DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, OREGON HEALTH INSURANCE MARKETPLACE

DIVISION 1

PROCEDURAL RULES

945-001-0002

Definitions

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

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

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

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

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

(5) "Benefit year" has the meaning given in 45 CFR 155.20.

(6) "Catastrophic plan" means a health plan described in §1302(e) of the Affordable Care Act.

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

(8) "Cost sharing" has the meaning given in 45 CFR 155.20.

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

(10) "DCBS" means the Oregon Department of Consumer and Business Services.

(11) "Employee" has the meaning given in section 2791 of the Public Health Services Act.

(12) "Employer" has the meaning given in 45 CFR 155.20.

(13) "Enrollee" has the meaning given in 45 CFR 155.20.

(14) "Essential health benefits" has the meaning given in OAR 836-053-0008.

(15) “Federal poverty level” or “FPL” has the meaning given in 45 CFR 155.300.

(16) “Full-time employee”:

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

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

(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) “Household” has the meaning given in 42 CFR 435.603.

(23) “Household income” has the meaning given in 26 CFR 1.36B and 42 CFR 435.603.

(24) “Individual market” 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 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” has the meaning given in 26 CFR 1.36B-1(e)(2).

(34) “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) “Oregon Insurance Division” means the Insurance Division of DCBS.

(36) “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.

(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.

(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.

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

(44) “Small employer” has the meaning given in 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.

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

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

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 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 Marketplace 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 Marketplace may send notice of intended action to other persons, agencies, or organizations that the Marketplace, 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 Marketplace shall maintain an interested parties list for each OAR chapter of rules for which the Marketplace 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 Marketplace 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 Marketplace 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 Marketplace shall honor all written requests that notification be sent by postal mail instead of electronically if a mailing address is provided.

(4) If the Marketplace adopts or suspends a temporary rule, the Marketplace 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 Marketplace 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 Marketplace may send notice to other persons, agencies, or organizations that the Marketplace, 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 Marketplace 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 & 741.002(3)
Stats. Implemented: ORS 183.330, 183.335 & 183.341
Hist.: OHIE 1-2012, f. & cert. ef. 3-6-12

DIVISION 20

CERTIFICATION OF HEALTH AND DENTAL PLANS

945-020-0010

Purpose; Applicability

(1) The purpose of OAR chapter 945, division 20 is to establish the process for certification of:

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

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

(2) Except for multistate plans, as defined in 45 CFR 800.20, OAR chapter 945, division 20 applies to:

(a) All QHPs offered through the Marketplace; and

(b) All SADPs marketed through or outside the Marketplace as providing pediatric dental benefits.

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

945-020-0020

Certification of QHPs and Marketplace SADPs

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

(2) The Marketplace will issue a request for applications. To be considered for participation and plan certification, an insurer must submit a completed application to the Marketplace in the form and manner, and within the timeframes specified by the Marketplace.

(3) For QHPs, 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 health benefit plans in Oregon;

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

(c) 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) Marketplace administrative fees and assessments;

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

(F) Tribal requirements;

(G) Premium tax credit and cost sharing reductions;

(H) Performance reporting standards; and

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

(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.

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

(A) Plan discontinuance;

(B) Plan withdrawal;

(C) Plan decertification; or

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

(7) Every QHP or SADP offered through the 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.

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

(a) For QHPs, essential health benefits, or for SADPs, pediatric dental benefits;

(b) For QHPs:

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

(B) 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.

(9) Subject to the limitation on the number of QHPs that may be offered through the Marketplace in the insurer's contract with the Marketplace, the Marketplace will recertify health benefit or dental plans that are submitted by approved 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

QHP Addendum for Indian Health Care Providers

(1) If a health insurer contracts with a Tribal Health Provider in the state of Oregon for services provided through a Marketplace QHP, the insurer shall:

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

(b) Notify the Marketplace in writing of the contractual relationship by emailing the information to info.marketplace@Oregon.gov.

(2) The 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.

Exhibit 1:

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

Purpose

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 plan or stand-alone dental plan through the Marketplace to pay the administrative and operational expenses of the 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) 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 Marketplace's website for public review and comment.

(3) At a minimum, the report will include

(a) A projection of 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 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 Marketplace shall not exceed the limits set forth in ORS 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
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

2015 Administrative Charge on Insurers

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

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

Stat. Auth.: ORS 741.002
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 Marketplace shall pay a monthly administrative charge equal to $9.66 times the number of members enrolled through the Marketplace in that month.

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

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 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 day of each month.

(3) Each insurer's monthly administrative charge will be based on the number of members enrolled through the Marketplace in that month. The Marketplace may adjust the administrative charge for any changes or corrections to prior 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.

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

(5) For any month in which the insurer does not make full payment within 5 days following the 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.

(6) 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 Marketplace plans to new enrollment until all outstanding charges are paid; and/or

(c) De-certify that insurer's qualified health plans and/or 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
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 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 Marketplace.

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

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

Stat. Auth.: ORS 741.002
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

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 Marketplace's Small Business Health Options Program (SHOP), a small employer must:

(a) 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, an employer remains eligible for SHOP regardless of the number of additional employees it hires.

(4) An employee is eligible to enroll in a qualified health plan through SHOP if 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) Have household income greater than or equal to 100 percent, but not more than 400 percent of the Federal Poverty Level 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 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 Marketplace 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) Have household income that does not exceed 250 percent of 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 Marketplace must use the following eligibility categories for cost sharing reductions:

(a) Individuals that have household income less than or equal to 150 percent of 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 who have household income greater than 150 percent of the federal poverty level and less than or equal to 200 percent of 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 who have household income greater than 200 percent of the federal poverty level and less than or equal to 250 percent of 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.

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 Marketplace 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) 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