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Insurance Regulation - Chapter 836

Division 53

HEALTH BENEFIT PLANS

836-053-0012

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;
- (D) Exclusions for the treatment of erectile dysfunction or sexual dysfunction as defined in the "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition" (DSM-5) or the "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition" (DSM-IV);
- (E) Exclusions for medically necessary surgeries and procedures related to sex transformations and gender identity disorder or gender dysphoria;
- (F) Any blanket exclusion for a diagnosis made using the diagnostic criteria of the DSM-5 or the DSM-IV;
- (G) Exclusions for court-order screening interviews or drug or alcohol treatment programs;
- (H) Any limitations or waiting periods for pre-existing conditions;
- (I) Time limits for treatment of jaw or teeth or orthognathic surgery; and
- (b) Dollar limits for coverage of durable medical equipment 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.
- (c) The following provisions of the base-benchmark plan must be modified:
 - (A) Any waiting periods must be consistent with limitations imposed by state or federal law;
 - (B) Wigs following chemotherapy or radiation therapy must be covered up to the actuarial equivalent of \$150 per calendar year;
 - (C) The limitation on cosmetic or reconstructive surgery to one attempt within 18 months of injury or defect must be modified to remove these limitations in cases of medical necessity in accordance with 45 CFR 156.125(a) and to avoid discrimination based on health factors under 45 CFR 146.121;
 - (D) Contraceptive coverage must comply with Centers for Medicare and Medicaid Services guidance and requirements related to contraception issued jointly by the United States Departments of Labor, Health and Human Services, and Treasury on May 11, 2015;
 - (E) Provisions related to telemedical health services must reflect changes made to ORS 743A.058 by chapter 340, Oregon Laws 2015 (Enrolled Senate Bill 144); and
 - (F) Housing and travel expenses for transplant services are not considered essential health 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.

[ED. NOTE: Exhibit referenced is available from the agency.]

[ED. NOTE: To view attachments referenced in rule text, click here for PDF copy.]

Statutory/Other Authority: ORS 731.097

Statutes/Other Implemented: ORS 731.097

History:

ID 5-2016, f. & cert. ef. 4-26-16

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