[*OAR 836-010-0012*]**OAR 836-010-0013**
Exhibit 1

Oregon
John A. Kitzhaber, MD, Governor

Department of Consumer and Business Services
Insurance Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
503-947-7980
Fax: 503-378-4351
www.insurance.oregon.gov

DATE: November 22, 2013

TO: Issuers of Nongrandfathered Individual and Small Group Health Benefit Plans

RE: Guidance for 2013 Oregon Health Benefit Plan Renewals

On Friday, November 15, 2013, the Oregon Insurance Division (OID) announced a decision to allow carriers the option to renew existing 2013 individual and small group health benefit plans. This memo sets forth regulatory requirements and guidance for carrying out the renewal plan.

TOPIC	**REQUIREMENT/GUIDANCE**	**DUE DATE** (if applicable)
Rates	*If a carrier chooses to offer renewals of 2013 plans to provide coverage through 2014, can the carrier file for rate changes on these 2013 plans?*	
	No. Rates for 2013 individual and small group plans renewed to provide coverage through 2014 cannot be changed. No exceptions will be granted. Small group rates cannot be changed to apply additional impact of trend beyond the latest quarter included in a carrier's most recent rate filing. Carriers may continue existing practices with regard to premium increases due to an increase in age during the renewal period, consistent with approved age rating factors.	
Rates	*If a carrier chooses to offer renewals of 2013 plans, can the carrier file for rate changes on 2014 ACA-compliant plans in the individual market?*	
	No. Rates for ACA-compliant plans offered for sale in 2014 are final and cannot be changed.	
Rates	*If a carrier chooses to offer renewals of 2013 plans, can the carrier file for rate changes on 2014 ACA-compliant plans in the small group market?*	
	Possibly yes, but only for policies incepting July 1, 2014 or later (Q3 & Q4 effective dates). This depends on CCIIO's ability to support such changes. However, in accordance with the existing rate review framework, OID will analyze the reasonableness of assumptions, profit provisions and contributions to surplus. Carriers may not consider expected individual market loss experience in its small group	

	filings.	

Rates	*If a carrier chooses to offer renewals of 2013 plans, can the carrier include an additional profit provision or contribution to surplus to recoup anticipated losses arising from the inability to adjust rates for renewals of 2013 plans or 2014 ACA-compliant plans?*	
	No. In accordance with the existing rate review framework, OID will analyze the reasonableness of profit provisions and contributions to surplus included in 2015 and 2016 rate filings. A carrier choosing to offer renewals of 2013 plans must do so in consideration of its current financial position. OID will evaluate necessary changes to the 2015 review process and filing requirements in the near term.	
Offer	*Can a carrier choose to offer renewal of some 2013 plans, but not others?*	
	No. If offering renewals of 2013 plans, carriers must offer to renew all 2013 plans to all policyholders in a given market (i.e., individual and small group). Carriers are not required to make the same decision for both individual and small group plans.	
Offer	*Which individual and small group policyholders can be given the option to renew their existing 2013 plans?*	
	a) In the individual market, a policyholder must have been covered on his/her existing plan on October 1, 2013 and be continuously covered on that plan through December 31, 2013. The renewal can either be structured to provide coverage effective December 31, 2013 through March 31, 2014 (a policy period of 3 months plus 1 day) or through December 31, 2014 (a policy period of 12 months plus 1 day) at the option of the carrier. Carriers must select one of these options. **b) In the small group market, a carrier that chooses to renew existing, 2013 coverage may renew such coverage for 12 months or longer regardless of whether a policyholder had such coverage on October 1, 2013. Renewals of existing coverage must occur no later than December 31, 2013. Renewed coverage may not extend beyond December 31, 2014.** **c) In both markets, plans renewed or issued on or after January 1, 2014 must comply with ACA market reforms.**	
OID Notice	*When must a carrier notify OID of its decision to offer or not offer renewals of 2013 plans?*	Noon (PT) Nov. 22
	Carriers must notify OID of their decisions no later than Friday, November 22 at 12pm Pacific time. This deadline applies to all carriers with existing individual and small group plans, and notice to OID is required regardless of the decision made by the carrier. Exceptions will not be granted. Notice must include the number of policyholders and members, by market, being offered the option to renew 2013 plans and should be made by e-mail to Annette Boyce	

	at annette.c.boyce@state.or.us. OID will provide a template for reporting member/policyholder count data.	

Design	*Can a carrier make the renewal of 2013 plans an "opt-out" option by automatically renewing policyholders' 2013 plans effective December 31, 2013 instead of rolling policyholders into new 2014 plans according to the mapping outlined in carrier discontinuation notices?*	
	No. Individual or small group policyholders must "opt in" to renew existing 2013 plans beyond the scheduled discontinuation date and must notify their carrier of their decisions no later than a date specified by the carrier. Carriers must follow the approach laid out in their respective discontinuation notices regarding plan mapping and policyholder response, with the option to renew a 2013 plan for coverage through 2014 treated in the same manner as a policyholder selecting a plan other than the new "mapped" plan. This approach will minimize confusion amid conflicting communications from carriers.	
Design	*How must the renewals of 2013 plans be structured?*	
	a) In the individual market, a carrier choosing to renew 2013 plans to provide coverage through 2014 must ensure that existing coverage is continuously effective from October 1, 2013 through December 31, 2013. The effective date of renewed 2013 plans must be December 31, 2013, and coverage must be provided through either March 31, 2014 or December 31, 2014. b) **Small group: Coverage must be renewed no later than December 31, 2013 and may be renewed for 12 months or longer regardless of whether a policyholder had such coverage on October 1, 2013. Renewed coverage may not extend beyond December 31, 2014.**	
Design	*How will deductibles and out-of-pocket maximums work?*	
	a) Carriers offering to renew 2013 plans in the individual market must use calendar year accumulators, resetting these accumulators on January 1, 2014. These carriers must also credit expenses inuring to deductibles and out-of-pocket maximums toward new accumulators if a policyholder enrolls in a new 2014, ACA-compliant individual plan with the same carrier during 2014. **b) Carriers offering to renew 2013 plans in the small group market must use plan year accumulators as defined in the existing contract. If a renewed plan is issued for more than 12 months, the plan year is the renewal period. These carriers must also credit expenses inuring to deductibles and out-of-pocket maximums toward new accumulators if a policyholder enrolls in a new-2014, ACA-compliant small group plan with**	

	the same carrier prior to discontinuation of renewed coverage. **c) Any carrier may, at its option, offer credit for deductible and out-of-pocket maximum expenses paid by a policyholder on another carrier's plan.**	

PH Notice	*When must carriers communicate the option to renew 2013 plans to policyholders?*	Nov. 29
	a) Carriers choosing to offer renewal of 2013 plans must communicate the option to its policyholders no later than Friday, November 29, 2013. b) **Communication by mail is effective on the date it is postmarked. Communication by electronic means is effective on the date sent.**	
PH Notice OID Filing	*What information must be included in the communication to policyholders, and what are OID's filings requirements?*	Nov. 29 Info. Filing
	OID has developed a notice required for use by all carriers choosing to offer renewals of 2013 plans. A carrier must use this notice without modification, other than to include its logo and contact information. Prior approval from OID is not required but all carriers must file the notice, including carrier logo and contact information, with OID as an informational filing by November 29, 2013.	
PH Notice OID Filing	*What other consumer communications are required?*	Jan. 15
	a) For policyholders opting to renew 2013 plans, carriers must provide confirmation of renewal by January 15, 2014. OID will draft the notice language required for use by all carriers offering 2013 renewals. A carrier must use this notice without modification, other than to include its logo and contact information. Prior approval from OID is not required but all carriers must file the notice, including carrier logo and contact information, with OID as an informational filing by January 15, 2014. The notices will address such things as the following: ▪ **Tax credits are not available for renewals of 2013 plans;** ▪ **Renewed 2013 plans do not include benefits required by the ACA.** ▪ **Opportunities to enroll in ACA-compliant coverage during the 2014 calendar year, including the last day of the initial open enrollment and the relevant effective dates.** **b) Similar notice will be required to be sent to policyholders renewing 2013 plans by March 1, 2014.**	Confirm Extension with PH Info. Filing to OID

Report	*What information will OID require carriers to report?*	Date and timing to be determined
	a) OID will require all carriers to report several pieces of information, separately for the individual and small group market. OID is still developing reporting requirements, and the information required may include, but is not limited to the following: ▪ **The number of policyholders and members who received discontinuation notices as of December 31, 2013;** ▪ **The number of policyholders and members opting to renew their 2013 plans for coverage through 2014;** ▪ **The number of policyholders and members selecting a new-2014, ACA-compliant plan with the same carrier;** ▪ **The number of policyholders and members automatically enrolled in a "mapped" plan;** ▪ **The number of policyholders and members being cancelled by the carrier with no offer to map or renew 2013 coverage;** ▪ **The number of existing policyholders and members enrolled through Cover Oregon with a January 1, 2014 effective date;** ▪ **The number of policyholders and members who declined direct offers of ongoing coverage with the carrier (does not include policyholders/members enrolling through Cover Oregon); and** ▪ **Updated financial projections for 2014 reflecting the impact of the option to renew 2013 plans for coverage through 2014 on projections of enrollment, written premium, claims costs, administrative costs, loss ratio, and year-end capital and surplus.**	
Rates	*What rates can be applied to renewing policies? For example, the current rate plus age adjustment (if the carrier chooses to apply it) or the same rate a newly enrolled customer would receive?*	
	For individual and small group, a carrier may use existing filed and approved 2013 rates corresponding to the effective date of coverage.	
Offer	*Can a customer that purchased a policy after October 1, 2013 be offered a renewal?*	
	For individual coverage to be renewed, it must be continuously in effect from at least 10/1/2013 through 12/31/13. There is no similar requirement for renewal of small group coverage.	
Design	*Can a customer choose a new plan or change plan features (deductibles, etc.)?*	
	For individual coverage, the renewed plan must be the same. [We will evaluate any new mandates that had an immediate effective date and issue further guidance.]	

Dental	*Can dental coverage be renewed?*	
	There are no changes to the current renewal process for dental coverage. Renewed 2013 coverage is not subject to the pediatric dental requirements of the ACA.	
Rates	*Can rates for renewed plans include 2014 trend?*	
	No. A carrier must use rates approved for 2013.	
Offer	*Can consumers be required to accept a plan renewal?*	
	No. Acceptance of the 2013 plan renewal is optional for the consumer.	
Offer	*Must the rates applicable to the renewal accompany the policyholder notice of the renewal option?*	
	Yes.	
	NEWLY ADDED FAQ	
Rates	*Is a carrier permitted to add the ACA taxes and fees to 2013 plan renewals as provided for in HB 2240?*	
	A carrier has the option to include the federal reinsurance assessment and the federal health insurance providers' fee, as outlined in Section 6 of HB 2240. These additions must be netted against the removal of the 2013 charges for OMIP, Children's Reinsurance, the 1% premium tax, and any load for portability coverage. A carrier cannot include a charge for the 2014 Oregon state supplemental reinsurance program or the PCOR fee. Carriers opting to include the allowable fees must disclose the additional amount in their notice to members on Nov. 29 and must provide a justification of the additional amount to the division by Nov. 29.	Nov. 29
PH Notice	*Are carriers required to send CMS' standard notices for transition to ACA compliant policies per the 11/21/2013 bulletin?*	
	No. Oregon's 2013 renewal plan will result in policies being renewed no later than 12/31/2013. The CMS bulletin applies to policies renewed between January 1, 2014 and October 1, 2014.	

Additional questions can be addressed to Annette Boyce by e-mail annette.c.boyce@state.or.us or by phone at 503/947-7211.

[*OAR 836-010-0012*] **OAR 836-010-0013**
Exhibit 2

Oregon
John A. Kitzhaber, MD, Governor

Department of Consumer and Business Services
Insurance Division
350 Winter St. NE
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Fax: 503-378-4351
www.insurance.oregon.gov

CORRECTED

April 17, 2014

TO: Issuers that Offered Early Renewals of 2013 Non-grandfathered Individual and Small Group Health Benefit Plans

RE: Updated Guidance for Transitional Health Benefit Plans Permitted by Enrolled Senate Bill 1582 (2014 Legislative Session)

The 2014 Oregon Legislature enacted Senate Bill 1582, which allows insurers ("carriers") the option to continue all in-force 2013 transitional health benefit plans through December 31, 2015.

Transitional health benefit plans do not comply with the January 1, 2014 market reforms, but do comply with the requirements in effect on December 31, 2013 and will be renewed in 2014 for coverage that continues into 2015. The bill amends Oregon law to make it possible for transitional health benefit plans to renew beyond 2014 pursuant to federal guidance and to give Oregonians more health insurance options. Without this change, carriers could not renew transitional health benefit plans beyond their termination date in 2014.

This memo sets forth regulatory requirements and guidance for transitional health benefit plans ("transitional plans"). The term "grandmothered" is used occasionally and refers to individual and small group non-grandfathered plans that do not meet the 2014 Affordable Care Act (ACA) requirements. In Oregon, these plans were afforded an "early" renewal on or before 12/31/2013.

TOPIC	DATE	QUESTION	ANSWER
Rates	4/23	*If a carrier chooses to offer transitional plans to provide coverage through 2015, can the carrier file for rate changes on these 2013 plans?*	**Yes. Rate filings are due 6/2/2014. No exceptions will be granted.** **For small group filings, a carrier can request an effective date for their transitional plan rates as early as October 1, 2014. If no special effective date is requested, rate changes are effective and allowed at plan renewal on 12/31/2014. Rates are effective for 12 months for each group.** **For individual, rate changes are effective and allowed at plan renewal on 12/31/2014.**
Rates	4/23	*If a carrier has grandfathered and grandmothered plans how should the rates be pooled and filed?*	**Grandfathered and transitional plans must be pooled together, consistent with pricing in 2013. Oregon law requires all plans in the pool to have the same effective date. Therefore, individual**

			grandfathered plans effective dates will match the transitional plans with an effective date of 12/31/2014. Grandfathered and transitional plans must be filed separately in SERFF (transitional plans are still non-grandfathered plans). **OID issued an emergency rule, OAR 836-053-0066 requiring transitional plans be pooled with grandfathered plans. The emergency rule will be posted on our website at; http://www.oregon.gov/DCBS/insurance/legal/laws/Pages/laws-rules.aspx**
Rates	3/12	*If a carrier chooses to offer transitional plans, can the carrier file for rate changes on 2014 ACA-compliant plans in the individual market?*	**No. Rates for ACA compliant plans offered for sale in 2014 are final and cannot be changed until the 2015 plan year.**
Rates	3/12	*If a carrier chooses to offer transitional plans, can the carrier file for rate changes on 2014 ACA-compliant plans in the small group market?*	**No. The last opportunity to file small group rate changes for effective dates in 2014 has passed.**
Policy-holder notice	4/17	*Are carriers required to send notices that comply with HHS/CMS guidance?*	**Yes. Carriers should follow federal guidance. See the federal guidance at this link: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf** **We are not allowing changes to the CMS model. These filings will be considered an informational filing.**
Discontinuation	3/12	*Can transitional plans be discontinued?*	**Yes. The plans may be discontinued by the carrier at the end of the calendar year and in accordance with requirements for discontinuation. The affected policyholders may be mapped by the carrier or personally select an ACA compliant plan, which will result in joining the ACA-compliant "single risk pool."**
Grand-fathered plans	3/12	*If a carrier either has no transitional plans or does not plan to make a rate filing for a transitional plan, how does that affect grandfathered plan rate filings?*	**If a carrier only files grandfathered plans, there is no applicable rate filing deadline.**
Rate filing product standards	3/12	*What product standards should be used to file rates for a transitional plan?*	**The 2015 rate filing product standards should be used. If a particular rating requirement is not applicable to the transitional plans or grandfathered plans, please identify it in the rate filing.**
Offer	4/11	*Which individual and small group policyholders can be given the option for a transitional plan?*	**Carriers that offered 2013 renewals through 03/31/2014 now have the option to extend those policies through 12/31/2014 and may then choose to offer transitional plans in compliance**

			with SB 1582. **In the small group and individual market, a carrier may offer a transitional plan to policyholders of 2013 plans that renew in 2014.** **Policyholders that have already moved to an ACA compliant plan are not eligible for a transitional plan.**

Offer	4/11	*Can a carrier choose to offer transitional plans to some policyholders, but not others?*	**No. If offering transitional plans, carriers must offer such plans to all eligible policyholders in a given market (i.e., individual or small group). Carriers are not required to make the same decision for both the individual and small group market.**
Offer	4/23	*Does SB 1582 allow an ORS 743.734(7)-exempt health benefit plan issued to a small group through an association to renew in 2014 as a transitional plan?*	**No. A health benefit plan operating under the exemption described in the pre-HB 2240 version of ORS 743.734(7), cannot be renewed in 2014 as a transitional plan.**
Offer	4/23	*Can an association plan issued to individuals or small groups renew in 2014 as a transitional plan?*	**Individual policies issued through associations and small group plans issued through associations may be renewed in 2014 as transitional plans if they comply with their relevant market requirements (e.g., individual – individual, small group – small group) and are not operating under the exemption in pre-HB 2240 ORS 743.734(7).**
Benefits	4/11	*Do transitional plans meet the definition of "minimum essential coverage" under the individual mandate?*	**Yes. These are plans sold in the individual or small group market and therefore, meet the definition of "minimum essential coverage."**
Benefits	4/11	*Does Mental Health Parity apply to these transitional plans?*	**Individual plans will be required to comply with the Mental Health Parity requirements upon renewal on or after July 1, 2014.** **Small Group plans are NOT required to comply with the Mental Health Parity requirements effective July 1, 2014. These requirements are tied to Essential Health Benefits and transitional plans are not subject to EHB.**
Benefit	3/19	*What are the ACA provisions that apply to transitional plans?*	• **Prohibition on Annual Limits (Sec. 2711); Mental Health Parity (Sec. 2726) (individual plans only);** • **90-Day Waiting Period (Small Group) (Sec. 2708);** • **Pre-existing Conditions for Adults (Small Group) (Sec. 2704)**
Filings	4/11	*Do transitional plans have to be filed in a binder filing?*	**No. These plans cannot be filed in a binder filing.**

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Exhibit 2

Notices	4/11	*May carriers include other materials with the CMS model notice?*	**No. The notice must be sent separately.**
Rates	4/23	*May a carrier charge ACA fees on transitional plans?*	**Not for transitional plans that are issued using previously filed and approved rates. ACA fees as well as other fees and taxes may be included in the 2015 transitional plan rate filing due 6/2.**
Rates	4/11	*For small groups, can trend be added to the filed/approved rates?*	**No. Trend factors were not approved for use in 2014 for transitional plans.**
Benefit	4/11	*Which of the 2014 state legislation that require reimbursement apply to transitional plans?*	**ORS 743A.082 Diabetes management for pregnant women.** **HB 4110 Inmate (pre-adjudicated) coverage** **HB 4013 Prescription drug step therapy** **SB 1579 Prescription drug synchronization Plan** **HB 4104 Workers Compensation Claims**
Policy-holder notice	4/11	*Are carriers required to send a 30 day renewal notice (business as usual) as well as the CMS notice?*	**Yes. The CMS notice is not a renewal notice. Renewal notices are still required providing policyholders the options available and premium information.**
Grand-fathered plans	4/17	*Will grandfathered plans require a rate hearing?*	**Yes. For carrier convenience, we will try to schedule grandfathered, transitional, and ACA compliant plan hearings at the same date and time.**
Benefits	4/17	*Do transitional plans have to comply with ORS 743A.124 colorectal cancer screening and laboratory test?*	**Yes. ORS 743A.124 applies to all health benefit plans (including grandfathered, non-grandfathered, transitional, and ACA-compliant) upon issuance or renewal on or after March 3, 2014.**

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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].]

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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.]
-

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.