

**INDIVIDUAL AND SMALL GROUP
PRODUCT STANDARD UPDATES**
OREGON INSURANCE DIVISION - MARCH 2014

UPDATES THAT APPLY TO BOTH INDIVIDUAL AND SMALL GROUP

OREGON INSURANCE DIVISION - MARCH 2014

GENERAL UPDATES

- Completely revamped both product standards for the 2015 filing season.
- General editing and housekeeping.
- Reorganized data.
- Changed a lot of page/paragraph answer fields to checkboxes or added N/A boxes as appropriate.
- Updated all hyperlinks to match our new website.
- Added hyperlinks to referenced forms and exhibits.
- Reorganized sections in alphabetical order by category.
- Incorporated Affordable Care Act (ACA) updates that were formerly at the end of the product standards within the standards alphabetically.

GENERAL UPDATES

- Removed repealed rules, statutes, and items that didn't apply to that market.
- Updated many of the text to the standards to match the language in rule or statute.
- Added Health Care Service Contractor exemption asterisks as needed.
- Updated statute or rule numbers as needed.
- **Updated recently-renumbered statutes:**
 - All ORS 743.730 Definitions references were updated per House Bill 2240 (2013) changes.
 - Emergency eye care services was updated from ORS 743.842 to mandate number ORS 743A.250.
 - Craniofacial anomalies treatment mandate (House Bill 4128 (2012)) was given a mandate number, ORS 743A.150.

GENERAL REQUIREMENTS SECTION

- **New standard for issuers to include the contact information of two people in your company that are able to discuss this filing.**
 - Last year, it was sometimes difficult to get in contact with someone that understood the filing (for both form and binder filings).
 - We sometimes found that what was entered on the Companies and Contact tab in SERFF was outdated information. Unfortunately, this information cannot be changed on the filing itself once it is submitted to us. Also, if the carrier does change the information during the filing, we can't see changes made to this information.
 - Cover letters are easy to update as appropriate or if filers change in the middle of a filing review.

GENERAL FORMS REQUIREMENTS SECTION

New standard that requires small and large group filings to be submitted in separate filings.

- Last year, combined filings were incredibly difficult to review because they're under such different standards.
- This will create much faster and easier review for the health analysts.

Revised and expanded the **Variability in forms** section.

- Will address this in detail during the “Variability in forms” presentation later today.

POLICY PROVISIONS SECTION

House Bill 2240 statute updates:

Many of the updates in House Bill 2240 were removing references to the small employer basic plan and portability plans. Will not be calling those changes out here.

ORS 743.730 Definitions

- Updated definition of preexisting condition exclusion to include all ages, not just under age 19. (26)

ORS 743.731 Purposes

- Updated to prohibit use of preexisting condition exclusions except in grandfathered health plans. (4)

POLICY PROVISIONS SECTION

House Bill 2240 statute updates:

ORS 743.822 Requirement to offer bronze and silver plans; rules.

- Updated to in each individual or small group market, in which a carrier offers a health benefit inside or outside of the exchange, the carrier must offer to residents of this state approved bronze and silver plans. (1)

ORS 746.045 Prohibition on rebates; exceptions; rules

- Added that a premium discount or rebate is not prohibited by this section if the discount or rebate is:
 - Offered in connection with a program of health promotion or disease prevention, as described in 42 U.S.C. 300gg-4;
 - Paid for participation in a program to promote healthy behaviors under ORS 743.824; or
 - Offered in connection with a wellness program defined by the Department of Consumer and Business Services by rule.

POLICY PROVISIONS SECTION

House Bill 2240 mandate updates:

Natural and adopted children (ORS 743A.090)

- Removed language that limited prohibition of pre-existing conditions to only those under 19.

Clinical trials (ORS 743A.192 and PHSA 2709)

- Updated language to better align with federal mandate.
- Added may not exclude, limit, or impose additional conditions on the coverage of routine costs of items and services in connection with participation of a clinical trial.
- Added may not include provisions that discriminate against an individual on the basis of the individual's participation in an approved clinical trial.
- Issuers should follow both Oregon and federal mandates.
- Federal mandate limits approved clinical trials to “prevention, detection, or treatment of cancer or other life-threatening condition or disease” but Oregon mandate does not limit to just those items.
- Now mandate will not be automatically repealed. (6) Any mandate with the text: “This section is exempt from ORS 743A.001.” will not be automatically repealed.

POLICY PROVISIONS SECTION

House Bill 2240 new rule:

OAR 836-053-0008 Essential Health Benefits (EHB)

- Defines Oregon's EHBs.
- Transplants are no longer allowed to have a 24 month waiting period. (1)(b)(A)
- Pediatric dental benefits are benefits from the state's CHIP plan.
- Pediatric vision benefits the vision provisions of the Federal Employee Dental and Vision Insurance Plan Blue Vision High Option.
- **Benefits that are not allowed to be EHBs:**
 - Routine non-pediatric dental services;
 - Routine non-pediatric eye exam services;
 - Long-term care or custodial nursing home care benefits; or
 - Non-medically necessary orthodontia services.

POLICY PROVISIONS SECTION

House Bill 2240 new rule:

OAR 836-053-0009 Oregon Standard Bronze and Silver Health Benefit Plans

- Defines Oregon's standard plan.
- Coverage does not include cost sharing, out-of-network coverage, wigs, or administrative functions. (1)
- When offering a plan required under ORS 743.822, an issuer must use the following naming convention: "[Name of Issuer] Oregon Standard [Bronze/Silver] Plan". For example, "Acme Oregon Standard Bronze Plan". (3)
- Actuarial substitution of coverage within an essential health benefits category is prohibited. (4)(a)
- Copays and coinsurance for coverage required under ORS 743.822 must comply with the following: (8)
 - 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.
 - Subject to the 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.
 - Coinsurance for emergency room coverage must be waived if a patient is admitted. If a patient is admitted, inpatient coinsurance applies.

POLICY PROVISIONS SECTION

House Bill 2240 new rule:

OAR 836-053-0009 Oregon Standard Bronze and Silver Health Benefit Plans

- Deductibles for coverage required under ORS 743.822 must comply with the following: (9)
 - For a bronze plan, in accordance with the coinsurance, copayment and deductible amounts and coverage requirements for a bronze plan set forth in the Senate Bill 91 exhibit. The bronze plan deductible must be integrated applicable to prescription drugs and all services except preventive services.
 - For a silver plan, in accordance with the coinsurance, copayment and deductible amounts and coverage requirements for a silver plan set forth in the Senate Bill 91 exhibit. The silver plan deductible applies to all services except preventive services, office visits, urgent care, and prescription drugs.
- Dollar limits for coverage required under ORS 743.822 must comply with the following: (10)
 - Annual dollar limits must be converted to a non-dollar actuarial equivalent.
 - Lifetime dollar limits must be converted to a non-dollar actuarial equivalent.

POLICY PROVISIONS SECTION

House Bill 2240 rule updates:

Several rules included updates in the Oregon Insurance Division's website or contact information. Will not be calling these out here.

OAR 836-020-0785 Rules for Coordination of Benefits (COB)

- Clarification on COB for a dependent child who has coverage under a parent's plan and also has dependent coverage under a spouse's plan.

POLICY PROVISIONS SECTION

House Bill 2240 rule updates:

OAR 836-053-1020 Drug Formularies

- Added requirement that a formulary must comply with the requirements of 45 CFR 156.22 and if the formulary doesn't meet the requirements, a specific form justifying this should be included in the binder filing. (6),(7)

OAR 836-053-1030 Written Information to Enrollees

- Updated outdated statute references.
- Added insurers must include a notice, with the information required by ORS 743.804, that discloses additional information is available to enrollees upon request. The notice must also include DCBS consumer advocacy contact information and that additional information is available from DCBS. (12)

OAR 836-080-0050 and OAR 836-080-0055 Unfair Discrimination Identified

- Added “sexual orientation” to the list of unfair discrimination distinctions.

POLICY PROVISIONS SECTION

New mandate:

ORS 743A.082 Diabetes management for pregnant women

- Created under House Bill 2432 (2013 session) and amended under Senate Bill 1562 (2014 session).
- A health benefit plan may not require a copayment or impose a coinsurance requirement or a deductible on the covered health services, medications, and supplies that are medically necessary for a woman to manage her diabetes during the period of each pregnancy, beginning with conception and ending six weeks postpartum.
- This coverage may be limited by network and formulary restrictions that apply to other benefits under the plan.
- An insurer may require an enrollee or the enrollee's health care provider to notify the insurer orally, in a timely manner, that the enrollee is diabetic and is pregnant or has given birth and is within six weeks postpartum.

POLICY PROVISIONS SECTION

Updated statutes from other bills of the 2013 legislative session:

- **Court ordered screening (House Bill 2385)**
 - Updated mandate ORS 743A.168 (Mental health/chemical dependency).
 - Removed formerly-allowed exclusion for screening interview or treatment programs.
- **Ambulance payments (House Bill 2969)**
 - Updated mandate ORS 743A.014 (Ambulance payments).
 - Used to say that payments will be made jointly to the provider and the insured.
 - Updated language to “the insurer shall indemnify directly the provider of the ambulance care and transportation”.
- **Services provided by certified nurse practitioner or licensed physician assistant (House Bill 2902)**
 - Updated mandate ORS 743A.036.
 - Relating to equal pay for health practitioners.
 - Updated language to add “licensed physician assistant” to be reimbursed the same as licensed physicians are when performing the same service.

POLICY PROVISIONS SECTION

Added information that dollar limits on essential health benefits must be converted to a non-dollar actuarial equivalent on the following **items**:

- ORS 743A.141 Hearing aids
- ORS 743A.185 Tobacco use cessation
- OAR 836-053-0008(1)(b)(C) Pediatric vision

POLICY PROVISIONS SECTION

New standards:

- **Same sex married couples validly married in other states (OAR 105-010-0018)**
 - Oregon recognizes the marriages of same-sex couples validly performed in other jurisdictions to the same extent that they recognize other marriages validly performed in other jurisdictions. In addition, same-sex married couples validly married in other states now qualify as spouses under COBRA and state continuation.
- **Gender Identity Disorders (ORS 742.005, ORS 746.015, Bulletin 2012-01)**
 - Bulletin 2012-1 was issued in December 2012.
 - Health insurance plans cannot discriminate against people on the basis that the treatment is for gender identity issues. Health insurers must cover medically necessary treatments related to gender identity disorder if those same treatments are covered for other conditions.
- **Inducements not specified in policy (ORS 746.035)**
 - Not a new statute.
 - Seeing issues with inducements in other health lines and will be adding this standard to all health product standards.

POLICY PROVISIONS SECTION

New standards, continued:

- **Tobacco use definition (45 CFR 147.102)**
 - Added from federal statute.
 - Tobacco use is defined as use of tobacco on average four or more times per week within no longer than the past six months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

Updated standards:

- **Domestic partners (Oregon Family Fairness Act (ORS 106.300 to 106.340))**
 - Statute has not changed.
 - Updated statute references that were incorrect.
 - Matched text more with statute.

ADDITIONAL UPDATES TO INDIVIDUAL STANDARDS

OREGON INSURANCE DIVISION - MARCH 2014

POLICY PROVISIONS SECTION (INDIVIDUAL)

House Bill 2240 statute updates:

ORS 743.405 General requirements for health insurance policies

- Updated that the policy must include a statement of the entire money and other considerations due. (1)
- Updated that the policy must state the time at which the insurance takes effect and terminates. (2)

ORS 743.730 Definitions

- Updated definition of individual health benefit plan. Now includes individual coverage through a trust, association, or similar group. (20)

ORS 743.751 Use of health-related information

- Added for nongrandfathered plans, a carrier may require an applicant to provide health-related information solely for health care management and may not deny coverage based on this information. (1)
- If the carrier requires applicant to provide health information, the carrier must notify the applicant that the information may not be used to deny coverage. (2)

POLICY PROVISIONS SECTION (INDIVIDUAL)

House Bill 2240 statute updates:

ORS 743.766 Individual health benefit plans; waiting or exclusion periods; preexisting condition exclusions; essential health benefits.

- A carrier may not impose an individual coverage waiting period that exceeds 90 days. (1)(a)
- A carrier may impose an exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan. (1)(b)
- Nongrandfathered plans must cover, at a minimum, all essential health benefits. (3)

POLICY PROVISIONS SECTION (INDIVIDUAL)

House Bill 2240 rule updates:

OAR 836-020-0770 Authority, Purpose and Effective Date of OAR 836-020-0770 to 836-020-0806 (Coordination of Benefits Provisions)

- Removed references to repealed statute ORS 743.749.
- Removed references to group and blanket insurance, so individual is now included.

OAR 836-020-0775 Definitions

- Individual insurance was added to the definition of “Plan”.

POLICY PROVISIONS SECTION (INDIVIDUAL)

House Bill 2240 rule updates:

OAR 836-053-0510 Evaluating the Health Status of an Applicant for Individual Health Benefit Plan Coverage

- Oregon Standard Health Statement may only be used for grandfathered plans.
- A carrier may require a nongrandfathered-plan applicant to provide health-related information for the sole purpose of health care management.
- If collecting health-related information before enrollment, a carrier must prominently state:
 - Health-related information will be used solely for health care management purposes.
 - The applicant's coverage cannot and will not be denied, terminated, delayed, limited, or rescinded based on the applicant's responses or failure to respond to the questions.
 - The premium charged cannot and will not change based on applicant responses or failure to respond to questions.
- A carrier must:
 - Limit pre-enrollment health-related questions to whether an applicant:
 - Has a disability or chronic health condition.
 - Has been advised by a licensed medical professional in the 12 months before application that hospitalization, surgery, or treatment is necessary or pending.
 - Is pregnant.

POLICY PROVISIONS SECTION (INDIVIDUAL)

House Bill 2240 new rules:

OAR 836-053-0431 Underwriting, Enrollment and Benefit Design

- A carrier must offer all of its approved nongrandfathered individual health benefit plans and plan options, including individual plans offered through associations, to all individuals eligible for such plans on a guaranteed issue basis without regard to health status, age, immigration status or lawful presence in the United States. (1)
- For individual health benefit plans approved by October 1 of each calendar year for sale in the following calendar year, a carrier may limit enrollment to:
 - November 15, 2014 through January 15, 2015 for coverage effective in 2015; and
 - October 15 to December 7 of each preceding calendar year for coverage effective on or after January 1, 2016; and (1)(a)
 - Coverage must be effective consistent with the dates described in 45 CFR 155.410(c) and (f). (1)(b)

POLICY PROVISIONS SECTION (INDIVIDUAL)

House Bill 2240 new rules:

OAR 836-053-0431 Underwriting, Enrollment and Benefit Design (continued)

- A carrier **must deny** enrollment under the following circumstances:
 - To an individual who is not lawfully present in the United States in a plan provided through the exchange.
 - To an individual entitled to benefits under a Medicare plan under part A or B or a Medicare Choice or Medicare Advantage plan described in 42 USC 1395W-21, *if and only if the individual is enrolled in such a plan.* (2)(a)
- A carrier must enroll an individual who, within 60 days before application for coverage with the carrier:
 - Loses minimum essential coverage.
 - Gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or foster care. The effective date for coverage for enrollment under this paragraph must be:
 - In the case of marriage, no later than the first day of the first calendar month following the date the carrier receives the request for special enrollment.
 - In the case of birth, on the date of birth.
 - In the case of adoption or placement for adoption or foster care, no later than the date of adoption or placement for adoption or foster care.
 - Experiences a qualifying event as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended.
 - Experiences an event described in 45 CFR 155.420(d)(4), (5), (6), or (7). (2)(b)

POLICY PROVISIONS SECTION (INDIVIDUAL)

House Bill 2240 new rules:

OAR 836-053-0431 Underwriting, Enrollment and Benefit Design (continued)

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

ADDITIONAL UPDATES TO SMALL GROUP STANDARDS

OREGON INSURANCE DIVISION - MARCH 2014

POLICY PROVISIONS SECTION (SMALL GROUP)

House Bill 2240 statute updates:

ORS 743.730(30) Definitions

- Updated small employer definition minimum employees from “two” to “one”. It is now “at least one but not more than 50 employees”.

ORS 743.734 Group health benefit plans subject to provisions of specified laws; exemptions

- Removed references to preexisting condition exclusions only prohibited for those under 19.
- Removed references to small employers with 26-50 employees.

ORS 743.736 Requirement to offer all health benefit plans to small employers; offering of plan by carriers; exceptions

- Updated that a carrier shall offer all of the carrier’s approved health benefit plans for which the small employer is eligible.

POLICY PROVISIONS SECTION (SMALL GROUP)

House Bill 2240 statute updates:

ORS 743.737 Requirements for small employer health benefit plans

- Updated that small employer health benefit plans must cover essential health benefits consistent with 42 U.S.C. 300gg-11. (1)
- A carrier may:
 - Require an affiliation period that does not exceed two months for an enrollee or 90 days for a late enrollee.
 - Impose an exclusion period for specified covered services (established under ORS 743.745) applicable to all individuals enrolling for the first time in the small employer health benefit plan.
 - Not apply a preexisting condition exclusion to any enrollee.
- Late enrollees may be subjected to a group eligibility waiting period that does not exceed 90 days. (2)
- Added a carrier may not deny an employer's application for coverage based on participation or contribution requirements but may require small employers that do not meet these requirements to enroll during the open enrollment period of November 15 to December 15.

POLICY PROVISIONS SECTION (SMALL GROUP)

House Bill 2240 rule updates:

OAR 836-053-0021 Plans Offered to Oregon Small Employers

- Added that the “Oregon Standardized Group Profile Form” is only required for non-exchange plans. (1)
- Added information for determining whether an employer is a small employer. (2)
- Removed information about reasonable employer participation and contribution requirements.

OAR 836-053-0030 Marketing of a Health Benefit Plan to Small Employers

- Changed basic plan references to bronze and silver plans.
- A carrier may limit enrollment to November 15 to December 15 for small employers that fail to meet the carrier’s reasonable participation or contribution requirements.
- A carrier may require reasonable assurance of pediatric dental coverage consistent with Health Benefits, Final Rule, 78 Fed. Reg. 12853 (February 25, 2013).

POLICY PROVISIONS SECTION (SMALL GROUP)

House Bill 2240 rule updates:

OAR 836-053-0050 Trade Practices Relating to Small Employer Health Benefit Plans

- Added nongrandfathered plans are available without regard to health status, claims experience or industry, and offered on a guaranteed issue basis. (1)(a)
- Added grandfathered plans are available under limited circumstances to a small employer that has existing grandfathered coverage. (1)(b)
- Updated (2) to be applicable to the exchange.
- A carrier, that also issues individual plans, may not include with an invoice for small employer coverage individual plan premiums or bill the employer for such premiums. (6)

POLICY PROVISIONS SECTION (SMALL GROUP)

House Bill 2240 new rules:

OAR 836-053-0221 Participation, Contribution, and Eligibility Requirements for Group Health Benefit Plans Including Small Group Health Benefit Plans

- A carrier that chooses to enforce participation, contribution or eligibility requirements must:
 - Specify in the plan all of participation, contribution and eligibility requirements that have been agreed upon by the carrier and the group; and
 - Apply the participation and eligibility requirements uniformly to all categories of eligible members and their dependents. (1)
- Provides guidelines on contribution and participation requirements established by the carrier. (2)

POLICY PROVISIONS SECTION (SMALL GROUP)

House Bill 2240 new rules:

OAR 836-053-0835 Rescission of an Individual's Coverage under a Group Health Benefit Plan or Group Health Insurance Policy

- Provides guidelines on rescission of an individual's coverage in a group plan.
- Establishes guidelines on the required notice to affected enrollees.

HELPFUL LINKS

Oregon Insurance Division (OID) website: www.insurance.oregon.gov

OID Rates and Forms page: <http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/Pages/rates-forms.aspx>

Health filing requirements (where product standards and other requirements are found):
<http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/filing/Pages/Health/health.aspx>

Senate Bill 91 exhibit – Standard Plan Chart:
<http://www.oregon.gov/DCBS/insurance/legal/bulletins/Documents/2013-02-attachments/StandardPlan-RxCharts-full.pdf>

Standard plan cost share matrix: <http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/Documents/training/standard-plan-cost-share-matrix.pdf>

Oregon Mandate Matrix: <http://www.oregon.gov/dcbs/insurance/insurers/rates-forms/Documents/Helpful-Hints/mandated-health-benefits.pdf>

2013 Oregon Revised Statutes: http://www.oregonlegislature.gov/bills_laws/Pages/ORS.aspx

Oregon Administrative Rules, Insurance Division, Chapter 836:
<http://www.oregon.gov/DCBS/insurance/legal/laws/Pages/oars.aspx>

QUESTIONS?

OREGON INSURANCE DIVISION - MARCH 2014

Contact:

Jenni Bertels, Health Analyst

503-947-7255

jennifer.bertels@state.or.us

www.insurance.oregon.gov