Department of Consumer & Business Services
Oregon Division of Financial Regulation - 5
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Standard Provisions for Individual and Small Group Health Benefit Plan
MEDICAL BINDER FILINGS

This guide is provided to assist insurers in preparing binder filings and is required to be submitted as part of a filing. These standards are summaries only and review of the entire statute or rule may be necessary. Complete each item to confirm that diligent consideration has been given to each and is certified by the signature on the certificate of compliance form. "Not applicable" can be used only if the item does not apply to the coverage being filed and an explanation must be provided. Not including the required information may result in disapproval of the filing.

These standards are subject to change as more information becomes available.

Insurer Name: _____ Requested effective date: _____

SERFF numbers of related form filings to plans in this binder: _____

Market: ☐ Individual ☐ Small group

Metal levels submitted in this binder filing:

☐ Bronze	☐ Standard plans	☐ QHP On Exchange	☐ Outside exchange
☐ Silver	☐ Standard plans	☐ QHP On Exchange	☐ Outside exchange
☐ Gold	☐ Standard plans	☐ QHP On Exchange	☐ Outside exchange
☐ Catastrophic			

HIOS/Template issues:
If an issuer has questions specific to the HIOS system or Excel templates, contact the CMS Help Desk directly at 855-267-1515 or CMS_FEPS@cms.hhs.gov.

Required documents and information to be included in the binder filing		
Plans tab ***(this information is automatically completed from what is entered in the Plan and Benefits template)*:**		Answer
The number of plans in the binder cannot be changed after submission. If plans need to be added or deleted, a new binder will need to be submitted.		
Standard Component ID – List the appropriate 14 digit HIOS ID (without the dash and variant level) for each plan.		Confirmed ☐
Plan Name – List the appropriate plan name for each plan. For each standard plan, issuers must use the prescribed plan naming convention as required by OAR 836-053-0013(4)(a)		Confirmed ☐
Metal Level – List the appropriate metal level for each plan—Gold, Silver, Bronze, or Catastrophic.		Confirmed ☐
Availability – List where each plan will be offered for sale—either On Exchange, Off Exchange, or Both (off and on exchange).		Confirmed ☐
State Status, Disposition Status, Network Adequacy, and Exchange Workflow Status – These other fields will change throughout the process and are updated by either the Oregon Division of Financial Regulation reviewer or the exchange reviewer.		
Associate Schedule Items tab:		Answer
All relevant rate, form, and endorsement filings must be referenced, complete with SERFF Tracking Number, Form Name, and Form Number.		Confirmed ☐
Templates tab:		Answer
Download the latest versions of any of the templates mentioned below or their instructions at https://www.qhpcertification.cms.gov/s/Application%20Instructions		
Plan and Benefits Template	This is a federal data collection template for high level plan information, benefit information, and cost-sharing information.	Confirmed ☐
	Cost Share Variance tabs should have cost shares (deductibles, copays, and coinsurance) that fall within the approved bracketed ranges on the benefit summaries approved in the form filing.	Confirmed ☐
	The deductible for the standard silver plan applies to all services except preventive services, office visits, and urgent care. There is no deductible for prescription drugs in the standard silver plan.	Confirmed ☐
	The deductible for the standard bronze plan is an integrated deductible applicable to prescription drugs and all services except preventive services.	Confirmed ☐

Templates tab, continued:		Answer
Plan and Benefits Template, continued	On each of the Benefits Package tabs, please list all appropriate quantity limits, visit limits, exclusions, and EHB variances.	Confirmed ☐
	Since there is only one category for "Habilitation Services", we are interpreting that category as for outpatient habilitation services, so please list the appropriate cost shares for outpatient habilitation services in this category.	Confirmed ☐
	On standard plans, all of the prescribed visit limits must be listed as below: • Hospice Services – Respite care: Maximum of 5 consecutive days; lifetime maximum of 30 days • Skilled Nursing Facility – 60 days per year • Outpatient Rehabilitation Services – 30 (to 60) visits per year • Habilitation Services – 30 visits per year Mental Health Services covered under Habilitation and Rehabilitation must comply with state and federal rules on Mental Health Parity. Carriers should review state and federal laws regarding mental health parity for benefits and limitations, including visit limitations, in relation to requirements outlined in http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf. If carriers apply benefit limitations to mental health services the carrier will be required to prove compliance with state and federal law. Visit limits should not apply to Mental Health Services; this exception should be noted in column I of the Benefit Package tab.	Confirmed ☐
	We have confirmed with CCIIO that the "Allergy Testing" category includes both allergy testing and allergy injections. CCIIO is planning on updating the name of this category in a future year. *(This field is not anticipated to be shown on the plan compare web display.)*	Confirmed ☐
	Carriers are required to complete the SBC Scenario cells on the Cost Share Variance Tab.	Confirmed ☐
Prescription Drug Template	This is a federal data collection template which collects formulary information and prescription drug list details. Formularies are associated with plans defined on the Plan and Benefits template. *Mid year changes are allowed only if the change is within the +/- 2% cumulative variant, which may occur, for example, due to dropping a drug that is no longer available or changing drug's tier due to the drug moving from a brand name to a generic. If a carrier uses a PBM to manage their formularies, the requirement still applies. This change is calculated by reviewing a change in rate, not AV and will use the Plan Adjusted Index Rate.*	Confirmed ☐

Templates tab, continued:		Answer
Network ID Template	This is a federal data collection template for information about the provider network name and URL for display to a consumer.	Confirmed ☐
Service Area Template	This is a federal data collection template which allows issuers to identify service areas by county and ZIP code. Service areas are used in combination with the Rating Engine when determining plan availability and rates. Make sure that this report matches what is entered on the Plan and Benefits Template.	Confirmed ☐
Essential Community Providers Template / Network Adequacy Template	**All fields must be completed accurately for all plans and filers. This includes a complete list of current plan providers in the Network Adequacy section.** This is a federal data collection template for provider and street address information about the Essential Community providers in issuer networks. Oregon also uses the provider listing in the Network Adequacy information to analyze and evaluate provider networks and network adequacy.	Yes ☐ N/A ☐
Rate Table Template	This is a federal data collection template which collects rate data for each plan and rating area. Fill out information for all rating areas the carrier is in.	Confirmed ☐
Business Rules Template	This is a federal data collection template for the issuer specific business rules to calculate rates based on various factors.	Confirmed ☐
Transparency in Coverage Template	Used to provide accurate and timely disclosure of certain information to the Health Insurance Marketplace, HHS, the state insurance commissioner, and the public: • Information on whether the issuer was on the Exchange in 2020 • HIOS Issuer IDs and all PY2022 plan IDs • Number of PY2020 claims and denials • Number of PY2020 appeals • Claims Payment Policy and Other Information URL (“Transparency in Coverage URL”)	Confirmed ☐

Supporting Documentation tab:		Answer
Binder Cover Letter	***The binder cover letter serves as the filing description and includes the following:***	
	List of all plans being filed, including the plan name, issuer plan identification number, actuarial value, and whether the plan will be sold inside the exchange only, inside and outside of the exchange, or outside the exchange only.	Confirmed ☐
	For new plans, a description of any variations that were used to modify the standard benefit design.	Yes ☐ N/A ☐
	For previously-approved plans, a description of changes made to the plans and/or variations between proposed plans.	Yes ☐ N/A ☐
	A description of differences between in-network and out-of-network cost-sharing.	Yes ☐ N/A ☐
	Include the names and contact information for at least two people in your company that can answer questions about this filing.	Confirmed ☐
Certificate of Compliance	Certificate of Compliance form signed and dated by the both filer and an authorized company officer.	Confirmed ☐
4953 – Binder Filing Standards	The medical binder product standards (this document) are required to be submitted with your filing.	Confirmed ☐
Essential Community Provider Supplemental Response Form	Supplemental response form for issuers QHP application.	Yes ☐ N/A ☐
Partial Service Area justification	Instructions for this form - To satisfy county integrity requirements, issuers must identify proposed service areas. In almost all situations, only service areas covering full counties will be approved. If the issuer is requesting to cover a service area containing a partial county, the issuer must provide the included ZIP codes, a justification for why the entire county will not be served, and a detailed description that illustrates why the request is not discriminatory.	Yes ☐ N/A ☐
Unique Plan Design Supporting Documentation and Justification	If any of your plans are marked as a “Unique Plan Design” on the Plan and Benefits template and the actuarial value calculator cannot be used, this form must be submitted. This form must describe the reasons for the plan being unique and the methods used to calculate actuarial value and the form must be signed by an actuary.	Yes ☐ N/A ☐
EHB-Substituted Benefit (Actuarial Equivalent) Justification	This form is required if an *EHB Variance Reason* on the Plan and Benefits template is marked as “Substituted”. This form identifies the EHB benchmark benefits that have been substituted, the substituted benefits, and the associated values of each. This document must be signed by an actuary.	Yes ☐ N/A ☐
Formulary—Inadequate Category/Class Count Justification	This form is required if category or class does not cover the greater of (1) one drug in every USP category and class; or (2) the same number of prescription drugs in each category and class as the state benchmark plan. This form identifies reasons for an inadequate count in particular category or class.	Yes ☐ N/A ☐

Supporting Documentation tab, continued:		Answer
Limited Cost Sharing Plan Variation—Estimated Advance Payment Supporting Documentation and Justification (inside exchange only)	This form certifies that an issuer has followed the CMS standards for developing limited cost sharing CSR advance payment estimates. Meets the requirement at 45 CFR 156.430(a)(2)(i) for QHP issuers that choose to seek advance payments for a limited cost sharing plan variation. This document must be signed by an actuary.	Yes ☐ N/A ☐
Part I - Unified Rate Review Template (URRT)	***The URRT does not have to be provided at submission time. However, the URRT is required to be uploaded into the binder after the rate filing decision and before August 18th, 2021.*** Provides information and data necessary for ERR Reasonableness Review, rate increase monitoring and Market Rating Rules Compliance Reviews by states and CMS.	Confirmed ☐
Part III - Actuarial Memorandum	***The actuarial memorandum does not have to be provided at submission time. However, the actuarial memorandum is required to be uploaded into the binder after the rate filing decision and before August 18th, 2021.*** Provides actuarial written narrative describing and supporting the information provided in the Part I (URRT) and actuarial certifications. This document must be signed by an actuary.	Confirmed ☐
Program Attestation for SBE Issuers	Applicant attests that any QHP's offered will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit. Use the State Partnership Exchange Issuer Program Attestation Response Form.	Confirmed ☐
Discrimination - Treatment Protocol Supporting Documentation and Justification	Identifies reasons why a drug list may be an outlier in terms of out-of-pocket cost but is not discriminatory. Required if the out-of-pocket cost is determined to be an outlier.	Confirmed ☐
Plan ID Crosswalk Template	This is a federal data collection template for insurers to map plan ID's from one year to the next.	Confirmed ☐

PLAN REQUIREMENTS			
Review requirements	Reference	Description of review standards requirements	Answer
Annual or lifetime limits prohibited	ORS 743B.013 (small group), ORS 743B.125 (individual)	A health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.	Confirmed ☐

Review requirements	Reference	Description of review standards requirements	Answer
Catastrophic plans (individual only)	ORS 743.826	A carrier may offer a catastrophic plan only through the exchange and only to an individual who: (1) Is under 30 years of age at the beginning of the plan year; or (2) Is exempt from any state or federal penalties imposed for failing to maintain minimal essential coverage during the plan year.	Yes ☐ N/A ☐
Essential health benefits	ORS 743B.125 (individual), ORS 743B.013 (small group)	A health benefit plan must cover, at a minimum, all essential health benefits.	Confirmed ☐
	OAR 836-053-0012(2)(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.	Confirmed ☐
	OAR 836-053-0012(2)(c), 45 CFR 156	"Essential health benefits" means coverage provided in compliance with 45 CFR 156.	Confirmed ☐
	OAR 836-053-0012(3)(a)(A)	The base-benchmark health benefit plan, excluding the 24-month waiting period for transplant benefits.	Confirmed ☐
	OAR 836-053-0012(2)(D) 45 CFR 156.115	<u>Habilitative services</u> "Habilitative benefits" means the rehabilitative services provisions of the base benchmark when the services are medically necessary for the maintenance, learning or improving skills and function for daily living.	Confirmed ☐
	OAR 836-053-0012(2)(c)(B)(f)	<u>Pediatric dental benefits</u> "Pediatric dental benefits" means the benefits described in the children's dental provisions of the State Children's Health Insurance Plan. Pediatric dental benefits are payable to persons until at least the end of the month in which the enrollee turns 19 years of age. *Pediatric dental benefits are not allowed in standard plans.*	Confirmed ☐
	OAR 836-053-0012(2)(c)(C)(g)	<u>Pediatric vision benefits</u> "Pediatric vision benefits" means the benefits described in the vision provisions of the Federal Employee Dental and Vision Insurance Plan Blue Vision High Option. Pediatric vision benefits are payable to persons under 19 years of age.	Confirmed ☐

Review requirements	Reference	Description of review standards requirements	Answer
Essential health benefits, continued	45 CFR 156.115(6)	Pediatric benefits For pediatric services that are required under 45 CFR 156.110(a)(10) plans must provide coverage for enrollees until at least the end of the month in which the enrollee turns 19 years of age.	Confirmed ☐
	OAR 836-053-0012(4) Benefits not allowed as essential health benefits	An issuer of a 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.	Confirmed ☐
Forms required for submission	OAR 836-010-0011(2)	All required forms are located on SERFF or on our website.	Confirmed ☐
Formulary requirements	OAR 836-053-1020(6), 45 CFR 156.122	A formulary must comply with the requirements of 45 CFR 156.122 and include the greater of: (a) At least one drug in every United States Pharmacopeia therapeutic category and class; or (b) The same number of drugs in each United States Pharmacopeia category and class as the prescription drug benefit of the Oregon benchmark plan.	Confirmed ☐
Formulary requirements, continued	OAR 836-053-1020(7)	An insurer that issues a formulary that does not comply with the requirements of OAR 836-053-1020(6) must file the form entitled **"Formulary-Inadequate Category/Class Count Justification"** on the Supporting Documentation tab. The director may approve a formulary that does not meet the requirements of OAR 836-053-1020(6) if: (a) Drugs in a category or class have been discontinued by the manufacturer; (b) Drugs in a category or class have been deemed unsafe by the Food and Drug Administration or removed from market by the manufacturer due to safety concerns; (c) Drugs in a category of class have a Drug Efficacy Study Implementation classification; (d) Drugs in a category or class have become available as generics; or (e) Drugs in a category or class are provided in a medical setting and are covered under the medical provisions of the plan.	Yes ☐ N/A ☐

Review requirements	Reference	Description of review standards requirements	Answer
Formulary requirements, discrimination	OAR 836-053-1020(8)	An insurer that issues a small group or individual health benefit plan formulary does not comply with the nondiscrimination requirements of OAR 836-053-0012 if most or all drugs to treat a specific condition are placed in the highest cost tier.	Confirmed ☐
Health Savings Accounts	OAR 836-053-0011	If a plan or product is HSA eligible under applicable federal law, the insurer or health care service contractor shall clearly indicate on any applicable plan and benefits template or other plan or product specific filing document that the plan is HSA eligible.	Confirmed ☐
Maximum out of pocket (MOOP),	Federal rule amounts	For 2022 plans, the proposed MOOP limit is $9100 for self-only coverage and $18,200 for family coverage. This MOOP limit only applies to essential health benefits (EHBs).	Yes ☐ N/A ☐
Maximum out of pocket (MOOP), high deductible plans, and health savings accounts	IRS guidance High deductible health plans MOOP	For 2022 high deductible health plans, the MOOP complies with updated guidance from the IRS.	Yes ☐ N/A ☐
	IRS guidance High deductible health plan minimum deductibles	For 2022 high deductible health plans, minimum deductibles comply with updated guidance from the IRS.	Yes ☐ N/A ☐
	IRS guidance Health savings accounts (HSA) annual contribution limitation	For 2022 plans, annual contribution limits to the HSA comply with updated guidance from the IRS.	Yes ☐ N/A ☐
Networks and providers	45 CFR 156.230	The service areas and provider networks are identified in this plan filing.	Confirmed ☐
Number of plans allowed	Exchange requirement (inside exchange only)	Carriers may submit up to one standard plan and four non-standard plans per metal level for sale inside the exchange.	Confirmed ☐
Plans match the form filing	ORS 742.005(2)	Plan cost shares and benefits submitted in the binder filing must be within the bracketed ranges approved in the form filing.	Confirmed ☐
Provider non-discrimination	PHSA 2706	Benefits do not discriminate against providers based on provider type.	Confirmed ☐

STANDARD PLAN REQUIREMENTS			
Review requirements	Reference	Description of review standards requirements	Answer
Standard plans	Bronze, Silver and Gold Plans OAR 836-053-0013(10)(a)(b), ORS 743B.130, HB 3391(2017), OAR 836-053-0435	If a carrier offers a health benefit plan in Oregon, the carrier must offer a standard bronze plan and a standard silver plan in each market type and service area in which it operates. In order to participate in the exchange, carriers must also offer a gold standard plan mandated by the exchange. Preventive service requirements must comply with preventive services as described in HB 3391(2017)	Confirmed ☐
Coverage required	ORS 743B.130, OAR 836-053-0013(2)	"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.	Confirmed ☐
Inpatient coverage	ORS 743B.130, OAR 836-053-0013(3)(a)	"Inpatient" includes but is not limited to: (A) Surgery; (B) Intensive care unit, neonatal intensive care unit, maternity and skilled nursing facility services; and (C) Mental health and substance abuse treatment.	Confirmed ☐
Outpatient coverage	ORS 743B.130, OAR 836-053-0013(3)(b)	"Outpatient" includes, but is not limited to, services received from ambulatory surgery centers and physician and anesthesia services and benefits when applicable.	Confirmed ☐
Habilitation services	ORS 743B.130, OAR 836-053-0013(8)(e) 45 CFR 156.115	"Habilitation services" are medically necessary services for maintenance, learning or improving skills and function for daily living and are subject to the same cost sharing as rehabilitation services.	Confirmed ☐
Code or manual version	ORS 743B.130, OAR 836-053-0013(3)(C)(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-V, 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.	Confirmed ☐

Review requirements	Reference	Description of review standards requirements	Answer
Plan naming conventions	Standard plan naming convention: OAR 836-053-0013(4)(a)	The plan name for standard plans must be in the exact naming convention below: "[Name of Issuer]Standard [Bronze/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 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.	Confirmed ☐
Coverage required	ORS 743B.130, OAR 836-053-0013(5), HB 3391(2017), SB 1549(2018), ORS 743A.067	Coverage required must be provided in accordance with the requirements of OAR 836-053-0013(5), OAR 836-053-0013(10), and 45 CFR 156.	Confirmed ☐
	ORS 743B.130, OAR 836-053-0013(5)	Coverage must be provided in a manner consistent with the requirements of: (a) 45 CFR 156; (b) OAR 836-053-1404 and 836-053-1405; and (c) The federal Mental Health Parity and Addiction Equity Act of 2008.	Confirmed ☐
Essential health benefits	ORS 743B.130, OAR 836-053-0013(7)	Coverage must provide essential health benefits as defined in OAR 836-053-0012.	Confirmed ☐
Prescription drug coverage	ORS 743B.130, OAR 836-053-0013(8)(h) OAR 836-053-1020(8)	**Prescription drug coverage** at the greater of: (A) 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)(b); or (B) 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). An insurer that issues a small group or individual health benefit plan formulary does not comply with the nondiscrimination requirements of OAR 836-053-0012 if most or all drugs to treat a specific condition are placed in the highest cost tier.	Confirmed ☐

Review requirements	Reference	**Description of review standards requirements**	Answer
Copays and coinsurance	ORS 743B.130, OAR 836-053-0013(9)	**Copays and coinsurance for coverage required** 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 Mental Health Parity and Addiction Equity Act of 2008, 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.	Confirmed ☐
Bronze plan deductibles	ORS 743B.130, OAR 836-053-0013(10)(a) HB 3391(2017)	For each bronze plan, in accordance with the coinsurance, copayment and deductible amounts and coverage requirements for a bronze plan set forth on our website. The bronze plans deductible must be integrated applicable to prescription drugs and all services except preventive services. The above must be modified to reflect additional legal requirements found in HB 3391(2017).	Confirmed ☐
Silver plan deductibles	ORS 743B.130, OAR 836-053-0013(10)(b)	For a silver plan, in accordance with the coinsurance, copayment and deductible amounts and coverage requirements for a silver plan set forth in Exhibit 2 of OAR 836-053-0013 and related guidance on DFR's website.	Confirmed ☐
Dollar limits	ORS 743B.130, OAR 836-053-0013(11)	Dollar limits for coverage required 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.	Confirmed ☐
Benefits must match and not exceed benchmark plan	ORS 743B.130, OAR 836-053-0013(5)	Benefits must provide coverage consistent with the state's base-benchmark plan as supplemented with the FEDVIP Blue High Vision benefit for pediatric vision benefits. Actuarial substitution within or across categories is prohibited.	Confirmed ☐
Benefits that must be excluded from standard plans	ORS 743B.130, OAR 836-053-0012(4)	Notwithstanding, coverage for pediatric dental benefits, routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia services must be excluded even if covered by the base-benchmark as supplemented.	Confirmed ☐

Review requirements	Reference	**Description of review standards requirements**	Answer
Coverage requirements are in-network only	ORS 743B.130, OAR 836-053-0013(2)	Coverage requirements apply to in-network benefits only. Out-of-network benefits do not count toward actuarial value.	Confirmed ☐
Rates and plans required	ORS 743B.130, OAR 836-053-0030(1) 45 CFR 156.210	Each company must submit standard bronze and standard silver rates and plans for each area in which they transact business. In addition, plans that offer Marketplace plans must also submit a standard gold plan.	Confirmed ☐