

Medical Binder Training, Part I

Online viewers: Submit questions during the training at insurance.video@state.or.us

Agenda

- Introductions and welcome
- What we know now
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- Associate Schedule Items tab
- Templates tab
- Supporting Documentation tab
- Company and Contact tab
- Correspondence tab
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What we know now...

- All of the information presented today will be what we know of as today.
- All of the information and handouts presented are subject to change as we learn more.
- Updates from this information will be addressed either before or during the next medical binder training on June 12.
- Any updates in information will be posted as soon as possible to our Training webpage at <http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/Pages/training.aspx>

Recently updated documents

- Medical binder product standards (Form 440-4953)
- Standard plan cost share chart
- Filing timelines – As of now, filing timelines have not changed. We believe our current filing timelines will not change but will confirm this in the coming weeks as Cover Oregon and CMS conclude their negotiations.

***All of the above documents
are found on our Training website.***

Standard Plan Cost Share Chart

- OID Analysts also call this the “Color Chart”
- We created this document last year for guidance and consistency for both carriers and analysts.
- This is a crosswalk document between the Senate Bill 91 (standard plans) exhibit created by OID and CMS’s Plan and Benefits template.
- Blue column on left represents the category as listed on the Senate Bill 91 exhibit.
- Green column on right represents the category as listed on the Plan and Benefits template.
- Contains prescribed benefits, cost shares, and day/visit limits as contained in the standard plan.
- Recently updated the MOOP amounts and reordered the green column to reflect the documents in the order they’re listed on the Plan and Benefits template.
- Will revise again, if needed, when the final Add-In file for the Plan and Benefits template is released by CMS. We do not anticipate too much will be changed.

Senate Bill 91 (2011) Standard Plan - EHB and Cost Share Matrix

Benefit as listed on the SB 91 Exhibit document	Gold	Silver	Bronze	Day/visit limits	EHB Category as listed on the Plan and Benefits Template
Deductible	Medical: \$1,300; Rx: \$0	Medical: \$2,500; Rx: \$0	Integrated Medical/Rx: \$5,000		
Maximum OOP	Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$6,350		
Family Multiplier	2x Individual	2x Individual	2x Individual		
Primary Care Office Visit to Treat an Injury or Illness	\$20	\$35	\$60 After Deductible		Primary Care Visit to Treat an Injury or Illness
Specialist Office Visit	\$40	\$70	\$100 After Deductible		Specialist Visit
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$20	\$35	\$60 After Deductible		Other Practitioner Office Visit (Nurse, Physician Assistant)
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% After Deductible	30% After Deductible	50% After Deductible		Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Outpatient Surgery Physician/Surgical Services	10% After Deductible	30% After Deductible	50% After Deductible		Outpatient Surgery Physician/Surgical Services
Hospice Services	10% After Deductible	30% After Deductible	50% After Deductible	Respite care - max of 5 consecutive days; lifetime max of 30 days	Hospice Services
<i>Not covered in standard plan</i>					Non-Emergency Care When Traveling Outside the U.S.
<i>Not covered in standard plan</i>					Routine Dental Services (Adult)
<i>Not covered in standard plan</i>					Infertility Treatment
<i>Not covered in standard plan</i>					Long-Term/Custodial Nursing
<i>Not covered in standard plan</i>					Private-Duty Nursing
<i>Not covered in standard plan</i>					Routine Eye Exam (Adult)
Urgent Care Centers or Facilities	\$60	\$90	\$120 After Deductible		Urgent Care Centers or Facilities

Plans tab



- Fields such as the Plan Name, Metal Level, and Availability are updated automatically based on the Plan and Benefits template. If the fields are incorrect on the Plan and Benefits template, they will display incorrectly on the Plans tab.
- Once a binder is submitted, the number of plans in the binder is locked into place. Additions and deletions are not allowed or supported. If a change is necessary, a new binder filing will need to be completed and the previous binder filing withdrawn.

Associate Schedule Items tab



- Each plan will have a number of associated documents, including policies, certificates (if applicable), rates, applications, benefit summaries, etc.
- Once a document is associated with a plan, it will be automatically updated to the latest version of the document in the form or rate filing.
- All relevant rate, form, application, and endorsement filings must be referenced, complete with SERFF Tracking Number, Form Name, and Form Number.

Templates tab



This tab consists of eight CMS templates:

- Administrative Data Template
- Plan and Benefits Template
- Prescription Drug Template
- Network Template
- Service Area Template
- Essential Community Providers Template
- Rate Data Template
- Rating Business Rules Template

Templates tab

- All templates must be uploaded in both XML and Excel format.
- All 2015 templates may be downloaded from:
http://www.serff.com/plan_management_data_templates_2015.htm

Templates tab – Administrative Data Template

- This is a federal data collection template which collects general corporate, marketing, contact, and administrative information about the issuer.
- OID does not review this template; it is for exchange purposes only.
- Does not need to be submitted for binders with outside-exchange plans only.

Templates tab – Plan and Benefits Template

- This is a federal data collection template for high-level plan information, benefit information, and cost-sharing information.
- This template also calculates the Actuarial Value.
- Required for all medical binders, regardless of exchange participation.
- OID reviews this template.
- **The Add-in File, which includes Oregon-specific information, is not available for 2015 plans yet.** CMS is still finalizing the information and has been working with OID over the past couple of weeks to finalize it.
- CMS has proposed to add a new benefit to the Oregon Add-in File this year: “Mastectomy-Related Coverage”. Because we don’t know if it will make the final template, we have not added this information to the Standard Plan Cost Share Chart. We will update that chart as necessary after the final Add-in File is released.

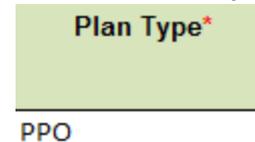
Templates tab – Plan and Benefits Template

2015 Cost Sharing Amounts (per IRS and Federal final rule):

- **Maximum out of pocket (medical)** - \$6,600 (self-only) and \$13,200 (family). ***Updated 5/20/14: The MOOP for standard plans will remain at \$6,350 (self-only) and \$12,700 (family) for 2015 plans. Only the MOOP for non-standard plans changed to \$6,600/\$13,200.***
- **Maximum out of pocket (pediatric dental)** – \$350 (one child) and \$700 (two or more children).
- **High deductible health plans, maximum out of pocket** - \$6,450 (self-only) and \$12,900 (family).
- **High deductible health plan minimum deductibles** - \$1,300 (self-only) and \$2,600 (family).
- **Health savings accounts annual contribution limits** - \$3,350 (self-only) and \$6,650 (family).

Templates tab – Plan and Benefits Template

- In each individual and small group market, inside or outside of the exchange, the issuer must offer at least a standard bronze and standard silver plan.
- For inside-exchange plans, issuers may submit one standard plan and four non-standard plans per metal level for sale through the exchange.
- On the Benefits Package tab, plans may not be marked as “HMO” in the Plan Type field, since there are no licensed HMOs in Oregon (instead we have Health Care Service Contractors). Issuers must select the most appropriate Plan Type.



A screenshot of a dropdown menu for the 'Plan Type' field. The menu is open, showing a list of options. The option 'PPO' is highlighted in blue, indicating it is the selected value. The text 'Plan Type*' is visible at the top of the dropdown.

- 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.
- On each Benefits Package tab, please list all appropriate quantity limits, visit limits, exclusions, and EHB variances.

Templates tab – Plan and Benefits Template

- On the Benefits Package tabs, if EHB is listed as “Yes” and/or State Mandate is listed as “Yes” and the benefit is listed as “Not Covered” we may send objections.

Benefit Information			
Benefits	EHB	State Mandate	Is this Benefit Covered?
Delivery and All Inpatient Services for Maternity Care	Yes	Yes	Covered

- In limited cases, these are acceptable. For example, on standard plans pediatric dental benefits are not allowed, so even though “Dental Check-Up for Children” is listed as “Yes” in the “EHB” column, it should either be listed as “Not Covered” or a blank column for this benefit.
- Please list any applicable day or visit limits on the Benefits Package tabs.
- Because EHBs cannot have annual or lifetime limits, please do not list dollar amounts in the General Information section of the Benefits Package tab. Issuers should be providing an actuarially-equivalent benefit instead.

General Information						
Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay	Exclusions	Explanation (text field)	EHB Variance Reason

Templates tab – Plan and Benefits Template

- Since there is only one category for “Habilitation Services”, we are interpreting that category as for inpatient habilitation services, so please list the appropriate cost shares for inpatient habilitation services in this category. Habilitation Services
- This year, since Oregon will be working with federal technology, we will not be requiring carriers to manually add any benefit categories because they will not show up on the federal plan compare web display.
- 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.)* Allergy Testing

Templates tab – Plan and Benefits Template

Standard plans:

- Each issuer is required to submit standard bronze and standard silver plans and rates for each area they transact business.
- We will not allow less or more benefits or day/visit limits than the benchmark plan.
- Must follow the same cost shares and day/visit limits as listed on the Standard Plan Cost Share Chart.
- Pediatric dental is not allowed in standard plans and must be listed as “Not Covered”.
- 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.
- The deductible for the standard bronze plan is an integrated deductible applicable to prescription drugs and all services except preventive services.
- 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

Templates tab – Plan and Benefits Template

Standard plan naming conventions:

- Issuers must use the following naming convention for standard plans per OAR 836-053-0009(3):

[Name of Issuer] Oregon Standard [Bronze/Silver] Plan

For example, “Acme Oregon Standard Bronze Plan”.

- “Name of Issuer” in the rule means whatever the issuer wants to call itself—within reason. Even issuer DBA names, within reason, are acceptable.
- **This naming convention must be present and exactly the same on the Plan and Benefits template, benefit summary, and SBC.** Beyond these three places, the plan name may be listed however the issuer wants it (e.g., on marketing materials, etc.).
- Non-standard plans may be named whatever the issuer chooses.

Templates tab – 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.
- Required for all medical binders, regardless of exchange participation.
- OID reviews this template.
- Prescription drug coverage must be provided 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 836-053-0008(1)(a); or
 - (B) The same number of prescription drugs in each category and class as the prescription drug coverage of the plan described in OAR 836-053-0008(1)(a).
- Last year, we discovered that if drugs were not in the same order as our list, our prescription drug review tool output would come back as “insufficient” in a certain category.

Templates tab – Network Template

- This is a federal data collection template for information about the provider network name and URL for display to a consumer.
- Required for all medical binders, regardless of exchange participation.
- OID reviews this template.
- Please make sure the URL given is valid and accurate.

Templates tab – 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 the plan availability and rates.
- Required for all medical binders, regardless of exchange participation.
- Make sure that this report matches what is entered on the Plan and Benefits Template.
- OID reviews this template.

Templates tab – Essential Community Providers Template

- This is a federal data collection template for provider and street address information about the Essential Community providers in issuer networks.
- OID does not review this template; it is for exchange purposes only.
- Does not need to be submitted for binders with outside-exchange plans only.

Templates tab – Rate Data Template

- This is a federal data collection template which collects rate data for each plan and rating area to be offered.
- Required for all medical binders, regardless of exchange participation.
- OID reviews this template.
- Fill out information for all rating areas the carrier is in. *For example, if a carrier offers coverage statewide, please fill out information for all seven rating areas.*
- Not required to be uploaded at submission time, but must be uploaded into the binder by **September 15**.

Templates tab – Rating Business Rules Template

- This is a federal data collection template for the issuer specific business rules to calculate rates based on various factors.
- Required for all medical binders, regardless of exchange participation.
- OID reviews this template.
- Not required to be uploaded at submission time; but must be uploaded into the binder by **September 15**.

Template Tools

- **Data Integrity Tool (DIT)** – CMS specifically designed for issuers to provide a method for issuers to check that the data contained in their templates is in the correct format; and provide issuers with feedback immediately and reduce resubmissions.
- **QHP Application Review Tools** – CMS created for federal and state reviewers but have made the tools available for issuer use this year:
 - **Cost Sharing Tool**
 - **Essential Community Providers (ECP) Tool** *(for inside exchange plans only)*
 - **Category Class Drug Count Tool**
 - **Non-Discrimination Clinical Appropriateness Tool**

The other tools available and listed below will not be useful for a single issuer, as they are built to compare all data from multiple issuers for a state: *Meaningful Difference Tool, Non-Discrimination Tool, Non-Discrimination Formulary Outlier Tool*

Download the QHP Application Review Tools here:
<https://login.serff.com/StateQHPReview2015.html>

From CMS: “Use of tools by issuers is completely optional. Issuers are encouraged to use these tools proactively before submitting their QHP applications and can also reference them when a state or federal regulator requests corrections after an initial review that included use of these tools. However, please note that issuers should respond to any deficiencies identified by a state or federal regulator even if the identified issue is different than the results an issuer obtained by using these tools.”

We strongly encourage issuers to run their templates through the appropriate tools before submission.

Supporting Documentation tab



This tab consists of several submission items:

- Binder Cover Letter
- Certificate of Compliance
- 4953 – Binder Filing Standards
- Plan Relativities
- SBC
- Essential Community Provider Supplemental Response Form
- Program Attestations for Issuers
- SHOP tying justification
- Partial Service Area justification
- Unique Plan Design Supporting Documentation and Justification
- EHB-Substituted Benefit (Actuarial Equivalent) Justification
- Formulary-Inadequate Category/Class Count Justification
- Limited Cost Sharing Plan Variation-Estimated Advance Payment Supporting Documentation and Justification
- Unified Rate Review Template (URRT)
- Actuarial Memorandum

Supporting Documentation tab

– 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.
- For new plans, a description of any variations that were used to modify the standard benefit design.
- For previously-approved plans, a description of changes made to the plans and/or variations between proposed plans.
- A description of differences between in-network and out-of-network cost sharing.
- Include the names and contact information for at least two people in your company that can answer questions about this filing. If the contact people change during the course of the filing, issuers are required to submit a revised binder cover letter with updated information.

Supporting Documentation tab – 4953 – Binder Filing Standards

- Completely revised and available on our website today.
- Much more useful this year. Last year, we were guessing at what would be helpful. With one year under our belts, we have a much better grasp of the guidance needed.

Supporting Documentation tab – Rate related documents

- **Plan Relativities**
 - *The same number of plans should be listed on this document than what is included in the binder filing. For example, if the binder includes 30 plans, then 30 plans should be listed on the Plan Relativities document.*
- **Unified Rate Review Template (URRT)**
- **Actuarial Memorandum**
- These should be the exact same documents found in the corresponding rate filing. Follow the rate product standards for more guidance on these documents.
- Not required to be uploaded at submission time; but must be uploaded into the binder by **September 15**.

Supporting Documentation tab - SBC

- Not required to be uploaded into the binder until **August 15**.
- This year, OID will perform an audit of the SBCs.
- In-depth training on the SBCs will be held on **June 12**.
- Provide one SBC for each plan submitted within the binder. *If there are 30 plans submitted, please submit 30 SBCs.*
- No ZIP files are allowed; individual PDFs of each plan should be attached.
- For standard plans, the required plan naming convention per OAR 836-053-0009(3) should be listed as the plan name.

Supporting Documentation tab – Exchange documents

- Essential Community Provider Supplemental Response Form
- Program Attestations for Issuers
- SHOP tying justification
- Limited Cost Sharing Plan Variation-Estimated Advance Payment Supporting Documentation and Justification

These documents are needed for inside-exchange plans only. The forms are self-explanatory; instructions are located on the forms themselves.

Supporting Documentation tab – Partial Service Area Justification

- This document is required of any issuers that include partial counties in any of their service areas.
- If one or more of an issuer's service areas includes a partial county, the issuer must submit a detailed justification document describing why the entire county will not be served. For each requested exception, the justification must outline why the partial county is necessary, non-discriminatory, and in the best interest of potential enrollees, consistent with 45 CFR 155.1055.

Supporting Documentation tab – Unique Plan Design Supporting Documentation and Justification

- Submit this form when the Actuarial Value (AV) Calculator is not used.
- If this form is not needed due to the AV Calculator being used for all submitted plans, this requirement may be bypassed.
- This document must be signed by an actuary.
- If any plans are marked as “yes” in the “Unique Plan Design?” field on the Benefits Package tab of the Plan and Benefits template, this form must be submitted.

Unique Plan Design?*

Yes

Supporting Documentation tab – EHB-Substituted Benefit (Actuarial Equivalent) Justification

- If an EHB is substituted within a category, this form must be submitted.
- Submit one for each affected plan design.
- This document must be signed by an actuary.

Supporting Documentation tab – Formulary-Inadequate Category/ Class Count Justification

- If there is an inadequate category or class count within the formulary as required, this justification must be submitted.
- Please use the form as provided.
- Choose the appropriate justification letter as listed on the form. Last year, many issuers didn't list the justification options as given and we wrote many objections. Justification reasons beyond these are unlikely to be acceptable.

* Choose the appropriate letter in the Justification column or use free text to describe an “other” justification.

A = Drugs in this category and class have been discontinued by the manufacturer.

B = Drugs in this category or class have been deemed unsafe by the FDA or removed from market by the manufacturer due to safety concerns.

C = Drugs in this category and class have a DESI classification.

D = Drugs in this category or class have become available as generics during or after December 2012.

Company and Contact tab



- Company contact information may not be changed after submission. Please check all contact information for accuracy before submission.
- The phone number provided should be a direct line to the filer or a company contact familiar with the binder contents and process.
- Beginning this year, we are asking for contact information for two people at your company. Contact information for both individuals should be included in the cover letter.
- In the event contact information changes, please attach a revised cover letter on the binder and contact your OID analyst.
- This tab also includes issuer's accreditation information. If company not accredited, explain in binder cover letter.

Correspondence tab



- Last year, Objection Letters and Binder Notes appeared out of order.
- This year, OID analysts still are unable to tie objections to a specific item, like in SERFF form and rate filings.

Helpful Links

- **2015 QHP Templates:**

http://www.serff.com/plan_management_data_templates_2015.htm

- **2015 Supporting Documentation and Instructions for Submissions:**

http://www.serff.com/plan_management_instructions_2015.htm

- **2015 Actuarial Value (AV) Calculator:**

http://www.serff.com/plan_management_instructions_2015.htm

- **HHS Notice of Benefit and Payment Parameters for 2015 (3/11/14):**

<http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf>

- **SERFF Industry User Manual Appendix II:**

<https://login.serff.com/Appendix%20II.pdf>

- **IRS Guidance (4/25/14):**

<http://www.irs.gov/pub/irs-drop/rp-14-30.pdf>

- **Senate Bill 91 (standard plans) exhibit:**

<http://www.oregon.gov/DCBS/insurance/legal/bulletins/Documents/2013-02-attachments/StandardPlan-RxCharts-full.pdf>

Helpful Links

SBC guidance:

- **Group SBC completion instructions from the Department of Labor:**
<http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf>
- **Individual SBC completion instructions from the Department of Labor:**
<http://www.cms.gov/CCIIO/Resources/Files/Downloads/instructions-individual-final.pdf>
- **SBC Uniform Glossary:**
<http://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf>
- **CMS - RegTap (Registration for Technical Assistance Portal):**
www.regtap.info
- **For HIOS/Template issues:**
 - For questions specific to the HIOS system or the Excel templates, contact the CMS Help Desk directly at 855-267-1515 or CMS_FEPS@cms.hhs.gov.

Upcoming Trainings

- Dental Binder Training - Monday, June 2, from 9:00 – 10:30 a.m.
- Medical Binder Training, Part II - Thursday, June 12, from 1:30 – 3:30 p.m.
- Association Training – Monday, July 21, from 2:00 – 4:00 p.m.

All trainings will be located in Room 260 of the Labor & Industries Building at 350 Winter St. N.E., in Salem.

View trainings live online at: www.oregon.gov/DCBS/Pages/video_hearing.aspx

OID Rates and Forms Training Website:

<http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/Pages/training.aspx>

Training handouts, presentations, updated information after trainings, and archived trainings are found on our Training website.

Questions?

Online viewers:

Submit questions now at

insurance.video@state.or.us

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