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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

HMP 2-2019

CHAPTER 945
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
HEALTH INSURANCE MARKETPLACE

FILED

09/20/2019 2:46 PM
ARCHIVES DIVISION
SECRETARY OF STATE
& LEGISLATIVE COUNSEL

FILING CAPTION: Amendment to Insurer Administrative Charge Calculation and Rebate Credit Schedule

EFFECTIVE DATE: 09/20/2019 THROUGH 03/17/2020

AGENCY APPROVED DATE: 09/20/2019

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NEED FOR THE RULE(S):

The administrative charge calculation in the current rules does not accurately reflect the amount to be refunded to carriers. The amendment ensures that the calculation takes into account the entire ending fund balance and shortens the time to credit the rebate in full from 24 months to 12 months.

JUSTIFICATION OF TEMPORARY FILING:

- Failure to immediately amend the rule will result in miscalculation of the amount that the Marketplace must refund to carriers.
- Consumers who rely on services, education, and outreach provided by the Marketplace would suffer as result because the amount refunded would negatively impact the Marketplace's budget and could impact services.
- OAR 945-030-0020 requires the Marketplace to calculate the refund by September 30, 2019. There is not time to conduct a regular rulemaking prior to September 30, 2019 to fix the calculation error. Filing the amendment via temporary rule will allow the Marketplace to correct the calculation error prior to the September 30, 2019 deadline.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

ORS 741.002, 741.003, and 741.105 can be found here: https://www.oregonlegislature.gov/bills_laws/ors/ors741.html

RULES:

945-001-0002, 945-030-0020

AMEND: 945-001-0002

RULE TITLE: Definitions

RULE SUMMARY: 945 Definitions, the amendment adds the definition for "biennium" to OAR Chapter 945

RULE TEXT:

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

- (1) "Advance payments of the premium tax credit" means payment of the federal health insurance premium tax credit on an advance basis to an eligible individual enrolled in a QHP through the Marketplace.
- (2) "Affordable Care Act" or "ACA" has the meaning given in 45 CFR 155.20.
- (3) "American Indian", for purposes of eligibility for tax credits and cost sharing benefits, means an enrolled member of a federally recognized tribe.
- (4) "Applicant" has the meaning given in 45 CFR 155.20.
- (5) "Automatically enroll" means the process of enrolling a qualified individual into a new qualified health plan when, at renewal:
 - (a) The qualified individual's qualified health plan issuer no longer offers qualified health plans through the health insurance exchange; or
 - (b) There are no qualified health plans offered through the health insurance exchange under the individual's previous qualified health plan product.
- (6) "Benefit year" has the meaning given in 45 CFR 155.20.
- (7) "Biennium" means a two-year period beginning on July 1 of an odd year and ending on June 30 of the following odd year.
- (8) "Catastrophic plan" means a health plan described in §1302(e) of the Affordable Care Act.
- (9) "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.
- (10) "Cost sharing" has the meaning given in 45 CFR 155.20.
- (11) "Cost sharing reductions" has the meaning given in 45 CFR 155.20.
- (12) "DCBS" means the Oregon Department of Consumer and Business Services.
- (13) "Effectuation" means the activation of QHP or SADP coverage through enrollment and payment of the first month's premium.
- (14) "Employee" has the meaning given in section 2791 of the Public Health Services Act.
- (15) "Employer" has the meaning given in 45 CFR 155.20.
- (16) "Enrollee" has the meaning given in 45 CFR 155.20.
- (17) "Essential health benefits" has the meaning given in OAR 836-053-0008.
- (18) "Federal poverty level" or "FPL" has the meaning given in 45 CFR 155.300.
- (19) "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.
- (20) "Health benefit plan" has the meaning given in ORS 741.300.
- (21) "Health care service contractor" has the meaning given in ORS 741.300.
- (22) "Health insurance" has the meaning given in ORS 741.300.
- (23) "Health insurance exchange" or "exchange" has the meaning given in ORS 741.300.
- (24) "Health plan" has the meaning given in ORS 741.300.
- (25) "Household" has the meaning given in 42 CFR 435.603.
- (26) "Household income" has the meaning given in 26 CFR 1.36B and 42 CFR 435.603.
- (27) "Individual market" has the meaning given the term in section 1304(a)(2) of the ACA.
- (28) "Insurer" has the meaning given in ORS 741.300.
- (29) "Insurance affordability program" has the meaning given in 42 CFR 435.4.
- (30) "Lawfully present" has the meaning given in 45 CFR 152.2.
- (31) "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.
- (32) "Medicaid" means medical assistance programs established by Title XIX of the Social Security Act and administered in Oregon by the Oregon Health Authority.

(33) "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.

(34) "Minimum essential coverage" has the meaning given in section 5000(A)(f) of the Internal Revenue Code.

(35) "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.

(36) "Modified adjusted gross income" or "MAGI" has the meaning given in 26 CFR 1.36B-1(e)(2).

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

(38) "Oregon Insurance Division" means the Insurance Division of DCBS.

(39) "Pediatric dental benefits" has the meaning given in OAR 836-053-0008.

(40) "Plan year" has the meaning given in 45 CFR 155.20.

(41) "Qualified employer" means an employer who meets the requirements to participate in the Small Business Health Options Program.

(42) "Qualified health plan" or "QHP" has the meaning given in ORS 741.300.

(43) "Qualified Individual" has the meaning given in 45 CFR 155.20.

(44) "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.

(45) "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.

(46) "Small Business Health Options Program" or "SHOP" has the meaning given in ORS 741.300.

(47) "Small employer" has the meaning given in ORS 743.730.

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

(49) "State program" has the meaning given in ORS 741.300.

(50) "Tax filer" has the meaning given in 45 CFR 155.300.

STATUTORY/OTHER AUTHORITY: ORS 741.002

STATUTES/OTHER IMPLEMENTED: ORS 741.500

AMEND: 945-030-0020

RULE TITLE: Establishment of Administrative Charge Paid by Insurers

RULE SUMMARY: The amendment makes changes to when an administrative charge refund is calculated, and the length of time over which the refund is disbursed (as a reduction of the ongoing Marketplace administrative charge), from 24 months to 12 months.

RULE TEXT:

- (1) After consulting with the advisory committee created by Section 13 of 2015 Senate Bill 1, the Marketplace will annually provide a report on administrative charges to the Director of the Department of Consumer and Business Services.
- (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's share of the department's shared services expenses and operating expenses borne by the Marketplace and reimbursed by another agency, based on the department's 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 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) By the 30th day of September of every odd year, the department shall:
 - (a) Determine the maximum amount of funds that the department may hold under ORS 741.105(3)(b) by calculating:
 - (A) The Marketplace's fund balance as of the end of the biennium immediately before the date by which the calculation is required to be made minus:
 - (B) One-fourth of the Marketplace's budgeted operating expenses for the biennium in which the calculation must be made as required by paragraph (9).
 - (b) Credit each individual carrier participating in the Marketplace an amount equal to the pro-rata share of any positive difference obtained from the calculation described in paragraph (9)(a) of this rule based on the total assessments the carrier reported to the department during the two-year period described in paragraph (9)(a)(A) of this rule plus the pro-rata share of the total assessments reported during the two-year period described in paragraph (9)(a)(A) of this rule by carriers no longer selling qualified health plans through the Marketplace.
- (10) Examples:
 - (a) Example 1: If the Marketplace's fund balance is \$1 million as of the end of the 2017-2019 biennium and its operating budget is \$4 million for the 2019-2021 biennium, the department would retain \$1 million and credit carriers \$0.00 because there is no excess fund balance - \$1 million minus (\$4 million divided by 4) is zero;
 - (b) Example 2: If the Marketplace's fund balance is \$1 million as of the end of the 2017-2019 biennium and its operating budget is \$2.4 million the 2019-2021 biennium, the department would retain an excess fund balance of \$600,000 and credit a total of \$400,000 to carriers - \$1 million minus (\$2.4 million divided by 4) equals \$400,000; and
 - (c) Example 3: If the difference in the calculation described in paragraph (9)(a) of this rule is less than or equal to zero, there is no excess fund balance and the department would not credit any individual carrier because the fund balance is either zero or negative.

(d) Example 4: If, after performing the calculation described in paragraph (9)(a) of this rule, the excess fund balance is \$1.8 million and Carrier A reported 10% of the total assessments reported during the two-year time period described in paragraph (9)(a)(A), the department must credit Carrier A a total of \$180,000 — \$1.8 million multiplied by .10 equals \$180,000.

(11) Except as provided in paragraph 12 of this rule, the department shall apply the credit described in paragraph (9)(b) of this rule by reducing each monthly charge assessed during the period described in paragraph (9)(a)(B) by one-eleventh of the credit rounded to the nearest whole dollar beginning the first day of January following the date specified in paragraph (9) of this rule for 11 consecutive months. Any remaining credit rounded to the nearest whole cent shall be credited in the twelfth month. For example, if, after performing the calculation described in paragraph (9)(a) of this rule, the excess fund balance is \$1.2 million and Carrier A reported 10% of the total assessments during the time period specified in paragraph (9)(a) of this rule, the department must credit Carrier A \$10,909 per month beginning the first of January following the date specified in paragraph (9) of this rule for 11 consecutive months or until Carrier A no longer provides coverage through the Marketplace. In the twelfth month following the date specified in paragraph (9) of this rule, the department must credit Carrier A \$1.09. (The product of \$1.2 million and the quotient of .10 divided by 11 equals \$10,909.09090909091 rounded to the nearest dollar equals \$10,909. The product of .09090909091 and 12 equals 1.09090909092 rounded to the nearest cent equals \$1.09.)

(12) Notwithstanding paragraphs (9)(b) and (11) of this rule:

(a) If the director determines that application of the credit as described in paragraph (11) of this rule would jeopardize a Marketplace carrier's financial solvency, the department may use any reasonable method to credit the carrier the amount due under paragraph (9)(b) of this rule; and

(b) A carrier is not entitled to credit or payment for assessments:

(A) If the assessments were not paid to the Marketplace; or

(B) If the carrier does not offer coverage through the Marketplace.

STATUTORY/OTHER AUTHORITY: ORS 741.002, 741.005

STATUTES/OTHER IMPLEMENTED: ORS 741.105