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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
08/30/2021 7:33 PM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILING CAPTION: Amendment to the 2022 standard bronze and silver health benefit plan

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 09/29/2021 5:00 PM
The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT: Karen Winkel
503-947-7694
karen.j.winkel@oregon.gov

350 Winter St NE
Salem,OR 97301

Filed By:
Karen Winkel
Rules Coordinator

HEARING(S)
Auxilary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 09/22/2021
TIME: 11:00 AM
OFFICER: Ethan Baldwin
ADDRESS: Labor & Industries Building
350 Winter St NE
Salem, OR 97301
SPECIAL INSTRUCTIONS:
Virtual only due to COVID-19:

Please join my meeting from your
computer, tablet or smartphone.
https://global.gotomeeting.com/join/6
46268749

You can also dial in using your phone.
United States: +1 (872) 240-3311
Access Code: 646-268-749

NEED FOR THE RULE(S):

ORS 743B.130 requires the Department of Consumer and Business Services (DCBS) to prescribe by rule the form, level of coverage, and benefit design for bronze and silver health benefit plans that must be offered by insurance carriers. These plans must meet federal requirements issued by the Department of Health and Human Services (HHS). Each year, HHS updates the actuarial value (AV) calculator used for determining coverage levels. Changes may include costs, plan

designs, populations, developments in the function and operation of the AV calculator and other actuarially relevant factors. DCBS provides exhibits to the standard bronze and silver plans, in rule, that prescribe the benefits the plans must provide.

As a result of the passage of Oregon House Bill 2623, DCBS was required to amend the exhibits to the standard bronze and silver plans in order to comply with both federal and state law. HB 2623 limits the cost-sharing for health benefit plan coverage of insulin prescribed for treatment of diabetes. As a result, the AV for the standard plans was too high, requiring DCBS to lower certain other benefits to come into compliance with HHS requirements.

In a previous rulemaking for OAR 836-053-0017, effective 1/1/2021, DCBS made changes to essential health benefits (EHBs), reflecting changes to chiropractic and acupuncture care, which were approved by the Centers for Medicare and Medicaid Services (CMS). The standard plan exhibits were updated to accurately reflect these previously approved and already covered benefits.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Draft rules are available from Karen Winkel, Rules Coordinator, Division of Financial Regulation located at 350 Winter St. NE, Salem, OR 97301 and are available on the division's website:
https://dfr.oregon.gov/laws-rules/Pages/proposed-rules.aspx

The 2022 AV Calculator Methodology is available at:
https://ww.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2022-AV-Calculator-Methodology.pdf

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FISCAL AND ECONOMIC IMPACT:

This amended rule updates the Oregon standard bronze and silver plans for plan years beginning on and after January 1, 2022. The amended rule does contain a new requirement, limiting cost-sharing on insulin as required by House Bill 2623. This requirement adjusts certain benefits within plans. The implementation of HB 2623 will likely have a fiscal impact on consumers who purchased the standard bronze or silver plan in 2021 and purchase the same plan again 2022 as the newly selected plan will have a reduction in certain benefits to accommodate the increased insulin benefit. However, there is no data available to demonstrate what that impact would be, and the amended rule does not change the impact of the bill.

The additions to Oregon's EHB under these rules are expected to increase the premium charged for non-grandfathered individual and small employer health benefit plans beginning with the 2022 plan year. An actuarial analysis performed by NovaRest Actuarial Consulting estimates the average premium impact of the additional EHBs as $2.84 per member per month (PMPM), with $1.89 PMPM attributable to spinal manipulation visits and $0.95 PMPM attributable to acupuncture visits. It is worth noting that the increased premium charge was analyzed as a marketwide average and not a specific analysis of impacts to standard plans. A copy of the NovaRest report is available from the division's Essential Health Benefits website at:
https://dfr.oregon.gov/help/committees-workgroups/Pages/EHB-rulemaking-committee.aspx.

The fiscal impacts to insurers could include a small increase in administrative costs resulting from insurers needing to update plan language. Because insurers are already required to adjust plan language to conform to current requirements, the fiscal impact is not solely resulting from adoption of these rules. Inclusion of clearer language providing clear guidance to insurers may help to counter any increased administrative costs.

The plans selected by the rulemaking advisory committee are an updated version of the current standard bronze and silver plans.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Based on available information, these proposed rules would have no financial impact on state agencies or local governments, because they create no new mandates for state or local government entities.

The proposed rules apply to commercial payers only and would require minimal administrative effort to comply with the requirements of proposed rules. The insurers would already be required to adjust plan language to conform to current requirements, so this cost is not solely resulting from adoption of these rules. Inclusion of clearer language providing guidance to insurers may help to counter any increased administrative cost.

Also, because members of the public may or may not choose a standard bronze or silver plan, we are unable to quantify any potential fiscal impact on individual members of the public may experience in price differentials between plans.

(2)(a) The department does not have information on the number of small businesses that purchase small employer health benefit plans. Based on quarterly enrollment reports submitted to the Division of Financial Regulation (DFR), the total number of Oregonians enrolled in these plans was approximately 171,000 as of June 30, 2020.

The most direct impact of these proposed rules would be on health insurers, and no health insurers in Oregon employ 50 or fewer employees.

(2)(b) The proposed rule effectively results in no change and would not require additional resource for compliance for small businesses.

(2)(c) Based on available information, the department does not anticipate insurers acquiring equipment and supplies, or hiring or contracting for staff to comply with these proposed rules. The insurers would be required to adjust plan language to conform to current requirements, so this cost is not solely resulting from adoption of these rules. Inclusion of clearer language providing clear guidance to insurers may help to counter any increased administrative cost.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Members of organizations representing small businesses served on the rulemaking advisory committee.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

AMEND: 836-053-0013

RULE SUMMARY: Amended 2022 Standard Bronze and Silver Plans. Refiling to include the 2022 Standard Bronze and Silver Plan attachment within the rule text.

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~~, ORS 743A.067~~

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

2022 Standard Bronze Plan

Benefit	2021 Standard Bronze	2022 Standard Bronze
2022 Federal AV	**64.99%**	**64.72%**
Deductible	Combined Medical and Drug $8,550	Combined Medical and Drug $8,700
Maximum OOP	Combined Medical and Drug $8,550	Combined Medical and Drug $8,700
Family multiplier	2x Individual; Embedded Approach	2x Individual; Embedded Approach
Primary Care Visit to Treat an Injury or Illness	$50	$50
Specialist Visit	$100	$100
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0% After Deductible	0% After Deductible
Outpatient Surgery Physician/Surgical Services	0% After Deductible	0% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	0% After Deductible	0% After Deductible
Inpatient Physician and Surgical Services	0% After Deductible	0% After Deductible
Inpatient Rehabilitation Services	0% After Deductible	0% After Deductible
Inpatient Habilitation Services	0% After Deductible	0% After Deductible
Urgent Care Centers of Facilities	$100	$100
Emergency Room Services	0% After Deductible	0% After Deductible
Generic Drugs	$20	$20**
Preferred Brand Drugs	0% After Deductible	0% After Deductible**
Non-Preferred Brand Drugs	0% After Deductible	0% After Deductible**
Specialty Drugs	0% After Deductible	0% After Deductible**
Pediatric Vision	Exams at $0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply. Contact lenses - Actuarial equivalent of $150 per year. Frames - Actuarial equivalent of $150 per year. Lenses at $0 for codes V2100-2299, V2300-2399, V2121, V2221, V2321; for other codes cost shares may apply.	Exams at $0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply. Contact lenses - Actuarial equivalent of $150 per year. Frames - Actuarial equivalent of $150 per year. Lenses at $0 for codes V2100-2299, V2300-2399, V2121, V2221, V2321; for other codes cost shares may apply.
Outpatient Rehabilitation Services	$50 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.	$50 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.
Outpatient Habilitation Services	$50 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.	$50 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.
Biofeedback	0% After Deductible	0% After Deductible
Cardiac Rehabilitation	$50	$50
Imaging (CT/PET Scans, MRIs)	0% After Deductible	0% After Deductible
Preventive Benefits *	$0	$0
Diabetes Education	0% After Deductible	0% After Deductible
Nutritional Counseling	0% After Deductible	0% After Deductible
Diabetic Supplies	0% After Deductible	0% After Deductible
Laboratory Outpatient and Professional Services	0% After Deductible	0% After Deductible
X-rays and Diagnostic Imaging	0% After Deductible	0% After Deductible
Acupuncture	n/a	$50 - limit 12 visits per year
Chiropractic	n/a	$50 - limit 20 visits per year

* Preventive Benefits include, but are not limited to, services a carrier is required to provide without cost sharing under Oregon Laws 2017, Chapter 721 (HB 3391).

**HB 2623 Limits cost-sharing for health benefit plan coverage of insulin prescribed for treatment of diabetes

2022 Standard Silver Plan

Benefit	2021 Standard Silver	2022 Standard Silver
2022 Federal AV	**71.92%**	**71.92%**
Deductible	Medical: $3,650 Drug: $0	Medical: $3,650 Drug: $0
Maximum OOP	Combined Medical and Drug $8,550	Combined Medical and Drug $8,550
Family multiplier	2x Individual; Embedded Approach	2x Individual; Embedded Approach
Primary Care Visit to Treat an Injury or Illness	$40	$40
Specialist Visit	$80	$80
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% After Deductible	30% After Deductible
Outpatient Surgery Physician/Surgical Services	30% After Deductible	30% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	30% After Deductible	30% After Deductible
Inpatient Physician and Surgical Services	30% After Deductible	30% After Deductible
Inpatient Rehabilitation Services	30% After Deductible	30% After Deductible
Inpatient Habilitation Services	30% After Deductible	30% After Deductible
Urgent Care Centers of Facilities	$70	$70
Emergency Room Services	30% After Deductible	30% After Deductible
Generic Drugs	$15	$15**
Preferred Brand Drugs	$60	$60**
Non-Preferred Brand Drugs	50%	50%**
Specialty Drugs	50%	50%**
Pediatric Vision	Exams at $0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply. Contact lenses - Actuarial equivalent of $150 per year. Frames - Actuarial equivalent of $150 per year. Lenses at $0 for codes V2100-2299, V2300-2399, V2121, V2221, V2321; for other codes cost shares may apply.	Exams at $0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply. Contact lenses - Actuarial equivalent of $150 per year. Frames - Actuarial equivalent of $150 per year. Lenses at $0 for codes V2100-2299, V2300-2399, V2121, V2221, V2321; for other codes cost shares may apply.
Outpatient Rehabilitation Services	$40 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.	$40 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.
Outpatient Habilitation Services	$40 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.	$40 (Applies to PT,OT, ST provided in an office setting); PT OT, ST provided in emergency room or urgent care setting is subject to applicable co-insurance.
Biofeedback	$40	$40
Cardiac Rehabilitation	$40	$40
Imaging (CT/PET Scans, MRIs)	30% After Deductible	30% After Deductible
Preventive Benefits *	$0	$0
Diabetes Education	$0	$0
Nutritional Counseling	$0	$0
Diabetic Supplies	$0	$0
Laboratory Outpatient and Professional Services	30% After Deductible	30% After Deductible
X-rays and Diagnostic Imaging	30% After Deductible	30% After Deductible
Acupuncture	n/a	$40 - limit 12 visits per year
Chiropractic	n/a	$40 - limit 20 visits per year

* Preventive Benefits include, but are not limited to, services a carrier is required to provide without cost sharing under Oregon Laws 2017, Chapter 721 (HB 3391).

**HB 2623 Limits cost-sharing for health benefit plan coverage of insulin prescribed for treatment of diabetes