Binders

Where should insurers look for information about binder filings?
DFR expects issuers to consult all applicable regulations, including the 2023 Letter to Issuers in the Federally-facilitated Marketplaces (when available), to ensure full compliance with requirements of the Affordable Care Act.

When are medical and dental binders due to the DFR?
Carrier must have completed binders submitted to DFR by May 18, 2022 so the Marketplace can meet the CMS transfer deadline. Information submitted in these binders will be considered draft data. Final data is not due to DFR until August 12, 2022.

We missed the binder deadline but are interested in offering plans in 2023. What options are available?
Due to the Marketplace's use of federal technology carriers must adhere to the deadlines identified by DFR in response to the CMS deadlines. If filing deadlines are missed the carrier may reach out to DFR for more information about available options – however, we are unable to guarantee active participation in the market.

If template errors are found after the close of the data submission window can insurers make corrections?
Permission to make corrections will be given on a case by case basis. Throughout the plan year, insurers may be required to correct deficiencies identified by DFR, the Marketplace, CMS, or as the result of an insurer's own compliance audits. In the event DFR or the Marketplace finds an error after the final data submission deadline the insurer will be contacted by a member of the DFR staff. If insurers identify errors the insurer should contact their Forms Analyst *immediately* with a description of the error. If the plan is offered on the exchange, the insurer should also contact the Marketplace. Failure to promptly notify DFR and OHIM may result in possible market conduct action.

A template error has been identified after the binder lock date, how can the information be corrected?
CMS *may* allow limited data correction windows after the binder lock date. The availability of data correction windows are not guaranteed. If an error is identified contact DFR and the Marketplace as soon as possible. If the change is allowed, the Marketplace will work with the insurer on next steps.
During a data correction window, insurers may request to make changes necessary to correct data display errors or align QHP data with products and plans approved by DFR, or from a limited list of changes that do not impact certification (example: plan marketing names). Changes to benefits or plan designs will not be permitted after the binder lock date.

Plans

Bronze and Silver Plans: Coinsurance for new Essential Health Benefits
For the following new Essential Health Benefits, added to the Oregon Benchmark Plan beginning in plan year 2023, DFR has determined each benefit should apply the

coinsurance for Primary Care Visit to Treat an Injury or Illness specified in Exhibits 1 and 2 to OAR 836-053-0013:

- Coverage for up to 20 spinal manipulation visits per year
- Coverage for up to 12 acupuncture visits per year

If plans were approved in previous years are we required to resubmit?
Yes. For all plans, medical and certified pediatric dental, offered in 2022, insurers must submit a complete SERFF filing. Plans previously approved, including plans certified as QHPs, must be resubmitted each calendar year. Small group employer plans retain their approval, and if applicable QHP certification, through the end of the employer's plan year, which may extend beyond the calendar year.

Can carriers submit additional plans after May 18, 2022?
No. After the binder submission deadline of May 18, 2022 carriers will not be able to add plan offerings for 2023 due to limitations with CMS technology.

Can carriers decide not to offer plans after May 18, 2022?
Yes. However, if an insurer changes an application to indicate that a plan will only be offered off-exchange the plan will no longer be available for certification. In the event an insurer decides not to seek approval or certification of a plan after the plan has been submitted the insurer should reach out to their Forms analyst.

We have a plan that we would like to be recertified for 2023 however, there have been changes. Can the plan still be re-approved or recertified?
To be eligible for recertification a plan must be the same "plan" as defined in 45 C.F.R. 144.103. Plans being reapproved and recertified for 2023 must use the same HIOS plan identification numbers that it used for 2022. This requirement applies to both medical and SADP.

Summary of Benefits and Coverage (SBC)

When are we required to submit the Summary of Benefits and Coverage (SBC)?
The Division is not requiring insurers to file SBCs this year; instead we will be reviewing the documents based on the SBC link of the Cost Share Variance tab of the Plan and Benefits Template. The links, and SBCs for each plan, must be live no later than September 1, 2022.

URRT

When is the last date for the URRT to be submitted into HIOS if the insurer is not participating in the exchange?
All risk pools with no QHPs must be in final status in the URR system by August 12, 2022.

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

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

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

Plan Preview

How do carriers offering on-exchange plans review information for accuracy before it is displayed to the public on healthcare.gov?
Insurers with QHPs will be able to view plan data in the Plan Preview environment, which is part of HIOS, in order to identify and correct errors before the binder lock date. Questions about the Plan Preview environment should be directed to the Marketplace. Failure to utilize Plan Preview and pro-actively review your files for potential corrections may result in market conduct action.

If an insurer identifies issues with information displayed on Plan Preview how should the information be updated?
Between May 18, 2022 and August 12, 2022 inaccurate information identified through Plan Preview can be revised by uploading revised templates and sending a request to the Marketplace to push the new plan data to HIOS. Insurers should also make changes to templates in response to State or CMS feedback during this review period.

An issuer making changes to the Service Area or Service Area Template should be discussed with DFR prior to making the change. All changes to the Service area must be authorized by DFR. All changes to the Service Area must be made prior to the binder lock deadline. CMS will have final say on if a service area can be changed.

We have submitted updated templates in SERFF; however, the data on Plan Preview is still out of date. How is the data updated on Plan Preview once new templates are submitted?
The Marketplace must transfer the updated data from SERFF to HIOS for Plan Preview to update. Sometimes this takes a few days. The Marketplace will notify you when your new plan data has been loaded into Plan Preview.

Plan Information on Healthcare.gov

A large error has been identified with the information appearing on healthcare.gov but it is too late to make changes – how can an insurer correct this information?
Insurers that request to make changes that affect consumers may have the plan suppressed until the data can be refreshed for consumer display. The insurer should reach out to DFR, and the Marketplace, as soon as the error is identified. The Marketplace will work with the insurer and CMS to suppress the plan.

HIOS

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

Does the insurer's legal entity name in HIOS need match information provided to DFR and the Marketplace?
Yes, insurers should ensure that legal entity information is identical across all agencies. Insurers undergoing some company changes (mergers, assumptions, and acquisitions) should review CMS 9944-F for more information about applicable requirements for reporting these changes to CMS. Contact Tammy Vance for more information about DFR requirements regarding company changes.

Plan Crosswalk Template

Are insurers required to complete the plan crosswalk template for the 2023 plan year?
Yes, the Plan Crosswalk template is required for medical plans regardless of exchange certification status as well as SADPs. While SADPs are excepted benefits, and not subject to the guaranteed renewability standards in 45 CFR 147.106, the 2023 Plan Crosswalk template is required for the purpose of modification and discontinuance.

Off-exchange plans do not automatically populate in the Plan Crosswalk template but are still required. For plans offered off-exchange, a separate Plan Crosswalk template must be completed manually.

Completed plan crosswalk templates should be submitted on the supporting documentation tab. Exchange certified medical plans and SADPs should also submit the completed Crosswalk template and Marketplace approval to CMS in the Plan Management Community.

Multi-State Plan Program (MSP)

Where can we find more information on the multi-state plan program (MSP)?
Insurers seeking to offer MSP coverage must apply to participate via OPM's online application portal.

Service Areas

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

May an insurer change the list of counties associated with a particular plan (change the service area of a plan)?
Any change to the counties associated with a plan is considered a change in service area, even if the issuer offers other plan or products in the counties (or partial counties) in question.

However, after binders have been submitted insurers will not be permitted to change plan service areas without petitioning DFR, and the Marketplace for plans offered on-exchange. Requested changes to plan service areas after the May 18, 2022 binder date will be considered but only approved under very limited circumstances.

Essential Community Providers (ECP)

Where can we find information on Essential Community Providers?
A non-exhaustive list of Essential Community Providers can be accessed on the CCIIO website at:https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.

Is the ECP/Network Adequacy Template required for off-exchange plans?
Yes, the template has been combined with the Network Adequacy template; carriers should complete the combined ECP/ Network Adequacy template for off-exchange only plans with particular emphasis on completing the Network Adequacy portion.

Stand Alone Pediatric Dental Plans

Will SADPs be reviewed for accreditation status?
No.

Are SADPs required to meet Essential Community Provider requirements?
Yes, exchange certified pediatric dental plans must complete the ECP template. More information on these requirements can be found in the 2023 Letter to Issuers in the Federally-facilitated Marketplaces.

Are SADPs required to follow prescription drug standards?
No.

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

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

Carrier Accreditation

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

New insurers must meet the deadline specified in the Marketplace Request for Applications (RFA). Questions about accreditation should be submitted to the Marketplace.

Benchmark Plan

The benchmark has plan limitations; however, we received an analyst objection stating that the plan limitation was impermissible. Please explain.
EHB-benchmark plans may not reflect all requirements for plan years beginning on or after January 1, 2023. Plan benefits, including coverage and limitations, should be designed to comply with state and federal regulations that apply to plans beginning in 2023.

Member Age Questions

May we require members under the age of 65 with ESRD to enroll in Medicare?
No. Individuals under the age of 65 with ESRD are not required to sign up for or enroll in Medicare. More information about DFR's expectations for ESRD and dialysis coverage can be found at: Division of Financial Regulation : Kidney dialysis coverage : Health insurance regulation : State of Oregon

May we prohibit enrollment to individuals over the age of 65?
No, individuals who do not have Medicare Part A or Part B are eligible to enroll in individual market coverage, including QHPs, if the individual meets the eligibility requirements for enrollment. Further OAR 836-053-0431(10) addresses eligibility requirements related to Medicare in Oregon.

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

Prescription Benefits

We have multiple links for our formularies. Are the links required to match?
The formulary drug list URL should be the same direct formulary drug list link across all documents, including the SBC and Plan and Benefits Template.

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

Standard Plan Adjustment

Where can we find information on Oregon's standard plan adjustments?
http://dfr.dcbs.oregon.gov/rates-forms/Pages/base-benchmark-plan.aspx

CMS Tools

Are we required to use the tools provided by CMS to check the accuracy of our data and the design of our plans?
While not required, use of the tools is strongly encouraged. Running the templates through the various tools, including the Data Integrity Tool (DIT), provides insurers immediate feedback regarding the quality of their templates. If completed before uploading the final versions into HIOS or SERFF the tool output may reduce the need for rework and resubmission. The tools do not replicate all HIOS and SERFF validations, but it does contain many checks necessary for correct template submissions that are not performed by HIOS or SERFF. It is highly encouraged that filers run these tools.

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

Important Links

CCIIO Homepage:	http://www.cms.gov/cciio/index.html
Templates and Tools:	https://www.qhpcertification.cms.gov/s/Application%20Materials
Filing Requirements:	http://dfr.dcbs.oregon.gov/rates-forms/Pages/index.aspx
SERFF:	https://login.serff.com
Marketplace:	http://www.oregonhealthcare.gov/carrier-resources.html
Acronym Dictionary:	http://www.cms.gov/apps/acronyms/
Standard Plan Cost Share Matrix:	https://dfr.dcbs.oregon.gov/rates-forms/Pages/base-benchmark-plan.aspx

DFR Contact Information

Tashia Sizemore– Manager
503-947-7270
tashia.m.sizemore@dcbs.oregon.gov

Tammy Vance
503-947-7236
tammy.vance@dcbs.oregon.gov

Rick Barry
503-947-7255
rick.a.barry@dcbs.oregon.gov

Carolyn Hancock
503-947-7214
carolyn.a.hancock@dcbs.oregon.gov

Michael Holmes
503-947-7491
michael.r.holmes@dcbs.oregon.gov

Marketplace Contact Information

Katie Button
503-507-2349
katie.button2@dhsoha.state.or.us