

Binders

Where should insurers look for information about binder filings?

OID expects issuers to consult all applicable regulations, including the FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces, to ensure full compliance with requirements of the Affordable Care Act.

When are medical and dental binders due to the OID?

Carrier must have completed binders submitted to OID by May 1, 2015 so OID can meet the CMS transfer deadline. Information submitted in these binders will be considered draft data. Final data is not due to OID until August 20, 2015.

We missed the binder deadline but are interested in offering plans in 2016. What options are available?

Due to OIDs use of federal technology carriers must adhere to the deadlines identified by OID in response to the CMS deadlines. If filing deadlines are missed the carrier may reach out to OID for more information about available options – however, we are unable to guarantee active participation in the market.

If template errors are found after the close of the data submission window can insurers make corrections?

Generally yes. Throughout the plan year, insurers may be required to correct deficiencies identified by OID, CMS, or as the result of an insurer's own compliance audits. In the event OID finds an error after the final data submission deadline the insurer will be contacted by a member of the OID staff. If insurers identify errors the insurer should contact their Forms Analyst immediately with a description of the error.

A template error has been identified after the binder lock date, how can the information be corrected?

CMS *may* allow limited data correction windows after the binder lock date. The availability of data correction windows are not guaranteed. If an error is identified contact OID as soon as possible and complete the Data Change Request form.

During a data correction window, insurers may request to make changes necessary to correct data display errors or align QHP data with products and plans approved by OID, or from a limited list of changes that do not impact certification (examples: URLs and plan marketing names). Changes to benefits or plan designs will not be permitted after the binder lock date.

Plans

If plans were approved in previous years are we required to resubmit?

Yes. For all plans, medical and certified pediatric dental, offered in 2016 insurers must submit a complete SERFF filing. Plans previously approved, including plans certified as QHPs, must be resubmitted each calendar year. Small group employer plans retain their approval, and if applicable QHP certification, through the end of the employer's plan year, which may extend beyond the calendar year.

Can carriers submit additional plans after May 1, 2015?

No. After the binder submission deadline of May 1, 2015 carriers will not be able to add plan offerings for 2016 due to limitations with CMS.

Can carriers decide not to offer plans after May 1, 2015?

Yes. However, if an insurer changes an application to indicate that a plan will only be offered off-exchange the plan will no longer be available for certification. In the event an insurer decides not to seek approval or certification of a plan after the plan has been submitted the insurer should reach out to their Forms analyst.

We have a plan that we would like to be recertified for 2016 however, there have been changes. Can the plan still be re-approved or recertified?

To be eligible for recertification a plan must be the same “plan” as defined in 45 C.F.R. 144.103. Plans being reapproved and recertified for 2016 must use the same HIOS plan identification numbers that it used for 2015. This requirement applies to both medical and SADP.

Summary of Benefits and Coverage (SBC)**When are we required to submit the Summary of Benefits and Coverage (SBC)?**

The Division is not requiring insurers to file SBCs this year; instead we will be reviewing the documents based on the SBC link of the Cost Share Variance tab of the Plan and Benefits Template. The links, and SBCs for each plan, must be live no later than September 1, 2015.

URRT**When is the last date for the URRT to be submitted into HIOS if the insurer is not participating in the exchange?**

All risk pools with no QHPs must be in final status in the URR system by October 1, 2015.

We need to make changes to the URRT. Do we have to change it for both OID and CCIIO?

Yes. Insurer’s offering coverage on and/or off-exchange submit the URRT into the HIOS Rate Review Module for both their QHPs and their non-QHPs at the same time. When the URRT is updated or changed the insurer must revise the URRT in HIOS and in SERFF, ensuring both OID and CCIIO have matching URRTs.

Are URRTs required for SADPs?

No, issuers do not need to submit URRTs for SADPs.

Plan Preview**How do carriers offering on-exchange plans review information for accuracy before it is displayed to the public on healthcare.gov?**

Insurers with QHPs will be able to view plan data in the Plan Preview environment, which is part of HIOS, in order to identify and correct errors before the binder lock date. Questions about the Plan Preview environment should be directed to CMS.

If an insurer identifies issues with information displayed on Plan Preview how should the information be updated?

Between May 1, 2015 and August 25, 2015 inaccurate information identified through Plan Preview can be revised by uploading revised templates. Insurers should also make changes to templates in response to State or CMS feedback during this review period.

An issuer making changes to the Service Area or Service Area Template should be discussed with OID prior to making the change. All changes to the Service area must be authorized by OID. All changes to the Service Area must be made prior to the binder lock deadline.

We have submitted updated templates in SERFF; however, the data on Plan Preview is still out of date. How is the data updated on Plan Preview once new templates are submitted?

The exchange must transfer the updated data from SERFF to HIOS for Plan Preview to update. If changes occur after the binders are locked, SERFF must activate the transfer function, and the FFM must accept the new plan data from HIOS. Sometimes this takes a few days. The exchange will notify you when your new plan data has been loaded into Plan Preview.

Plan Information on Healthcare.gov

A large error has been identified with the information appearing on healthcare.gov but it is too late to make changes – how can an insurer correct this information?

Insurers that request to make changes that affect consumers may have the plan suppressed until the data can be refreshed for consumer display. The insurer should reach out to OID, the exchange, and CMS as soon as the error is identified. More information about plan suppression and additional requirements about plan suppression may be released by CMS in the future.

HIOS

Are insurers required to use HIOS?

Yes, an insurer's HIOS issuer ID will be used to link State and Federal records. Therefore, insurers must access HIOS and obtain the necessary identification numbers and user roles. This requirement is the same for plans offered both on and off-exchange.

Does the insurer's legal entity name in HIOS need match information provided to OID and the exchange?

Yes, insurers should ensure that legal entity information is identical across all agencies. Insurers undergoing some company changes (mergers, assumptions, and acquisitions) should review CMS 9944-F for more information about applicable requirements for

reporting these changes to CMS. Contact Tammy Vance for more information about OID requirements regarding company changes.

Plan Crosswalk Template

Are insurers required to complete the plan crosswalk template for the 2016 plan year?

Yes, the Plan Crosswalk template is required for medical plans regardless of exchange certification status as well as SADPs. While SADPs are excepted benefits, and not subject to the guaranteed renewability standards in 45 CFR 147.106, the 2016 Plan Crosswalk template is required for the purpose of modification and discontinuance.

Off-exchange plans do not automatically populate in the Plan Crosswalk template so OID has developed a “work around”. A separate Plan Crosswalk template should be completed for plans offered off-exchange only. Please contact your OID analyst for this work around.

Completed plan crosswalk templates should be submitted on the supporting documentation tab. Exchange certified medical plans and SADPs should also submit the completed Crosswalk template to the CMS email address.

Multi-State Plan Program (MSP)

Where can we find more information on the multi-state plan program (MSP)?

Insurers seeking to offer MSP coverage must apply to participate via OPM’s online application portal.

Service Areas

Does OID permit partial county service areas?

OID will review requests for partial county service areas against guidelines established by CMS. Generally, service areas must be established without regard to racial, ethnic, language, or health status-related factors as specified by PHSA 2705, or other factors that exclude specific high utilizing, high cost, or medically under served populations.

May an insurer change the list of counties associated with a particular plan (change the service area of a plan)?

Any change to the counties associated with a plan is considered a change in service area, even if the issuer offers other plan or products in the counties (or partial counties) in question.

However, after binders have been submitted insurers will not be permitted to change plan service areas without petitioning OID, and the Oregon Exchange for plans offered on-exchange. Requested changes to plan service areas after the May 1, 2015 binder date will be considered but only approved under very limited circumstances.

Essential Community Providers (ECP)

Is the ECP template required for off-exchange plans?

For 2016 Binders the Essential Community Providers (ECP) Template is being required for insurers regardless of Marketplace intention. This means the ECP Template is required for both on and off-Marketplace.

Why is the ECP template being required for off-Marketplace?

The templates are developed by CMS to serve a variety of purposes including review of plan compliance and data collection by some government agencies for use on consumer website. One example of this is the Rate and Benefits Information System (RBIS) uses the templates to collect information for the off-Marketplace plan finder found at <https://finder.healthcare.gov>.

RBIS guidelines have changed since they first began collecting information – and often RBIS guidance and data change requests begin reaching insurers long after binders have been reviewed and closed. Making changes to the binders late in the year poses problems for insurers, SERFF, OID, RBIS, and HIOS.

For 2016 OID decided that we would require all templates for plans offered on and off-Marketplace early in the review process in an effort to prevent any issues that not having these templates may long after binders have closed

Are insurers required to contract with a specific number of ECPs for plans offered outside of the Marketplace?

No. OID has no rules or statutes that require insurers to contract with a specific number of ECPs for plans offered outside of the Marketplace. Insurers seeking exchange certification are still required to follow federal law and Oregon Health Insurance Marketplace requirements for ECPs.

What type of measurement will OID use to determine an ECP template is acceptable once submitted for plans outside of the Marketplace?

If the template is complete and submitted in SERFF with any contracted ECPs the requirement is complete. *Carriers who are submitting only off-Marketplace plans are not required to complete the ECP justification supporting document.*

Is there a list of ECPs available?

CMS has provided a non-exhaustive list of ECPs on their website, please visit the link below where you can find the list in XLS format under “Other Qualified Health Plan Application Resources: <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html>.

If we are an insurer that offers outside the Marketplace and we have not contracted with any ECPs what do we do?

Email Tashia Sample so we can make sure to make a quick note in your filing. Tashia’s email is Tashia.m.sample@oregon.gov.

If we have questions about the ECP template who do we contact?

CMS has provided a manual for all each template at <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html>. However, if your question is not answered in that template go submit a helpdesk ticket to CMS_FEPS@cms.hhs.gov or call 1-855-CMS-1515 (1-855-267-1515).

If we have questions regarding the requirement for carriers offering plans only outside of the Marketplace to provide the ECP template who should we contact?
Please contact Tashia Sample at Tashia.m.sample@oregon.gov.

Stand Alone Pediatric Dental Plans

Will SADPs be reviewed for accreditation status?

No.

Are SADPs required to meet Essential Community Provider requirements?

Yes, exchange certified pediatric dental plans must complete the ECP template. More information on these requirements can be found in the Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces.

Are SADPs required to follow prescription drug standards?

No.

As a QHP are we permitted to omit “embedded” coverage of pediatric dental benefits?

QHP issuers are permitted to offer plans that omit coverage of the pediatric dental EHB if a SADP is offered in the same service area in which they intend to offer coverage.

The standard plans may not have “embedded” pediatric dental benefits

Carrier Accreditation

We are a new medical carrier in the market this year and do not have accreditation information to display. How do we meet the requirement?

New insurers must meet the requirements for accreditation found in 45 C.F.R. 155.1045(b)(1).

My accreditation information is not appearing in the SERFF filing. How do I make it appear?

Company accreditation information appears on the Company and Contact tab in SERFF and must be completed before the submission of the binder. If you have already submitted the binder you will be asked to withdraw it and submit a new binder so the information will populate correctly.

Benchmark Plan

The benchmark has plan limitations; however, we received an analyst objection stating that the plan limitation was impermissible. Please explain.

EHB-benchmark plans may not reflect all requirements for plan years beginning on or after January 1, 2014. Insurers designing plan benefits, including coverage and limitations, should design them to comply with requirements that apply to plans beginning in 2014.

Member Age Questions

May we require members under the age of 65 with ESRD to enroll in Medicare?

No. Individuals under the age of 65 with ESRD are not required to sign up for or enroll in Medicare.

May we prohibit enrollment to individuals over the age of 65?

No, individuals who do not have Medicare Part A or Part B are eligible to enroll in individual market coverage, including QHPs, if the individual meets the eligibility requirements for enrollment. Further OAR 836-053-0431(10) addresses eligibility requirements related to Medicare in Oregon.

May we limit coverage of services based on age?

CMS cautions that age limits may be potentially discriminatory when applied to services that have been found clinically effective at all ages. Insurers should not attempt to circumvent coverage of medically necessary benefits by labeling the benefit as a “pediatric service” thereby excluding adults.

Prescription Benefits

We have multiple links for our formularies. Are the links required to match?

The formulary drug list URL should be the same direct formulary drug list link across all documents, including the SBC and Plan and Benefits Template.

What is considered a complete “formulary drug list”?

CMS 9944-F clarified that for the purpose of 45 CFR 156.122(d) the list must all the drugs that are EHB and list all the drug names currently covered by the plan at that time. Insurers must also include accurate information about any prior-authorization restrictions, step therapy requirements, quantity limits, and any pharmacy access restrictions.

Standard Plan Adjustment

Where can we find information on Oregon’s standard plan adjustments?

<http://resources.coveroregon.com/carrier-information.html>

CMS Tools

Are we required to use the tools provided by CMS to check the accuracy of our data and the design of our plans?

Running the templates through the various tools, including the Data Integrity Tool (DIT), provides insurers immediate feedback regarding the quality of their templates. If completed before uploading the final versions into HIOS or SERFF the tool output may reduce the need for rework and resubmission. The tools do not replicate all HIOS and

SERFF validations, but it does contain many checks necessary for correct template submissions that are not performed by HIOS or SERFF.

Insurers who do not use the DIT incur the risk that their plan information will not display properly on Plan Compare, including the risk that their plans will not be displayed at all due to plan errors.

If you chose not to run the tools please contact your forms analyst immediately.

Important Links

CCIIO Homepage:	http://www.cms.gov/cciio/index.html
Templates and Tools:	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/ghp.html
Filing Requirements:	http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/filing/Pages/Health/health.aspx
SERFF:	http://www.serff.com/
Cover Oregon:	http://resources.coveroregon.com/carrier-information.html
Acronym Dictionary:	http://www.cms.gov/apps/acronyms/
Standard Plan Cost	
Share Matrix:	http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/Documents/training/standard-plan-cost-share-matrix.pdf

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