



Medical Binder Training, Part II

Oregon Insurance Division and Cover Oregon

June 12, 2014

Online viewers:

Submit questions during the training

at insurance.video@state.or.us

Agenda

- Introductions and welcome
- What we know now
- Updates since the last training
- Clarifications since the last training
- Carrier questions and answers
- Summary of Benefits and Coverage (SBC)
- Ask Cover Oregon
- Helpful links
- Upcoming trainings
- Questions?

What we know now...

- All of the information presented today will be what we know of as today and is the best of our current knowledge.
- Because of the complexity and many changes, it is possible we do not have the current answer. Please speak up if you believe any of this information may not be correct.
- All of the information and handouts presented are subject to change as we learn more.
- Any updates from this information will be posted as soon as possible on our Training webpage at <http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/Pages/training.aspx>

What we know now...

- For 2015, Cover Oregon is a State Based Marketplace (SBM) that is supported with federal technology, otherwise known as a “supportive SBM model.”
- Cover Oregon will be performing the same functions as they did for the 2014 plan year, but this year will be using federal technology for plan display and individual enrollment.

Updates since the last training

- We have confirmed that carriers do not need to submit the Network Adequacy Template or Accreditation Template in their binder filings.
- For 2015, standard plan maximum out of pocket (MOOP) amounts are staying at **\$6,350/\$12,700**. Standard plan MOOPs cannot be less or more than this amount—they must all have these amounts exactly.
- For 2015, non-standard plan (including catastrophic plans) MOOP amounts are now **\$6,600/\$13,200**. Non-standard plans may have MOOPs *less than* this but cannot have MOOPs *more than* this.

Updates since the last training

- **No new attestations required:** We have confirmed with CMS that since Cover Oregon will be a State Based Marketplace again for the 2015 plan year, issuers will complete the same attestations that were completed last year. NAIC has confirmed that the appropriate attestations are listed in SERFF.
- **No new templates required:** The same templates as last year are listed and required. *The new Network Adequacy Template and Accreditation Template are not required.*

Updates since the last training

- **Mastectomy-Related Services** – We have questions into CMS about this benefit. It should be a part of the Add-In File, as it's a benefit that CMS added to the Oregon information to mirror our Mastectomy-Related Services mandate (ORS 743A.110). Unless you hear differently from us, if CMS tells you to manually add it, please do so.
- If the Mastectomy-Related Services benefit is added, the cost shares for standard plans will be 10% / 30% / 50% because those are the cost shares listed under “Breast Reconstruction” in the Senate Bill 91 exhibit. Please use those amounts on standard plans, unless you hear differently from us.

Rate-related items in binders

- **Rate items in binders must be uploaded September 15, this includes:**
 - Unified Rate Review Template (URRT)
 - Actuarial Memorandum
 - Plan Relativities
 - Rate Data Template
 - Rating Business Rules Template

If you have your items ready before this date, please do not wait to submit. Because of needed time to view the items on Plan Compare before your binders are finalized, we recommend uploading these items as soon as you can after the rate filings are finalized and updated with the approved amounts.

Clarifications since the last training

- Carriers can have up to five plans per metal tier *per service area* within the exchange.
- XML versus XLS: You only need to upload the .xml version of each template. At validation, the federal hub converts the .xml version to .xls so OID and Cover Oregon can open and review it.

Clarifications since the last training

- If you have a partial county service area, the Service Area template must list the file name in column G using the following naming convention:
 - *[Issuer ID]-Partial County-[Service Area ID]-[County Name]*
 - For example, “12345-Partial County-ORS001-Multnomah.doc”
 - Then, upload the justification document on the Supporting Documentation tab.
 - The text “See partial service area justification” is not acceptable in column G.
- **Same plan, different networks** - Each plan submitted must be associated with a single Network ID as identified in the Network ID Template. If you wish to offer two plans that are identical except for different networks, you must create two plans with separate HIOS Plan IDs. If you wish to offer a plan that includes both of those networks for each consumer, you may create a third network ID that consists of those two networks and create one plan associated with this third network.

Clarifications since the last training

- **Routine Foot Care:** Do not indicate “not covered” for the Routine Foot Care benefit, because that does not accurately reflect the benefit required to be provided by the benchmark plan. The benchmark plan includes Routine Foot Care but for diabetics only. Instead, it should be listed as “Covered” but in the explanation text field, list that it is only covered for people with diabetes.

Clarifications since the last training

- **Accidental dental** benefit on the Plan and Benefits Template. We are interpreting this as an EHB because it is listed in the [benchmark plan](#) (p. 29-30, in the Covered Services list under 7.1.8). Please list as “Covered” in your Plan and Benefits templates.
 - *Services of a state-licensed dentist and/or physician for treatment of the jaw or natural teeth only as follows:*
 - *A. Treatment of injury to the jaw or natural teeth.*
 - *B. Orthognathic surgery when necessary due to an accidental injury.*
 - *C. Orthognathic surgery when necessary for removal of a malignancy and the subsequent reconstruction.*

Clarifications since the last training

- “Prescription drugs other” benefit on the Plan and Benefits Template
 - We still have outstanding questions to CMS about this field and what it means.
 - Until we receive information that interprets this differently, we are interpreting these fields as Specialty Drugs, so please use the same cost shares you would for Specialty Drugs (*for standard plans, that means 50% coinsurance for all metal levels*).

Clarifications since the last training

- Carriers do not have to fill out the SBC Scenario section of the Plan and Benefits template. However, if the issuer does not provide the information in the template, Plan Compare will show “not available”.
- Carriers may add extra benefits to the Plan and Benefits template, but they will not show on Plan Compare. A list of anticipated template data elements to be shown on Plan Compare is found [here](#), pages 10-56 through 10-61.

Carrier questions answered

- Per ORS 743.822, all carriers (regardless of exchange participation) must file at least a standard silver and a standard bronze plan.
- In order to participate in the exchange, a standard gold plan must also be submitted.
- For off-exchange medical binders only, all of the templates are required except the Administrative Data Template and the Essential Community Providers Template and carriers may bypass both of these templates.

Carrier questions answered

- The Add-In File for the Plan and Benefits Template is required. It contains items specific to Oregon such as mandates and benchmark plan benefits.
- Because carriers are required to use the Add-In File we will not require you to add extra benefits as we did last year in both medical and dental binders. However, if CMS requires you to add something, please do so.

Carrier questions answered

- Carriers may change the benefit explanations that auto populate on the Plan and Benefits Template. For example, dollar amounts are populated for the pediatric vision benefit. Please remove those dollar limits, as carriers must provide an actuarially-equivalent benefit instead.
- For Mental Health Services on standard plans, reflect whatever your company does for mental health services. As long as carriers comply with MHPAEA, you may list whatever cost shares make sense for your company and plans.

Carrier questions answered

- **Habilitation services** benefit we are interpreting as **inpatient** habilitation, since there is only one habilitation services category. CMS has confirmed that our interpretation of this field is correct. Please list your cost shares and day limits accordingly.
- **Standard plan visit limits for rehabilitation and habilitation:** Per the Senate Bill 91 exhibit, both **inpatient rehabilitation** and **inpatient habilitation services** have visit limits of **30 days per year** total. Only the **outpatient rehabilitation** and **outpatient habilitation services** have a visit limit of **30 visits per year plus up to an additional 30 visits per condition**, based on certain conditions.
- On the Cost Share Variance tab of the Plan and Benefits Template, carriers may enter either “0%” or “No charge”. We have no requirement of one way or another of how to list it, since they both mean the same thing—the consumer will have no cost share.

Carrier questions answered

What the variant numbers mean for plans:

-00 = non-exchange variant

-01 = exchange variant

-02 = Zero Cost Sharing Plan Variation

-03 = Limited Cost Sharing Plan Variation

-04 = 73% AV Level Silver Plan CSR

-05 = 87% AV Level Silver Plan CSR

-06 = 94% AV Level Silver Plan CSR

CMS Application Review Tools

- CMS Application Review Tools are strongly encouraged to be used by issuers before submitting their binders. These tools are a set of Excel-based evaluation services for specific issuer and benefit standards for the QHP application process.
- CMS Application Review Tools are found at CMS Zone, SERVIS, or on the OID Binder requirements page at <http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/filing/Pages/Health/health-planbinders.aspx>
- On 6/10/2014, CMS released an updated version of the QHP Application Review Tools for the 2015 plan year. The latest version includes updates only to the Essential Community Provider (ECP) Review Tool and includes a new tool, Stand-alone Dental Plan (SADP) ECP Tool. The updated ECP Tool (version 1.1) addresses an error received in the case where a service area only covers one county. The SADP ECP Review Tool (version 1.0) is applicable to SADPs. CMS has also released step-by-step user guides with screen shots to assist states with the 2015 QHP Application Review Tools.
- Please submit questions related to the 2015 QHP Application Review Tools to **QHPinfo_States@cms.hhs.gov** and include “QHP Application Review Tools” in the subject line and first sentence of the body of the message.

CMS Revised Benchmark Spreadsheet

- We have already found some discrepancies between what Oregon requires and what is listed on the template from CMS.
- We are making a list of these and will address them with CMS after the filing season, so hopefully they will be fixed for next year.
- We asked for several of these items to be fixed earlier this year, but CMS was unable to change them for programming or resource issues.
- When you find possible discrepancies, please let us know.
- If the OID reviewer determines that an item is a covered benefit in the benchmark plan or by state mandate, but the benefit is not listed as “Yes” in either the EHB or State Mandate columns, they will ask you to list the benefit as “Covered” and will provide you with the text and cite of how they made this covered benefit determination.

Standard Plans and Color Chart

- **Gray rows** on the Color Chart indicate that the benefit will be listed on the Plan and Benefits template, but these items should be listed as “**Not Covered**” for standard plans.

Not covered in standard plan

Routine Dental Services (Adult)

- If the benefit is listed in **green** on the Color Chart, it should be listed as “**Covered**” for the standard plans.

Emergency Room Services

- All benefits and day or visit limits listed on the Color Chart should match what you have listed for your standard plans. No more, no less.

60 days per
year

Skilled Nursing Facility

Standard Plans and Color Chart

For standard plans, on the Benefit Package tab, please list the data items as listed below for **outpatient rehabilitation**:

Quantitative Limit of Service = Yes

Limit Quantity = 30

Limit Unit = Visits per year

Explanation (text field) = 30 visits with up to an additional 30 visits per condition for certain conditions

- Some of these fields will auto populate, but make sure the end result matches the information above for this benefit.
- The Limit Quantity field only accepts numbers, this is why we're asking carriers to list as shown above.

Standard plan naming convention

OAR 836-053-0009(3): Issuers must use the following naming convention for standard plans, with no exceptions or abbreviations allowed:

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

For example: Acme Oregon Standard Bronze Plan

You may enter network names or any other identifying information after the word “Plan” if needed. However, the naming convention must stay intact so it is exactly the same from carrier to carrier. *For example: Acme Oregon Standard Bronze Plan Legacy*

This specific plan naming convention is only required on the standard plans and only on the benefit summary (in the form filing) **and the SBC and Plan and Benefits Template** (in the binder filing). Beyond that, you may name your plans whatever you wish.



Summary of Benefits and Coverage



**COVER
OREGON**

Carrier Survey Results



Communication

The number one concern from Carriers last year was communication between OID and Cover Oregon. This year:

- OID Analyst
- Cover Oregon Analyst
- Carrier Plan Filer and SME if needed.

Plan Review and Cover Oregon Portal Display

- Federal Plan Review and Web Portal Display
- No deductible asterisk
- More flexibility – Standard Plan input
- Less flexibility - Deadlines

Short Timelines

Key Dates

6/30/14 – Binders due to OID

7/7 to 7/11/14 – Cover Oregon validates SERFF Templates

7/14 to 7/18/14 – Carriers begin data review
(assuming templates are correct and all systems are working)

8/8/14 - First Plan Data push to Federal System

9/4/14 - Final Plan Data push to Federal System (through SERFF). No further data changes are allowed by CMS.

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 instructions:

http://www.serff.com/documents/plan_management_data_instructions_ch11_2015.pdf

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>

Standard Plan Color Chart: <http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/Documents/training/standard-plan-cost-share-matrix.pdf>

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

Association Training – Monday, July 21, at 2:00 p.m.
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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