OAR 836-010-0013
Exhibit 3

Oregon
Kate Brown, Governor

Department of Consumer and Business Services
Division of Financial Regulation
350 Winter St. NE, Room 410
P.O. Box 14480
Salem, OR 97309-0405

April 1, 2016

TO: Carriers Offering Transitional Plans

RE: Small Group Transitional Health Benefit Plans

In conjunction with Senate Bill 1582 (2014 Legislative Session), the Division of Financial Regulation (division) (formerly the Insurance Division) of the Department of Consumer and Business Services (DCBS) issued regulatory requirements and guidance in April 2014 for transitional health benefit plans[1], allowing renewals in 2014 for health insurance coverage that continued through December 31, 2015. The division adopted the guidance as an exhibit to Oregon Administrative Rule (OAR) 836-010-0013 and OAR 836-053-0066.

In 2015, the division needed to decide whether to allow individual and small group transitional health benefit plans to be renewed through policy years beginning on or before October 1, 2016 to provide coverage into 2016 and 2017. After stakeholder feedback and careful consideration of the current marketplace, the division has determined that carriers:

- Must discontinue individual transitional health benefit plans effective no later than January 1, 2016.
- May not renew small group transitional health benefit plans after October 1, 2016 and must discontinue these plans effective no later than October 1, 2017.

This memo sets forth the regulatory requirements and guidance for discontinuance of individual transitional health benefit plans and renewal of small group transitional health benefit plans.

This guidance is subject to revision if applicable state or federal laws change.

Individual Transitional Health Benefit Plans

Individual transitional health benefit plans must be discontinued effective no later than January 1, 2016 (last day of coverage December 31, 2015) and in accordance with the requirements for discontinuation set forth in 45 CFR 146.152(c), 147.106(c) and 148.122(d).

[1] April 2014 Guidance: http://www.oregon.gov/DCBS/insurance/legal/laws/Documents/OAR/div10-0013_ex2.pdf

Carriers must provide at least 90-days notice prior to discontinuation. The Oregon-specific notice[2], *Discontinuation notice for the individual market outside of the marketplace,* must be used. A copy of this notice is included as Appendix A. Marketing materials or other documents may be included in the mailing of the notice. Carriers are required to include the Summary of Benefits and Coverage for the new plan offered in place of the discontinued plan.

Small Group Transitional Plans

Carriers may not renew small group transitional health benefit plans after October 1, 2016 (last day of coverage September 30, 2017). Carriers will need to make a decision whether and when they will discontinue small group transitional plans.

Discontinuation of small group transitional plans
Carriers of small group transitional health benefit plans scheduled for discontinuation must provide at least 90-days notice prior to discontinuation. The Oregon-specific notice[2], *Discontinuation notice to employers for the small group market,* must be used. A copy of this notice is included as Appendix B.

Continuation of small group transitional plans
Carriers of small group transitional health benefit plans that will renew in 2015 and 2016 may continue that coverage until no later than September 30, 2017. Carriers must provide at least 60-days prior notice of the renewal in accordance with the requirements of 45 CFR 146.152 and 148.122. The notice from CMS' March 5 bulletin[33], *Attachment 2-Small group transitional plan renewal notice,* must be used. A copy of this notice is included as Appendix C.

Marketing materials or other documents may be included in the mailing of discontinuation and renewal notices. Carriers are required to include the Summary of Benefits and Coverage for the new plans offered in place of discontinued plans and for plans being renewed.

Carriers are required to notify the division whether they will continue to renew small group transitional health benefit plans. The division will issue separate guidance with reporting requirements.

Form Filing Requirements

Discontinuation of an individual or small group transitional health benefit plan
The Modification and Discontinuance of Health Benefit Plans filing requirements apply. Filing instructions for discontinuations can be located at:

http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/filing/Pages/Health/health-moddis.aspx.

[2] Centers for Medicare and Medicaid Services (CMS) September 2, 2014 bulletin included model notices, labeled as Attachments 1through 6. States were permitted to revise the notices in compliance with the guidance. The division sent the revised notices to carriers on 9/11/2014 by email from D'Anne Gilmore.
[3] CMS March 5, 2014 bulletin included model renewal notices labeled Attachments 1 and 2

Since the required notices are models, the division will consider these filings informational.

Continuation of small group transitional health benefit plans

When continuing small group transitional plans, the form filing requirements and recently released timelines apply. Binder filings are not required for transitional plans.

Rate Filing Requirements

There are no additional form or rate filings required for individual transitional health benefit plans since they are discontinued December 31, 2015.

Rate filing options for small group transitional plans (options also apply to grandfathered plans[44])

Carriers that renew small group transitional health benefit plans may choose one of the following rate filing options:

Option 1: 10/1/2015 Rate effective date

- Carriers will file rates for 4Q2015 through 3Q2016
- Filing must be submitted by 2/28/2015

Option 2: 1/1/2016 Rate effective date

- Rates for 4Q2015 will remain at the last approved level without trend adjustment
- Carriers will file rates for 1Q2016 through 4Q2016
- Filing must be submitted by 7/1/2015
- Under current state and federal guidance, 4Q2016 rates will only be available for use if the transitional program is modified to allow transitional coverage to renew after October 1, 2016

[4] Transitional and grandfathered plans must be pooled for rate filings

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Appendix A
Discontinuation notice for the individual market outside the marketplace
(Oregon-Specific Notice[2])

Important: We Will Not Offer Your Current Health Plan Next Year.
But You Have Options for New Coverage.

Dear [Policyholder or Name],

Your current health plan will not be offered next year. Your current coverage will end on December 31, 2015. This means **you must choose a new health plan to have health insurance coverage on January 1,** 2016. This letter explains the options available to you.

Options from [Issuer Name]
[We have selected a new [Issuer Name] plan for you that's similar to your current plan. **You'll automatically be enrolled in [Plan Name and Plan ID] unless you choose another option by [Date].** Below are key differences from your current plan. You can review all the benefits and coverage for this plan at [Issuer website].

- Premium – Your new premium starts in January. You'll pay $[Dollar amount] each month. **Check to see if you have other options or can get a tax credit to help reduce your premium at healthcare.gov.**
- [List differences to new plan, including:
  - Name of new plan and Plan ID
  - Benefit changes
  - Cost-sharing changes, including whether the plan is a different metal level from the previous plan.]
- [Point to differences in new plan with reference to other document received by recipient in this same mailing.]
-

[Plan Name and Plan ID] [is/isn't] being offered through the Marketplace. [We do offer other plans through the Marketplace.] If you qualify for lower costs on monthly premiums or lower out-of-pocket costs, you can get those savings only if you enroll in a plan through the Marketplace.

If you want this plan, simply pay the plan premium. [You can also tell us you want this plan by [filling out the enclosed form] [visiting our website]]. If not, you can also choose any of our other plans available to you.]

[You can choose any individual coverage offered by [Issuer Name] in your service area. Visit [Issuer website] or call [Issuer phone number] to learn about the plans available to you.]

What other options do I have?

- You may be able to choose a new health plan from [Issuer name] or another insurance company through the Marketplace or with the help of any agent or broker. You or your family may also qualify for the Oregon Health Plan (OHP).

- You can choose to buy a new health plan outside the Marketplace—directly from an insurance company or with the help of an agent or broker. But remember: If you qualify for lower costs, you can get those savings **only** if you enroll through the Marketplace at healthcare.gov.

What else should I look at before deciding?

Call or visit the plan's website to make sure your doctor and other health care providers will be in the plan network next year. Also check to make sure any prescription medications you take will be covered.

When do I need to make a decision?

To avoid a gap in coverage, enroll in a new plan by [Date] and coverage can begin on the 1st of the following month. In addition, the [2015] Open Enrollment period is from [Start date to End date].

Questions?

- If you have questions about your current benefits and plans offered by [Issuer Name], call or visit the website [Issuer Name and Contact Information and Hours of Operation].

- Visit healthcare.gov or call 1-800-318-2596 (Telecommunications Relay Service: 711 or call TTY 1-855-889-4325.) to learn more about the Marketplace.

- If you worked with an agent or broker in [2014] or intend to in [2015], you may also direct questions to your agent or broker.

Getting Help in Other Languages

[*Include the tagline below for the top languages spoken by 10% or more of the population in the state.*

Spanish (Español): Para obtener asistencia en Español, llame al [Issuer Contact Information].]

Appendix B
Discontinuation notice to employers for the small group market
(Oregon-Specific Notice[2])

Important: Your Group Health Coverage Will Not Be Available Next Year.

Dear [Plan Sponsor, a generic such as "Valued Group Customer" or Name]

Your group's current health coverage will not be offered next year. The current coverage will end on [Date]. This means **you may need to choose a new plan for your group members to have health insurance coverage**. This letter explains the options available to you.

Options from [Issuer Name]
[We have selected a new [Issuer Name] plan for your group members that's similar to their current plan. [**If you continue to qualify for small employer coverage, we'll] [We'll] [automatically enroll your group members in [Plan Name and Plan ID]] [automatically enroll your group members in the plan shown in the enclosed [title of document used by carrier]] unless you choose another option.** Below are key differences between the new coverage and the current coverage. You can review all the benefits and coverage for this plan at [Issuer website].]

- Premium – Your new premium starts in [Month]. [Your estimated monthly premium will be $[Dollar amount]]. [Your new plan and estimated monthly premium is shown in the enclosed [title of rate document used by carrier]]. This is an estimate based on current enrollment. This amount may change depending on the individuals who actually enroll in the plan.
- [List differences in new plan, including:
  - Name of new plan and Plan ID
  - Benefit changes
  - Cost-sharing changes, including whether the plan is a different metal level from
  - the previous plan.]
- [Point to differences in new plan with reference to other document received by recipient in this same mailing.]
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What other options do I have?

- You can choose any of our other small group plans. Call [Issuer phone number] or visit [Issuer website] to learn about plans available to you. Or you may work with your agent or broker to select another [Issuer Name] plan.

- You can choose to buy a new health plan directly from any insurance company or with the help of an agent or broker.

Small Employer Tax Credit
If you have fewer than 25 full time equivalent employees, you might qualify for a small business health care tax credit. For more information visit healthcare.gov or call 1-800706-7893 (Telecommunications Relay Service: 711).

Your tax consultant can determine whether your business qualifies for the small business health care tax credit and the amount you are entitled to be credited.

What else should I look at before deciding?
Call or visit the plan's website to check which doctors, other health care providers, and prescription medications are covered by the plan. This is an important step when choosing a plan that meets the needs of your group members.

When do I need to make a decision?
You generally can buy coverage any time. If group members enroll by the [Day] of the month, coverage can begin on the 1st of the following month.

We are notifying your employees
Federal law requires that we notify all group members with this coverage that it is no longer being offered. Because we might not know about other coverage decisions you have made, we'll tell your employees to check with the plan sponsor or administrator about coverage options that might be available through your organization.

Questions?
- ☐ Call or visit the [Issuer Name] website [Contact Information and Hours of Operation].

- ☐ If you worked with an agent or broker in [2014] or intend to in [2015], you may also direct questions to your agent or broker.

Getting Help in Other Languages
[*Include the tagline below for the top languages spoken by 10% or more of the population in the state.*

Spanish (Español): Para obtener asistencia en Español, llame al [Issuer contact information].]

Appendix C
Small group transitional plan renewal notice
(March 5, 2014 Attachment 2)

Important: We're Continuing to Offer Your Group Health Coverage.
It's time to renew!

Dear Policyholder,

We are writing to inform you that, consistent with federal guidance initially announced in November 2013 and extended in March 2014, you may keep your existing coverage for the upcoming policy year.

How Do I Keep My Current Policy?

To keep your current policy, please contact us.

As you think about your options, there are some things to keep in mind. If you choose to renew your current policy, it may NOT provide all of the protections of the Affordable Care Act. These include one or more of the following new protections of the Public Health Service Act (PHS Act) that were added by the health care law and took effect for coverage beginning in 2014. If you choose to renew your current policy, your coverage:

- May not meet standards for fair health insurance premiums, so you might be charged more based on factors such as gender or a pre-existing medical condition, and it might not comply with rules limiting the ability to charge older people more than younger people (PHS Act section 2701).
- May not meet standards for guaranteed availability, so it might exclude consumers based on factors such as a pre-existing medical condition (PHS Act section 2702).
- May not meet standards for guaranteed renewability (PHS Act section 2703).
- If the coverage is an individual market policy, may not meet standards related to pre-existing medical conditions for adults, so it might exclude coverage for treatment of an adult's pre-existing medical condition such as diabetes or cancer (PHS Act section 2704).
- If the coverage is an individual market policy, may not meet standards related to discrimination based on health status (PHS Act section 2705).
- May not meet standards for non-discrimination with respect to health care providers (PHS Act section 2706).
- May not cover essential health benefits or limit annual out-of-pocket spending, so it might not cover benefits such as prescription drugs or maternity care, or might have unlimited cost sharing (PHS Act section 2707).

- May not meet standards for participation in clinical trials, so you might not have coverage for services related to a clinical trial for a life-threatening or other serious disease (PHS Act section 2709).

How Do I Choose A Different Policy?

You have options for getting quality health insurance. [You may shop in the Health Insurance Marketplace, where all policies meet certain standards to help guarantee health care security, and no one who is qualified to purchase coverage through the Marketplace can be turned away or charged more because of a pre-existing medical condition. The Marketplace allows you to choose a private policy that fits your budget and health care needs. You may qualify for tax credits or other federal financial assistance to help you afford health insurance coverage purchased through the Marketplace.]

[You can also get new health insurance outside the Marketplace.] All new policies guarantee certain protections, such as your ability to buy a policy even if you have a pre-existing medical condition. [However, federal financial assistance is not available outside the Marketplace.]

You should review your options as soon as possible, because you may have to buy your coverage within a limited time period.

How Can I Learn More?

To learn more about the Health Insurance Marketplace and protections under the health care law, visit HealthCare.gov or call 1-800-318-2596 or TTY: 1-855-889-4325. If you have questions, please contact us.