

OAR 945-020-0030 (New Rule)

To the extent permitted by state law, 45 CFR 155.335(j)(2) and (j)(3) allow the Federally Facilitated Marketplace (FFM) to cross-walk a qualified individual into a new plan at renewal when the individual's previous carrier ceases to offer qualified health plan coverage through the exchange or ceases to offer a plan under the individual's previous qualified health plan product. Despite an agreement with the Oregon Health Insurance Marketplace (the Marketplace) not to cross-walk affected individuals during the 2017 plan year, the FFM cross-walked several such individuals into plans with new carriers without notifying the Marketplace, causing significant carrier, consumer, and agent confusion.

ORS 741.002(2)(f) requires the Marketplace to assist individuals to enroll in qualified health plans through the health insurance exchange. The Director, acting through the Marketplace, is in the best position to determine whether individuals who lose coverage under a qualified health plan offered through the health insurance exchange should be cross-walked to a new plan, or whether targeted marketing urging these individuals to shop for new plan would be more beneficial. Moreover, in the event that the Director determines that these individuals should be cross-walked to a new plan, the Director, acting through the Marketplace, is in the best position to determine to which plans these individuals should be cross-walked.

Enactment of OAR 945-020-0030, which gives the director the sole authority to determine whether cross-walking should occur and if so, to which plans individuals should be cross-walked, will prevent the FFM from cross-walking individuals into plans that are not the best plans for these individuals or for the market. It will also prevent the federal government from cross-walking these individuals without their knowledge and without the knowledge of the Marketplace.

1 **945-001-0002 (AMENDED)**

2 **Definitions**

3 The following definitions govern the meaning of terms used in administrative rules in this
4 chapter, except where the context otherwise requires:

5 (1) “Advance payments of the premium tax credit” means payment of the federal health
6 insurance premium tax credit on an advance basis to an eligible individual enrolled in a QHP
7 through the Marketplace.

8 (2) “Affordable Care Act” or “ACA” has the meaning given in 45 CFR 155.20.

9 (3) “American Indian”, for purposes of eligibility for tax credits and cost sharing benefits, means
10 an enrolled member of a federally recognized tribe.

11 (4) “Applicant” has the meaning given in 45 CFR 155.20.

12 **(5) “Automatically enroll” means the process of enrolling a qualified individual into a new**
13 **qualified health plan when, at renewal:**

14 **(a) The qualified individual’s qualified health plan issuer no longer offers qualified health**
15 **plans through the health insurance exchange; or**

16 **(b) There are no qualified health plans offered through the health insurance exchange**
17 **under the individual’s previous qualified health plan product.**

18 [(5)] (6) “Benefit year” has the meaning given in 45 CFR 155.20.

19 [(6)] (7) “Catastrophic plan” means a health plan described in §1302(e) of the Affordable Care
20 Act.

21 [(7)] (8) “CHIP” or “Children’s Health Insurance Program” means the portion of the Oregon
22 Health Plan established by Title XXI of the Social Security Act and administered by the Oregon
23 Health Authority.

24 [(8)] (9) “Cost sharing” has the meaning given in 45 CFR 155.20.

25 [(9)] (10) “Cost sharing reductions” has the meaning given in 45 CFR 155.20.

26 [(10)] (11) “DCBS” means the Oregon Department of Consumer and Business Services.

27 [(11)] (12) “Effectuation” means the activation of QHP or SADP coverage through enrollment
28 and payment of the first month’s premium.

29 [(12)] (13) “Employee” has the meaning given in section 2791 of the Public Health Services Act.

- 1 [(13)] (14) “Employer” has the meaning given in 45 CFR 155.20.
- 2 [(14)] (15) “Enrollee” has the meaning given in 45 CFR 155.20.
- 3 [(15)] (16) “Essential health benefits” has the meaning given in OAR 836-053-0008.
- 4 [(16)] (17) “Federal poverty level” or “FPL” has the meaning given in 45 CFR 155.300.
- 5 [(17)] (18) “Full-time employee”:
- 6 (a) For plan years beginning prior to January 1, 2016, means an “eligible employee” as defined
7 in ORS 743.730.
- 8 (b) For plan years beginning on or after January 1, 2016, full-time employee has the meaning
9 given in section 4980H(c)(4) of the Internal Revenue Code.
- 10 [(18)] (19) “Health benefit plan” has the meaning given in ORS 741.300.
- 11 [(19)] (20) “Health care service contractor” has the meaning given in ORS 741.300.
- 12 [(20)] (21) “Health insurance” has the meaning given in ORS 741.300.
- 13 [(21)] (22) “Health insurance exchange” or “exchange” has the meaning given in ORS 741.300.
- 14 [(22)] (23) “Health plan” has the meaning given in ORS 741.300.
- 15 [(23)] (24) “Household” has the meaning given in 42 CFR 435.603.
- 16 [(24)] (25) “Household income” has the meaning given in 26 CFR 1.36B and 42 CFR 435.603.
- 17 [(25)] (26) “Individual market” has the meaning given the term in section 1304(a)(2) of the
18 ACA.
- 19 [(26)] (27) “Insurer” has the meaning given in ORS 741.300.
- 20 [(27)] (28) “Insurance affordability program” has the meaning given in 42 CFR 435.4.
- 21 [(28)] (29) “Lawfully present” has the meaning given in 45 CFR 152.2.
- 22 [(29)] (30) “MAGI-based Medicaid and CHIP” means Medicaid and CHIP programs for which
23 eligibility is based on modified adjusted gross income, and not primarily on age or disability.
- 24 [(30)] (31) “Medicaid” means medical assistance programs established by Title XIX of the
25 Social Security Act and administered in Oregon by the Oregon Health Authority.

1 [(31)] (32) “Minimum contribution requirement in the case of a medical plan” means a small
2 employer must contribute at least 50 percent of the employee-only premium. If a small employer
3 elects to offer more than one medical plan to employees through SHOP, the minimum
4 contribution requirement will be determined based on a reference plan selected by the employer.
5 In the case of a dental plan, the employer must contribute at least \$20 per enrolling employee.

6 [(32)] (33) “Minimum essential coverage” has the meaning given in section 5000(A)(f) of the
7 Internal Revenue Code.

8 [(33)] (34) “Minimum participation requirement”, in the case of a medical plan, means that at
9 least 75 percent of the employees offered SHOP medical coverage must enroll. In the case of a
10 dental plan, at least 50 percent of the employees offered SHOP dental coverage must enroll.

11 [(34)] (35) “Modified adjusted gross income” or “MAGI” has the meaning given in 26 CFR
12 1.36B-1(e)(2).

13 [(35)] (36) “Oregon Health Insurance Marketplace” or “Marketplace” means the health insurance
14 exchange operated within DCBS for the State of Oregon pursuant to ORS chapter 741.

15 [(36)] (37) “Oregon Insurance Division” means the Insurance Division of DCBS.

16 [(37)] (38) “Pediatric dental benefits” has the meaning given in OAR 836-053-0008.

17 [(38)] (39) “Plan year” has the meaning given in 45 CFR 155.20.

18 [(39)] (40) “Qualified employer” means an employer who meets the requirements to participate
19 in the Small Business Health Options Program.

20 [(40)] (41) “Qualified health plan” or “QHP” has the meaning given in ORS 741.300.

21 [(41)] (42) “Qualified Individual” has the meaning given in 45 CFR 155.20.

22 [(42)] (43) “Resident” means an individual who lives in Oregon with or without a fixed address,
23 or intends to live in Oregon, including an individual who enters Oregon with a job commitment
24 or looking for work. There is no minimum amount of time an individual must live in Oregon to
25 be a resident. An individual continues to be a resident of Oregon during a temporary period of
26 absence if he or she intends to return when the purpose of the absence is completed. An
27 individual is not a resident if the individual is in Oregon solely for a vacation or other leisure
28 activity.

29 [(43)] (44) “Silver-level qualified health plan” means a QHP that provides a level of coverage
30 that is designed to on average provide benefits that are actuarially equivalent to 70 percent of the
31 full actuarial benefits provided under the plan.

32 [(44)] (45) “Small Business Health Options Program” or “SHOP” has the meaning given in ORS
33 741.300.

1 [(45)] (46) “Small employer” has the meaning given in ORS 743.730.

2 [(46)] (47) “Standalone dental plan” or “SADP” means a health plan that provides pediatric
3 dental benefits and that is not offered in conjunction with a QHP.

4 [(47)] (48) “State program” has the meaning given in ORS 741.300.

5 [(48)] (49) “Tax filer” has the meaning given in 45 CFR 155.300.

6 Stat. Auth.: ORS 741.002

7 **945-020-0030 (New)**

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9 **Enrollment Authority of the Director**

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11 **In the event that an insurer ceases to provide qualified health plan coverage or ceases to**
12 **offer one or more qualified health plans under a qualified health plan product through the**
13 **health insurance exchange, the Director shall have the sole authority to determine:**

14 **(1) Whether a qualified individual enrolled in such a plan shall be automatically enrolled**
15 **into another qualified health plan offered through the health insurance exchange; and**

16 **(2) Into which, if any, qualified health plan, the qualified individual shall be automatically**
17 **enrolled.**

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19 Stat. Auth.: ORS 705.135, 741.002, and 741.003

20 Stats. Implemented: ORS 741.002

21 Hist.:

