836-010-0155 (NEW)

Gender Specific Contract Language

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

(a) A physician as defined in ORS 677.010.

(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.

(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.

(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.

Stat. Auth.: ORS 731.244
Stats Implemented: ORS 743A.066, 743A.080, 743A.100, 743A.104, 743A.105, 743A.108, 743A.110 and 743A.120
Hist.: New.

836-053-0002 (Amended)

Modification of a Health Benefit Plan Subject to Levels of Coverage Requirements

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

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

(b) ORS [*743.766*]**743B.125**, regarding individual health benefit plans.
[*(2) One or more decreases or increases in the services or benefits covered in a health benefit plan are a modification and not a discontinuance when the decrease or decreases, or the increase or increases, or any combination thereof, occur at the time of renewal and the change or changes together do not alter the level of coverage as defined in 42 U.S.C. 18022(d).*]

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

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

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

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

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

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

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

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

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

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

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

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

(3) Insurers must:

(a) Give the individual notice of a modification to which this rule applies not later than 30 days before the date of renewal of the plan to which the modification applies.
(b) Use either the standard notice created by Centers for Medicare and Medicaid Services or the standardized notice of modification or discontinuance as set forth on website for the Department of Consumer and Business Services at www.insurance.oregon.gov .

Stat. Auth.: ORS 731.244, [*743.566 & 743.773*] **743B.127 & 743B.324**
Stats Implemented: ORS [*743.737, 743.754 & 743.766*]**743B.013, 743B.105 and 743B.125**
Hist.: ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

836-053-0004 (NEW)

Compliance with Federal and State Law

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

Stat. Auth.: ORS 731.244
Stats Implemented: ORS 742.005
Hist.:

836-053-0008 (Amended)

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

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

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

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

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

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

(B) Pediatric dental benefits;

(C) Pediatric vision benefits; and

(D) Habilitative services.

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

(d) "Pediatric dental benefits" means the benefits described in the children's dental provisions of the State Children's Health Insurance Plan as set forth on the [*Insurance Division*] website of the Department of Consumer and Business Services at www.insurance.oregon.gov. Pediatric dental benefits are payable to persons under 19 years of age.

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

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

(a) Routine non-pediatric dental services;

(b) Routine non-pediatric eye exam services;

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

(d) Non-medically necessary orthodontia services.

Stat. Auth.: [*Sec. 2, Ch. 681, OL 2013*] **ORS 731.097**
Stats. Implemented: [*Sec. 2, Ch. 681, OL 2013*] **ORS 731.097**
Hist.: ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

836-053-0012 (NEW)

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

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

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

(a) "Applied behavior analysis" has that meaning given in Section 2, chapter 771, Oregon Laws 2013 as amended by Section 9, chapter 674, Oregon Laws 2015.

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

(c) "Essential health benefits" or "EHB" means the following coverage provided in compliance with 45 CFR 156:

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

(B) Pediatric dental benefits;

(C) Pediatric vision benefits; and

(D) Habilitative services and devices.

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

(e) "Mental or nervous condition" has that meaning given in OAR 836-053-1404.

(f) "Pediatric dental benefits" means the benefits described in the Dental Plan of the Oregon Health Plan Children's' Health Insurance Plan as provided in Exhibit 2 of this rule. Pediatric dental benefits are payable to persons under 19 years of age.

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

(h) "Treatment of a mental health condition" includes medical treatments and prescription drugs used to treat a mental or nervous condition.

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

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

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

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

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

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;

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

(a) Routine non-pediatric dental services;

(b) Routine non-pediatric eye exam services;

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

(d) Non-medically necessary orthodontia services.

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

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

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

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

Stat. Auth.: **ORS 731.097**
Stats. Implemented: **ORS 731.097**
Hist.:

836-053-0009 (Amended)

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

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

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

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

(a) "Inpatient" includes but is not limited to:

(A) **Inpatient** surgery;

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

(C) Mental health and substance abuse treatment.

(b) "Outpatient" includes but is not limited to services received from ambulatory surgery centers and physician and anesthesia services and benefits when applicable.

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

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

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

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

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

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

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

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

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

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

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

(A) 11 — Office;

(B) 12 — Patient's home;

(C) 20 — Urgent care facility;

(D) 22 — Outpatient hospital;

(E) 24 — Ambulatory surgical center;

(F) 25 — Birthing center;

(G) 49 — Independent clinic;

(H) 50 — Federally qualified health center;

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

(J) 72 — Rural health clinic;

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

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

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

(A) V20 to V20.2;

(B) V22 to V39; and

(C) 630-677;

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

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

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

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

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

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

(h) Prescription drug coverage at the greater of:

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

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

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

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

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS [*743.822*] **743B.130**
Stats. Implemented: ORS [*743.822*] **743B.130**
Hist.: ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

836-053-0013 (NEW)

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

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

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

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

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

(A) Inpatient surgery;

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

(C) Mental health and substance abuse treatment.

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

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

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

(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.

(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.

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

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

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

(b) OAR 836-053-1404, 836-053-1405, 836-053-1407 and 836-053-1408; and

(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;

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

(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:

(a) Ambulatory services;

(b) Emergency services;

(c) Hospitalization services;

(d) Maternity and newborn services;

(e) Rehabilitation and habilitation services including:

(A) Professional physical therapy services;

(B) Professional occupational therapy;

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

(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.**
45

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

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

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

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

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

Stat. Auth.: ORS 743B.130
Stats. Implemented: ORS 743B.130
Hist.:

836-053-1020 (Amended)

Drug Formularies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 731.244 & [*sec. 2, ch.681, OL 2013*] **ORS 731.097**
Stats. Implemented: ORS 743.804 & [*sec. 2, ch. 681, OL 2013*] **ORS 731.097**
Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 12-2013, f. 12-31-13, cert. ef. 1-1-14

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

836-053-1404 (Amended)

Definitions; Noncontracting Providers; Co-Morbidity Disorders

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

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

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

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

(A) Tobacco;

(B) Tobacco products; or

(C) Foods.

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

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

Stat. Auth.: ORS 731.244 & 743A.168
Stats. Implemented: ORS 743A.168
Hist.: ID 13-2006, f. 7-14-06 cert. ef. 1-1-07; ID 19-2012(Temp), f. & cert. ef. 12-20-12 thru 6-17-13; ID 3-2013, f. 6-10-13, cert. ef. 6-17-13; ID 19-2014(Temp), f. & cert. ef. 11-14-14 thru 5-12-15; ID 3-2015, f. & cert. ef. 5-12-15

836-053-1405 (Amended)

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

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

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

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

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

(c) **If** annual or lifetime limits **apply** for treatment of mental or nervous conditions and chemical dependency, including alcoholism,[*may be no less than the annual or lifetime limits for medical and surgical services otherwise provided under the health insurance policy*] **the limits must comply with the "predominately equal" to and "substantially all" tests 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**.

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 731.244 & 743A.168
Stats. Implemented: ORS 743A.168

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

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

Purpose; Statutory Authority; Enforcement

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

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

Stat. Auth.: ORS 731.244, [*743.731(4)*]**743B.003** & 746.240
Stats. Implemented: ORS [*743.730 et seq*] **743B.003 to 743B.013 and 743B.100**.
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. & cert. ef. 3-9-98

Cost Estimates

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

Definitions

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

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

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

(b) The "billed charge" is the estimated amount charged by a provider for performance of a procedure or service.

Stat. Auth.: ORS 731.244 & [*743.893*] **743B.285**
Stats. Implemented: ORS [*743.874 & 743.876*] **743B.281 & 743B.282**
Hist.: ID 16-2008, f. & cert. ef. 9-24-08