Oregon Insurance Division
Binder Questions from Carriers and Answers
June 12, 2014

DENTAL BINDER QUESTIONS

1. We are planning to submit our binder for Oregon in the upcoming week and have been using the checklist on SERFF. We noticed that the Network Adequacy template and the Essential Community Provider (ECP) templates were not listed as required templates on the checklist; however, there was a reference to the CFR where compliance with both Network Adequacy and ECP was required. We are curious if we just confirm that we are compliant with that provision, or if we should submit those two templates as proof of our confirmation?

We have confirmed that the Essential Community Provider template is required for dental binders inside the exchange. The Network Adequacy Template is not required for dental or medical binders. However, the Network Template (found on the Templates tab) is required for both medical and dental binders.

GENERAL BINDER QUESTIONS

2. Do we have to file a gold standard plan inside the exchange?

If your company is selling inside the exchange, you must offer at least one standard gold plan and at least one standard silver and one standard bronze plan. The one standard gold plan requirement is for inside the exchange plans only. The standard silver and standard bronze plan submission requirement is for all carriers, regardless of exchange participation, per ORS 743.822.

3. What is Cover Oregon's status for the 2015 plan year?

For 2015, Cover Oregon is a State Based Marketplace (SBM) that is supported with federal technology, otherwise known as a "supportive SBM model". They will be performing the same certification functions as they did in the 2014 plan year but will use the federal website technology for individual enrollment.

4. Do we have to attach the templates in both formats (.xml and .xls)?

No. Upload the .xml version only at submission. The .xml version is submitted for validation to the federal hub and the federal hub changes the .xml back to .xls and returns it back to SERFF for attachment to the filing upon successful validation. The .xml version of the template is for the federal system. The .xls version is what OID and Cover Oregon reviews.

5. Are <u>all</u> federal templates required for the binder filing for an individual medical off-exchange product?

No. For binders with off-exchange products only, all of the templates are required on the Templates tab in SERFF except the Administrative Data Template and the Essential Community Providers Template. You may bypass these two templates in your medical binder filing. (For dental binders, the Administrative Data Template is required for all binders, regardless of exchange participation, for exchange certification reasons.) Also, we have confirmed that the two new templates-- Network Adequacy and AAAHC Accreditation Templates-- are not required to be submitted for any binders, regardless of exchange participation.

6. Can you confirm that a carrier can have up to 5 plans (1 being the standard plan and 4 non-standard plans) per metal tier *per service area* inside the exchange, correct?

Correct. Inside the exchange, a carrier may have up to five plans total per metal tier per service area: one standard plan and four non-standard plans.

7. What extra documents or templates will be required by CMS this year?

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. For required templates, please see question/answer #5.

8. Since OID is strongly encouraging carriers to use the CMS Review Tools before submitting their binders, where can we find them?

They are available on CMS Zone, SERVIS, or at https://login.serff.com/StateQHPReview2015.html. You may also find the link on our Binder requirements website at http://www.oregon.gov/DCBS/insurance/insurers/rates-forms/filing/Pages/Health/health-planbinders.aspx.

On June 10, 2014, CMS released an updated version of the QHP Application Review Tools for the 2015 plan year. These tools are a set of Excel-based evaluation services for specific issuer and benefit standards for the QHP application process. 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.

NETWORK ADEQUACY TEMPLATE QUESTIONS

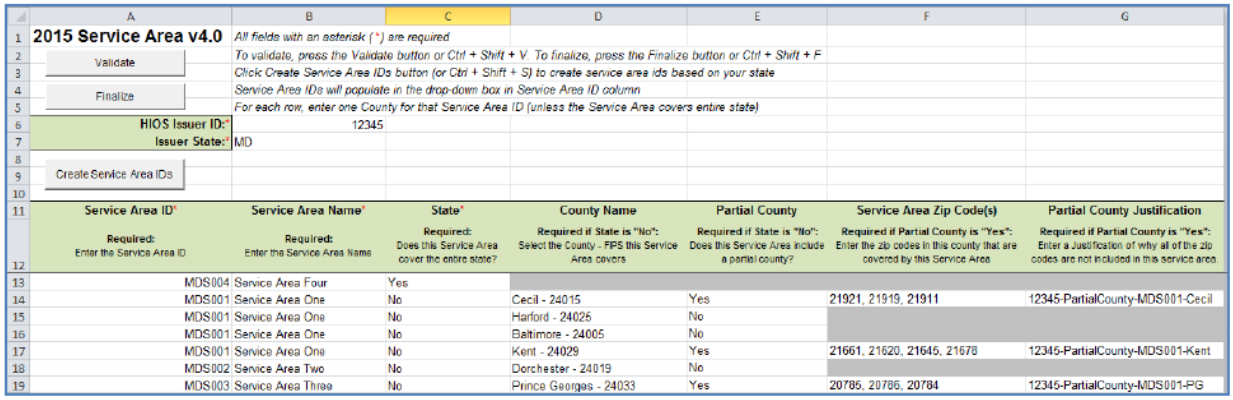
9. I was unable to attend the first medical binder training and am looking at slide 26 "Supporting Documentation" and don't see mention of the Network Adequacy template. I just want to double check that we are filling out this template for both on and off exchange plans in Oregon and that they should be uploaded under supporting documentation?

We have confirmed that the Network Adequacy Template is not required by CMS, the exchange, or OID.

PARTIAL COUNTY SERVICE AREAS

10. If we have a partial county service area, on the Service Area Template can we just say "see partial service area justification" and then fully explain it on the justification document?

No. In column G of the Service Area template, enter the justification file name using the following naming convention: [Issuer ID]-Partial County-[Service Area ID]-[County Name], for example, "12345-Partial County-ORS001-Multnomah.doc." Upload the justification document under the Supporting Documentation tab.



	A	B	C	D	E	F	G
1	2015 Service Area v4.0	All fields with an asterisk (*) are required					
2	Validate	To validate, press the Validate button or Ctrl + Shift + V. To finalize, press the Finalize button or Ctrl + Shift + F					
3		Click Create Service Area IDs button (or Ctrl + Shift + S) to create service area ids based on your state					
4	Finalize	Service Area IDs will populate in the drop-down box in Service Area ID column					
5		For each row, enter one County for that Service Area ID (unless the Service Area covers entire state)					
6	HIOS Issuer ID:*	12345					
7	Issuer State:*	MD					
8							
9	Create Service Area IDs						
10							
11	Service Area ID*	Service Area Name*	State*	County Name	Partial County	Service Area Zip Code(s)	Partial County Justification
12	Required: Enter the Service Area ID	Required: Enter the Service Area Name	Required: Does this Service Area cover the entire state?	Required if State is "No": Select the County - FFS this Service Area covers	Required if State is "No": Does this Service Area include a partial county?	Required if Partial County is "Yes": Enter the zip codes in this county that are covered by this Service Area	Required if Partial County is "Yes": Enter a Justification of why all of the zip codes are not included in this service area.
13	MDS004	Service Area Four	Yes				
14	MDS001	Service Area One	No	Cecil - 24015	Yes	21921, 21919, 21911	12345-PartialCounty-MDS001-Cecil
15	MDS001	Service Area One	No	Harford - 24025	No		
16	MDS001	Service Area One	No	Baltimore - 24005	No		
17	MDS001	Service Area One	No	Kent - 24029	Yes	21661, 21620, 21645, 21678	12345-PartialCounty-MDS001-Kent
18	MDS002	Service Area Two	No	Dorchester - 24019	No		
19	MDS003	Service Area Three	No	Prince Georges - 24033	Yes	20785, 20786, 20784	12345-PartialCounty-MDS001-PG

PLAN AND BENEFITS TEMPLATE QUESTIONS

11. How do we account for the same plan on 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.

12. Should we indicate "not covered" for the Routine Foot Care benefit?

No, because that would not accurately reflect the benefit you are required to provide by the benchmark plan. The benchmark includes Routine Foot Care for diabetics only. Listing Routine

Foot Care as "Not Covered" would not accurately reflect the benefit your company is required to provide. Instead, it should be listed as "Covered" but in the explanation text field please list that it is only covered for people with diabetes.

13. The CMS Revised benchmark spreadsheet that came out 5/23/14 found at http://www.serff.com/plan_management_data_templates_2015.htm and then click on "Revised Benchmark Spreadsheet" seems to list inaccurate information for Oregon. For example, it lists that "Quantitative limit units apply" for Primary Care Visits and Specialist Visits that Oregon doesn't have.

We are not sure why these quantitative limits are listed, but we know and carriers know what the required benefits are. We will follow up with CMS at the end of this filing season to see why the information is listed in that way and work with them to update it for next year. We are keeping a list of discrepancies found throughout this filing season. Regardless, it should not impact your binder filing this year. Please fill out the templates to accurately reflect the benefits your company provides. The OID reviewers will also be checking to make sure the appropriate benefits and quantitative limits, required by mandate or the standard plan, are listed in your templates.

14. Are the EHB variance reason codes list up to date?

As far as we know, they are. If you find any discrepancies or issues with these codes when preparing your templates, please let us know.

15. The color chart includes gray-colored benefits. Are these benefits listed on the Plan and Benefits template?

The gray color on the color chart indicates the benefit will be listed on the Plan and Benefits template, but are not allowed benefits in standard plans. On your standard plan Benefit Package tabs, these benefits should be listed as "Not Covered".

16. What discretion do carriers have in listing day and visit limits on the Plan and Benefits template?

For standard plans, all of the day or visit limits listed on the color chart should be listed on the Benefits Package tab. No more or less limits are allowed for standard plans, it must exactly reflect what the color chart lists. For non-standard plans, you should list any day or visit limits that accurately reflect the benefit your company is providing. Also, if there are any applicable exclusions or special instructions for that benefit, please list those as well. This is information that further explains the benefit provided and helps your OID reviewer.

17. What should be used for the catastrophic deductible and MOOP?

Since catastrophic plans aren't considered "standard plans", the MOOP can be up to $6,600. The deductible can also be up to $6,600.

18. Will OID complete a sample template for the standard plans?

We do not have the resources to do that this year.

19. Per the previous binder training, we would like some clarification on the standard plans benefit explanation for pediatric vision – glasses. The add-in file auto populates the following comment:

> One pair of glasses per year. Collection frames (up to $250) are covered in full. Non-collection lenses are covered up to $150 and then 20% off. Standard lenses are covered in full.

We were preparing our standard plans benefit explanation for pediatric vision – glasses as:

> One standard frame per calendar year.

Should we use the benefit explanation that auto-populates? Then, the bigger question for the rest of the standard plan templates is can we change the benefit explanations that auto populate?

Yes, you can change the auto populate field as appropriate to match our requirements for the standard plan. This is a great example because the auto-populated example does not accurately reflect the benefit required by the standard plan. Your proposed standard plan benefit explanation is great for the frame benefit. Lenses or contact lenses should also be addressed in the explanation field. Dollar amounts must come out of the explanation.

20. On the standard plans, at the training we were instructed to only include the information that is found on the Color Chart. What about explanations of limits, exclusions, or coverage specifics? Can we include explanation information if it is found on other EHB benchmark information, or do we generally leave the explanation fields blank on the standard plan?

You are welcome to include any extra information, as long as it fits in with the standard plan. For example, you may not provide a greater or lesser benefit than the standard plan nor include exclusions or limitations that are not allowed in the standard plan. Please keep in mind that only the OID and exchange reviewers will see this information and it will not be shown on the web to consumers. If the clarification information will be helpful to your reviewer, we would encourage you to add it. However, if it's for consumer-clarification purposes, consumers will never see it--so save yourself some work. For an example of what will be shown on the federal Plan Compare website, please look at pages 10-56 through 10-61 of [*http://www.serff.com/documents/plan_management_data_instructions_ch10_2015.pdf*](http://www.serff.com/documents/plan_management_data_instructions_ch10_2015.pdf)*.*

21. When there is no quantitative limit, but an explanation is necessary, is it okay to include an explanation (i.e., emergency room services to explain that out-of-network emergency services are covered at the in-network rate)?

Again, if the information is helpful to your reviewer, include it. If it's for consumer-clarification purposes, consumers will never see it.

22. For the standard plans, is it ok to show a maximum out-of-pocket (MOOP) amount lower than the Oregon maximum?

No. For 2015, all standard plans must show MOOPs of $6,350/$12,700.

23. On non-standard plans, can we show MOOPs lower than the federal guideline of $6,600/$13,200?

Yes. You may not go above the MOOP amount, but can definitely go lower than the MOOP amount.

24. Are there any special instructions for completing the Plan and Benefits Template and Prescription Drug Template that are specific to Oregon?

No, there are no specific Oregon requirements this year. Last year, we had carriers add many Oregon-specific benefits, but we are not requiring that this year.

25. Is the Add-In File for the Plan and Benefits Template required for 2015 plans?

Yes, the Add-in File is required for 2015 plans because it includes and fills in all of the Oregon-specific items. You would not have to add any specific items for Oregon beyond what is included in the Add-in File, unless CMS requires something to be added.

26. In looking at the Standard Plan Color Chart, I noticed you have listed biofeedback, cardiac rehab, hospitalization for dental procedures, inpatient rehab services, outpatient habilitation services, sleep studies, and vasectomy. These benefits were added to the EHB portion of the Plan and Benefits Template last year at the request of Cover Oregon. I don't think that I need to add benefits to the template this year, correct?

Correct.

27. I have questions on this section which is on page 11 of the Product Standards document for the QHP binder.
1. Is this section for the standard plans only?
2. For b), we have primary care copays in order to meet mental health parity. How should we address this section?

Copays and coinsurance	ORS 743.822, OAR 836-053-0009(8)	**Copays and coinsurance for coverage required** must comply with the following: (a) Non-specialist copays apply to physical therapy, speech therapy, occupational therapy and vision services when these services are provided in connection with an office visit. (b) Subject to the Mental Health Parity and Addiction Equity Act of 2008, specialist copays apply to specialty providers including, mental health and substance abuse providers, if and when such providers act in a specialist capacity as determined under the terms of the health benefit plan. (c) Coinsurance for emergency room coverage must be waived if a patient is admitted, at which time the inpatient coinsurance applies.	Confirmed ☐

1. Yes, any requirement labeled OAR 836-053-0009 refers to standard plans only, because -0009 is the standard plan rule. (Page 9 starts the "STANDARD BRONZE AND SILVER PLAN REQUIREMENTS" section in the product standards.)
2. Address it in the same manner as you did last year. Reflect whatever your company does for mental health services. We realize that this will be one of the areas that standard plans won't seem standard. As long as carriers comply with MHPAEA, you may list whatever cost shares make sense for your company.

28. Question to CMS: I have reviewed the state-specific Plan Benefits Revised Benchmarks, and noticed that for Oregon, the last benefit listed is "Mastectomy-Related Services." However, this benefit does not populate when the EHB refresh is completed in the template. Here are the options that I see and please let me know which one is the correct answer – (A) Will this be added in a future update to the Plan and Benefits Template's EHB refresh functionality? (B) Will we need to add this as a custom-added benefit? Or (C) Do we ignore this benefit and produce the Plan and Benefits Template per the state's guidance?

CMS Answer: *The revised spreadsheets show you how the Plans and Benefits Template should auto-populate. Since "mastectomy-related services" show up as covered on the revised spreadsheet, and show up as an EHB and state-required benefit, you should choose "add benefit" when you fill out the template and add that as a covered benefit in your plans.*
Follow-up from OID: *We were previously told by CMS that this would be part of Oregon's Add-In File, thus carriers would not have to manually add it. Now, it seems that is not the case. Rule of thumb: If CMS tells you to add something to the template, add it.*

29. As mentioned at the training, this benefit is included on the recently released state-specific EHB benchmark worksheets. It is important to get an answer on this question because we cannot begin any Cost-Share Variance tabs without this answer.

If the Mastectomy-Related Services benefit is added, the cost shares will probably be 10% / 30% / 50% because those are the cost shares listed under "Breast Reconstruction" in the Senate Bill 91 exhibit. Please use those amounts, unless you hear differently from us.

30. Can we add this benefit proactively and have it be up to the carriers on whether or not to include it?

You may add the benefit if you would like but consumers will never see it, so it would be added for no real purpose. The purpose of the Plan and Benefits template is for approval of plan information that will be ultimately shown to consumers on Plan Compare. However, if CMS requires that it be added, the benefit must be added.

31. Slide 16 of your training states you will not require carriers to add any benefit categories. Does this mean we only need to populate the Plan and Benefits template with the EHBs that auto-populate using the CMS Add-In file?

Yes. Whatever benefits are auto-populated on the Plan and Benefits template (with the Add-in File) are all the benefits we will need. We will not ask carriers to manually add additional benefits like we did last year. This goes for both medical and dental binders.

32. On the Plan and Benefits template in regards to the "Prescription drugs other" and "Off label prescription drugs" benefit categories. Last year, our company left the fields as "no charge" in both the copay and coinsurance fields. We cover off label use for all drugs that are on our formulary but putting a specific benefit cost share was not ideal since it could hit any one of the tiers based on the drug they selected. For the "prescription drugs other" benefit, what is this meant to explain? We have formulary generic, formulary preferred brand, formulary non preferred brand, and formulary specialty fields listed that list out the cost shares for those benefits.

We have questions out to CMS that we have not received answers to about these fields. So, in the mean time, we are interpreting these fields as below until further notice from CMS.

For "Prescription drugs other" – This is a category for everything that doesn't quite fit into the normal categories listed. For the standard plans, we asked that carriers put a 50% cost share for all metal tiers (same as Specialty Drugs).

For "Off label prescription drugs" – For the standard plans, we asked that carriers put a 50% cost share for all metal tiers (same as Specialty Drugs). We would not encourage the use of "no charge" in the copay and coinsurance fields, because that does not accurately reflect the benefit provided—since you do cover it and not at "no charge". It is better to put a cost share in there instead of "no charge". We understand the reluctance to pick a cost share, but listing some cost share is more accurate than listing no cost share.

33. Last year, there were questions about whether the bronze standard plan was HSA qualified. We received guidance from the OID that it does appear to meet the regulations for HSA qualified. Therefore, on the Plan and Benefits template, can we indicate that the bronze standard plan is HSA qualified?

It is up to the insurer to determine whether their plans are HSA qualified. If you believe a plan is HSA qualified, mark it appropriately on the Plan and Benefits template.

34. My understanding of the benchmark plan is that a member can get 30 days of combined rehab visits and up to 60 days if there are neurological issues/complications. When filling out the standard plans, should we add anything in the limits section? This is column F-H. If so, do we put 30 days or 60 days? Or should we indicate a combined limit on column K for the Rehab benefits instead?

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
Outpatient	10% After Deductible	30% After Deductible	50% After Deductible		**Nutritional Counseling**
Breast Reconstruction	10% After Deductible	30% After Deductible	50% After Deductible		**Reconstructive Surgery**
Oregon Mandates (ORS 743 and 743A)	10% After Deductible	30% After Deductible	50% After Deductible		**Clinical Trials**
	10% After Deductible	30% After Deductible	50% After Deductible		**Inherited Metabolic Disorder - PKU**
Specialty Drugs	50%	50%	50% After Deductible		**Off Label Prescription Drugs**
Specialty Drugs	50%	50%	50% After Deductible		**Prescription Drugs Other**
Outpatient Rehabilitation Services	$20 (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	$35 (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	$60 After Deductible (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	30 (to 60) visits per year	**Rehabilitative Occupational Therapy**
					Rehabilitative Physical Therapy
					Brain Injury

For outpatient rehabilitation, list the following on the Plan and Benefits template:
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

The Limit Quantity field will only accept numbers and will not let you put "30 (up to 60)", so list 30 in this field because the explanation field will explain the additional benefits per condition for certain conditions.

Per the Senate Bill 91 exhibit, both inpatient rehabilitation and inpatient habilitation services have a visit limit of 30 days per year total. Only the outpatient rehabilitation and outpatient habilitation services have visit limits of 30 visits per year plus up to an additional 30 visits per condition, based on certain conditions.

35. Is it better to put "0%" or "No Charge" as the cost share on the Cost Share Variance tab? They mean the same thing, but we didn't know what is better.

Either 0% or No Charge is fine.

36. Do we have to fill out the SBC Scenario section of the Plan and Benefits template?

Per the Plan and Benefits template instructions document, found at http://www.serff.com/documents/plan_management_data_instructions_ch10_2015.pdf, 4.14 SBC Scenario on page 10-28 says the data fields are optional, but may display certain data elements from the SBC in Plan Compare. If the issuer does not provide the information in the template, Plan Compare shows "not available".

37. Do we need to add extra benefits we provide on some of our plans on the Plan and Benefits Template?

We are not sure there is a need to, as the extra benefits probably will not be shown on Plan Compare. Here is the list of anticipated data elements to be shown on Plan Compare, found at http://www.serff.com/documents/plan_management_data_instructions_ch10_2015.pdf, to help guide you: 5.9 Anticipated Template Data Elements To Be Shown on Plan Compare – Pages 10-56 through 10-61.

38. Why is our OID reviewer asking us to list something as "Covered" that is not listed as a "Yes" either the EHB or State Mandate columns on the Plan and Benefits Template?

The OID reviewer has determined that it is a covered benefit either in the benchmark plan or by state mandate and they will be able to provide you with the text and cite of how they came to this conclusion. We already have discovered some discrepancies between what the Plan and Benefits template lists and what Oregon law requires. We are keeping a list of the discrepancies and will address these with CMS after this year's filing season. (See also question/answer #13.)

For example, the benefit Accidental Dental is not listed as "Yes" in the EHB column. However, this benefit is found in the benchmark plan. Therefore, it is considered an EHB and must be listed as "Covered" in plans.

> *Pages 29-30 of the benchmark plan, in the Covered Services list:*
> 7.1.8 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, provided services are rendered within 18 months after the injury.
> B. Orthognathic surgery when necessary due to an accidental injury, provided services are rendered within one year after the injury.
> C. Orthognathic surgery when necessary for removal of a malignancy and the subsequent reconstruction, provided services are rendered within one year.

Please fill out the templates to accurately reflect the benefits your company provides. OID reviewers will be checking to make sure the appropriate benefits and quantitative limits, required by mandate, benchmark plan, or standard plan, are listed in your templates.

39. In the Plans and Benefits Template, how will American Indian variations for plans for above 300% of the Federal Poverty Level (FPL), the limited cost share plans, be distinguished in the certification materials?

Plans are certified at the Standard Component ID level. All cost sharing variants, including the Zero Cost Sharing and Limited Cost Sharing variants, must meet the QHP certification standards to be certified. On the Cost Sharing Variance worksheet of the Plans and Benefits template, the variants are distinguished by adding a code to the Standard Component Plan ID as follows:

- *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

40. What are the requirements for populating the two different AV Percentage columns on the Plan and Benefits Template (Columns E and F)?

- **When the AV calculator is used in conjunction with the Plan and Benefits Template, there are many known issues and errors that are caused as a result. This is an issue that is frequently discussed on weekly REGTAP calls.**
- **Therefore, what is the approved workaround for populating this column within the Plan and Benefits Template? Last year, for unique plan designs, we were able to populate the issuer AV column, provide a screenshot of the independent AV calculator reading for the applicable plan, and provide an actuarial attestation. Will this be an option this year as well?**

We do not have an answer for you at this time but are researching it. Unless you hear differently from CMS or OID in the near future, you may use the same process as last year. Additional guidance about the AV calculator process may be found here:
http://www.serff.com/documents/plan_management_data_instructions_ch11_2015.pdf

PRESCRIPTION DRUG TEMPLATE QUESTIONS

41. At last training, you mentioned that the QHP formulary template needed to have the drugs listed in the same order as the benchmark formulary in order to avoid error messages. Where would I obtain a copy of the "official formulary" to ensure we prepare this template in the same order? I tried searching the Insurance Division website, but have been unsuccessful in locating the source document.

We recently discovered that with the move to our new website, it was no longer listed (it definitely was listed on our old website). We are working to get it back on our website. In the meantime, you may contact your OID analyst and they can e-mail the Excel document to you.

RATE-RELATED BINDER ITEM QUESTIONS

42. For the rate items that OID says may be submitted later, how does this work with the federal submission windows?

We have confirmed with CMS that the rate-filing items also duplicated in binders (Unified Rate Review Template (URRT), Actuarial Memorandum, and Plan Relativities document) are acceptable to be uploaded into the binder filing by September 15 after rate approval, because these rate documents have already been previously submitted in the rate filings.

SBC QUESTIONS

43. Question pertaining to SBCs from page 30 of the Medical Binder training presentation. It states: Provide one SBC for each plan submitted within the binder. If there are 30 plans submitted, please submit 30 SBCs. **Does this mean that there must be a SBC submitted for every plan combination? I ask because due to the network/service area split, we technically have eight duplicate versions of each plan.**

Yes—there should be an SBC for every plan in the binder; one for every Standard Component ID.

STANDARD PLAN NAMING CONVENTION QUESTIONS

We've received a lot of questions regarding the standard plan naming conventions. Remember that the naming convention required by OAR 836-053-0009(3) ONLY applies to standard plans. Carriers may name the rest of their plans whatever they wish. Also, the standard plan naming convention required by rule ONLY applies to the benefit summary, the SBC, and the Plan and Benefits Template.

44. Our actuarial department asked if changing our Summary names to be compliant with the mandate will affect HIOS IDs or the way naming is done in the rate templates?

No. It will not affect HIOS IDs or the way the naming is done on the rate templates. In fact, it shouldn't impact the rate filing in any way. 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.

45. Information from our template expert that dealt closely with both our OID analyst and Cover Oregon on this type of issue last year responded that it looks as if it would not affect HIOS IDs at all, but it would mean that we need to ensure the use of appropriate names in the rates templates.

While it would be encouraged to use the same exact name in the rate templates, it is not required. So, for example, if you wanted to abbreviate Oregon to "OR" in the rate filing, that would be acceptable.

46. We addressed naming last year with Cover Oregon because we did name the plans as indicated and then Cover Oregon inserted the carrier name at the beginning so the plans ultimately ended up reading as follows online: Acme Acme Oregon Standard ABC Plan. We were permitted to remove the carrier name from the plan marketing name to avoid duplication (all carriers did this). We also asked about abbreviating Oregon to OR to shorten the names to deal with character limitations in systems and with vendors and were told it was fine. We think most carriers abbreviated it to OR.

Cover Oregon did not change marketing names. They were displayed exactly as filed. The carrier logo was displayed in front of the name, but the names themselves were not changed. Last year, OID did not have an administrative rule that dealt with naming conventions, so a lot of things were allowed then that will not be allowed this year. This year, OID is requiring all carriers to name their standard plans exactly according to rule.

47. Perhaps adjusting to working with the feds vs. Cover Oregon means these two original allowances must be reversed. Healthcare.gov does not identify the carrier before the plan name like Cover Oregon did – though it does indicate which carrier offers the plan – but this may not be sufficient for the OID. We want to double check before proceeding--especially when it comes to abbreviating Oregon to OR (this will mess up character counts for systems).

Please use the standard plan naming convention as required by OAR 836-053-0009(3)—[Name of Issuer] Oregon Standard [metal level] Plan [add additional or network information as necessary].

48. Due to this rule on naming convention, would what we have currently in place be acceptable? In other words:
1. Is our insurer logo sufficient for [Name of Issuer], or do we need to have our insurer name spelled out in text as well?
2. Is it ok to abbreviate OR, or must we have Oregon spelled out?
3. The rule doesn't have requirement for Network Name, but since we did file the variable for that option, is the abbreviation acceptable (ABC), or must it be spelled out (Always Be Covering Network)? We do spell it out just under the header already.

1. Logo is not sufficient. Need insurer name spelled out in text.
2. Must have "Oregon" spelled out, as that is how it is listed in the rule.
3. Network names or network abbreviations aren't required in the rule, but you can definitely add it for clarity if you would like at the end (and abbreviations would be acceptable). For example, "Acme Oregon Standard Bronze Plan ABC" would be acceptable.

49. A couple of things we noticed is that our standard plans were named according to your naming convention and based on what we submitted last year but do not say "Plan" at the end, and our group plans have extra verbiage at the end after "Plan". For example:
- **Acme Oregon Standard Silver**
- **Acme Oregon Standard Silver Plan Group ABC Network**

In order to get possible re-working completed and everything submitted in time, do we need to add the word "Plan" at the end to meet the naming convention requirement for individual? And, do we need to remove the "Group ABC Network" from the group standard plans?

The rule states:

OAR 836-053-0009(3) When offering a plan required under ORS 743.822, an issuer must use the following naming convention: "[Name of Issuer] Oregon Standard [Bronze/Silver] Plan". For example, "Acme Oregon Standard Bronze Plan".

Since "Plan" is a part of the standard plan naming convention requirement per rule, it must be included. However, you are welcome to put anything you want at the end. So, your example of "Acme Oregon Standard Silver Plan Group ABC Network" is definitely acceptable. The rule wasn't effective until 1/1/2014, so that's why names without "Plan" at the end were allowed last year. This year, we are requiring all carriers to follow the naming convention as prescribed by rule.

OTHER FILING QUESTIONS

50. An OID analyst contacted me via phone last week and advised for the nonstandard form filing that a dental products checklist was needed. Can you please confirm with me if that is the case; and if so which checklist version (440-4978) or (440-3172A) must be used? I believed that since I completed the individual medical product standards checklist that no other checklist was needed.

When pediatric dental benefits are embedded in the medical contract, we require that the pediatric dental form product standards also be submitted (Form 440-4978) so the carrier can properly confirm that they are providing at least the minimum benefits of the CHIP plan, so this benefit can be properly certified at Cover Oregon. When embedded in the medical contract: On Form 440-4978, please fill out page 5 (confirming compliance with the CHIP benefit checklist and D Codes) and then fill out pages 10-23. You may skip all other pages of the product standard. (For stand-alone dental forms we require the entire product standard to be completed.) You may mark "confirmed" on benefits that are not specifically listed in the contract or provide the specific page and paragraph for those benefits that are listed. Also, we are asking carriers to associate the pediatric dental product standards to their binder filings (either dental binders or medical binders where plans have embedded pediatric dental).