

Oregon Statutes and Federal CFR's Related to 2017 Cross-walk Rulemaking

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

- (a) Administering a health insurance exchange in accordance with federal law to make qualified health plans available to individuals and groups throughout this state.
 - (b) Providing information in writing, through an Internet-based clearinghouse and through a toll-free telephone line, that will assist individuals and small businesses in making informed health insurance decisions and that may include:
 - (A) The rating assigned to each health plan and the rating criteria that were used;
 - (B) Quality and enrollee satisfaction survey results; and
 - (C) The comparative costs, benefits, provider networks of health plans and other useful information.
 - (c) Establishing and maintaining an electronic calculator that allows individuals and employers to determine the cost of coverage after deducting any applicable tax credits or cost-sharing reduction.
 - (d) Operating a call center for answers to questions from individuals seeking enrollment in a qualified health plan or in the state medical assistance program.
 - (e) Providing information about the eligibility requirements and the application processes for the state medical assistance program.
- (2) The department shall:
- (a) Screen, certify and recertify health plans as qualified health plans according to the requirements, standards and criteria adopted by the department under ORS 741.310 and ensure that qualified health plans provide choices of coverage.
 - (b) Decertify or suspend, in accordance with ORS chapter 183, the certification of a health plan that fails to meet federal and state standards in order to exclude the health plan from participation in the exchange.
 - (c) Promote fair competition of carriers participating in the exchange by certifying multiple health plans as qualified under ORS 741.310.
 - (d) Assign ratings to health plans in accordance with criteria established by the United States Secretary of Health and Human Services and by the department.
 - (e) Establish open and special enrollment periods for all enrollees, and monthly enrollment periods for Native Americans in accordance with federal law.
 - (f) Assist individuals and groups to enroll in qualified health plans, including defined contribution plans as defined in section 414 of the Internal Revenue Code and, if appropriate, collect and remit premiums for such individuals or groups.
 - (g) Facilitate community-based assistance with enrollment in qualified health plans by awarding grants to entities that are certified as navigators as described in 42 U.S.C. 18031(i).
 - (h) Provide employers with the names of employees who end coverage under a qualified health plan during a plan year.
 - (i) Certify the eligibility of an individual for an exemption from the individual responsibility requirement of section 5000A of the Internal Revenue Code.
 - (j) Provide information to the federal government necessary for individuals who are enrolled in qualified health plans through the exchange to receive tax credits and reduced cost-sharing.
 - (k) Provide to the federal government any information necessary to comply with federal requirements including:

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

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

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

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

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

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

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

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

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

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

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

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

(A) An insurer or third party administrator;

(B) An insurance producer; or

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

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

(A) Insurers or third party administrators; or

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

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

[Formerly 741.201]

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

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

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

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

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

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

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

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

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

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

(iv) If the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP that is at the same metal level as, or one metal level higher or

lower than the enrollee's current QHP, the enrollee's coverage will be renewed in any other QHP offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll.

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

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

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

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

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

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

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