OAR 836-010-0013
Exhibit 4

Oregon
Kate Brown, Governor

Department of Consumer and Business Services
Division of Financial Regulation
350 Winter St. NE, Room 410
P.O. Box 14480
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April 22, 2016

TO: Carriers Offering Small Group Transitional Plans

RE: Extension of Small Group Transitional Health Benefit Plans

In conjunction with Senate Bill 1582 (2014 Legislative Session), the Division of Financial Regulation (division) (formerly the Insurance Division) of the Department of Consumer and Business Services (DCBS) issued regulatory requirements and guidance in April 2014 for transitional health benefit plans[1], allowing renewals in 2014 for health insurance coverage that continued through December 31, 2015. The division adopted the guidance as an exhibit to Oregon Administrative Rule (OAR) 836-010-0013 and OAR 836-053-0066.

On February 6, 2015, in response to previous federal guidance, the division decided to allow small group transitional health benefit plans to be renewed through policy years beginning on or before October 1, 2016 to provide coverage into 2016 and 2017 but to discontinue all individual transitional health benefit plans no later than January 1, 2016. At that time, guidance from CMS allowed states to allow renewals of small group transitional health benefit plans only until September 30, 2016 and stated that all insurers must discontinue these plans effective no later than September 30, 2017.

Recently, CMS issued a new guidance allowing states to extend small group transitional plans for a period up to three months.[2] In that guidance, CMS has extended the transitional policy to policy years beginning on or before October 1, 2017, provided that all policies end by December 31, 2017. States are permitted to decide whether to allow the extension at all or to allow an extension for a shorter period. CMS will work with states if necessary to implement this policy including allowing options of a plan year less than 12 months or early renewals with a January 1, 2017 start date.

After considering the options available, the Department of Consumer and Business Services, Division of Financial Regulation has determined to extend the small group transitional plans for two months. Therefore, insurers who issue small group transitional health benefit plans may not

[1] April 2014 Guidance: http://www.oregon.gov/DCBS/insurance/legal/laws/Documents/OAR/div10-0013_ex2.pdf

[2] February 29, 2016 CMS Guidance: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf

renew small group transitional health benefit plans after November 30, 2016 and must discontinue these plans effective no later than December 1, 2017.

This memo sets forth the regulatory requirements and guidance for discontinuance of individual transitional health benefit plans and renewal of small group transitional health benefit plans.

This guidance is subject to revision if applicable state or federal laws change.

Small Group Transitional Plans

Carriers may not renew small group transitional health benefit plans after December 1, 2016 (last day of coverage November 30, 2017). Carriers will need to make a decision whether and when they will discontinue small group transitional plans.

Discontinuation of small group transitional plans
Carriers of small group transitional health benefit plans scheduled for discontinuation must provide at least 90-days notice prior to discontinuation. The Oregon-specific notice[2], *Discontinuation notice to employers for the small group market,* must be used. A copy of this notice is included as Appendix B.

Continuation of small group transitional plans
Carriers of small group transitional health benefit plans that will renew in 2015 and 2016 may continue that coverage until no later than November 30, 2017. Carriers must provide at least 60-days prior notice of the renewal in accordance with the requirements of 45 CFR 146.152 and 148.122. The notice from CMS' March 5 bulletin[33], *Attachment 2-Small group transitional plan renewal notice,* must be used. A copy of this notice is included as Appendix A.

Marketing materials or other documents may be included in the mailing of discontinuation and renewal notices. Carriers are required to include the Summary of Benefits and Coverage for the new plans offered in place of discontinued plans and for plans being renewed.

Carriers are required to notify the division whether they will continue to renew small group transitional health benefit plans. The division will issue separate guidance with reporting requirements.

Form Filing Requirements

Discontinuation of a small group transitional health benefit plan
The Modification and Discontinuance of Health Benefit Plans filing requirements apply. Filing instructions for discontinuations can be located at:

http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/filing/Pages/Health/health-moddis.aspx.

Since the required notices are models, the division will consider these filings informational.

[3] CMS March 5, 2014 bulletin included model renewal notices labeled Attachments 1 and 2

Continuation of small group transitional health benefit plans

When continuing small group transitional plans, the form filing requirements and recently released timelines apply. Binder filings are not required for transitional plans.

Rate Filing Requirements

Rate filing options for small group transitional plans (options also apply to grandfathered plan[4])

Carriers that renew small group transitional health benefit plans may choose one of the following rate filing options:

Option 1: 10/1/2015 Rate effective date

- Carriers will file rates for 4Q2015 through 3Q2016
- Filing must be submitted by 2/28/2015

Option 2: 1/1/2016 Rate effective date

- Rates for 4Q2015 will remain at the last approved level without trend adjustment
- Carriers will file rates for 1Q2016 through 4Q2016
- Filing must be submitted by 7/1/2015
- Under current state and federal guidance, 4Q2016 rates will only be available for use if the transitional program is modified to allow transitional coverage to renew after October 1, 2016

[3] Transitional and grandfathered plans must be pooled for rate filings

Appendix A
Discontinuation notice to employers for the small group market
(Oregon-Specific Notice[2])

Important: Your Group Health Coverage Will Not Be Available Next Year.

Dear [Plan Sponsor, a generic such as "Valued Group Customer" or Name]

Your group's current health coverage will not be offered next year. The current coverage will end on [Date]. This means **you may need to choose a new plan for your group members to have health insurance coverage**. This letter explains the options available to you.

Options from [Issuer Name]
[We have selected a new [Issuer Name] plan for your group members that's similar to their current plan. [**If you continue to qualify for small employer coverage, we'll] [We'll] [automatically enroll your group members in [Plan Name and Plan ID]] [automatically enroll your group members in the plan shown in the enclosed [title of document used by carrier]] unless you choose another option.** Below are key differences between the new coverage and the current coverage. You can review all the benefits and coverage for this plan at [Issuer website].]

- Premium – Your new premium starts in [Month]. [Your estimated monthly premium will be $[Dollar amount]]. [Your new plan and estimated monthly premium is shown in the enclosed [title of rate document used by carrier]]. This is an estimate based on current enrollment. This amount may change depending on the individuals who actually enroll in the plan.
- [List differences in new plan, including:
  - Name of new plan and Plan ID
  - Benefit changes
  - Cost-sharing changes, including whether the plan is a different metal level from
  - the previous plan.]
- [Point to differences in new plan with reference to other document received by recipient in this same mailing.]
-

What other options do I have?

- You can choose any of our other small group plans. Call [Issuer phone number] or visit [Issuer website] to learn about plans available to you. Or you may work with your agent or broker to select another [Issuer Name] plan.

- You can choose to buy a new health plan directly from any insurance company or with the help of an agent or broker.

Small Employer Tax Credit
If you have fewer than 25 full time equivalent employees, you might qualify for a small business health care tax credit. For more information visit healthcare.gov or call 1-800706-7893 (Telecommunications Relay Service: 711).

Your tax consultant can determine whether your business qualifies for the small business health care tax credit and the amount you are entitled to be credited.

What else should I look at before deciding?
Call or visit the plan's website to check which doctors, other health care providers, and prescription medications are covered by the plan. This is an important step when choosing a plan that meets the needs of your group members.

When do I need to make a decision?
You generally can buy coverage any time. If group members enroll by the [Day] of the month, coverage can begin on the 1st of the following month.

We are notifying your employees
Federal law requires that we notify all group members with this coverage that it is no longer being offered. Because we might not know about other coverage decisions you have made, we'll tell your employees to check with the plan sponsor or administrator about coverage options that might be available through your organization.

Questions?
- ☐ Call or visit the [Issuer Name] website [Contact Information and Hours of Operation].

- ☐ If you worked with an agent or broker in [2014] or intend to in [2015], you may also direct questions to your agent or broker.

Getting Help in Other Languages
[*Include the tagline below for the top languages spoken by 10% or more of the population in the state.*

Spanish (Español): Para obtener asistencia en Español, llame al [Issuer contact information].]

Appendix C
Small group transitional plan renewal notice
(March 5, 2014 Attachment 2)

Important: We're Continuing to Offer Your Group Health Coverage.
It's time to renew!

Dear Policyholder,

We are writing to inform you that, consistent with federal guidance initially announced in November 2013 and extended in March 2014, you may keep your existing coverage for the upcoming policy year.

How Do I Keep My Current Policy?

To keep your current policy, please contact us.

As you think about your options, there are some things to keep in mind. If you choose to renew your current policy, it may NOT provide all of the protections of the Affordable Care Act. These include one or more of the following new protections of the Public Health Service Act (PHS Act) that were added by the health care law and took effect for coverage beginning in 2014. If you choose to renew your current policy, your coverage:

- May not meet standards for fair health insurance premiums, so you might be charged more based on factors such as gender or a pre-existing medical condition, and it might not comply with rules limiting the ability to charge older people more than younger people (PHS Act section 2701).
- May not meet standards for guaranteed availability, so it might exclude consumers based on factors such as a pre-existing medical condition (PHS Act section 2702).
- May not meet standards for guaranteed renewability (PHS Act section 2703).
- If the coverage is an individual market policy, may not meet standards related to pre-existing medical conditions for adults, so it might exclude coverage for treatment of an adult's pre-existing medical condition such as diabetes or cancer (PHS Act section 2704).
- If the coverage is an individual market policy, may not meet standards related to discrimination based on health status (PHS Act section 2705).
- May not meet standards for non-discrimination with respect to health care providers (PHS Act section 2706).
- May not cover essential health benefits or limit annual out-of-pocket spending, so it might not cover benefits such as prescription drugs or maternity care, or might have unlimited cost sharing (PHS Act section 2707).

- May not meet standards for participation in clinical trials, so you might not have coverage for services related to a clinical trial for a life-threatening or other serious disease (PHS Act section 2709).

How Do I Choose A Different Policy?

You have options for getting quality health insurance. [You may shop in the Health Insurance Marketplace, where all policies meet certain standards to help guarantee health care security, and no one who is qualified to purchase coverage through the Marketplace can be turned away or charged more because of a pre-existing medical condition. The Marketplace allows you to choose a private policy that fits your budget and health care needs. You may qualify for tax credits or other federal financial assistance to help you afford health insurance coverage purchased through the Marketplace.]

[You can also get new health insurance outside the Marketplace.] All new policies guarantee certain protections, such as your ability to buy a policy even if you have a pre-existing medical condition. [However, federal financial assistance is not available outside the Marketplace.]

You should review your options as soon as possible, because you may have to buy your coverage within a limited time period.

How Can I Learn More?

To learn more about the Health Insurance Marketplace and protections under the health care law, visit HealthCare.gov or call 1-800-318-2596 or TTY: 1-855-889-4325. If you have questions, please contact us.