

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES,
OREGON HEALTH INSURANCE EXCHANGEMARKETPLACE

DIVISION 1

PROCEDURAL RULES

945-001-~~0001~~0002

Model Rules of Procedure

~~The Oregon Health Insurance Exchange Corporation adopts the Attorney General Model Rules applicable to rulemaking, effective August 19, 2011, with the exception of OAR 137-001-0080.~~

~~[ED. NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the office of the Attorney General or the Oregon Health Insurance Exchange.]~~

~~Stat. Auth: ORS 183.341 & 2011 OL Ch. 415, Sec. 3(5)~~

~~Stats. Implemented: ORS 183.341 & 413.042~~

~~Hist.: OHIE 1-2012, f. & cert. ef. 3-6-12~~

945-040-0010

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 ~~Exchange~~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.

~~(3) Appellant means an applicant or enrollee who has submitted an appeal request.~~

(4) ~~Applicant means (a) An individual who is seeking eligibility for him or herself through an application submitted to the Exchange or transmitted to the Exchange by an agency administering insurance affordability programs for enrollment in a QHP, Medicaid, and/or CHIP, and (b) an employer or employee seeking eligibility for enrollment in a QHP through SHOP.~~
“Applicant” has the meaning given in 45 CFR 155.20.

~~(5) Authorized representative means an individual or organization designated in writing by the applicant (individual or employee) to act on his or her behalf in applying for an eligibility determination or redetermination, and in carrying out other ongoing communications with the Exchange pursuant to 45 CFR §155.227. “Benefit year” has the meaning given in 45 CFR 155.20.~~

~~(6) Benefit year means a calendar year for which a health plan provides coverage for health benefits.~~

~~(7) “Catastrophic plan” means a health plan described in §1302(e) of the Affordable Care Act.~~

~~(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.~~

~~(9) “Cost sharing” has the meaning given in 45 CFR 155.20.~~

~~(10) Complete application means an application received by the Exchange that has the necessary information to determine eligibility and complete the enrollment process through the Exchange, in accordance with 45 CFR 155.315 and 155.310. “Cost sharing reductions” has the meaning given in 45 CFR 155.20.~~

~~(11) Cost sharing means any expenditure required by or on behalf of an enrollee with respect to essential health benefits. This includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services. “DCBS” means the Oregon Department of Consumer and Business Services.~~

~~(12) Cost sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level QHP in the Exchange or for an individual who is an eligible American Indian enrolled in a QHP through the Exchange.~~

~~(13) Date of request, for Medicaid eligibility, means the date that the initial request for benefits is made.~~

~~(14) Department of Health and Human Services or HHS means the United States Department of Health and Human Services.~~

~~(15) Eligible employee has the meaning given in the Oregon Insurance Code. (16) “Employee” has the meaning given in section 2791 of the Public Health Services Act.~~

~~(17) “Employer” has the meaning given to the term in section 2791 of the PHS Act except that such term includes employers with one or more employees. in 45 CFR 155.20.~~

~~(18) Enrollee means a qualified individual or a qualified employee enrolled in a QHP. (19) “Enrollee” has the meaning given in 45 CFR 155.20.~~

~~(18) Exchange means the Oregon Health Insurance Exchange doing business as Cover Oregon.~~

~~(19) 14~~ “Essential health benefits consists of the following general categories and the items and services covered within the categories:-

~~(a) Ambulatory patient services;-~~

~~(b) Emergency services;-~~

~~(c) Hospitalization;-~~

~~(d) Maternity and newborn care;-~~

~~(e) Mental health and substance use disorder services and devices;-~~

~~(f) Prescription drugs;-~~

~~(g) Rehabilitative and habilitative services and devices;-~~

~~(h) Laboratory services;-~~

~~(i) Preventive and wellness services and chronic disease management; and-~~

~~(j) Pediatric services, including oral and vision care.-”~~ has the meaning given in OAR 836-053-0008.

~~(2015) “Federal poverty level” (or “FPL) means the most recently published Federal poverty level as of the first day of the annual open enrollment period for coverage in a QHP through the Exchange.-”~~ has the meaning given in 45 CFR 155.300.

~~(216)~~ “Full-time employee”:

~~(a) For plan years beginning prior to January 1, 2016, a full-time employee means an employee that works at least 17.5 hours and not more than 40 hours per week and is otherwise determined to be a full-time employee by a small employer provided that the same number of hours for fulltime employment applies to all employees.~~ 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.~~

(17) “Health benefit plan” has the meaning given in ORS 741.300.

(18) “Health care service contractor” has the meaning given in ORS 741.300.

- (19) “Health insurance” has the meaning given in ORS 741.300.
- (20) “Health insurance exchange” or “exchange” has the meaning given in ORS 741.300.
- (21) “Health plan” has the meaning given in ORS 741.300.
- (22) ~~Grandfathered health plan~~ “Household” has the meaning given in 4542 CFR §147.140-435.603.
- (23) ~~Household has the meaning given in 42 CFR §435.603.~~ “(24) “Household income” has the meaning given in 26 CFR §1.36B and 42 CFR §435.603.
- ~~(25) “Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan” has the meaning given the term in section 1304(a)(2) of the ACA.~~
- (25) “Insurer” has the meaning given in ORS 741.300.
- (26) “Insurance affordability programs means advance payments of the federal health insurance premium tax credit, cost sharing reductions, and MAGI-based Medicaid and CHIP program” has the meaning given in 42 CFR 435.4.
- (27) “Lawfully present” has the meaning given in 45 CFR §152.2.
- (28) “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.
- (29) “Medicaid” means medical assistance programs established by Title XIX of the Social Security Act and administered in Oregon by the Oregon Health Authority.
- (30) “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.
- (31) “Minimum essential coverage” has the meaning given in section 5000(A)(f) of the Internal Revenue Code.
- (32) “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.
- (33) “Modified adjusted gross income” (or MAGI) means adjusted gross income adjusted by any amount excluded from gross income under IRS Code §911, any interest accrued, and social security benefits not included in gross income. or “MAGI” has the meaning given in 26 CFR 1.36B-1(e)(2).

~~(34) OHA means Oregon Health Authority.~~ “Oregon Health Insurance Marketplace” or “Marketplace” means the health insurance exchange operated within DCBS for the State of Oregon pursuant to ORS chapter 741.

~~(35) Plan year means a consecutive 12-month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year or otherwise.~~ “Oregon Insurance Division” means the Insurance Division of DCBS.

~~(36) Primary applicant means the individual named on the application who is responsible for providing information necessary to determine eligibility and calculate benefits and who will receive all information from the Exchange related to the application.~~ “Pediatric dental benefits” has the meaning given in OAR 836-053-0008.

~~(37) “Plan year” has the meaning given in 45 CFR 155.20.~~

~~(38) “Qualified employer” means an employer who meets the requirements to participate in the Small Business Health Options Program.~~

~~(38) Qualified health plan (or QHP) means a health plan that is certified by the Exchange as eligible to be sold and purchased through the Exchange.~~

~~(39) “Qualified health plan” or “QHP” has the meaning given in ORS 741.300~~

~~(40) “Qualified Individual” has the meaning given in 45 CFR 155.20.~~

~~(41) “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.~~

~~(40)42) “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.~~

~~(41)43) “Small Business Health Options Program” or “SHOP” has the meaning given in ORS 741.300.~~

~~(44) “Small employer” has the meaning given in the Oregon Insurance Code~~ ORS 743.730.

~~(45) “Standalone dental plan” or “SADP” means a health plan that provides pediatric dental benefits and that is not offered in conjunction with a QHP.~~

~~(42)46) “State program” has the meaning given in ORS 741.300.~~

(47) “Tax filer” has the meaning given in 45 CFR §155.300.

~~(43) United States nationals are persons who owe permanent allegiance to the United States and may enter and work in the United States without restriction. This includes persons born in American Samoa or Swain’s Island after December 24, 1952, and residents of the Northern Mariana Islands who did not elect to become United States citizens.~~

~~(44) Valid appeal request means an appeal request or amended appeal request from an applicant or an authorized representative made in accordance with OAR 945-040-0100(1) and that is received by the Exchange within 90 days of the date of the eligibility notice in the manner prescribed in 945-010-0100(5).~~

Stat. Auth.: ORS 741.002

Stats. Implemented: ORS 741.500

Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13; OHIE 3-2014, f. & cert. ef. 5-12-14

945-001-0006

Notice of Proposed Rulemaking and Adoption of Temporary Rules

(1) Except as provided in ORS 183.335(7) or (12) or 183.341, before permanently adopting, amending, or repealing an administrative rule, the Oregon Health Insurance ~~Exchange Corporation (Exchange)~~ [Marketplace](#) shall give notice of the intended action:

(a) To legislators specified in ORS 183.335(15) at least 49 days before the effective date of the rule;

(b) To persons on the interested parties lists described in section (2) of this rule for the pertinent OAR chapter or pertinent subtopics or programs within an OAR chapter at least 28 days before the effective date of the rule;

(c) In the Secretary of State's Bulletin referred to in ORS 183.360 at least 21 days before the effective date of the rule;

(d) To other persons, agencies, or organizations that the [ExchangeMarketplace](#) is required to provide an opportunity to comment pursuant to state statute or federal law or as a requirement of receiving federal funding, at least 28 days before the effective date of the rule; and

(f) In addition to the above, the [ExchangeMarketplace](#) may send notice of intended action to other persons, agencies, or organizations that the [ExchangeMarketplace](#), in its discretion, believes to have an interest in the subject matter of the proposed rule at least 28 days before the effective date of the rule.

(2) Pursuant to ORS 183.335(8), the [ExchangeMarketplace](#) shall maintain an interested parties list for each OAR chapter of rules for which the [ExchangeMarketplace](#) has administrative responsibility, and an interested parties list for subtopics or programs within those chapters. A person, group, or entity that desires to be placed on the list to receive notices regarding proposed

permanent adoption, amendment, or repeal of a rule must make the request in writing or by electronic mail to the rules coordinator for the chapter. The request must include either a mailing address or an electronic mail address to which notices may be sent.

(3) Notices under this rule may be sent by hand delivery, state shuttle, postal mail, electronic mail, or facsimile. The [ExchangeMarketplace](#) recognizes state shuttle as "mail" and may use this means to notify other state agencies.

(a) An email notification under section (1) of this rule may consist of any of the following:

(A) An email that attaches the Notice of Proposed Rulemaking or Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact.

(B) An email that includes a link within the body of the email, allowing direct access online to the Notice of Proposed Rulemaking or Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact.

(C) An email with specific instructions within the body of the email, usually including an electronic Universal Resource Locator (URL) address, to find the Notice of Proposed Rulemaking or Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact.

(b) The [ExchangeMarketplace](#) may use facsimile as an added means of notification, if necessary. Notification by facsimile under section (1) of this rule shall include the Notice of Proposed Rulemaking or Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact, or specific instructions to locate these documents online.

(c) The [ExchangeMarketplace](#) shall honor all written requests that notification be sent by postal mail instead of electronically if a mailing address is provided.

(4) If the [ExchangeMarketplace](#) adopts or suspends a temporary rule, the [AuthorityMarketplace](#) shall notify:

(a) Legislators specified in ORS 183.335(15);

(b) Persons on the interested parties list described in section (2) of this rule for the pertinent OAR chapter, subtopics, or programs within an OAR chapter;

(c) Other persons, agencies, or organizations that the [ExchangeMarketplace](#) is required to notify pursuant to state statute or federal law or as a requirement of receiving federal funding; and

(d) In addition to the above, the [ExchangeMarketplace](#) may send notice to other persons, agencies, or organizations that the [ExchangeMarketplace](#), in its discretion, believes to have an interest in the subject matter of the temporary rulemaking.

(5) In lieu of providing a copy of the rule or rules as proposed with the notice of intended action or notice concerning the adoption of a temporary rule, the [ExchangeMarketplace](#) may state how and where a copy may be obtained on paper, by electronic mail, or from a specified web site.

Stat. Auth: ORS 183.341 & ~~2011 OL Ch. 415, Sec. 3(5)~~[741.002\(3\)](#)

Stats. Implemented: ORS 183.330, 183.335 & 183.341

Hist.: OHIE 1-2012, f. & cert. ef. 3-6-12

~~945-001-0011-~~

~~Delegation of Rulemaking Authority~~

~~Any officer or employee of the Oregon Health Insurance Exchange who is identified on a completed Delegation of Authority form signed by the Director or Deputy Director of the Department of Consumer and Business Services and filed with the Secretary of State, Administrative Rules Unit, is vested with the authority to adopt, amend, repeal, or suspend administrative rules as provided on that form until the delegation is revoked by the Director or Deputy Director, or the person leaves employment with the Exchange.~~

~~Stat. Auth: ORS 183.341 & 2011 OL Ch. 415, Sec. 3(5) (2015 SB 1)~~

~~Stats. Implemented: ORS 183.330, 183.335 & 183.341~~

~~Hist.: OHIE 1-2012, f. & cert. ef. 3-6-12; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~DIVISION 10-~~

~~EMPLOYEE CRIMINAL RECORDS CHECK AND FITNESS DETERMINATION RULE~~

~~945-010-0001~~

~~Employee Criminal Records Check and Fitness Determination Rule~~

~~Statement of Purpose: These rules provide for the reasonable screening of subject individuals to determine if they have a history of criminal behavior such that they are not fit to be employed or volunteer in positions covered by OAR 945-010-0011. A determination by the Corporation that a subject individual is fit does not guarantee the individual a position with the corporation in any capacity.~~

~~Stat. Auth.: SB 99 (2011)~~

~~Stats. Implemented:~~

~~Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-010-0006~~

~~Definitions~~

~~As used in OAR chapter 945, division 010, unless the context of the rule requires otherwise, the following definitions apply:~~

~~(1) Conviction: A final judgment on a verdict or finding of guilty, a plea of guilty, a plea of nolo contendere (no contest); or any determination of guilt entered by a court of law against a subject individual in a criminal case unless that judgment has been reversed or set aside by a subsequent court decision.~~

~~(2) Corporation: The Oregon Health Insurance Exchange Corporation.~~

~~(3) Criminal Offender Information: Records and related data as to physical description and vital statistics; fingerprints received and compiled by the Oregon Department of State Police, Bureau of Criminal Identification, for purposes of identifying criminal offenders and alleged offenders; and records of arrests and the nature and disposition of criminal charges, including sentencing, confinement, parole, and release.~~

~~(4) Criminal Records Check: One or more of the following three processes used by the Corporation to check the criminal history of a subject individual:~~

~~(a) A name-based check of criminal offender information conducted through use of the Law Enforcement Data System (LEDS) maintained by the Oregon Department of State Police, in accordance with the rules adopted and procedures established by the Oregon Department of State Police (LEDS Criminal Records Check);~~

~~(b) A check of Oregon criminal offender information through fingerprint identification, conducted by the Oregon Department of State Police at the Corporation's request (Oregon Criminal Records Check); or~~

~~(c) A nationwide check of federal criminal offender information through fingerprint identification, conducted by the Oregon Department of State Police through the Federal Bureau of Investigation at the Corporation's request (Nationwide Criminal Records Check).~~

~~(5) Criminal records request form: A Corporation-approved form, completed by a subject individual, requesting the Corporation to conduct a criminal records check.~~

~~(6) False Statement: In association with an activity governed by these rules, a subject individual either:~~

~~(a) Provided the corporation with materially false information about his or her criminal history, such as, but not limited to, materially false information about his or her identity or conviction record; or~~

~~(b) Failed to provide to the corporation information material to determining his or her criminal history.~~

~~(7) Fitness Determination: A determination made by the corporation pursuant to the process established in OAR 945-010-0031 that a subject individual is or is not fit to be a corporation employee or to provide services in a position covered by 945-010-0011.~~

~~(8) Subject Individual: An individual identified in OAR 945-010-0021 as someone from whom the corporation may require a criminal records check.~~

~~Stat. Auth.: SB 99 (2011)~~

~~Stats. Implemented:~~

~~Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-010-0011~~

~~Subject Individual~~

~~The Health Insurance Exchange Corporation may require an individual to complete a criminal records check pursuant to these rules because the person:~~

~~(1) Works or has applied to work for the corporation; or~~

~~(2) Is or will be providing services to the corporation in the areas of:~~

~~(a) Information technology services;~~

~~(b) Payroll functions or financial transactions;~~

~~(c) Mailroom duties;~~

~~(d) Auditing responsibilities;~~

~~(e) Personnel or human resources functions;~~

~~(f) Tax or financial information; or~~

~~(g) Working with information that is confidential, including access to Social Security numbers, dates of birth or criminal background information.~~

~~Stat. Auth.: SB 99 (2011)~~

~~Stats. Implemented:~~

~~Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-010-0021~~

~~Criminal Records Check Required~~

~~The corporation may conduct, or request the Oregon Department of State Police to conduct, a criminal records check when:~~

~~(1) An individual meets the definition of a subject individual; or~~

~~(2) Required by federal law or regulation, by state or federal administrative rule or by contract or written agreement with the corporation.~~

~~Stat. Auth.: SB 99 (2011)~~

~~Stats. Implemented:~~

~~Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-010-0031~~

~~Criminal Records Check Process~~

~~(1) Disclosure of information by Subject Individual~~

~~(a) Preliminary to a criminal records check, a subject individual must complete and sign the corporation's criminal records request form and, if requested by the corporation, a fingerprint card. The corporation's criminal records request form will require the following information: name, birth date, social security number, physical characteristics, driver's license or identification card number and current address, prior residency in other states and any other identifying information deemed necessary by the corporation.~~

~~(b) A subject individual must complete and submit to the corporation the Criminal Records Request form and, if requested, a fingerprint card within three business days of receiving the forms. The corporation may extend the deadline for good cause.~~

~~(c) The corporation may require additional information from the subject individual as necessary to complete the criminal records check and fitness determination, such as, but not limited to, proof of identity; or additional criminal, judicial, or other background information.~~

~~(d) The corporation shall not request a fingerprint card from a subject individual under the age of 18 years unless the subject individual is emancipated pursuant to ORS 419B.550 et seq, or unless the corporation also requests the written consent of a parent or guardian. In such case, such parent or guardian and youth must be informed that they are not required to consent. Notwithstanding, failure to consent may be construed as a refusal to consent under OAR 863-003-0050(3).~~

~~(2) When the corporation determines under OAR 945-010-0021 that a criminal records check is required, the corporation may request or conduct a LEADS Criminal Records Check, an Oregon Criminal Records Check a Nationwide Criminal Records Check or any combination thereof.~~

~~Stat. Auth.: SB 99 (2011)~~

~~Stats. Implemented:~~

~~Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-010-0041~~

~~Potentially Disqualifying Crimes~~

~~(1) Crimes relevant to a fitness determination:-~~

~~(a) All felonies;-~~

~~(b) All misdemeanors; or~~

~~(c) Any United States Military crime or international crime.-~~

~~(2) The corporation shall evaluate a crime on the basis of Oregon laws and, if applicable, federal laws or the laws of any other jurisdiction that are valid and in effect at the time of the fitness determination.-~~

~~(3) At no time will a subject individual be determined to be not fit under these rules because of a juvenile record that has been sealed or deleted in agreement with ORS 419A.260 and 419A.262.~~

~~Stat. Auth.: SB 99 (2011)-~~

~~Stats. Implemented:-~~

~~Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-010-0051~~

~~Final Fitness Determination~~

~~(1) If a criminal records check is conducted, the corporation shall make a fitness determination about a subject individual based on:-~~

~~(a) Information given to the corporation by the subject individual;-~~

~~(b) Information received as a result of the criminal records check; and~~

~~(c) Any false statements made by the subject individual and found during the fitness determination process.-~~

~~(2) When considering these factors, the corporation may request additional information from the subject individual or any source inside or outside Oregon, including:-~~

~~(a) Law enforcement;-~~

~~(b) Criminal justice agencies; or~~

~~(e) Courts.-~~

~~(3) To obtain other criminal offender information from the subject individual, the corporation may request:-~~

~~(a) To meet with the person;-~~

~~(b) Written materials from the person; or~~

~~(c) Authorization from the person to acquire relevant information from other sources.-~~

~~(4) If requested, the subject individual must meet with or provide the requested information to the corporation within a reasonable period of time determined by the corporation.-~~

~~(5) In making the final fitness determination, the corporation will consider:-~~

~~(a) The nature of the crime;-~~

~~(b) Facts that support the conviction or pending charge or that indicate the making of a false statement; and~~

~~(c) The relevancy, if any, of the crime or the false statement to the specific requirements of the subject individual's present or proposed position, services, or employment.-~~

~~(d) Intervening circumstances relevant to the responsibilities and circumstances of the position, services, or employment. Intervening circumstances include but are not limited to:-~~

~~(A) The passage of time since the commission of the crime;-~~

~~(B) The age of the subject individual at the time of the crime;-~~

~~(C) The likelihood of a repetition of offenses or of the commission of another crime;-~~

~~(D) The subsequent commission of another relevant crime;-~~

~~(E) Whether the conviction was set aside and the legal effect of setting aside the conviction; and~~

~~(F) A recommendation of an employer.-~~

~~(6) If a subject individual refuses to submit information or consent to a criminal records check, including fingerprint identification, the corporation shall deny the employment of the subject individual or deny any applicable position or authority to provide services. A person may not appeal any determination made based on a refusal to consent.-~~

~~(7) If a subject individual is determined to be not fit, the subject individual may not be employed by the corporation or provide services as a volunteer, contractor or vendor to the corporation in a position covered by OAR 945-010-0011.-~~

~~(8) A completed final fitness determination is a final order of the corporation unless the affected subject individual appeals by requesting either a contested case hearing as provided by OAR 945-010-0081 or an alternative appeals process as provided by 945-010-0081.~~

~~(9) The corporation shall inform the subject individual who has been determined not to be fit on the basis of a criminal records check via personal service or registered or certified mail to the most current address provided by the subject individual.~~

~~Stat. Auth.: SB 99 (2011)~~

~~Stats. Implemented:~~

~~Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-010-0061~~

~~Hiring On a Preliminary Basis~~

~~(1) If the corporation conducts a criminal records check pursuant to these rules, the corporation, in its sole discretion, may hire, appoint or accept services from a subject individual on a preliminary basis pending completion of criminal records check when:~~

~~(a) The subject individual has provided all information (including a fingerprint card, if requested) as required by the corporation pursuant to OAR 945-010-0031; and~~

~~(b) The corporation, in its sole discretion, determines that it is in the corporation's best interests to hire, appoint, or accept services from the subject individual on a preliminary basis.~~

~~(2) A subject individual hired, appointed, or otherwise engaged to perform services on a preliminary basis under this rule may provide services, or participate in training, orientation, or work activities as deemed appropriate by the corporation.~~

~~(3) Nothing in this rule shall be construed as requiring the corporation to hire, appoint, or accept services from a subject individual on a preliminary basis.~~

~~Stat. Auth.: SB 99 (2011)~~

~~Stats. Implemented:~~

~~Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-010-0071~~

~~Incomplete Fitness Determination~~

~~(1) The corporation will close a preliminary or final fitness determination as incomplete when:~~

~~(a) Circumstances change so that a person no longer meets the definition of a "subject individual" under OAR 945-010-0011;~~

~~(b) The subject individual does not provide materials or information under OAR 945-010-0031 within the time frames established under that rule;~~

~~(c) The corporation cannot locate or contact the subject individual;~~

~~(d) The subject individual fails or refuses to cooperate with the corporation's attempts to acquire other relevant information under OAR 945-010-0031;~~

~~(e) The corporation determines that the subject individual is not eligible or not qualified for the position for a reason unrelated to the fitness determination process; or~~

~~(f) The position is no longer open.~~

~~(2) A subject individual does not have a right to a contested case hearing under OAR 945-010-0081 or a right to an alternate appeals process under 945-010-0081 to challenge the closing of a fitness determination as incomplete.~~

~~Stat. Auth.: SB 99 (2011)~~

~~Stats. Implemented:~~

~~Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-010-0081~~

~~Contesting a Fitness Determination~~

~~(1) Purpose. Sections (2)–(5) of this rule set forth the contested case hearing process a subject individual must use to appeal a completed final fitness determination made under OAR 945-010-0051 that the individual is not fit to hold a position with, or provide services to the corporation as an employee, volunteer, contractor, or vendor. Section (6) of this rule identifies an alternative appeal process available only to current corporation employees, if applicable.~~

~~(2) Appeal Process~~

~~(a) To request a contested case hearing, the subject individual or the subject individual's legal representative must submit a written request for a contested case hearing to the address specified in the notice provided under OAR 945-010-0031. To be timely, the request must be received by the corporation at the specified address within 14 calendar days of the date stated on the notice. The corporation shall address a request received after expiration of the deadline as provided under 137-003-0528.~~

~~(b) When a timely request is received by the corporation under subsection (a), a contested case hearing shall be conducted by an administrative law judge assigned by the Office of Administrative Hearings, pursuant to the Attorney General's Uniform and Model Rules, "Procedural Rules, Office of Administrative Hearings" OAR 137-003-0501 to 137-003-0700, as supplemented by the provision of this rule.~~

~~(3) Discovery. The administrative law judge may protect information made confidential by ORS 181.534(15) or other applicable law as provided under OAR 137-003-0570(7) or (8).~~

~~(4) No Public Attendance. Contested case hearings on fitness determinations are closed to non-participants.~~

~~(5) Proposed and Final Order:~~

~~(a) Proposed Order. After a hearing, the administrative law judge will issue a proposed order.~~

~~(b) Exceptions. Exceptions, if any, shall be filed within fourteen (14) calendar days after service of the proposed order. The proposed order shall provide an address to which exceptions must be sent.~~

~~(c) Default. A completed final fitness determination made under OAR 945-010-0051 becomes final:~~

~~(A) unless the subject individual makes a timely request for a hearing; or~~

~~(B) when a party withdraws a hearing request, notifies the corporation or the administrative law judge that the party will not appear, or fails to appear at a hearing.~~

~~(6) Alternative Process. A subject individual currently employed by the corporation may choose to appeal a fitness determination either under the process made available by this rule or through a process made available by applicable personnel rules and policies, if any. A subject individual's decision to appeal a fitness determination through applicable personnel rules and policies is an election of remedies as to the rights of the individual with respect to the fitness determination and is a waiver of the contested case process made available by this rule.~~

~~(7) Remedy. The only remedy that may be awarded is a determination that the subject individual is fit or not fit. Under no circumstances shall the corporation be required to place a subject individual in any position, nor shall the corporation be required to accept services or enter into a contractual agreement with a subject individual.~~

~~(8) Challenging Criminal Offender Information. A subject individual may not use the appeals process established by this rule to challenge the accuracy or completeness of information provided by the Oregon Department of State Police, the Federal Bureau of Investigation, or agencies reporting information to the Oregon Department of State Police or the Federal Bureau of Investigation.~~

~~(a) To challenge information identified in this section of the rule, a subject individual may use any process made available by the agency that provided the information.~~

~~(b) If the subject individual successfully challenges the accuracy or completeness of information provided by the Oregon Department of State Police, the Federal Bureau of Investigation, or an agency reporting information to the Oregon Department of State Police or the Federal Bureau of Investigation, the subject individual may request that the corporation conduct a new criminal~~

~~records check and re-evaluate the original fitness determination made under OAR 863-003-0050 by submitting a new corporation criminal records request. This provision only applies if the position for which the original criminal history check is vacant and available.~~

~~(9)Appealing a fitness determination under section (2) or section (6) of this rule, challenging criminal offender information with the agency that provided the information, or requesting a new criminal records check and re-evaluation of the original fitness determination under section (8)(b) of this rule, will not delay or postpone the corporation's hiring process or employment decisions.~~

~~Stat. Auth.: SB 99 (2011)~~

~~Stats. Implemented:~~

~~Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-010-0091~~

~~Record Keeping, Confidentiality~~

~~Any information obtained in the criminal records check is confidential. The corporation must restrict the dissemination of information obtained in the criminal records check. Only those persons, as identified by the corporation, with a demonstrated and legitimate need to know the information, may have access to criminal records check records.~~

~~Stat. Auth.: SB 99 (2011)~~

~~Stats. Implemented:~~

~~Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-010-0101~~

~~Fees~~

~~(1) The corporation may charge a fee for acquiring criminal offender information for use in making a fitness determination. In any particular instance, the fee shall not exceed the fee(s) charged the corporation by the Oregon Department of State Police and the Federal Bureau of Investigation to obtain criminal offender information on the subject individual.~~

~~(2) The corporation may charge a fee to the subject individual on whom criminal offender information is sought, or, if the subject individual is an employee of a corporation contractor and is undergoing a fitness determination in that capacity, the corporation may charge a fee to the subject individual's employer.~~

~~Stat. Auth.: SB 99 (2011)~~

~~Stats. Implemented:~~

~~Hist.: OHIE 2-2012, f. & cert. ef. 3-6-12; Suspended by OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

DIVISION 20

~~QUALIFIED HEALTH PLAN ADDENDUM FOR INDIAN HEALTH PROVIDERS~~

CERTIFICATION OF HEALTH AND DENTAL PLANS

945-020-0010

~~Statutory Authority; Purpose; Applicability~~

(1) ~~OAR chapter 945, division 20 is adopted pursuant to the general rulemaking authority of the Exchange in ORS 741.002. (2)~~ The purpose of OAR chapter 945, division 20 is to establish the process for certification of ~~health~~.

(a) Health plans as qualified health plans (QHPs); and

(b) Standalone dental plans (SADPs) as providing pediatric dental benefits.

~~(3)~~(2) Except for multistate plans, as defined in 45 CFR 800.20, OAR chapter 945, division 20 applies to ~~all qualified health plans~~.

(a) All QHPs offered through the Exchange, except the following: Marketplace; and

~~(a) Multistate plans, as defined in 45 CFR § 800.20; and.~~

(b) ~~Consumer Operated and Oriented Plans (CO-OPs), as defined in 45 CFR §156.505. All~~ SADPs marketed through or outside the Marketplace as providing pediatric dental benefits.

Stat. Auth.: ORS 741.002 ~~(2015 SB 1)~~

Stats. Implemented: ORS 741.310

Hist.: OHIE 3-2012(Temp), f. 9-13-12, cert. ef. 10-1-12 thru 3-13-13; OHIE 4-2012, f. & cert. ef. 12-13-12; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-020-0020

Certification of ~~Qualified Health Plans~~ QHPs and Marketplace SADPs

(1) Each health benefit plan or dental plan offered through the Oregon Health Insurance ~~Exchange (Exchange)~~ Marketplace must have in effect a certification issued by the ~~Exchange~~ Marketplace. This certification ~~demonstrates evidences~~ that the health benefit plan is a ~~qualified health plan (QHP)~~ QHP and that the dental plan is a SADP providing pediatric dental benefits.

~~(2)~~ The ~~Exchange~~ Marketplace will issue a request for applications ~~(RFA)~~. To be considered for participation and plan certification, ~~a health insurance issuer~~ an insurer must submit a completed

application to the [ExchangeMarketplace](#) in the form and manner, and within the timeframes specified by the [ExchangeMarketplace](#).

~~(2) Conditional~~ 3) For QHPs, the Marketplace will grant conditional approval to participate in the Exchange will be granted to applicants who Marketplace to an insurer whose application demonstrates the insurer:

(a) ~~Are licensed~~ Has a certificate of authority and is in good standing with the Oregon Insurance Division to offer health insurance benefit plans in Oregon;

(b) ~~Agree to~~ Will offer at least one standardized QHP at the bronze, silver, and gold levels of coverage;

~~(c) Meet any other performance standards that may be adopted by the Exchange; and (d) Agree to contract with the Exchange to offer QHPs. Contracts will require issuers to comply with Exchange standards and requirements~~ Will contract with the Marketplace to offer QHPs and abide by the terms of the contract. insurers, including but not limited to the following provisions:

(A) Transparency in coverage standards;

(B) Accreditation requirements;

(C) Network adequacy standards;

(D) [ExchangeMarketplace](#) administrative fees and assessments;

(E) Quality improvement strategies, quality reporting, and enrollee satisfaction surveys;

~~(F) Exchange agent management program requirements; (G) Tribal requirements;~~

~~(H) Premium tax credit and cost sharing reductions;~~

(H) Performance reporting standards; and

(I) [ExchangeMarketplace](#) processes and procedures, including those related to enrollment, enrollment periods, premium payment, terminations of coverage, customer service, and QHP recertification and decertification.

~~(3) Issuer approval is conditioned upon certification of their health benefit plans. Issuers will be approved for a two-year period. No new issuers will be considered for participation during those two years unless there is a significant loss of statewide coverage. 4) For SADPs, the Marketplace will grant conditional approval to participate in the Marketplace to an insurer whose application demonstrates the insurer:~~

(a) Has a certificate of authority and is in good standing with the Oregon Insurance Division to offer dental plans in Oregon;

(b) Agrees to contract with the Marketplace to offer SADPs. ~~Contracts will require~~ insurers to comply with Marketplace ~~standards and requirements~~, including but not limited to the following:

(A) Transparency in coverage standards;

(B) Network adequacy standards;

(C) Marketplace administrative fees and assessments; and

(D) Marketplace processes and procedures, including those related to enrollment, enrollment periods, premium payment, terminations of coverage, customer service, and SADP recertification and decertification.

(5) An insurer's ~~approval is conditioned~~ on certification of its health benefit or dental plans. An insurer will be approved for a two-year period, subject to a decision by the Marketplace to issue another request for applications before the end of the two-year period. An insurer that did not participate in the request for application the process may not offer coverage through the Marketplace, unless the Marketplace determines that there is a significant loss of statewide coverage.

~~(46)~~ A loss of statewide coverage may include, but is not limited to, ~~plan~~:

(A) Plan discontinuance;

(B) Plan withdrawal;

(C) Plan decertification, ~~;~~ or enrollment

(D) Enrollment closures that result in ~~a lack of~~ inadequate coverage choices in ~~a one or more~~ geographic ~~area(s)~~ areas of the state.

~~(5) Any health benefit plan an approved issuer wants to offer~~ (7) Every QHP or SADP offered through the ~~Exchange~~ Marketplace must be filed with the Oregon Insurance Division and determined to meet applicable benefit design standards and all other insurance regulations as required under state and federal law.

~~(68)~~ Benefit design standards means coverage that includes, but is not limited to, the following:

~~(a) The~~ For QHPs, essential health benefits ~~package as defined in 45 CFR §156.20~~, or for SADPs, pediatric dental benefits;

(b) For QHPs:

(A) Cost sharing limits as defined in 45 CFR §156.130; and

~~(eB)~~ A bronze, silver, gold, or platinum level of coverage as defined in 45 CFR §156.140, or is a catastrophic plan as described in section 1302(e) of the Affordable Care Act.

~~(79) Subject to any the limitation on the number of plans QHPs that may be offered through the Exchange, the Exchange will certify Marketplace in the insurer's contract with the Marketplace, the Marketplace will recertify health benefit or dental plans that are submitted by approved issuers and determined by the Oregon Insurance Division to meet all applicable standards insurers and with benefit design standards and legal requirements in this rule.~~

~~(10) The Marketplace may at any time decertify a QHP or SADP if the Marketplace determines that the insurer or QHP or SADP is no longer in compliance with the Marketplace's certification criteria. An insurer may appeal decertification of a QHP or SADP through the informal process specified in the insurer's contract with the Marketplace. After resolution of the informal appeal, an aggrieved insurer may seek additional review through a contested case hearing as provided under ORS 183.411 to 183.471.~~

Stat. Auth.: ORS 741.002

Stats. Implemented: ORS 741.310

Hist.: OHIE 3-2012(Temp), f. 9-13-12, cert. ef. 10-1-12 thru 3-13-13; OHIE 4-2012, f. & cert. ef. 12-13-12; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-020-0025

Certification of Non-Marketplace Stand-alone Dental Plans

This rule applies only to SADPs offered outside the Marketplace. The Marketplace will, upon satisfaction of the following criteria, certify as providing pediatric dental benefits a stand-alone dental plan (SADP) that an insurer offers for sale outside of the Marketplace.

(1) To be considered for SADP certification, a dental plan must have its rates, form, and binder filed with and approved by the Oregon Insurance Division.

(2) For an SADP to be certified, the insurer must demonstrate to the Marketplace that the SADP:

(A) Provides pediatric dental benefits;

(B) Meets an actuarial value of 68% to 72% or 83% to 87%;

(C) For individual SADPs, imposes rates that are effective for the entire policy year;

(D) For small group SADPs, imposes rates that may be subject to increase every calendar quarter but that are effective for a specific group for the entire plan year; and

(E) Has been approved for sale in Oregon by the Oregon Insurance Division.

(3) The Marketplace will recertify an SADP that meets the criteria in paragraph (2) of this rule.

(4) (A) The Marketplace may at any time decertify an SADP if the Marketplace determines that the insurer or SADP no longer meets the Marketplace's certification criteria described in this rule.

(B) The insurer may appeal decertification. Appeal requests must be submitted within 15 days from receipt of the notice from the Marketplace informing the insurer of the decertification. The insurer's appeal request must be made in writing and must provide a thorough explanation of the grounds for appeal along with any supporting information. The Administrator of the Marketplace will rule on a valid and timely appeal request within 14 days of receipt of the request. If an insurer is unsatisfied with the Administrator's ruling, the insurer may seek additional review through a contested case hearing as provided under ORS 183.411 to 183.471.

(C) Upon decertification of an SADP, the Marketplace will provide notice of decertification to the insurer and the Insurance Division, and the insurer shall not terminate coverage before giving notice to enrollees.

945-020-0040

Qualified Health Plan ~~QHP~~ Addendum for Indian Health Care Providers

~~(1) The Exchange adopts by reference the Qualified Health Plan (QHP) Addendum for Indian Health Care Providers.~~ (2) If a health insurer contracts with a Tribal Health Provider in the state of Oregon for services ~~to be offered~~ provided through a ~~health benefit plan certified by the Exchange as a~~ Marketplace QHP, the ~~issuer must~~ insurer shall:

(a) Use the QHP Addendum for Indian Health Care Providers, [Exhibit 1 to this rule](#), to supplement and amend ~~their~~ its existing provider contract, and

(b) Notify the ~~Exchange~~ Marketplace in writing of the contractual relationship by ~~contacting an Exchange carrier account executive~~ emailing the information to info.marketplace@Oregon.gov.

~~(3) The Exchange reserves the right to~~ Marketplace may amend the QHP Addendum for Indian Health Care Providers using the rulemaking process. Contracted carriers and tribes will be required to amend their contracts to reflect any change to the QHP Addendum for Indian Health Care Providers within 90 days of adoption of the change.

~~[ED. NOTE: Tables referenced are not included in rule text. Click here for PDF copy of table(s).]~~ [Exhibit 1:](#)



Adobe Acrobat
Document

[QHP Addendum for Indian Health Care Providers](#)

Stat. Auth.: ORS 741.002

Stats. Implemented: ORS 741.310

Hist.: OHIE 4-2013, f. & cert. ef. 7-9-13

DIVISION 30

ADMINISTRATIVE CHARGE FOR OPERATING EXPENSES

945-030-0010

~~Statutory Authority; Purpose~~

~~(1) OAR chapter 945, division 30 is adopted pursuant to the general rulemaking authority of the Exchange in ORS 741.002.~~

~~(2) The purpose of division 30 is to establish a process for the adoption of an administrative charge to be paid by health insurers offering a qualified health ~~plans~~ plan or stand-alone dental plan through the ~~Exchange~~ Marketplace to pay the administrative and operational expenses of the ~~corporation~~ Marketplace, including costs of grants to certified navigators.~~

Stat. Auth.: ORS 741.002

Stats. Implemented: ORS 741.105

Hist.: OHIE 1-2013, f. & cert. ef. 3-18-13; Suspended by OHIE 3-2013(Temp), f. & cert. ef. 5-28-13 thru 11-22-13

945-030-0020

Establishment of Administrative Charge Paid by Insurers

(1) ~~Exchange~~ After consulting with the Advisory Committee created by Section 13 of 2015 Senate Bill 1, Marketplace staff will annually provide a Report on Administrative Charges to the Director of the Department of Consumer and Business Services (Director).

(2) The report will be posted on the ~~Exchange~~ Marketplace's website for public review and comment.

(3) At a minimum, the report will include

(a) A projection of ~~Exchange operating expenses for the next calendar year, Marketplace operating expenses (including the Marketplace share of DCBS shared services expenses, and operating expenses borne by the Marketplace and reimbursed by another agency) based on DCBS budgets, assuming for this purpose that the operating expenses in any actual or expected biennial budget are distributed evenly over the biennium;~~

(b) A projection of ~~Exchange~~ Marketplace enrollment for the next calendar year; and

(c) A proposed administrative charge for the next calendar year.

(4) The Department will hold a public hearing on a proposed administrative charge.

(5) No later than the end of the first quarter of a calendar year the Director shall amend or approve; an administrative charge for the next calendar year.

(6) Any administrative charge adopted by the Director shall be established in rule.

(7) The administrative charge shall be expressed as a per member per month figure.

(8) The annual administrative charge assessed by the ~~Exchange~~Marketplace shall not exceed the limits set forth in ORS ~~741.105~~.741.105(2) on the premium or other monthly charge, prior to tax credits and cost sharing reductions, based on the number of enrollees receiving coverage in qualified health plans or stand-alone dental plans through the Marketplace during the month of December preceding the report.

(9) The maximum amount permissible under ORS 741.105 will be calculated by comparing the Marketplace's fund balance at the end of each December with the Marketplace's budgeted operating expenses for the following six-month period (calculated as one-fourth of the budgeted operating expenses for the biennium that includes the six-month period). If the fund balance exceeds six months of budgeted operating expenses, the Department of Consumer and Business Services will return excess funds to carriers on a pro-rata basis, computed from the December assessments, in the form of a credit applied against future assessments. The credit will be applied no later than the end of the first quarter of the calendar year.

Stat. Auth.: ORS 741.002-~~(2015 SB 1)~~

Stats. Implemented: ORS 741.105

Hist.: OHIE 1-2013, f. & cert. ef. 3-18-13; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-030-0030

Annual2015 Administrative Charge on Insurers

(1) Effective January 1, 2015, each health insurer offering qualified health plans through the ~~Exchange~~Marketplace shall pay a monthly administrative charge equal to \$9.66 times the number of members enrolled through the ~~Exchange~~Marketplace in that month.

(2) Effective January 1, 2015, each health insurer offering ~~standalone~~stand-alone dental plans through the ~~Exchange~~Marketplace shall pay a monthly administrative charge equal to \$0.97 times the number of members enrolled through the ~~Exchange~~Marketplace in that month.

~~(3) If the total charges collected exceed the maximum amount permissible under ORS 741.105, the Department of Consumer and Business Services will return excess funds to carriers on a pro-rata basis no later than the end of the 2nd quarter of the next calendar year.~~

Stat. Auth.: ORS 741.002-~~(2015 SB 1)~~

Stats. Implemented: ORS 741.105

Hist.: OHIE 1-2013, f. & cert. ef. 3-18-13; OHIE 3-2013(Temp), f. & cert. ef. 5-28-13 thru

11-22-13; OHIE 5-2013, f. & cert. ef. 8-19-13; OHIE 2-2014, f. & cert. ef. 4-15-14; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-030-0035

2016 Administrative Charge on Insurers

(1) Effective January 1, 2016, each health insurer offering qualified health plans through the [ExchangeMarketplace](#) shall pay a monthly administrative charge equal to \$9.66 times the number of members enrolled through the [ExchangeMarketplace](#) in that month.

(2) Effective January 1, 2016, each health insurer offering ~~standalone~~[stand-alone](#) dental plans through the [ExchangeMarketplace](#) shall pay a monthly administrative charge equal to \$0.97 times the number of members enrolled through the [ExchangeMarketplace](#) in that month.

~~(3) If the total charges collected exceed the maximum amount permissible under ORS 741.105, the Department of Consumer and Business Services will return excess funds to carriers on a pro-rata basis no later than the end of the 2nd quarter of the next calendar year.~~

Stat. Auth.: ORS 741.002

Stats. Implemented: ORS 741.105

Hist.: OHIE 2-2015, f. 3-17-15, cert. ef. 3-31-15

945-030-0040

Assessment and Collection of Administrative Charge on Insurers

(1) The [Exchange](#)insurers will capture enrollments as of the 15th of the month for the following month. The insurers will submit their report to the Department of Consumers and Business Services by the last Wednesday of the month.

(2) The [Marketplace](#) shall assess the administrative charge on or before the 10th ~~business~~-day of each month.

~~(23)~~ Each insurer's monthly administrative charge will be based on the number of members enrolled through the [ExchangeMarketplace](#) in that month. The [Marketplace](#) may adjust the administrative charge ~~will be adjusted~~ for any changes [or corrections](#) to prior ~~months~~-enrollment-[, as follows:](#)

[\(a\) For report months beginning July of year 1 and ending June of year 2, insurers report enrollment for coverage months beginning January of year 1 through the report month.](#)

[\(b\) Changes or corrections will be made for coverage months in the reports described in paragraph \(a\) above. Changes or corrections will not be made for coverage months preceding the reports described in paragraph \(a\) above.](#)

(34) The administrative charge is due in full to the ~~Exchange~~Marketplace on the ~~last business~~ 10th day of the following month, after it was assessed.

(45) For any month in which the insurer does not make full payment within ~~105~~ days following the ~~last business day of that month, the Exchange shall~~ due date for the administrative charge, the Marketplace may impose a late payment charge of 1 percent of the amount due, to be paid on the next due date for the administrative charge.

(56) If an insurer fails to pay the administrative charge or any late payment charge or both, the Director may:

(a) Impose an annual 9% interest charge on the amount due;

(b) Close that insurer's ~~Exchange~~Marketplace plans to new enrollment until all outstanding charges are paid; and/or

(bc) De-certify that insurer's qualified health plans and/or ~~standalone~~stand-alone dental plans.

(7) The insurer must maintain data that are sufficient:

(a) To support the assessment reported to the director and any adjustments or corrections; and

(b) For the Director to verify the amount reported, adjusted, or corrected.

(8) Upon request and in the form, manner, and time prescribed by the Director, an insurer must provide to the Director the data described in paragraph 7 of this rule.

(9) An insurer may contest the amount of any assessment or charge under this section through a contested case hearing under ORS 183.411 to 183.471.

Stat. Auth.: ORS 741.002 ~~(2015 SB 1)~~

Stats. Implemented: ORS 741.105

Hist.: OHIE 1-2013, f. & cert. ef. 3-18-13; OHIE 3-2013(Temp), f. & cert. ef. 5-28-13 thru 11-22-13; OHIE 5-2013, f. & cert. ef. 8-19-13; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

945-030-0045

Administrative Assessment on State Programs

(1) The administrative assessment on state programs shall be established in an Intergovernmental Agreement between the ~~Exchange~~Marketplace and the Oregon Health Authority.

(2) The administrative assessment, expressed as a per member per month figure, shall be based on the number of individuals enrolled in state programs offered through the ~~Exchange~~Marketplace.

(3) The Intergovernmental Agreement shall specify the intervals and manner in which the administrative assessment is to be paid.

(4) ~~Exchange Marketplace~~ staff will annually report to the Director on the assessment on state programs.

Stat. Auth.: ORS 741.002 ~~(2015 SB-1)~~

Stats. Implemented: ORS 741.105

Hist.: OHIE 1-2014, f. & cert. ef. 1-16-14; OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15

DIVISION 40

~~ELIGIBILITY STANDARDS, APPLICATION PROCESS, AND APPEALS OF ELIGIBILITY DETERMINATIONS~~

~~945-040-0005~~

~~Scope~~

~~ORAR 945-040-0060 to 945-040-0180 apply only to Exchange processes for coverage beginning on or before December 31, 2014. For coverage beginning on or after January 1, 2015, the application process and appeals of eligibility determinations are handled by the Center for Consumer Information and Insurance Oversight (CCIO) through healthcare.gov.~~

~~Stat. Auth.: ORS 741.002~~

~~Stats. Implemented: ORS 741.500~~

~~Hist.: OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-040-0020~~

~~Eligibility for Enrollment in a Qualified Health Plan in the Individual Market~~

~~(1) To qualify for enrollment in a qualified health plan in the individual market, an applicant must:~~

~~(a) Be a United States citizen or national, or a lawfully present non-citizen;~~

~~(b) Be a resident of Oregon; and~~

~~(c) Not be incarcerated. Incarceration pending the disposition of charges is not a disqualifying factor.~~

(2) To qualify for enrollment in a qualified health plan that is a catastrophic plan, in addition to meeting the requirements of (1), an applicant must either:

(a) Have not attained the age of 30 before the beginning of the plan year; or

(b) Have a certification showing that he or she is exempt from the requirement to maintain minimum essential coverage for the plan year for which he or she is applying by reason of:

(A) Lack of access to affordable coverage, in accordance with §5000A(e)(1) of the Internal Revenue Code; or

(B) Hardship, in accordance with §5000A(e)(5) of the Internal Revenue Code.

Stat. Auth.: ORS 741.002

Stats. Implemented: ORS 741.500

Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13

945-040-0030

Eligibility for the Small Business Health Options Program (SHOP)

(1) To qualify for the [ExchangeMarketplace](#)'s Small Business Health Options Program (SHOP), a small employer must:

(a) ~~Have at least one but not more than 50 eligible employees;~~ [Meet the definition of small employer in ORS 743.730;](#)

(b) At a minimum, offer coverage in a qualified health plan to all full-time employees; and

(c) Have a principal business address in Oregon, or offer coverage to all eligible employees whose primary worksite is located in Oregon.

(2) A small employer that meets the minimum participation and contribution requirements for medical plans may apply for SHOP coverage throughout the year. A small employer that does not meet these requirements may apply for SHOP coverage between November 15 and December 15. The minimum participation and contribution requirements for dental plans apply throughout the year for a small employer offering dental plans through SHOP.

(3) Once enrolled, [if an employer remains eligible for SHOP regardless of the number of additional employees](#) ~~grows larger than 50, the group is eligible to stay enrolled through SHOP if~~ [hires.](#)

(4) An employee is eligible to enroll in a qualified health plan through SHOP if ~~such~~ [the](#) employee receives an offer of coverage from a qualified employer.

Stat. Auth.: ORS 741.002
Stats. Implemented: ORS 741.500
Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13

945-040-0040

Eligibility for Insurance Affordability Programs

(1) Advance Payments of the Premium Tax Credit. In order to qualify for advance payments of the premium tax credit, a tax filer must:

(a) ~~Be expected to have~~ Have household income greater than or equal to 100 percent, but not more than 400 percent of the Federal Poverty Level (~~FPL~~) for the benefit year; and one or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year including the tax filer and his or her spouse must:

(A) Be eligible for enrollment in a qualified health plan; and

(B) Not be eligible for minimum essential coverage, with the exception of coverage in the individual market; and

(b) Attest that he or she:

(A) Will file an income tax return for the benefit year;

(B) If married, will file a joint tax return for the benefit year;

(C) Will not be claimed as a tax dependent by another tax filer for the benefit year; and

(D) Will claim a personal exemption deduction on his or her tax return for the applicants identified as members of his or her family including the tax filer and his or her spouse.

(2) An individual is treated as eligible for employer-sponsored minimum essential coverage only if:

(a) The employee's share of the annual premium for self-only coverage does not exceed 9.5 percent of the taxpayer's household income for the taxable year and the insurer's share of the total allowed costs of benefits provided under the plan is at least 60 percent of those costs; or

(b) The individual actually enrolls in ~~the~~ coverage, including coverage that does not provide minimum value and exceeds 9.5 percent of the taxpayer's household income for the taxable year.

(3) A qualified individual must enroll through the ExchangeMarketplace in a qualified health plan that is not a catastrophic plan to receive advance payments of the premium tax credit.

(4) A qualified individual may accept less than the full amount of advance payments of the premium tax credit for which he or she is determined eligible.

(5) A qualified individual who receives advance payments of the premium tax credit and does not file an income tax return and reconcile payments of the tax credit as required by the federal government may not be eligible for advance payments of the premium tax credit for the next benefit year.

(6) Cost Sharing Reductions. In order to qualify for cost sharing reductions, an individual must:

(a) Be eligible for enrollment in a qualified health plan;

(b) Be eligible for advance payments of the premium tax credit;

(c) ~~Be expected to have~~ Have household income that does not exceed 250 percent of ~~FPL~~ the federal poverty level; and

(d) Be enrolled in a silver-level qualified health plan, except as provided in 945-040-0050 for members of federally recognized Indian tribes.

(7) The ~~Exchange~~ Marketplace must use the following eligibility categories for cost sharing reductions:

(a) Individuals ~~expected to that~~ have household income less than or equal to 150 percent of ~~FPL~~ the federal poverty level. Individuals in this category will be eligible for cost sharing reductions such that the silver plan covers between 93 and 95 percent of the average expected medical expenses for essential health benefits.

(b) Individuals ~~expected to who~~ have household income greater than 150 percent of ~~FPL~~ the federal poverty level and less than or equal to 200 percent of ~~FPL~~ the federal poverty level. Individuals in this category will be eligible for cost sharing reductions such that the silver plan covers between 86 and 88 percent of the average expected medical expenses for essential health benefits

(c) Individuals ~~expected to who~~ have household income greater than 200 percent of ~~FPL~~ the federal poverty level and less than or equal to 250 percent of ~~FPL~~ the federal poverty level. Individuals in this category will be eligible for cost sharing reductions such that the silver plan covers between 72 and 74 percent of the average expected medical expenses for essential health benefits.

~~(8) MAGI-based Medicaid and CHIP Programs. The Exchange must determine eligibility for MAGI-based Medicaid and CHIP programs in accordance with OAR 410-200.~~

Stat. Auth.: ORS 741.002

Stats. Implemented: ORS 741.500

Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13; OHIE 3-2014, f. & cert. ef. 5-12-14

945-040-0050

Eligibility Standards for Special Populations

(1) Advance Payments of the Premium Tax Credit for Lawfully Present Noncitizens Ineligible for Medicaid. The [ExchangeMarketplace](#) must determine a tax filer eligible for advance payments of the premium tax credit if he or she:

(a) Meets the requirements of 945-040-0040, except 945-040-0040(1)(a) and (b); and

(b) One or more applicants for whom the tax filer attests that he or she expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse, is a noncitizen who is lawfully present and ineligible for Medicaid by reason of immigration status in accordance with section 36B(c)(1)(B) of the Internal Revenue Code.

(2) Cost Sharing Reductions for American Indians/Alaska Natives. To qualify for cost sharing reductions, the applicant must:

(a) Be a member of a federally recognized tribe;

(b) Be eligible for and enroll in a qualified health plan;

(c) Be eligible for advance payments of the premium tax credit; and

(d) ~~Be expected to have~~ [Have](#) income that does not exceed 300 percent of the federal poverty level.

(3) An applicant qualified under section (2) of this rule is not required to enroll in a silver-level qualified health plan to receive cost sharing reductions.

(4) For an enrollee qualified under section (2) of this rule, carriers are required to eliminate any cost sharing under any plan chosen by the qualified applicant.

(5) A member of a federally recognized tribe who is enrolled in a qualified health plan is eligible for no cost sharing for services provided directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract services.

Stat. Auth.: ORS 741.002

Stats. Implemented: ORS 741.500

Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13

945-040-0060

Application Process

~~(1) An individual, authorized representative, or someone acting on behalf of an individual, must complete the application prescribed by the Exchange in order for the Exchange to determine eligibility for:-~~

~~(a) Enrollment in a qualified health plan;-~~

~~(b) Advance payments of the premium tax credit;-~~

~~(c) Cost sharing reductions; and-~~

~~(d) MAGI-based Medicaid and CHIP.-~~

~~(2) An applicant who has a Social Security number must provide such number to the Exchange.-~~

~~(3) An individual who is not seeking coverage for himself or herself is not required to provide a Social Security number, except that he or she must provide the Social Security number of the tax filer who is not an applicant only if the applicant attests that the tax filer has a Social Security number and filed a tax return for the year for which tax data would be used for verification of household income.-~~

~~(4) An applicant, authorized representative or other individual acting on behalf of the applicant may file an application:-~~

~~(a) Via the Exchange Internet Web site;-~~

~~(b) By telephone through a call center;-~~

~~(c) By mail, including emails and faxes; or-~~

~~(d) In person.-~~

~~(5) An applicant for individual market coverage may request an eligibility determination:-~~

~~(a) Only for enrollment in a qualified health plan; or-~~

~~(b) Both for enrollment in a qualified health plan, and insurance affordability programs.-~~

~~(6) An applicant for individual market coverage may not apply for less than all of the insurance affordability programs.-~~

~~(7) If an applicant for individual market coverage does not specify his or her preference to limit the eligibility determination to enrollment in a qualified health plan, the Exchange must determine the applicants' eligibility for insurance affordability programs.-~~

~~(8) The Exchange must provide written notice to an applicant of any eligibility determination made in accordance with this section, including information on the applicant's right to appeal the determination and instructions regarding how to file an appeal.-~~

~~(9) If the Exchange receives an incomplete application, the application will be suspended until further information is received.~~

~~(a) The Exchange will notify the applicant in a timely manner of the information that is missing, what information must be submitted to complete the application and by what date the information should be submitted.~~

~~(b) Upon receipt of a complete application, the Exchange will determine the applicant's eligibility within 45 days.~~

~~(c) If the applicant is Medicaid eligible and provides the requested information to complete the application within 45 days of the original date of request, that original date of request will be used to determine when coverage or benefits begin.~~

~~Stat. Auth.: ORS 741.002~~

~~Stats. Implemented: ORS 741.500~~

~~Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13; OHIE 3-2014, f. & cert. ef. 5-12-14~~

945-040-0070

~~Eligibility Verification Process~~

~~(1) The Exchange must process eligibility determinations based on the information attested to by the applicant.~~

~~(2) For an individual seeking enrollment in a QHP, the Exchange must verify:~~

~~(a) The Social Security number;~~

~~(b) Citizenship, status as a national, and lawful presence;~~

~~(c) Federal incarceration; and~~

~~(d) Enrollment in a federally recognized Tribe.~~

~~(3) For an individual seeking eligibility for both enrollment in a QHP and insurance affordability programs, the Exchange must verify household income, as well as the items listed in section (2) of this rule.~~

~~(4) Approved data sources for verification include, but are not limited to the following:~~

~~(a) The US Department of Health and Human Services;~~

~~(b) The US Internal Revenue Service;~~

~~(c) The US Department of Homeland Security;~~

~~(d) The Social Security Administration;~~

~~(e) The Oregon Employment Department; and~~

~~(f) Tribal communications.~~

~~(5) For an employee seeking coverage in an employer-sponsored plan through SHOP, the Exchange must check the list of employees who have been offered coverage by the subject employer to verify that the employee has an offer of coverage.~~

~~(6) If the Exchange receives information from the applicant that is inconsistent with information the Exchange receives from the data sources in section (4) of this rule, and the inconsistency cannot be resolved by the applicant and a customer service representative, the Exchange must issue a notice to inform the applicant of the inconsistency and request further documentation.~~

~~(7) The applicant has 90 days from the date on the notice to provide the required documentation.~~

~~(8) If the attestation cannot be verified during the 90-day period, the Exchange must make a determination based on the information available from the data sources listed in sections (4) and (5) of this rule.~~

~~(9) At the end of the 90-day period, the Exchange must issue a written eligibility determination notice to the applicant. The determination takes effect 30 days after the date on which it was sent but not earlier than January 1, 2014.~~

SStat. Auth.: ORS 741.002

Stats. Implemented: ORS 741.500

Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13

945-040-0080

Eligibility Redetermination During a Benefit Year

~~(1) The Exchange must redetermine the eligibility of an enrollee during the benefit year if it receives and verifies new information reported by an enrollee.~~

~~(2) An enrollee who participates in affordability programs is required to report any changes that may affect his or her eligibility within 30 days of such change.~~

~~(3) Changes may be reported via the Exchange web portal, by telephone through the call center, by mail, or in person.~~

~~(4) The Exchange must verify information prior to using it for an eligibility redetermination.~~

~~(5) For individuals who elect to receive such notifications, the Exchange must provide periodic electronic notifications regarding the requirement to report changes and an enrollee's opportunity to report such changes.~~

~~(6) If the Exchange verifies information reported by an enrollee, it must:-~~

~~(a) Redetermine the enrollee's eligibility;-~~

~~(b) Notify the enrollee regarding the determination in a manner that complies with 45 CFR §155.230; and~~

~~(c) Notify the enrollee's employer, as applicable.-~~

~~(7) Eligibility redeterminations take effect the first day of the month following the date of the notice.-~~

~~(8) When an individual is no longer eligible for enrollment in a qualified health plan, the Exchange must maintain his or her enrollment (without advance payments of the premium tax credit or cost sharing reductions) until the last day of the month following the date of the notice unless the enrollee requests an earlier termination date.~~

~~Stat. Auth.: ORS 741.002-~~

~~Stats. Implemented: ORS 741.500-~~

~~Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13~~

945-040-0090

~~Compliance with Code of Federal Regulations~~

~~(1) These rules incorporate by reference 45 CFR §155.305, §155.310, §155.315, §155.320, §155.330, §155.350, §155.710, §155.715, and Subpart F.-~~

~~(2) To the extent these rules do not address an applicable provision in the federal rules or are inconsistent with the federal rules, the applicable federal rule governs.-~~

~~Stat. Auth.: ORS 741.002-~~

~~Stats. Implemented: ORS 741.500-~~

~~Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13; OHIE 3-2014, f. & cert. ef. 5-12-14~~

945-040-0100

~~Appeals of Exchange Eligibility Determinations~~

~~(1) An applicant or enrollee, or an authorized representative of an applicant or enrollee has the right to appeal a decision by the Exchange concerning:-~~

~~(a) An initial determination of eligibility or redetermination of eligibility for:-~~

~~(A) Enrollment in a qualified health plan, including enrollment in a qualified health plan that is a catastrophic plan;-~~

~~(B) Advance payments of the premium tax credit, including the amount of advance payments of the premium tax credit;~~

~~(C) Cost sharing reductions, including the level of cost sharing reductions; and~~

~~(D) MAGI-based Medicaid and CHIP.~~

~~(b) Failure of the Exchange to issue the eligibility notice within 45 days of date of complete application.~~

~~(2) An individual or enrollee who wishes to appeal a decision regarding an exemption from the individual mandate must follow the instructions provided with the eligibility determination notice supplied by the US Department of Health and Human Services.~~

~~(3) An employer who wishes to appeal a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the coverage is not affordable coverage with respect to an employee must follow the instructions provided with the eligibility determination notice supplied by the US Department of Health and Human Services.~~

~~(4) To appeal an eligibility determination or the timeliness of such a decision an applicant or enrollee must submit an appeal request to the Exchange within 90 days of the date on the eligibility determination notice.~~

~~(5) The Exchange must accept appeal requests submitted to it:~~

~~(a) By telephone. Exchange or OHA staff will assist the applicant or enrollee over the telephone to complete Form CO-P-00012, incorporated by reference;~~

~~(b) By mail, using form CO-P-00012 that can be printed from the Exchange's website, if postmarked within the timeframe specified in section 4 of this rule;~~

~~(c) By fax; using form CO-P-00012 that can be printed from the Exchange's website; or~~

~~(d) Via the Internet on the Exchange's website or to the Exchange using electronic mail (email) to appeals@coveroregon.com and attaching form CO-P-00012.~~

~~(6) An appeal will not be denied for failure to complete form CO-P-00012.~~

~~(7) Upon receipt of a valid appeal request, the Exchange must:~~

~~(a) Send timely acknowledgement of the receipt of a valid appeal request to the appellant including:~~

~~(A) Information on the appellant's eligibility pending appeal; and~~

~~(B) An explanation that any advance payments of the premium tax credit paid on behalf of the tax filer pending appeal are subject to reconciliation under 26 CFR 1.36B-4; and~~

~~(b) Coordinate with OHA, if applicable, to review the appeal request and determine which entity will take the lead to process the appeal.~~

~~(8) Upon receipt of an appeal request that is not valid, the Exchange must promptly and without undue delay inform the applicant or enrollee in writing:~~

~~(a) That the appeal request has not been accepted;~~

~~(b) About the nature of the defect in the appeal request; and~~

~~(c) That within 21 days of such notice, the applicant or enrollee may cure the defect and resubmit the appeal request.~~

~~(9) An appellant has the right to an expedited appeal when the time otherwise allowed for an appeal could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function. The Exchange shall review the request to determine eligibility for an expedited appeal and approve or deny the request for an expedited appeal.~~

~~(10) If a request for an expedited appeal is denied, the Exchange shall:~~

~~(a) Use the standard appeal time frame; and~~

~~(b) Inform the appellant of the denial promptly and without undue delay, either orally or through electronic means. If oral notification is provided, the Exchange must follow up with written notice within the timeframe established by the secretary of HHS.~~

~~(11) Written notice of denial of a request for an expedited appeal must include:~~

~~(a) The reason for the denial;~~

~~(b) An explanation that the appeal request will be transferred to the standard process; and~~

~~(c) An explanation of the appellant's rights under the standard process.~~

~~Stat. Auth.: ORS 741.002~~

~~Stats. Implemented: ORS 741.500~~

~~Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13; OHIE 3-2014, f. & cert. ef. 5-12-14~~

~~945-040-0110~~

~~Eligibility Pending Appeal~~

~~(1) Continued Eligibility. After receipt of a valid appeal request that concerns a redetermination of eligibility, the Exchange shall continue the appellant's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed unless the appellant chooses not to continue eligibility.~~

~~(2) Continued Benefits~~

~~(a) After receipt of a valid appeal request that concerns a redetermination of eligibility, an appellant shall elect whether to maintain benefits, as applicable, in accordance with the level of eligibility immediately before the redetermination being applied.~~

~~(A) Benefits, for the purpose of this section, include enrollment in a Qualified Health Plan, advance payments of the premium tax credit, and cost-sharing reductions, as applicable.~~

~~(B) An appellant who meets the eligibility criteria in OAR 945-040-0040 may reduce the amount of tax credit previously selected.~~

~~(b) If the appellant elects to continue benefits during the appeal process, and the redetermination does not produce a new eligibility level, then the previous level of eligibility shall remain in effect.~~

~~(c) If the appellant elects to continue benefits during the appeal process and the redetermination produces a different level of benefits from the original determination, such benefits shall be retroactive, at the choice of the appellant, to the date on the eligibility determination notice.~~

~~(d) If the appellant elects to discontinue benefits during the appeal process and the redetermination produces a different level of benefits from the original determination, such benefits shall be retroactive, at the choice of the appellant, to the date on the eligibility determination notice.~~

~~(e) If the appellant elects to discontinue benefits during the appeal process and the original determination is maintained, the appellant's ability to enroll in QHP, will be limited by CFR-155.410, 155.420 and other applicable federal provisions.~~

~~(3) The Exchange shall determine an appellant's eligibility for continuing benefits in MAGI-based Medicaid and CHIP programs in accordance with OAR 410-200-0145.~~

~~Stat. Auth.: ORS 741.002~~

~~Stats. Implemented: ORS 741.500~~

~~Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13; OHIE 3-2014, f. & cert. ef. 5-12-14~~

~~945-040-0120~~

~~Informal Conference~~

~~Following receipt of a valid appeal request, the Exchange representative and the appellant may have an informal conference to:~~

~~(1) Provide an opportunity to resolve the matter;~~

~~(2) Review the basis for the eligibility determination, including but not limited to a review of the rules and facts that serve as the basis for the decision;~~

~~(3) Exchange additional information that may correct any misunderstandings of the facts relevant to the eligibility determination; and~~

~~(4) To consider any other matters that may expedite the orderly conduct of the proceeding.~~

~~Stat. Auth.: ORS 741.002~~

~~Stats. Implemented: ORS 741.500~~

~~Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13~~

~~945-040-0130~~

~~Contested Case Hearings~~

~~(1) All hearings under these rules must be conducted in accordance with OAR 137-003-0501 to 137-003-0700, except to the extent that Exchange rules are permitted to and provide for different procedures. Hearing must also be conducted in accordance with 45 CFR §155.535(e), (d) and (e).~~

~~(2) Except in the case of expedited hearing, the Exchange must ensure that written notice is sent to the appellant of the date, time, and location or format of the hearing no later than 15 days prior to the hearing date.~~

~~(3) The Exchange's contested case hearings governed by these rules are not open to the public and are closed to nonparticipants, except nonparticipants may attend subject to consent of the Exchange and the appellant and applicable confidentiality laws.~~

~~Stat. Auth.: ORS 741.002~~

~~Stats. Implemented: ORS 741.500~~

~~Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13~~

~~945-040-0140~~

~~Dismissals~~

~~(1) The Exchange shall dismiss an appeal if the appellant:~~

~~(a) Withdraws the appeal request in writing or on the record, including at the hearing;~~

~~(b) Fails to appear at a scheduled hearing without good cause;~~

~~(c) Fails to submit a valid appeal request;~~

~~(d) Fails to provide required information requested by an Exchange appeals representative;~~

~~(e) Dies while the appeal is pending; or~~

~~(f) No longer has a valid appealable issue in dispute.~~

~~(2) If an appeal is dismissed under this rule the Exchange shall provide a timely dismissal order to the appellant, including~~

~~(a) The reason for dismissal~~

~~(b) An explanation of the dismissal's effect on the appellant's eligibility; and~~

~~(c) An explanation of how the appellant may show good cause why the dismissal should be vacated in accordance with section (3) of this rule.~~

~~(3) The Exchange may vacate a dismissal and proceed with the appeal if the appellant makes a written request received by the Exchange with 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.~~

~~(4) If a request to vacate a dismissal is denied, the Exchange must provide timely written notice to the appellant of the denial.~~

~~(5) For purposes of this rule, "good cause" has the meaning given in OAR 137-003-0501(7).~~

~~Stat. Auth.: ORS 741.002~~

~~Stats. Implemented: ORS 741.500~~

~~Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13; OHIE 3-2014, f. & cert. ef. 5-12-14~~

945-040-0150

Appeal Decisions

~~Appeal decisions must comply with 45 CFR 155.545.~~

~~Stat. Auth.: ORS 741.002~~

~~Stats. Implemented: ORS 741.500~~

~~Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13~~

945-040-0160

Appeal to the United States Department of Health and Human Services

~~If an appellant disagrees with the appeal decision of the Exchange, he or she may make an appeal request to HHS within 30 days of the date of the notice of appeal decision through any of the methods described in OAR 945-040-0100(5).~~

~~Stat. Auth.: ORS 741.002~~

~~Stats. Implemented: ORS 741.500~~

~~Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13~~

945-040-0170

Appeal Record

~~Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the Exchange must make the appeal record accessible to the appellant at a convenient place and time.~~

~~Stat. Auth.: ORS 741.002-~~

~~Stats. Implemented: ORS 741.500-~~

~~Hist.: OHIE 6-2013, f. & cert. ef. 9-30-13~~

945-040-0180

Lay Representation in Contested Case Hearings-

~~(1) Subject to the approval of the Attorney General, an officer or employee of the Oregon Health Insurance Exchange (Exchange) is authorized to appear on behalf of the Exchange in the following types of contested case hearings conducted by the Office of Administrative Hearings:-~~

~~(a) Appeals by individual applicants or enrollees, or an authorized representative of an individual applicant or enrollee, of a decision by the Exchange concerning an initial determination of eligibility or redetermination of eligibility for:-~~

~~(A) Enrollment in a qualified health plan, including enrollment in a qualified health plan that is a catastrophic plan;-~~

~~(B) Advance payments of the premium tax credit, including the amount of advance payments of the premium tax credit;-~~

~~(C) Cost sharing reductions, including the level of cost sharing reductions;-~~

~~(D) MAGI-based Medicaid and CHIP program eligibility relevant to appeals described in subsection (a)(A)-(C); and coordination with the Oregon Health Authority concerning appeals of MAGI-based Medicaid and CHIP eligibility decisions; or~~

~~(b) Appeals by individual applicants and enrollees, or an authorized representative of an individual applicant or enrollee, alleging failure of the Exchange to act on an application within 45 days of the filing date.-~~

~~(2) The Exchange representative may not make legal argument on behalf of the Exchange.-~~

~~(3) "Legal argument" includes arguments on-~~

~~(a) The jurisdiction of the Exchange to hear the contested case;-~~

~~(b) The constitutionality of a statute or rule or the application of a constitutional requirement to the Exchange; and-~~

~~(c) The application of court precedent to the facts of the particular contested case proceeding.~~

~~(4) “Legal argument” does not include presentation of motions, evidence, examination and cross-examination of witnesses, or representation of factual arguments or arguments on;~~

~~(a) The application of the statutes or rules to the facts in the contested case;~~

~~(b) Comparison of prior actions of the Exchange in handling similar situations;~~

~~(c) The literal meaning of the statutes or rules directly applicable to the issues in the contested case;~~

~~(d) The admissibility of evidence; and~~

~~(e) The correctness of procedures being followed in the contested case hearing.~~

~~(5) If the administrative law judge determines that statements or objections made by the Exchange representative appearing under section (1) of this rule involve legal argument as defined in this rule, the administrative law judge shall provide reasonable opportunity for the Exchange to consult with the Attorney General and permit the Attorney General to present argument at the hearing or to file written legal argument within a reasonable time after conclusion of the hearing.~~

~~(6) For purposes of this rule, “applicant” has the meaning in OAR 945-040-0010(4)(a), and “enrollee” has the meaning in 945-040-0010(15) for qualified individuals.~~

~~Stat. Auth.: ORS 741.002~~

~~Stats. Implemented: ORS 741.002 & 183.452~~

~~Hist.: OHIE 7-2013(Temp), f. & cert. ef. 11-18-13 thru 5-17-14; OHIE 8-2013(Temp), f. & cert. ef. 12-23-13 thru 5-17-14; OHIE 3-2014, f. & cert. ef. 5-12-14~~

DIVISION 50

CERTIFICATION OF INSURANCE PRODUCERS

945-040-0005

Scope

~~OAR 945-040-0060 to 945-040-0180 apply only to Exchange processes for coverage beginning on or before December 31, 2014. For coverage beginning on or after January 1, 2015, the application process and appeals of eligibility determinations are handled by the Center for Consumer Information and Insurance Oversight (CCHIO) through healthcare.gov.~~

~~Stat. Auth.: ORS 741.002-~~

~~Stats. Implemented: ORS 741.500-~~

~~Hist.: OHIE 1-2015(Temp), f. & cert. ef. 3-11-15 thru 9-4-15~~

~~945-050-0010-~~

~~Statutory Authority and Purpose-~~

~~(1) OAR chapter 945, division 50 is adopted pursuant to the general rulemaking authority of the Exchange in ORS 741.002.-~~

~~(2) The purpose of division 50 is to establish the requirements for certification of health insurance producers.-~~

~~Stat. Auth.: ORS 741.002-~~

~~Stats. Implemented: ORS 741.310-~~

~~Hist.: OHIE 2-2013, f. & cert. ef. 4-15-13-~~

~~945-050-0020-~~

~~Health Insurance Producer Certification-~~

~~(1) The Exchange will certify a network of licensed health insurance producers.-~~

~~(2) To certify with the Exchange, insurance producers must:-~~

~~(a) Hold an active Oregon health license;-~~

~~(b) Have no history of administrative actions that resulted in a denial, suspension or revocation of their license;-~~

~~(c) Complete and pass all training required by the Exchange;-~~

~~(d) Uphold privacy and security standards in 45 CFR §155.260;-~~

~~(e) Maintain errors and omissions coverage at a minimum level established by the Exchange; and-~~

~~(f) Agree to contract with the Exchange. Producers that continue to meet the Exchange standards and requirements will maintain certification for as long as a contract is in effect.-~~

~~(3) An Exchange-certified producer cannot be an employee of a health insurer or a captive producer.-~~

~~(4) The Exchange reserves the right to adjust or amend the requirements of producer certification, and may do so with 60-day notification.-~~

~~Stat. Auth.: ORS 741.002~~
~~Stats. Implemented: ORS 741.310~~
~~Hist.: OHIE 2-2013, f. & cert. ef. 4-15-13~~

Document comparison by Workshare Compare on Wednesday, August 19, 2015
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Rendering set	standard

Legend:	
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Deletion	
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Style change	
Format change	
Moved deletion	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
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Insertions	287
Deletions	583
Moved from	4
Moved to	4
Style change	0
Format changed	0
Total changes	878