enrollees, and the family deductible applies**  
6 **when multiple family members incur claims.**

7  
8 **(11) Dollar limits for coverage required under ORS 743B.130 must comply with the**  
9 **following:**

10  
11 **(a) Annual dollar limits must be converted to a non-dollar actuarial equivalent.**

12  
13 **(b) Lifetime dollar limits must be converted to a non-dollar actuarial equivalent.**

14  
15 **Stat. Auth.: ORS 743B.130**

16 **Stats. Implemented: ORS 743B.130**

17 **Hist.:**

18  
19 836-053-1020 (Amended)

20  
21 Drug Formularies

22  
23 (1) For purposes of OAR 836-053-0000 to 836-053-1200:

24  
25 (a) "Open formulary" means a method used by an insurer to provide prescription drug benefits in  
26 which all prescribed FDA approved prescription drug products are covered except for any drug  
27 product that is excluded by the insurer pursuant to the insurer's policy regarding medical  
28 appropriateness or by the terms of a specific health benefit plan, or except for an entire class of  
29 drug product that is excluded by the insurer.

30  
31 (b) "Closed formulary" means a method used by an insurer to provide prescription drug benefits  
32 in which only specified FDA approved prescription drug products are covered, as determined by  
33 the insurer, but in which medical exceptions are allowed. Maximum benefits or coverage may be  
34 limited to formulary drugs in a health benefit plan with a closed formulary. [*; and*]

35  
36 (c) "Mandatory closed formulary" means a method used by an insurer to provide prescription  
37 drug benefits in which only specified FDA approved prescription drug products are covered, as  
38 determined by the insurer, and in which no exceptions are allowed.

39  
40 (2) An insurer that uses an open formulary must have a written procedure that includes the  
41 written criteria or explains the review process established by the insurer for determining when an  
42 item will be limited or excluded pursuant to the insurer's policy regarding medical  
43 appropriateness.

44  
45 (3) An insurer that uses a closed formulary must have a written procedure stating that FDA  
46 approved prescription drug products are covered only if they are listed in the formulary. The

1 procedure must also describe how the insurer determines the content of the closed formulary and  
2 how the insurer determines the application of a medical exception. The procedure must describe  
3 how a provider may request inclusion of a new item in the closed formulary and must ensure that  
4 the insurer will issue a timely written response to a provider making such a request.

5  
6 (4) An insurer that uses a mandatory closed formulary must have a written procedure stating that  
7 FDA approved prescription drug products are covered only if they are listed in the formulary and  
8 that no exception is allowed. The procedure must describe how the insurer determines the  
9 content of the mandatory closed formulary. The procedure must also describe how a provider  
10 may request inclusion of a new item in the formulary and must ensure that the insurer will issue a  
11 timely written response to a provider making such a request.

12  
13 (5) An insurer must furnish a copy of the procedures it has adopted under section (2), (3) or (4)  
14 of this rule to a provider with authority to prescribe drugs and medications, upon the request of  
15 the provider.

16  
17 (6) Except as provided in section (7) of this rule, a formulary must comply with the requirements  
18 of 45 CFR 156.122 and include the greater of:

19  
20 (a) At least one drug in every United States Pharmacopeia therapeutic category and class; or

21  
22 (b) The same number of drugs in each United States Pharmacopeia category and class as the  
23 prescription drug benefit of the plan described in OAR 836-053-0008(1)(a).

24  
25 (7) An insurer that issues a small group or individual health benefit plan formulary that does not  
26 comply with the requirements of section (6) of this rule must file with the Director of the  
27 Department of Consumer and Business Services the form entitled “Formulary-Inadequate  
28 Category/Class Count Justification” as set forth on the website of the [*Insurance Division of the*]  
29 Department of Consumer and Business Services at [www.insurance.oregon.gov](http://www.insurance.oregon.gov). The director, **in**  
30 **the director’s discretion**, may **consider** [*approve*]**approval of** a formulary that does not meet  
31 the requirements of section **(5)** [(6)] of this rule if:

32  
33 (a) Drugs in a category or class have been discontinued by the manufacturer;

34  
35 (b) Drugs in a category or class have been deemed unsafe by the Food and Drug Administration  
36 or removed from market by the manufacturer due to safety concerns;

37  
38 (c) Drugs in a category of class have a Drug Efficacy Study Implementation classification;

39  
40 (d) Drugs in a category or class have become available as generics; or

41  
42 (e) Drugs in a category or class are provided in a medical setting and are covered under the  
43 medical provisions of the plan.

1 **(8) An insurer that issues a small group or individual health benefit plan formulary does**  
2 **not comply with the nondiscrimination requirements of OAR 836-053-0012 if most or all**  
3 **drugs to treat a specific condition are placed in the highest cost tier.**

4  
5 **(9) A health benefit plan providing essential health benefits must have procedures in place**  
6 **that allow an enrollee to request and gain access to clinically appropriate prescription**  
7 **drugs not covered by the health plan.**

8  
9 **(10) An insurer may file a Bronze or Silver standard plan that substitutes a different**  
10 **prescription drug benefit from the prescription drug benefit described in the benchmark**  
11 **plan, provided that the insurer demonstrates that its proposed benefit complies with the**  
12 **prescription drug formulary requirements and will have a Bronze or Silver actuarial value.**

13  
14 Stat. Auth.: ORS 731.244 & [sec. 2, ch.681, OL 2013] **ORS 731.097**

15 Stats. Implemented: ORS 743.804 & [sec. 2, ch. 681, OL 2013] **ORS 731.097**

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

17  
18 **Coverage of Mental or Nervous Conditions; Mental Health Parity (New Heading)**

19  
20 836-053-1404 (Amended)

21  
22 Definitions; Noncontracting Providers; Co-Morbidity Disorders

23  
24 (1) As used in ORS 743A.168[, *this rule and OAR 836-053-1405 to 836-053-1408*] **and OAR**  
25 **Chapter 836:**

26  
27 (a) "Mental or nervous conditions" means any mental disorder covered by diagnostic categories  
28 listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth  
29 Edition" (DSM-IV) or the "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition"  
30 (DSM-5).

31  
32 (b) "Chemical dependency" means an addictive relationship with any drug or alcohol  
33 characterized by a physical or psychological relationship, or both, that interferes on a recurring  
34 basis with an individual's social, psychological or physical adjustment to common problems.

35  
36 (c) "Chemical dependency" does not mean an addiction to, or dependency on:

37  
38 (A) Tobacco;

39  
40 (B) Tobacco products; or

41  
42 (C) Foods.

43  
44 (2) A non-contracting provider must cooperate with a group health insurer's requirements for  
45 review of treatment in ORS 743A.168(10) and (11) to the same extent as a contracting provider  
46 in order to be eligible for reimbursement.

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

5  
6 Stat. Auth.: ORS 731.244 & 743A.168

7 Stats. Implemented: ORS 743A.168

8 Hist.: ID 13-2006, f. 7-14-06 cert. ef. 1-1-07; ID 19-2012(Temp), f. & cert. ef. 12-20-12 thru 6-  
9 17-13; ID 3-2013, f. 6-10-13, cert. ef. 6-17-13; ID 19-2014(Temp), f. & cert. ef. 11-14-14 thru 5-  
10 12-15; ID 3-2015, f. & cert. ef. 5-12-15

11  
12 836-053-1405 (Amended)

13  
14 General Requirements for Coverage of Mental or Nervous Conditions and Chemical  
15 Dependency

16  
17 (1) A group health insurance policy issued or renewed in this state shall provide coverage or  
18 reimbursement for medically necessary treatment of mental or nervous conditions and chemical  
19 dependency, including alcoholism, at the same level as, and subject to limitations no more  
20 restrictive than those imposed on coverage or reimbursement for medically necessary treatment  
21 for other medical conditions.

22  
23 (2) For the purposes of ORS 743A.168, the following standards apply in determining whether  
24 coverage for expenses arising from treatment for chemical dependency, including alcoholism,  
25 and for mental or nervous conditions is provided at the same level as, and subject to limitations  
26 no more restrictive than, those imposed on coverage or reimbursement of expenses arising from  
27 treatment for other medical conditions:

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

34  
35 (b) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not  
36 limited to, deductibles for wellness and preventive services for mental or nervous conditions and  
37 chemical dependency, including alcoholism, may be no more than the co-payment or  
38 coinsurance, or other cost sharing, including, but not limited to, deductibles for wellness and  
39 preventive services otherwise provided under the health insurance policy.

40  
41 (c) **If annual or lifetime limits apply for treatment of mental or nervous conditions and chemical**  
42 **dependency, including alcoholism, [ may be no less than the annual or lifetime limits for medical**  
43 **and surgical services otherwise provided under the health insurance policy] the limits must**  
44 **comply with the “predominately equal” to and “substantially all” tests the federal Paul**  
45 **Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C.**  
46 **1185a and implementing regulations at 45 CFR 146.136 and 147.160.**

1  
2 (d) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not  
3 limited to, deductibles expenses for prescription drugs intended to treat mental or nervous  
4 conditions and chemical dependency, including alcoholism, may be no more than the co-  
5 payment or coinsurance, or other cost sharing expenses for prescription drugs prescribed for  
6 other medical services provided under the health insurance policy.  
7

8 (e) Classification of prescription drugs into open, closed, or tiered drug benefit formularies, for  
9 drugs intended to treat mental or nervous conditions and chemical dependency, including  
10 alcoholism, must be by the same process as drug selection for formulary status applied for drugs  
11 intended to treat other medical conditions, regardless of whether such drugs are intended to treat  
12 mental or nervous conditions, chemical dependency, including alcoholism, or other medical  
13 conditions.  
14

15 (3) A group health insurance policy issued or renewed in this state must contain a single  
16 definition of medical necessity that applies uniformly to all medical, mental or nervous  
17 conditions, and chemical dependency, including alcoholism.  
18

19 (4) A group health insurer that issues or renews a group health insurance policy in this state shall  
20 have policies and procedures in place to ensure uniform application of the policy's definition of  
21 medical necessity to all medical, mental or nervous conditions, and chemical dependency,  
22 including alcoholism.  
23

24 (5) Coverage for expenses arising from treatment for mental or nervous conditions and chemical  
25 dependency, including alcoholism, may be managed through common methods designed to limit  
26 eligible expenses to treatment that is medically necessary only if similar limitations or  
27 requirements are imposed on coverage for expenses arising from other medical condition.  
28 Common methods include, but are not limited to, selectively contracted panels, health policy  
29 benefit differential designs, preadmission screening, prior authorization of services, case  
30 management, utilization review, or other mechanisms designed to limit eligible expenses to  
31 treatment that is medically necessary.  
32

33 *[(6) Coverage of mental or nervous conditions and chemical dependency, including alcoholism,*  
34 *may be limited for in-home services.]*  
35

36 ~~(6)~~[(7)] Nothing in this rule prevents a group health insurance policy from providing coverage  
37 for conditions or [*disorder*]**disorders** excepted under the definition of "mental or nervous  
38 condition" in OAR [*836-053-1400*]**836-053-1404**.  
39

40 ~~(7)~~[(8)] The Director shall review OAR [*836-053-1400 and this rule*]**836-053-1404 to 836-053-**  
41 **1408** and any other materials [*within two years of the rules' effective date*]**every two years** to  
42 determine whether the requirements set forth in the rules are uniformly applied to all medical,  
43 mental or nervous conditions, and chemical dependency, including alcoholism.  
44

45 Stat. Auth.: ORS 731.244 & 743A.168

46 Stats. Implemented: ORS 743A.168

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

3  
4 **836-053-0010 (Amend and Renumber to 836-053-0019)**

5  
6 Purpose; Statutory Authority; Enforcement

7  
8 (1) OAR 836-053-0010 to 836-053-0070 are adopted for the purpose of implementing ORS  
9 [743.730 to 743.745]**743B.003 to 743B.013 and 743B.100**, pursuant to the authority of ORS  
10 731.244 [and 743.730 to 743.745], **743B.003 to 743B.013 and 743B.100**.

11  
12 (2) Violation of any provision of OAR 836-053-0021 to 836-053-0065 is an unfair trade practice  
13 under ORS 746.240.

14  
15 Stat. Auth.: ORS 731.244, [743.731(4)]**743B.003** & 746.240

16 Stats. Implemented: ORS [743.730 et seq] **743B.003 to 743B.013 and 743B.100**.

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

19  
20 Cost Estimates

21  
22 **836-053-1406 (Amend and renumber to 836-053-1409)**

23  
24 Definitions

25  
26 (1) As used in ORS [743.874 and 743.876]**743B.281 and 743B.282**, “provider” means a person  
27 licensed, certified or otherwise authorized or permitted by laws of this state to administer  
28 medical or mental health services in the practice of a profession.

29  
30 (2) As used in ORS [743.876]**743B.282**, for the purpose of an insurer’s procedure for providing  
31 an estimate of an enrollee’s costs for a covered out-of-network procedure or service:

32  
33 (a) The “allowable charge” for a covered procedure or service is the estimated amount  
34 established under the insurance policy, whether expressed as an “allowable charge,” “allowable  
35 expense,” “eligible fee” or other term denoting the amount on which the benefit is calculated.

36  
37 (b) The “billed charge” is the estimated amount charged by a provider for performance of a  
38 procedure or service.

39  
40 Stat. Auth.: ORS 731.244 & [743.893] **743B.285**

41 Stats. Implemented: ORS [743.874 & 743.876] **743B.281 & 743B.282**

42 Hist.: ID 16-2008, f. & cert. ef. 9-24-08