Oregon Insurance Division

ACA Policy, Form, Plan, and Rate Development Questions, Answers and Clarifications

CATEGORY	TOPIC	PLAN YR.	NO.	QUESTION	ANSWER
Small group	Group Size	2014	1	**It's our understanding Cover Oregon will implement the ACA requirements for small employers to continue to be eligible as a SHOP employer even if they grow in size to a large employer. What will the market rules be outside of the exchange for small employers who grow in size too large? Will the division still expect carriers to force migrate groups from one segment to another?**	*For plans issued outside of the exchange, if an employer no longer qualifies as a small group or large group, it must be treated accordingly at renewal. Federal eligibility standards 45 CFR.710 (d) require SHOP to "treat a qualified employer which ceases to be a small employer solely by reason of an increase in the number of employees…as a qualified employer" as long as the employer continues to meet other eligibility criteria and elects to continue purchasing "coverage for qualified employees through the SHOP."*
Administration	Group Size	2014	2	**Will the division issue specific guidance for determining small employer qualification, such as who can be counted as an employee for purposes of sizing a group, including groups of one employee?**	*Existing state employee counting rules continue to apply until Jan. 1, 2016, when federal rules will be required.*
Administration	Group Size	2014	3	**Are there any anticipated changes to the list of valid waivers for calculating a group's minimum participation requirements? Specifically, will a waiver to an individual plan be considered a valid waiver?**	*Carriers determine participation and contribution requirements. The division does not intend to define these requirements or change current practice. 45 CFR §147.104(b)(1)(i) allows carriers to limit the availability of coverage for small groups to an annual enrollment period from Nov. 15 through Dec. 15 if the plan sponsor is unable to comply with a material plan provision relating to employer contribution or group participation rules. 45 CFR §147.104(b)(1)(i), however, prohibits carriers from denying coverage for failing to meet participation or contribution requirements.* *Open enrollment runs from Nov. 15, 2014, through Feb. 15, 2015.*
Small group	Eligibility	2014	4	**Regarding the new requirement for a group eligibility waiting period to not exceed 90 days, can the participant's effective date be first of the month following 90 days?**	*No, a waiting period is the period of time that must pass before coverage* ***can become effective*** *for an employee or dependent who is otherwise eligible to enroll under the terms of the plan. A waiting period cannot exceed 90 days.*
Administration	Continuation	2014	5	**Must carriers continue to offer portability plans after Dec. 31, 2013?**	*HB 2240 eliminates the portability requirement for plans issued on or after Dec. 31, 2013.*

Claims	Nonpayment of premium	2014	6	**Will carriers be required to pay interest on claims pended due to nonpayment of premium by individuals during their 90-day grace period? The ACA allows individuals up to 90 days to pay premium but current state law requires carriers to pay clean claims within 30 days to avoid paying interest.**	*When a individual is enrolled in a qualified health plan through the exchange and receiving advance payments of the premium tax credit and has previously paid at least one month's premium, the individual is given a 90-day grace period to pay premiums. Insurers must pay the cla ims through the first 30 days but may pend claims between 31 and 90 days. If the member does not pay his or her premium andis subsequently terminated the insurer is not required to pay the claims for services between 31 and 90 days. If the individual pays the premium, the claims become clean claims and must be processed accordingly.*
Claims	Benefit accrual	2014	7	**For individual products, we understand that there will be an open enrollment period for Jan. 1, 2014, and most new policies will have a Jan. 1 anniversary date. Does the division have any input on whether members must have their benefits accrue on a calendar-year basis?**	*For nongrandfathered individual plans renewed or issued in 2014 and subsequent years, benefits will accrue on a calendar-year basis. See division bulletin 2013-01 for more information. For nongrandfathered small group plans renewed or issued in 2014 and subsequent years, benefits may accrue on a calendar or plan-year basis.*
Small group	Dependents	2014	8	**Can small employers offer employee-only coverage, which would allow employees' dependents to go to the exchange and receive premium subsidies/tax credits, since they aren't offered group coverage?**	*Yes, small employers may offer employee-only coverage.*
Associations	Group Size	2014	9	**If I am a hypothetical bona fide association comprised of 10 small groups with 15 employees each, am I considered a 150-employee large group? Or, are each of my 10 small groups subject to the provisions of ACA?**	*A true large group, which meets the ERISA definition of a single "employer," is not subject to the single risk-pool rating requirement.* *However, in most situations, a health plan is established at the association member level. In these instances, a carrier must determine the applicable market (individual, small group, or large group) for each member of the association.*
Associations	Group Size	2014	10	**Is the Oregon Insurance Division considering following Washington's example by meeting and working with carriers and associations to determine whether associations will meet the ERISA standard to be deemed a large group by the DOL?**	*Whether an association meets the ERISA standard is a question of fact and complicated federal analysis. The division does not intend to interpret ERISA for associations on an individual basis.*

Group size	Associations	2014	11	**What will Oregon Insurance Division do with an association that goes forward assuming the association meets the DOL definition?**	*Carriers are responsible to ensure that they issue large group coverage to true large groups. There are significant regulatory and legal consequences to carriers and groups that fail to comply with the law.*
Administration	Service Area	2014	12	**Is it acceptable to have a service area that does not cover an entire geographic area?**	*The division recognizes that service areas and geographic areas may not be identical.*
Administration	Completion	2014	13	**What authority does the Oregon Insurance Division have to ensure that multi-state plans compete fairly in our marketplace?**	*Issuers of health benefit plans, including issuers of multi-state plans, are subject to the requirements of the Oregon Insurance Code.*
Small group	Applications	2014	14	**Will a uniform employer group application be required both inside the SHOP and for the outside small group market? If so, when will a template be available?**	*The division does not currently plan to create a uniform application for the outside market.*
Individual plans	Applications	2014	15	**Will a uniform individual application be required both inside the exchange and for the outside individual market? If so, when will a template be available?**	*The division does not currently plan to create a uniform application for the outside market.*
Filing	Plans	2015	16	**Will the division require carriers to file two contracts for each plan offering, one including the pediatric dental benefit and one excluding it?**	*For 2015 plans, the division will allow one contract with pediatric dental as a bracketed provision or two separate contracts.*
Filing	Dental	2014	17	**Will the division require carriers to file stand-alone dental plans that cover only the pediatric dental benefit under the essential health benefits? Will adult stand-alone dental plans need to include the pediatric dental benefit?**	*No to both questions.*
Administration	Vision	2014	18	**Regarding pediatric vision benefits, what types of benefit limits will be allowable? The Oregon benchmark plan materials on the HHS website include dollar limits. The division's 2014 form product standards reference "benefit maximums" but do not provide specifics. The plan filing standards reference "allowances." Please clarify.**	*Standard plans must cover the benefits provided under the Federal Employee Dental and Vision Insurance Plan (FEDVIP) plan. Actuarial equivalent visit or equipment/device limits must be substituted for dollar limits.*
Administration	EHB	2014	19	**What type of essential health benefit certification will be required, per the federal regulations, section 156.115(b)(2)?**	*The certification must meet the requirements that are enumerated in 45 CFR §115(b)(2).*

Administration	EHB	2014	20	**Is there a prohibition on adding coverage beyond the benchmark in the standard plan?**	*Yes, the standard plan cannot exceed the benchmark. Non-standard plans can exceed the coverage in the benchmark plan but coverage that exceeds essential health benefits does not count toward the actuarial value.*
Filing	Network	2015	21	**For the Essential Community Provider and network templates in the SERFF plan filing, what standards will be used to evaluate the sufficiency of a carrier's network? Also, it appears that the network template does not require specific providers to be listed (rather, the template requires a carrier to identify the general network being used). Please confirm.**	*For 2015 plans, the division requires carriers to certify that the networks are adequate to provide the benefits offered under their plans. The division is working with Cover Oregon to review future network adequacy requirements, which will be developed with industry input.*
Claims	Dental	2014	22	**What has been traditionally regarded as preventive dental services are not on the A or B list; can the division include cost sharing for these dental preventive services?**	*Not all preventive services are required to be covered without cost sharing. The only preventive services that carriers must provide without cost sharing are grade A and B USPSTF preventive services, Bright Futures recommended medical screenings for children, IOM recommended women's guidelines, and ACIP recommended immunizations for children.*
Claims	Hearing Aids	2014	23	**Will the state issue a standard about AV equivalence (e.g., $4K/year for audiology services = 2 hearing aids/year) or will each carrier decide?**	*The division does not intend to provide an actuarial equivalence for dollar limits included in the standard plans or essential health benefit benchmark plan.*
Administration	Group Size	2014	24	**Must carriers use the group profile form to determine group size for coverage offered to groups through the exchange?**	*No. For plans offered outside of the exchange, carriers must continue to use the group profile form. The group profile form will not be required for groups in the exchange.*
Administration	Preventive car	2014	25	**How frequently must carriers offer members the opportunity to participate in a smoking cessation program? Would the premiums have to be adjusted mid-year?**	*Coverage must be equal to or better than Oregon's benchmark plan, which covers two quit attempts per lifetime.* *In response to the second question, no, premiums cannot be adjusted mid-year.*
Claims	Dental	2014	26	**Is it an option for carriers to choose to embed dental benefits or not in both individual and small group plans, inside and outside the exchange?**	*Inside and outside of the exchange, carriers have flexibility to embed or exclude the pediatric dental benefit from a given plan. Outside of the exchange, a carrier must be reasonably assured that the applicant has pediatric dental coverage under an exchange-certified stand alone dental plan before the carrier can issue a plan without pediatric dental coverage.*

Claims	Dental	2014	27	**Do the exchange certified dental plans, for stand-alone dental, have to be identical when sold both inside and outside the exchange?**	*No. Cover Oregon will certify up to 10 pediatric dental plans to be sold outside of the exchange.*
Administration	Dental	2014	28	**Will pediatric dental be guaranteed issue in the outside market?**	*No.*
Administration	Dental	2014	29	**Will the state provide standard language or definitions for the carrier to have "reasonable assurances that a child has exchange certified pediatric dental"?**	*No.*
Administration	Dental	2014	30	**Can a medical carrier be required to accept reasonable assurance from any exchange certified pediatric dental carrier or may the carrier be more restrictive?**	*Medical carriers must accept reasonable assurance of coverage under all exchange-certified dental plans.*
Administration	Dental	2014	31	**Will pediatric dental be embedded in the standard plans?**	*No.*
Administration	Dental	2014	32	**Are child-only and family with pediatric dentalcoverage the only two stand-alone options that will meet the standard for outside market required purchase of EHB pediatric dental?**	*Yes, as long as the plan is certified by Cover Oregon.*
Administration	Dental	2014	33	**Do grandfathered plan members have to have minimum pediatric dental?**	*No. They are exempt from ACA requirements and can continue to purchase old dental plans.*
Group size	Eligibility	2014	34	**Can a sole proprietor buy group coverage?**	*No. There would need to be an employee in addition to the sole proprietor.*
Claims	EHB	2014	35	**Are carriers permitted to combine the rehabilitation/habilitation services with a 60-visit maximum combined?**	*Benefits cannot be combined across EHB categories. The two benefits structures may mirror each other, but they have to be separate.*
Administration	Nonpayment of premium	2014	36	**Must we accept group applications from groups terminated for nonpayment? If so, could they be required to repay back-owed premiums before being enrolled again?**	*Under ACA there can be no prohibition from reapplying.*
Rates	Development	2014	37	**Can the division provide further clarity regarding rating for "child-only" policies? The ACA refers only to members under 21 for purposes of counting children/dependents, so will there be a standard about each child enrolling separately or combining them under the responsible party signing the contract?**	*Individuals who do not purchase coverage for themselves, but decide to purchase coverage for their dependents may be offered a single combined child-only policy that covers all dependents under age 21. Carriers should consult Cover Oregon for their specific requirements inside the exchange.*

Rates	Development	2014	38	**Will the division standardize the tobacco question? Will the division define tobacco use or will that be up to the carriers?**	*The division will not standardize the questions used by carriers to determine whether a member uses tobacco but strongly recommends carriers mirror the examples provided by HHS and apply the federal definition of tobacco use.* *HHS defines tobacco use in 45 CFR §147.102(a)(iv) as follows: "…tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Tobacco use must be defined in terms of when a tobacco product was last used."* *HHS provides the following questions as examples of how carriers may determine a member's tobacco use: "Within the past six months, have you used tobacco regularly (four or more times per week on average excluding religious or ceremonial uses)?"* *Carriers may shorten the applicable period of the last regular tobacco use to a period of less than six months.*
Administration	Group Size	2014	39	**Will the division define standard participation and contribution requirements for all carriers, consistent with the exchange?**	*No, the division will not define standard participation and contribution requirements for all carriers to be consistent with Cover Oregon's requirements. Please note that 45 CFR 147.104 prohibits carriers from denying coverage to an employer that fails to meet minimum participation or contribution requirements*
Rates	Development	2014	40	**What do we do with the fact that the AV calculator doesn't consider things such as out-of-network benefits, different deductibles, network utilization?**	*Show the differences in benefit relativities. The actuarial values might be equal, but not necessarily the relativities. Pricing is in addition to the results of the AVC. Whatever you do needs to be documented, supported/justified, and consistent in the entire filing.*
Rates	Development	2014	41	**If actuarially equivalent substitutions are allowed, how does it remain the standard plan?**	*The only actuarial equivalencies that will be allowed in standard plans are for those items with dollar limits that must be translated into visits, etc.*
Rates	Development	2014	42	**How does the Oregon cessation mandate fit with the tobacco use rating factor?**	*A cessation program must meet federal wellness standards in order for a carrier to vary premiums based on the tobacco use rating factor.*

Rates	Development	2014	43	**Should the experience for associations be included?**	*Association experience must be included in the appropriate market risk pool (i.e., individual with individual and small group with small group). An association that is a true large group pursuant to ERISA (few associations meet this standard) is excluded from the single risk pool.*
Rates	Development	2014	44	**Do carriers need to spread the lost revenue from a three-child limit?**	*Yes.*
Rates	Development	2014	45	**The SERFF Business Rules Template asks, "How are rates for contracts covering two or more enrollees calculated?" Is it a PMPM buildup for Oregon small group, since the group will see 4-tiered rates on its bills? You could argue we don't need to do that because the group's total premium is calculated using the same PMPM buildup approach as everything else, but it's not totally clear. The choices on the template are either "There are rates specifically for couples and for families" and "A different rate for each enrollee is added together."**	*The rates are developed on a PMPM basis, with the different rates for each enrollee added together. The tiers deal only with allocation.*
Administration	Network	2015	46	**Can we expand our network at anytime throughout the plan year?**	*There is nothing that prohibits a carrier from expanding its network for individual plan members as long as it does not affect the current rate.* *A carrier can expand the network but cannot change the premium until the next open enrollment.* *Small groups can increase rates throughout the calendar year or quarterly, and can change the rate when increasing the network. A filed and approved plan binder and new rates for the new network, showing what plans will be offered, is required before launching the new network. If the network is described in the form filing, an endorsement would be required in all cases.*
Administration	Rates	2015	47	**Should a couple who was married in a state that recognized same-sex marriage be able to be rated as a married couple?**	*For premium tax credits, same-sex MARRIED couples must file as married, filing jointly. Their eligibility for tax credits will be determined on that basis. The IRS does not recognize domestic partnerships (registered or not). Thus, people in domestic partnerships must file as single and will have their tax credits determined on that basis.*

Administration	Rates	2015	48	**Should a couple who is registered as domestic partnership in Oregon be rated as individuals rather than a couple?**	*On the rating piece, marriage is irrelevant. Under the per-member rating methodology required under ACA, whenever two people are enrolled together on an individual plan, you just add their age and tobacco adjusted rates together. (There is no marriage discount.) For small group, it would work the same as it always has.*
Group size	Rates	2015	49	**When a final rate for a group is calculated, is the final rate based on the final enrollment of the group on the effective date of coverage or at the time the coverage is issued? There could be several months' difference and membership would vary.**	*The final rates will be based on the actual enrollment and may be different than the rates originally quoted. Additional information may be required by the carrier to verify eligibility of the group.*
Administration	Riders	2015	50	**Why are there no riders allowed under the single risk pool?**	*All medical benefits must be priced under a single risk pool. Typical rider pricing uses a separate risk pool to determine the cost, and is not allowed under the ACA. The cost of an optional benefit must be pooled.*
Administration	Riders	2015	51	**Will riders be allowed as long as the actuary certifies that the rider was priced according to the single risk pool adjustment?**	*We will consider this for 2016.*
Administration	Dental	2015	52	**What will happen to pediatric dental in the future? Will the Oregon Insurance Division eventually require it to be embedded?**	*Right now, no changes are happening to pediatric dental for 2015. It's difficult to say what will happen in the future. The Oregon Insurance Division will revisit this topic in the future.*
Filing	Plans	2015	53	**Who reviews the SBCs?**	*The Oregon Insurance Division will review the SBCs in August* nearing the end of plan and rate review.
Administration	Network	2015	54	**Can networks be priced per county; essentially, can there be multiple area factors?**	*There can be only one network factor across all counties that network is available. There can be only one set of area factors. Allowing multiple network factors essentially bypasses the requirement for a single set of area factors. There is a workaround that is allowed by the ACA. If a carrier wishes to offer an X% discount in area 1 and a Y% discount in area 2, the carrier can limit the availability of those networks to those areas.*

Filing	Plans	2015	55	**What is the limit on the number of plans a binder can hold?**	*Last year, SERFF set a maximum of 100 plans per binder. Last year, after our filing deadlines had passed, SERFF lifted the maximum number of plans.*
Administration	Plans	2015	56	**Will you extend 2013 plans again through 2015 or 2016?**	*See the transitional plan guidance.*
Administration	Dental	2015	57	**Will the $150 maximum (AV equivalent) pediatric vision benefit be the same for the 2015 filing year?**	*Yes.*
Administration	Waiting Periods	2015	58	**Can you clarify which types of benefits can have waiting periods?**	*Waiting periods will be allowed on elective benefits as long as they are nondiscriminatory and applied in the same way to every insured.*
Filing	Plans	2015	59	**Will the Oregon Insurance Division or Cover Oregon make a model Plans and Benefits template for standard plans for carriers to reference?**	*Yes. We will not be able to create it until CMS releases the new Plan and Benefits template. We will get it out to carriers as soon as possible after that date.*
Rates	Plans	2015	60	**Will there be a standard document that lists plan benefits and cost shares*?***	*The cost share amounts of the 2014 matrix will be the same in 2015; we will be adjusting the EHB categories as they are listed on the new Plan and Benefits templates as soon as CMS releases those templates.*
Filing	Riders	2015	61	**Do plans with riders need to have a different HIOS ID than those without?**	*Yes, but please note that no riders are allowed on ACA health plans, as they violate the single risk pool requirement in Oregon. However, there can be two plans in which the benefits of one are a subset of the benefits of the other.*
Administration	Reporting	2015	62	**What is the Edge Server, and *what* are the requirements for reporting on it?**	*The Edge Server is the data processing tool used by HHS to execute the federally administered Risk Adjustment and Reinsurance programs. HHS will set the reporting requirements.*
Administration	Reinsurance	2015	63	**Can carriers assess reinsurance fees on grandfathered plans?**	*Yes.*

Discontinuation	Material chang	2015	64	**Will carriers need to determine if a product is modified or discontinued on 2015?**	*Yes. With the exception of transitional plans, all discontinued products that were renewed before Jan. 1, 2014, are still discontinued. If a plan moves out of a metal tier, and into another tier, it is considered discontinued. If a plan exceeds 10 percent value benefit adjustments while remaining within a metal tier (for example, a significant change in deductibles), it is considered discontinued.*
Administration	EHB		65	**Will the standard plans change for 2015?**	*No.*
Claims	Deductibles	2015	66	**Are carriers required to cross-accumulate deductibles and out-of-pocket maximums when the pediatric dental essential health benefit is embedded in the medical plan?**	*Yes.*
Claims	Dental	2015	67	**Are carriers required to cross-accumulate deductibles and out-of-pocket maximums when the pediatric dental essential health benefit is not embedded in the medical plan and is satisfied through a stand-alone dental plan?**	*No.*
Filing	Network	2015	68	**For the Essential Community Provider and network templates in the SERFF plan filing, what standards will be used to evaluate the sufficiency of a carrier's network? Also, it appears that the network template does not require specific providers to be listed (rather, the template requires a carrier to identify the general network being used).**	*For 2015 plans, the division is requiring carriers to certify that the networks are adequate to provide the benefits offered under their plans. We are working with Cover Oregon to review future network adequacy requirements, which will be developed with industry input.*
Claims	Dental	2015	69	**For pediatric dental, will the standard plans define the cost sharing? Will the plan design be defined beyond which benefits are covered?**	*Pediatric dental will not be a standard plan benefit.*
Claims	Dental	2015	70	**Have annual maximums for pediatric dental benefits changed?**	*According to the final federal essential health benefit regulations, a state's exchange must establish what constitutes a reasonable out-of-pocket maximum for standalone dental plans. Additional federal guidance is expected. Cover Oregon recently announced $1,000 maximum out of pocket.*

Administration	Riders	2015	71	**Are benefit riders allowed?**	*No. Pricing a benefit rider separately from the medical benefits it accompanies violates the single risk pool pricing requirement.*
Claims	Dental	2015	72	**Can a carrier issue a health benefit plan that does not include pediatric dental outside the exchange?**	*Yes, if an issuer of a health benefit plan is reasonably assured that an applicant has purchased certified pediatric dental coverage the issuer may issue the coverage to the applicant.*
Administration	Dependents	2015	73	**Is the individual's age at the time of issuance the age for the entire policy year?**	*There are no restrictions on age rating for transitional and grandfathered plans. For ACA-compliant plans, the rate must stay the same as it was when the coverage was issued, throughout the policy year.*
Rates	Development	2015	74	**Will the division require standard age curve and family tier factors from all carriers?**	*The division will require carriers to use the national default age curve established by HHS. The division received HHS approval for our approach to small group rating.*
Rates	Development	2015	75	**How should the health insurance assessment fee and effective tax be described in the filing?**	*In the rate filing, report only the actual insurer's fee in administrative costs. "Effective tax" is not an appropriate administrative charge. Any impact the fee has on the margin should be reflected in the margin component of the rate filing.*
Rates	Actuarial Mem	2015	76	**Should the carrier add ceded risk experience back into the single risk pool or use those claims to justify morbidity assumptions?**	*Either method is actuarially appropriate.*
Rates	Development	2015	77	**What base experience may be used if the historical experience is not credible?**	*To the extent that the base period experience for a particular single risk pool is not credible, the Division will accept any reasonable development of the index rate that follows the Actuarial Standards of Practice. Note that this general guidance applies to all rate development.*
Rates	Development	2015	78	**What is the state mandated small group family tier structure?**	*Standardized tier factors: Employee Only: 1.0; Employee + Spouse: 2.0; Employee + Child = 1.85; Family: 2.85 (note that children include all dependent children ages 0 to 25)*
Rates	Development	2015	79	**Can tobacco factors vary by age?**	*Yes, as long at the smoker rates do not exceed the 3:1 age banding ratio.*
Rates	Development	2015	80	**For the cost metrics information, what year should we report?**	*Calendar Year 2013*
Rates	Filing		81	**On the standard review questions – are these to be submitted at the time of the filing? Or will we answer these when we get the objection letters?**	*These questions are submitted with the filing. These are pre-emptive questions.*

Rates	Dental	2015	82	**The Index Rate is required in URRT, and it is used to arrive at the Cost Share Reduction (CSR) Subsidies in the Binder Filing. This is different than the calculation for the base rate in Exhibit 1. How will the division review the URRT, cost sharing subsidies, and Exhibit 1?**	*The division approves only the requested rates, not the subsidies that result from those rates and benefits. The URRT is a required document in SERFF, but federal documents are not part of Oregon's product standards. We do, indirectly, check for accuracy in these calculations, but not as part of our rate decision.* *In the rate filing, you should be able to:* *• Demonstrate how to arrive at the requested rates from the supporting documentation, including Exhibit 1.* *• Demonstrate how to arrive at the approved rates from updated rate tables and binder documents.* *• Demonstrate how the base rate and index rate are inter-related (page 8 of the product standards). We do not have a prescriptive formula for this.* *When we do our last check of the rates before approval, the rate components of the binder filing will receive a brief check for consistency.*
Associations	Group Size	3/21	83	**Who determines if an association is bona fide?**	*It is up to the carrier to determine if an association is bona fide.*
Administration	Service Area	3/21	84	**Can a plan be extended to an area that it wasn't offered previously?**	*Yes, as long as you have approved area factors and use the approved index rates.*
Discontinuation	Plans	3/21	85	**Suppose an ACA plan changes metal level between 2014 and 2015. Is this allowed?**	*Yes. Note that the plan would need a new HIOS ID number.*
Administration	Plans	3/21	86	**Due to technical limitations, changing the benefit structure in an ACA-compliant plan would require the plan to have a new HIOS ID. How should we handle membership on those plans?**	*Simply map the members to the new plan ID number.*
Rates	Associations	3/21	87	**Suppose there is a bona fide association in Washington, but has some Oregon membership. Should we file rates in Oregon for those members?**	*No.*

Administration	Hearing Aids	3/25	88	**Based on the training info, we cannot impose $4,000 (or its CPI equivalent for each year) on hearing aids, but an actuarial equivalent is permissible. If so, can we:** **• Use a shorter period than 48 months if that is the actuarial equivalent?** **• Impose another limit on top of the 48 months limit prescribed by ORS 743A.141?**	*We will need to see the complete calculation for actuarial equivalence in the filing.*
Filing	Rates	3/25	89	**Rate binder requirements: Do we have to have all of the binder templates completed when we file the plans?**	*The final URRT and rate data template can be attached to the plan binder filing after the rates have been approved.*
Administration	Plans	3/25	90	**Will we have to change plan name because it was too long?**	*We were informed that Cover Oregon has resolved this issue.*
Administration	Dental	3/25	91	**Can we offer more than just the minimum EHB in plans covering children?**	*Yes.*
Discontinuation	Filing	3/25	92	**Does the Oregon Insurance Division need to see the modification or discontinuation notices prior to use?**	*Yes. They are a part of the filing approval.*