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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
02/27/2020 1:07 PM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILING CAPTION: Amendment to the 2021 standard bronze and silver health benefit plans

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 03/31/2020 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.

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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: 03/31/2020
TIME: 11:00 AM
OFFICER: Ethan Baldwin
ADDRESS: Labor & Industries Building
350 Winter Street NE
Conference Room E
Salem, OR 97301
SPECIAL INSTRUCTIONS:
Conference phone information:
Call 888-808-6929
Access code 4969117#

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.

As a result of changes made to the federal AV calculator for 2021, the AV for the standard bronze and silver plans prescribed in OAR 836-053-0013 exceeded federal requirements. Failure to update the rule would result in DCBS requiring carriers to submit plans that are illegal with respect to federal law.

DCBS convened a Rulemaking Advisory Committee (RAC) that met on January 28, 2020. Representatives from consumer advocacy groups, insurers, and business groups participated in the RAC. Representatives from the agent community were invited but did not participate.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

Draft rules are available from the division's rule coordinator, Karen Winkel and are accessible on the division's website at https://dfr.oregon.gov/laws-rules/Pages/proposed-rules.aspx.

The 2021 AV Calculator Methodology is available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2021-AV-Calculator-Methodology.pdf.

FISCAL AND ECONOMIC IMPACT:

This amended rule updates the Oregon standard bronze and silver plans for plan years beginning on and after January 1, 2021. The amended rule does not contain new requirements, but rather adjusts certain benefits within plans. There will likely be an economic impact to consumers who purchased the standard bronze or silver plan in 2020 and purchase the same plan again 2021 as the newly selected plan will have a reduction in certain benefits. The plans selected by the RAC 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) The 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. Based on feedback from the RAC, minimal administrative effort is required to comply with the requirements of proposed rules.

Also, because members of the public may or may not choose a standard bronze or silver plan, DCBS does not have data available to quantify any potential economic impact on individual members of the public.

(2)(a) Based on information available to DCBS and feedback from the RAC, it is estimated that zero small businesses are subject to compliance requirements under the proposed rule. Compliance requirements in the proposed rule apply only to health insurers. No health insurers meet the definition of a small business under ORS 183.310. The proposed rule contains no compliance requirements for small businesses that may purchase health insurance.

(2)(b) Based on information available to DCBS and feedback from the RAC, it is estimated that zero small businesses are subject to compliance requirements under the proposed rule.

(2)(c) Based on information available to DCBS and feedback from the RAC, it is estimated that zero small businesses are subject to compliance requirements under the proposed rule.

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

Members of organizations representing small businesses, including producers, and providers served on the rulemaking advisory committee.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

AMEND: 836-053-0013

RULE SUMMARY: Amends Exhibit 1 and Exhibit 2 to OAR 836-053-0013 with updated plan standards for Standard Bronze and Standard Silver health benefit 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
Statutes/Other Implemented: ORS 743B.130, ~~ORS 743A.067~~45 CFR 156.135(g)

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

DRAFT 2021 Standard Bronze Plan

Exhibit 1 to OAR 836-053-0013

Benefit	2021 Standard Bronze
2021 Federal AV	64.99%
Deductible	Combined Medical and Drug $8,550
Maximum OOP	Combined Medical and Drug $8,550
Family multiplier	2x Individual; Embedded Approach
Primary Care Visit to Treat an Injury or Illness	$50
Specialist Visit	$100
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	0% After Deductible
Outpatient Surgery Physician/Surgical Services	0% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	0% After Deductible
Inpatient Physician and Surgical Services	0% After Deductible
Inpatient Rehabilitation Services	0% After Deductible
Inpatient Habilitation Services	0% After Deductible
Urgent Care Centers of Facilities	$100
Emergency Room Services	0% After Deductible
Generic Drugs	$20
Preferred Brand Drugs	0% After Deductible
Non-Preferred Brand Drugs	0% After Deductible
Specialty Drugs	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.
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.
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.
Biofeedback	0% After Deductible
Cardiac Rehabilitation	$50
Imaging (CT/PET Scans, MRIs)	0% After Deductible
Preventive Benefits *	$0
Diabetes Education	0% After Deductible
Nutritional Counseling	0% After Deductible
Diabetic Supplies	0% After Deductible
Laboratory Outpatient and Professional Services	0% After Deductible
X-rays and Diagnostic Imaging	0% After Deductible

* 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).

DRAFT 2021 Standard Silver Plan

Exhibit 2 to OAR 836-053-0013

Benefit	2021 Standard Silver
2021 Federal AV	**71.92%**
Deductible	Medical: $3,650 Drug: $0
Maximum OOP	Combined Medical and Drug $8,550
Family multiplier	2x Individual; Embedded Approach
Primary Care Visit to Treat an Injury or Illness	$40
Specialist Visit	$80
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	30% After Deductible
Outpatient Surgery Physician/Surgical Services	30% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	30% After Deductible
Inpatient Physician and Surgical Services	30% After Deductible
Inpatient Rehabilitation Services	30% After Deductible
Inpatient Habilitation Services	30% After Deductible
Urgent Care Centers of Facilities	$70
Emergency Room Services	30% After Deductible
Generic Drugs	$15
Preferred Brand Drugs	$60
Non-Preferred Brand Drugs	50%
Specialty Drugs	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.
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.
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.
Biofeedback	$40
Cardiac Rehabilitation	$40
Imaging (CT/PET Scans, MRIs)	30% After Deductible
Preventive Benefits *	$0
Diabetes Education	$0
Nutritional Counseling	$0
Diabetic Supplies	$0
Laboratory Outpatient and Professional Services	30% After Deductible
X-rays and Diagnostic Imaging	30% After Deductible

* 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).