Marketplace Cross-walk Rule Summary

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.

945-001-0002 (AMENDED)

Definitions

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

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

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

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

(4) "Applicant" has the meaning given in 45 CFR 155.20.

(5) "Automatically enroll" means the process of enrolling a qualified individual into a new qualified health plan when, at renewal:

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

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

[*(5)*] **(6)** "Benefit year" has the meaning given in 45 CFR 155.20.

[*(6)*] **(7)** "Catastrophic plan" means a health plan described in ¦1302(e) of the Affordable Care Act.

[*(7)*] **(8)** "CHIP" or "Children's Health Insurance Program" means the portion of the Oregon Health Plan established by Title XXI of the Social Security Act and administered by the Oregon Health Authority.

[*(8)*] **(9)** "Cost sharing" has the meaning given in 45 CFR 155.20.

[*(9)*] **(10)** "Cost sharing reductions" has the meaning given in 45 CFR 155.20.

[*(10)*] **(11)** "DCBS" means the Oregon Department of Consumer and Business Services.

[*(11)*] **(12)** "Effectuation" means the activation of QHP or SADP coverage through enrollment and payment of the first month's premium.

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

[*(13)*] **(14)** "Employer" has the meaning given in 45 CFR 155.20.

[*(14)*] **(15)** "Enrollee" has the meaning given in 45 CFR 155.20.

[*(15)*] **(16)** "Essential health benefits" has the meaning given in OAR 836-053-0008.

[*(16)*] **(17)** "Federal poverty level" or "FPL" has the meaning given in 45 CFR 155.300.

[*(17)*] **(18)** "Full-time employee":

(a) For plan years beginning prior to January 1, 2016, means an "eligible employee" as defined in ORS 743.730.

(b) For plan years beginning on or after January 1, 2016, full-time employee has the meaning given in section 4980H(c)(4) of the Internal Revenue Code.

[*(18)*] **(19)** "Health benefit plan" has the meaning given in ORS 741.300.

[*(19)*] **(20)** "Health care service contractor" has the meaning given in ORS 741.300.

[*(20)*] **(21)** "Health insurance" has the meaning given in ORS 741.300.

[*(21)*] **(22)** "Health insurance exchange" or "exchange" has the meaning given in ORS 741.300.

[*(22)*] **(23)** "Health plan" has the meaning given in ORS 741.300.

[*(23)*] **(24)** "Household" has the meaning given in 42 CFR 435.603.

[*(24)*] **(25)** "Household income" has the meaning given in 26 CFR 1.36B and 42 CFR 435.603.

[*(25)*] **(26)** "Individual market" has the meaning given the term in section 1304(a)(2) of the ACA.

[*(26)*] **(27)** "Insurer" has the meaning given in ORS 741.300.

[*(27)*] **(28)** "Insurance affordability program" has the meaning given in 42 CFR 435.4.

[*(28)*] **(29)** "Lawfully present" has the meaning given in 45 CFR 152.2.

[*(29)*] **(30)** "MAGI-based Medicaid and CHIP" means Medicaid and CHIP programs for which eligibility is based on modified adjusted gross income, and not primarily on age or disability.

[*(30)*] **(31)** "Medicaid" means medical assistance programs established by Title XIX of the Social Security Act and administered in Oregon by the Oregon Health Authority.

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

[*(32)*] **(33)** "Minimum essential coverage" has the meaning given in section 5000(A)(f) of the Internal Revenue Code.

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

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

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

[*(36)*] **(37)** "Oregon Insurance Division" means the Insurance Division of DCBS.

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

[*(38)*] **(39)** "Plan year" has the meaning given in 45 CFR 155.20.

[*(39)*] **(40)** "Qualified employer" means an employer who meets the requirements to participate in the Small Business Health Options Program.

[*(40)*] **(41)** "Qualified health plan" or "QHP" has the meaning given in ORS 741.300.

[*(41)*] **(42)** "Qualified Individual" has the meaning given in 45 CFR 155.20.

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

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

[*(44)*] **(45)** "Small Business Health Options Program" or "SHOP" has the meaning given in ORS 741.300.

[*(45)*] **(46)** "Small employer" has the meaning given in ORS 743.730.

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

[*(47)*] **(48)** "State program" has the meaning given in ORS 741.300.

[*(48)*] **(49)** "Tax filer" has the meaning given in 45 CFR 155.300.

Stat. Auth.: ORS 741.002

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

Enrollment Authority of the Director

In the event that an insurer ceases to provide qualified health plan coverage or ceases to offer one or more qualified health plans under a qualified health plan product through the health insurance exchange, the Director shall have the sole authority to determine:
(1) Whether a qualified individual enrolled in such a plan shall be automatically enrolled into another qualified health plan offered through the health insurance exchange; and
(2) Into which, if any, qualified health plan, the qualified individual shall be automatically enrolled.

Stat. Auth.: ORS 705.135, 741.002, and 741.003
Stats. Implemented: ORS 741.002
Hist.:

Cross-walk Rule Oregon Statutory and Federal Authority

741.002 Duties, powers and functions of Department of Consumer and Business Services; rules. (1) The duties of the Department of Consumer and Business Services include:

(a) Administering a health insurance exchange in accordance with federal law to make qualified health plans available to individuals and groups throughout this state.

(b) Providing information in writing, through an Internet-based clearinghouse and through a toll-free telephone line, that will assist individuals and small businesses in making informed health insurance decisions and that may include:

(A) The rating assigned to each health plan and the rating criteria that were used;

(B) Quality and enrollee satisfaction survey results; and

(C) The comparative costs, benefits, provider networks of health plans and other useful information.

(c) Establishing and maintaining an electronic calculator that allows individuals and employers to determine the cost of coverage after deducting any applicable tax credits or cost-sharing reduction.

(d) Operating a call center for answers to questions from individuals seeking enrollment in a qualified health plan or in the state medical assistance program.

(e) Providing information about the eligibility requirements and the application processes for the state medical assistance program.

(2) The department shall:

(a) Screen, certify and recertify health plans as qualified health plans according to the requirements, standards and criteria adopted by the department under ORS 741.310 and ensure that qualified health plans provide choices of coverage.

(b) Decertify or suspend, in accordance with ORS chapter 183, the certification of a health plan that fails to meet federal and state standards in order to exclude the health plan from participation in the exchange.

(c) Promote fair competition of carriers participating in the exchange by certifying multiple health plans as qualified under ORS 741.310.

(d) Assign ratings to health plans in accordance with criteria established by the United States Secretary of Health and Human Services and by the department.

(e) Establish open and special enrollment periods for all enrollees, and monthly enrollment periods for Native Americans in accordance with federal law.

(f) Assist individuals and groups to enroll in qualified health plans, including defined contribution plans as defined in section 414 of the Internal Revenue Code and, if appropriate, collect and remit premiums for such individuals or groups.

(g) Facilitate community-based assistance with enrollment in qualified health plans by awarding grants to entities that are certified as navigators as described in 42 U.S.C. 18031(i).

(h) Provide employers with the names of employees who end coverage under a qualified health plan during a plan year.

(i) Certify the eligibility of an individual for an exemption from the individual responsibility requirement of section 5000A of the Internal Revenue Code.

(j) Provide information to the federal government necessary for individuals who are enrolled in qualified health plans through the exchange to receive tax credits and reduced cost-sharing.

(k) Provide to the federal government any information necessary to comply with federal requirements including:

(A) Information regarding individuals determined to be exempt from the individual responsibility requirement of section 5000A of the Internal Revenue Code;

(B) Information regarding employees who have reported a change in employer; and

(C) Information regarding individuals who have ended coverage during a plan year.

(L) Take any other actions necessary and appropriate to comply with the federal requirements for a health insurance exchange.

(m) Work in coordination with the Oregon Health Authority and the Oregon Health Policy Board in carrying out its duties.

(3) The department may adopt rules necessary to carry out its duties and functions under ORS 741.001 to 741.540.

(4) The department may contract or enter into an intergovernmental agreement with the federal government to perform any of the duties and functions described in ORS 741.001 to 741.540.

(5) The department may assign contracts to the Oregon Health Authority if necessary for the authority to administer the state medical assistance program. [2011 c.415 §3; 2012 c.38 §1; 2012 c.107 §88; 2015 c.3 §17]

741.003 Duties and powers of director. (1) The health insurance exchange is under the supervision of the Director of the Department of Consumer and Business Services.

(2) The director has such powers as are necessary to carry out ORS 741.001 to 741.540.

(3) The director may employ, supervise and terminate the employment of such staff as the director deems necessary. The director shall prescribe their duties and fix their compensation. An employee of the department, other than the director, who has management responsibilities or decision-making authority with respect to the administration of the health insurance exchange may not also have management responsibilities or decision-making authority with respect to reviewing rates, assessing provider network adequacy, approving forms, determining financial solvency or enforcing other legal requirements applicable to insurers offering health insurance, as defined in ORS 731.162, in this state. Employees administering the exchange may not be individuals who are:

(a) Employed by, consultants to or members of a board of directors of:

(A) An insurer or third party administrator;

(B) An insurance producer; or

(C) A health care provider, health care facility or health clinic;

(b) Members, board members or employees of a trade association of:

(A) Insurers or third party administrators; or

(B) Health care providers, health care facilities or health clinics; or

(c) Health care providers, unless they receive no compensation for rendering services as health care providers and do not have ownership interests in professional health care practices. [Formerly 741.201]

705.135 Delegation; rules; employee indebtedness; reporting. (1) The Director of the Department of Consumer and Business Services may delegate any duties, powers and functions of the director or of the Department of Consumer and Business Services, under such conditions as the director deems appropriate.

(2) In accordance with ORS chapter 183, and in addition to other rulemaking authority prescribed by law, the director may adopt rules for the purpose of carrying out the functions of the department.

(3) The director shall adopt rules governing circumstances under which employees or any category of employees of the department may or may not be or become indebted to or hold any interest in any entity subject to regulation by the department. The rules shall provide for reporting any such indebtedness or interest and for preventing or resolving possible conflicts of interest arising therefrom. [1987 c.373 §6; 2003 c.802 §180]

45 CFR 155.335(j) Re-enrollment. If an enrollee remains eligible for enrollment in a QHP through the Exchange upon annual redetermination and—

(1) The product under which the QHP in which he or she is enrolled remains available through the Exchange for renewal, consistent with §147.106 of this subchapter, such enrollee will have his or her enrollment through the Exchange in a QHP under that product renewed, unless he or she terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with §155.430. The Exchange will ensure that re-enrollment in coverage under this paragraph (j)(1) occurs under the same product (except as provided in paragraph (j)(1)(iii)(A) of this section) in which the enrollee was enrolled, as follows:

(i) The enrollee's coverage will be renewed in the same plan as the enrollee's current QHP, unless the current QHP is not available through the Exchange.

(ii) If the enrollee's current QHP is not available through the Exchange, the enrollee's coverage will be renewed in a QHP at the same metal level as the enrollee's current QHP within the same product.

(iii) If the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP at the same metal level as the enrollee's current QHP and—

(A) The enrollee's current QHP is a silver level plan, the enrollee will be re-enrolled in a silver level QHP under a different product offered by the same QHP issuer that is most similar to the enrollee's current product. If no such silver level QHP is available for enrollment through the Exchange, the enrollee's coverage will be renewed in a QHP that is one metal level higher or lower than the enrollee's current QHP under the same product;

(B) The enrollee's current QHP is not a silver level plan, the enrollee's coverage will be renewed in a QHP that is one metal level higher or lower than the enrollee's current QHP under the same product; or

(iv) If the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP that is at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the enrollee's coverage will be renewed in any other QHP offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll.

(2) No plans under the product under which the QHP in which he or she is enrolled are available through the Exchange for renewal, consistent with §147.106 of this subchapter, such enrollee may be enrolled in a QHP under a different product offered by the same QHP issuer, to the extent permitted by applicable State law, unless he or she terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with §155.430. The Exchange will ensure that re-enrollment in coverage under this paragraph (j)(2) occurs as follows:

(i) The enrollee will be re-enrolled in a QHP at the same metal level as the enrollee's current QHP in the product offered by the same issuer that is the most similar to the enrollee's current product;

(ii) If the issuer does not offer another QHP at the same metal level as the enrollee's current QHP, the enrollee will be re-enrolled in a QHP that is one metal level higher or lower than the enrollee's current QHP in the product offered by the same issuer through the Exchange that is the most similar to the enrollee's current product; or

(iii) If the issuer does not offer another QHP through the Exchange at the same metal level as, or one metal level higher or lower than the enrollee's current QHP, the enrollee will be re-enrolled in any other QHP offered by the same issuer in which the enrollee is eligible to enroll.

(3) No QHPs from the same issuer are available through the Exchange, the enrollee may be enrolled through the Exchange in a QHP issued by a different issuer, to the extent permitted by applicable State law, unless he or she terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with §155.430. The Exchange will ensure that re-enrollment in coverage under this paragraph (j)(3) occurs as follows:

(i) As directed by the applicable State regulatory authority; or

(ii) If the applicable State regulatory authority declines to provide direction, in a similar QHP from a different issuer, as determined by the Exchange.

STATEMENT OF NEED AND FISCAL IMPACT WORKSHEET

For internal agency use only. Not a valid filing form.

Department of Consumer and Business Services Health Insurance Marketplace | 945

Agency and Division Name | Administrative Rules Chapter Number

RULE CAPTION

Director's authority to automatically enroll in a new plan a consumer who has lost coverage

In the Matter of:

OAR 945-020-0030

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

Other Authority:

Stats. Implemented: ORS 741.002

Need for the Rule(s):

Documents Relied Upon, and where they are available:

ORS 705.135, 741.002, and 741.003. These documents are available in public libraries and on at this website: https://www.oregonlegislature.gov/bills_laws/Pages/ORS.aspx.

Fiscal and Economic Impact:

Absent this rule, the federal government cross-walked Oregon consumers into plans that may not have been well-suited for these individuals. Moreover, the federal government did this without the knowledge of the consumers, the insurers, and the Marketplace. In some cases, insurers have sent unnecessary communications to members who were cross-walked to other plans, resulting in unnecessary costs to the insurers, confusion to the consumers, and the use of additional resources by the Marketplace to alleviate the confusion. Some consumers have incurred expenses changing plans to which they were cross-walked because these plans were not well-suited to their needs. This rule is expected to result in a reduction in expenses for consumers, insurers, and the Department because the Director is best-suited to determine whether and to which plans (if any) consumers should be cross-walked. Moreover, the Director can provide targeted communications to affected consumers and insurers.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

As noted above, this rule is expected to reduce costs for the Department because the Department will no longer need to devote staff and resources to "undo" the difficulties created by unsuitable cross-walking.

2. Cost of compliance effect on small business (ORS 183.336):
a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

0.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

None.

c. Equipment, supplies, labor and increased administration required for compliance:

None.

How were small businesses involved in the development of this rule?

Representatives of small business were part of the advisory committee.

Administrative Rule Advisory Committee consulted? Yes or No?
If not, why not?

Yes.