



PERMANENT ADMINISTRATIVE ORDER

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CHAPTER 836

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES INSURANCE REGULATION

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FILING CAPTION: Amendment to 2027 standard bronze and silver health benefit plans

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AMEND: 836-053-0013

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RULE SUMMARY: Update Standard Bronze and Silver Plans.

CHANGES TO RULE:

836-053-0013

Oregon Standard Bronze and Silver Health Benefit Plans ¶¶

(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/HSA/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; ¶¶
 - (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; and¶¶
 - (d) For plan years beginning on or after January 1, 2019, Chapter 721, Oregon Laws 2017 (Enrolled House Bill 3391). ¶¶
 - (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;¶¶
 - (f) Laboratory services;¶¶
 - (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)(A) Prescription drug coverage at the greater of:¶¶
 - (i) At least one drug in every United States Pharmacopeia (USP) category and class as the prescription drug coverage of the plan described in OAR 836-053-0012(2); or¶¶
 - (ii) The same number of prescription drugs in each category and class as the prescription drug coverage of the plan described in OAR 836-053-0012(2).¶¶
 - (B) Insurers must submit the formulary drug list for review and approval. The formulary drug list must comply with filing requirements posted on the Department of Consumer and Business Services website.¶¶
 - (C) For plan years beginning on or after January 1, 2017 insurers must use a pharmacy and therapeutics committee that complies with the standards set forth in 45 CFR 156.122.¶¶
 - (9) Copays and coinsurance for coverage required under ORS 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, 29 U.S.C. 1185a, 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.¶¶
 - (10) Deductibles for coverage required under ORS 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 the cost-sharing matrix as adopted in Exhibit 1 to this rule.¶¶
 - (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 adopted 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.

Statutory/Other Authority: ORS 731.244, 45 CFR 156.135(g)

Statutes/Other Implemented: ORS 743B.130

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 836-053-0013.pdf from the Attachments panel. Alternately, you may view the attachments at the following link:

<https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=336682>