The following definitions apply to Division 50 of this Chapter for purposes of administering the COFA Program:

(1) “COFA applicant” means an individual submitting a COFA application.

(2) “COFA application” means the application for the COFA Premium Assistance Program established by Oregon Laws 2016, Chapter 94, Section 3.

(3) “COFA participant,” “participant,” or “program participant” means a COFA applicant who has been accepted into the COFA Premium Assistance Program established by Oregon Laws 2016, Chapter 94, Section 3.

(4) “Coverage provided by the plan” as used in Oregon Laws 2016, Chapter 94, Section 3(2), means, for purposes of a prescription drug, the maximum out-of-pocket costs for a generic form of the drug prescribed when a generic form is available.

(5) “Explanation of benefits” means a written statement from a participant’s qualified health plan issuer that lists medical services provided to the participant, benefits paid by the participant’s qualified health plan issuer, and out-of-pocket costs owed by the participant.

(6) “Participant” or “program participant” means a COFA applicant who has been accepted into the COFA Premium Assistance Program established by Oregon Laws 2016, Chapter 94, Section 3.

(7) “Program” means the COFA Premium Assistance Program established by Oregon Laws 2016, Chapter 94, Section 3.

Payment of Qualified Health Plan Premiums and Out-of-Pocket Costs

(1) The department shall pay qualified health plan premium costs only to the issuer of a qualified health plan unless the department determines good cause exists to directly reimburse a program participant for premium costs; and

(2) The department may cease payment of qualified health plan premium costs or deny payment of, or reimbursement for, out-of-pocket costs incurred after the following:

(a) The COFA Premium Assistance Program Fund becomes insufficient to cover the payment or reimbursement;
(b) The department cannot verify the address or residency of the participant after reasonable attempt;

(c) The participant fails to comply with the requirements of OAR 945-060-0025(1);

(d) The participant is disenrolled pursuant to OAR 945-060-0025(2);

(e) The participant becomes ineligible for the program;

(f) The participant becomes ineligible for the qualified health plan described in OAR 945-060-0005;

(g) The participant becomes eligible for:

(A) Medicaid; or

(B) Minimum essential coverage;

(h) The participant fails to submit a valid claim for reimbursement of out-of-pocket costs pursuant to paragraph (3) of this rule.

(3) The department shall reimburse a COFA participant may request reimbursement for out-of-pocket costs when a participant requests reimbursement and:

(a) When the participant’s expenditures for out-of-pocket costs total $50 or more; or

(b) No sooner than the last day of a month in which the participant’s expenditures for out-of-pocket costs do not total $50 or more by the last day of any given month; and

(c) The participant provides to the department no later than April 30 of the year following the year in which the out-of-pocket costs were incurred:

(A) A valid explanation of benefits; and

(B) A valid receipt establishing that the out-of-pocket costs were paid.

(4) If the department reimburses a participant for out-of-pocket costs for a claim that is subsequently denied by a qualified health plan issuer is invalid for any other reason, the department may:

(a) Withhold future payments to the participant until such payments equal the amount of the reimbursement; or

(b) Use all legal means available to collect from the participant the amount of the reimbursement if withholdings from future payments do not equal the amount of the reimbursement.

Statutory/Other Authority: OL 2016 & Ch. 94
Statutes/Other Implemented: OL 2016 & Ch. 94
History: HMP 9-2017, minor correction filed 11/02/2017, effective 11/02/2017
HMP 3-2016, f. & cert. ef. 9-8-16