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PROCEDURAL RULES

443-001-0000
Notice of Rulemaking

Prior to adoption, amendment or repeal or a rule, the Oregon Medical Insurance Pool Board shall give notice of the intended action:

(1) In the Secretary of State's Bulletin referred to in ORS 183.360 at least 15 days before the effective date of the intended action.

(2) By mailing copies of the notice to persons on the mailing list established by the Board under ORS 183.335(7).

(3) By mailing or delivering copies of the notice to the Associated Press, the Daily Journal of Commerce, and the United Press International.

(4) By mailing copies of the notice to organizations and publications that may provide notice to persons who may have an interest, such as the following:

(a) Authorized health insurers;
(b) Oregon Association of Health Underwriters;
(c) Portland Business Group for Health;
(d) Health Insurance Association of American;
(e) Oregon Life Underwriters Association;
(f) National Association, Multiple Sclerosis Society;
(g) Oregon Association of Hospitals;
(h) American Diabetes Association, Oregon Affiliate;
(i) Oregon Medical Association;
(j) American Heart Association, Oregon Affiliate;
(k) American Cancer Society, Oregon Division;
(l) Cascade Aids Project;
(m) Associated Oregon Industries;
(n) Oregon Association of Self-Insured Employers;
(o) Pacific Northwest Personnel Management Association.

Stat. Auth.: ORS 183 & ORS 705
Stats. Implemented:
Hist.: MIP 2-1989(Temp), f. & cert. ef. 10-4-89; MIP 1-1990, f. & cert. ef. 3-23-90

443-001-0005
Rules of Administrative Procedure

The Attorney General's Uniform and Model Rules of Procedure under the Administrative Procedures Act, adopted on September 15, 1997, are adopted as the rules of procedure for the Oregon Medical Insurance Pool Board.

[ED NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the Oregon Medical Insurance Pool Board.]
Stat. Auth.: ORS 183 & ORS 735
Stats. Implemented:
Hist.: MIP 1-1989, f. & cert. ef. 10-4-89; OMIPB 1-2000, f. 2-29-00, cert. ef. 3-1-00

443-001-0010
Rules Governing Contracting Procedures

The Public Bidding Rules, OAR 137-030-0000 to 137-030-0155, which were adopted by the Attorney General pursuant to ORS 279.049 and became effective October 1, 1984, are adopted by reference as the rules governing contracting procedures for the Oregon Medical Insurance Pool Board.

Stat. Auth.: ORS 183 & ORS 705
Hist.: MIP 2-1989(Temp), f. & cert. ef. 10-4-89; MIP 1-1990, f. & cert. ef. 3-23-90

DIVISION 5

LIMITATIONS, WAITING LISTS, ENROLLMENT PRIORITY, ENROLLMENT, AND ASSESSMENT REDUCTION FORMULA

443-005-0000
Eligibility, Benefits, Limitations, Exclusions and Premiums

(1) Individuals applying for Oregon Medical Insurance Pool (OMIP) coverage must meet the following eligibility requirements:

(a) The applicant must be a resident of the State of Oregon [for at least six months] or must have transferred from another state high risk pool and applied for OMIP coverage within sixty-three (63) days of coverage expiration; and either subsection (b) or (c);

(b) The applicant must meet one of the following medical eligibility requirements:

(A) Received a declination of individual health insurance coverage within the last six months due to health reasons;

(B) Had an agent fail to apply, as requested by the applicant, for individual health insurance within the last six months with a specific insurer which the agent represents due to health reasons;

(C) Individuals may apply for OMIP portability coverage if an application for coverage is made not later than the 63rd day after the date of first eligibility and the individual is an Oregon resident at the time of such application:

(c) Individuals may apply for OMIP after meeting one of the following requirements:

(A) An individual who has been an Oregon resident prior to termination of Oregon-based group coverage and who was otherwise eligible for portability coverage became ineligible because of a change of residence within Oregon taking the individual out of the service area of the portability carrier; or

(B) An individual who has been an Oregon resident prior to termination of coverage under any employee welfare benefit plan exempt from state regulation under the federal Employee Retirement Income Security Act of 1974, as amended or a multiple employer welfare arrangement subject to ORS 750.301 to 750.341, or who has left coverage with a public body of this state in accordance with ORS 731.036, and who has exhausted all rights under federal law to continue that coverage (i.e., COBRA), does not have portability coverage available and applies within 63 days of exhausting continuation benefits; or,

(C) An individual who has been an Oregon resident prior to termination of group coverage established in a state other than Oregon, has exhausted all rights under federal or Oregon state law to continue that coverage (i.e., COBRA or Oregon state continuation), does not

have portability coverage available and applies within 63 days of exhausting continuation benefits; or,

(D) An individual who is moving into Oregon after leaving group-based coverage, has exhausted all rights under federal or Oregon state law to continue that coverage (i.e., COBRA or Oregon state continuation), does not have portability coverage available and applies within 63 days of exhausting continuation benefits.

(d) Proof of eligibility for pool coverage must be submitted at the time of application. Such documentation must be dated within six months of making application for OMIP coverage and be on letterhead signed by a person with authority to transact health insurance business.

(2) Applicants and/or dependents of applicants will be ineligible for OMIP coverage under the following conditions regardless of whether other eligibility requirements are satisfied:

(a) The applicant or dependent is eligible for Medicare or health care benefits under ORS chapter 414 (Medical Assistance or Medicaid) and is receiving the standard benefit package unless, at the time the member becomes eligible for Medicare they have been enrolled with the Oregon Medical Insurance Pool for twelve consecutive months and elect to continue coverage through written request to OMIP and also enroll in Medicare A and B. If the member elects to continue OMIP coverage, it will become the secondary payer to any benefits provided by Medicare:

(A) If a person is enrolled in OMIP and then becomes eligible for health care benefits under Medicare for reasons other than turning 65, or becomes eligible for health care benefits under ORS chapter 414, the person may request a suspension of OMIP coverage. Suspension must be requested in writing and submitted to the Third Party Administrator (TPA). Coverage under the OMIP policy contract shall be suspended for a period not to exceed twelve months. Premiums will not be collected for suspended coverage during the suspension period;

(B) If the OMIP enrollee is eligible for health care benefits under Medicare for reasons other than turning 65, or becomes eligible for health care benefits under ORS chapter 414 and is receiving the standard benefit package, the request to suspend OMIP coverage must be made within 30 days of notice of eligibility for Medicare for reasons other than turning 65 or the notice of eligibility for the standard benefit package under ORS chapter 414:

(i) If the request is made as described, coverage under the OMIP policy contract shall be suspended effective at the end of the month in which the OMIP enrollee became eligible for Medicare for reasons other than turning 65 or for the standard benefit package under ORS chapter 414;

(ii) If the person loses eligibility for Medicare for reasons other than turning 65 or the standard benefit package under ORS chapter 414 during the twelve month suspension period, coverage under the OMIP policy contract may be resumed upon written request to the TPA. The request to resume OMIP coverage must be made in writing and submitted to the TPA within 30 days of notice of losing eligibility for the standard benefit package;

(iii) If the person is still eligible for Medicare for reasons other than turning 65 or the standard benefit package under ORS chapter 414 after the twelve month suspension period or fails to request the TPA to resume coverage as prescribed, the OMIP policy contract shall be terminated automatically effective at the end of the month in which the person became eligible for Medicare for reasons other than turning 65 or the standard benefit package under ORS chapter 414.

(C) If the OMIP enrollee is eligible for health care benefits under ORS chapter 414 but is not receiving the standard benefit package, the request to suspend OMIP coverage may be made at any time:

(i) If the request is made as described, coverage under the OMIP policy contract shall be suspended effective at the end of the month in which the request is received by the TPA;

(ii) Coverage under the OMIP policy contract may be resumed at any time during the twelve month suspension period. The request to resume OMIP coverage must be made in writing and submitted to the TPA. Coverage under the OMIP policy contract shall be resumed effective at the first of the month following the date the request is received by the TPA;

(iii) If the person fails to request that coverage be resumed before the twelve month suspension period expires, coverage under the OMIP policy contract shall be terminated as of the coverage suspension date.

(D) If OMIP no longer offers this policy at the time coverage is resumed, coverage available through the most similar current OMIP policy contract will be offered;

(E) A person whose coverage was suspended and then resumed under this rule shall receive credit toward the six month exclusion period for pre-existing conditions based on the number of months previously covered by the OMIP policy contract and the number of months the person was eligible for health care benefits under Medicare for reasons other than turning 65 or ORS chapter 414.

(b) The applicant or dependent is a patient or an inmate of a State correctional or mental institution;

(c) The applicant or dependent terminated OMIP coverage within the last twelve (12) months for a reason other than becoming eligible for health care benefits under Medicare for reasons other than turning 65 or ORS chapter 414 (Medical Assistance or Medicaid);

(d) The applicant or dependent received $1,000,000 in OMIP benefits;

(e) The applicant or dependent is covered by health insurance or a self-insurance arrangement which is substantially equivalent to OMIP coverage as of the effective date of pool coverage;

(f) The applicant or dependent has OMIP premiums paid or reimbursed by a public entity or a health care provider for the sole purpose of reducing the financial loss or obligation of the payer;

(g) The applicant or dependent is employed by a business with two or more employees and is applying to the pool for coverage at the direction of an insurance agent or insurance company for the purpose of separating oneself from health insurance benefits offered or provided in connection with one's employment;

(h) The dependent child is 23 years of age or older and is not mentally or physically incapacitated;

(i) The dependent child is under 23 years of age but there is a court order requiring that someone other than the applicant provide insurance for the child;

(j) The child is under 23 years of age but is married, independent, or is not a full-time student in an accredited institution of higher education.

(3)(a) Benefits, limitations, exclusions and premiums for the OMIP program are set forth in policy contracts (OMIP Plan I, OMIP Plan II, OMIP Plan III and OMIP Plan IV revised July 1999, and including any applicable endorsements); the OMIP application, revised February 1999; the OMIP handbook, revised January 1999; and the OMIP premium rate card, revised October 1999. These documents are hereby incorporated into this rule by reference.

(b) The individual eligible for OMIP pursuant to OAR 443-005-0000(1)(b) shall be required to pay a premium rate not more than 125% of the standard risk rate as determined by the OMIP Board in accordance with ORS 735.625(4)(c) and ORS 743.763(2)(b) provided application is made to OMIP within 63 days of prior health benefit coverage termination.

(c) The individual eligible for OMIP pursuant to OAR 443-005-0000(1)(c) shall be required to pay a premium rate not more than the standard risk rate as determined by the OMIP Board in accordance with ORS 735.625(4)(c) and ORS 743.763(2)(b) provided application is made to OMIP within 63 days of the prior health benefit coverage termination date.

(4)(a) The Oregon Medical Insurance Pool Board may modify the policy contracts (OMIP Plan I, OMIP Plan II, OMIP Plan III and OMIP Plan IV), including the schedule of benefits, limitations and exclusions, premium rates and eligibility requirements, the OMIP brochure and the OMIP application, by giving notice to interested parties as defined and adopted under OAR 443-01-0000.

(b) OMIP may request applicants to voluntarily release their social security numbers for the purposes of verifying health insurance coverage and tracking claims payments.

Stat. Auth.: ORS 735.610(4)(e) & ORS 735.610(6)

Stats. Implemented: ORS 735.610(4)(e) & (6)

Hist.: MIP 3-1990(Temp), f. & cert. ef. 6-19-90; MIP 1-1992, f. & cert. ef. 4-28-92; MIP 2-1992, f. & cert. ef. 7-1-92; MIP 1-1993, f. 1-6-93, cert. ef. 2-1-93; MIP 2-1993(Temp), f. & cert. ef. 2-1-93; MIP 3-1993, f. & cert. ef. 4-1-93; MIP 5-1993, f. 12-30-93, cert. ef. 1-1-94; MIP 1-1994, f. 6-29-94, cert. ef. 7-1-94; MIP 2-1994, f. 12-30-94, cert. ef. 1-1-95; MIP 1-1995, f. 12-28-95, cert. ef. 1-1-96; MIP 1-1996, f. 8-1-96, cert. ef. 10-1-96; MIP 1-1997(Temp), f. & cert. ef. 7-11-97; MIP 2-1997, f. 9-30-97, cert. ef. 10-1-97; OMIPB 1-1998, f. 1-6-98, cert. ef. 1-8-98; OMIPB 1-2000, f. 2-29-00, cert. ef. 3-1-00

443-005-0010
Enrollment Limitations

Enrollment Limitations: In accordance with ORS 735.625(4)(d), the Oregon Medical Insurance Pool Board may establish an enrollment schedule of new monthly enrollments and may state the maximum number of policies that may be in force at the end of each month to keep pool losses under one percent of the total of all medical insurance premiums, subscriber contract charges and 110 percent of all benefits paid by member self-insurance arrangements:

(1) The Pool Administrator may approve applications for enrollment up to the monthly allocation and within the maximum number of policies in force.

(2) In determining the monthly allocation, the Pool Administrator shall include enrollment vacancies created by policy terminations from the previous month.

(3) The monthly allocation shall be cumulative and shall be carried forward to the following month as long as total monthly enrollments plus policies in force do not exceed the maximum established by the Board.

(4) In establishing the maximum enrollment and the monthly enrollment allocation, the Board shall take into account agency expenditure limitations established by the Oregon State Legislature, claims and revenue projections, and the level of cash reserve required to pay claims incurred but not yet paid or reported.

(5) At least once a quarter, the Board shall review and may modify the enrollment limitations and monthly allocations. The criteria used in establishing the limitations and allocations shall also be used to determine if any modification is necessary.

Stat. Auth.: ORS 183.341 & ORS 705.135
Stats. Implemented:
Hist.: MIP 1-1991(Temp), f. & cert. ef. 11-1-91; MIP 1-1992, f. & cert. ef. 4-28-92; OMIPB 1-2000, f. 2-29-00, cert. ef. 3-1-00

443-005-0020
Waiting Lists

If the number of applications approved exceeds the maximum number of policies in force or the monthly allocation, enrollment shall be closed:

(1) Applications may be approved but the effective date of coverage shall not be established until openings occur.

(2) A waiting list will be established and applicants shall be notified as follows:

(a) A notification letter shall be sent to the applicant informing the applicant that the application has been approved but, because of enrollment limitations, the applicant has been placed on a waiting list and will be notified when an opening occurs;

(b) The initial premium payment shall be returned with the notification letter.

(3) Waiting lists shall be established in chronological order of applications approved.

Stat. Auth.: ORS 183.341 & ORS 705.135
Stats. Implemented:
Hist.: MIP 1-1991(Temp), f. & cert. ef. 11-1-91; MIP 1-1992, f. & cert. ef. 4-28-92; OMIPB 1-2000, f. 2-29-00, cert. ef. 3-1-00

443-005-0040
Enrollment When Waiting Lists Exist

As openings occur either through enrollment terminations, a new time period is reached or other additional allocations are made as described in OAR 443-005-0010, approved applicants on the waiting lists shall receive first priority and will be enrolled as follows:

(1) As an opening occurs, the Pool Administrator shall attempt to contact the next applicant on the waiting list and inform the applicant that there is an enrollment opening and that coverage may be received by resubmitting the initial premium payment.

(2) The applicant has 15 calendar days from the date of notice to resubmit the premium payment to the Pool Administrator:

(a) If the applicant fails to resubmit the premium payment within the 15 calendar days, the applicant's name shall be removed from the waiting list;

(b) If the applicant resubmits the premium payment within the prescribed time, the effective date of coverage shall be the first day of the month following the month of the postmark of the premium payment.

Stat. Auth.: ORS 183.341 & ORS 705.135
Stats. Implemented:
Hist.: MIP 1-1991(Temp), f. & cert. ef. 11-1-91; MIP 1-1992, f. & cert. ef. 4-28-92; OMIPB 1-2000, f. 2-29-00, cert. ef. 3-1-00

443-005-0050
Enrollment When No Waiting Lists Exist

When enrollments are below the maximum allocated, priority for enrollment shall be as follows:

(1) Applicants eligible for the pool shall complete an original application and provide the requested documentation to the OMIP third party administrator. The original application must be date stamped by the third party administrator for verification of receipt. If the original application is received incomplete, the date stamp on the original application will serve only as receipt of the application. The date of application becomes complete will be used in determining eligibility for enrollment.

(2) Applications will be processed on a first come, first enrolled basis. The Administrator has the authority to make exceptions to the application process.

(3) Upon enrollment, the applicant will be sent a premium notice, identification card and policy contract. Coverage will become effective when the premium is received and applied to the appropriate account.

Stat. Auth.: ORS 183.341 & ORS 705.135
Stats. Implemented:
Hist.: MIP 1-1991(Temp), f. & cert. ef. 11-1-91; MIP 1-1992, f. & cert. ef. 4-28-92; OMIPB 1-2000, f. 2-29-00, cert. ef. 3-1-00

443-005-0060
Credit Toward the Six-Month Pre-Existing Condition Exclusion

(1) Credit toward the six-month pre-existing condition exclusion shall be granted in the following situations after the applicant has met eligibility criteria:

(a) Coverage under a prior health benefit plan as used in ORS 735.625(5)(b) was continuous to a date not more than 63 days prior to the effective date of OMIP coverage.

(b) Enrollment is closed and approved applications are being placed on waiting lists as described in OAR 443-005-0020.

(2) The applicant must request credit toward the six-month pre-existing condition exclusion at the time of application for OMIP coverage and, in situations where prior health benefit plans have been terminated, provide documentation proving such coverage was terminated and was continuous to a date not more than 63 days prior to the effective date of OMIP coverage. Such documentation could include a certificate of coverage, notice of policy cancellation, notice of layoff or notice of employment termination.

(3) In cases where prior health benefit coverage has been terminated and no waiting lists exist, credit toward the six-month pre-existing condition exclusion will be granted for time the eligible insured was covered under a previous health benefit plan as follows:

(a) The eligible insured must make application for pool coverage within 63 days of the effective date of termination of prior health benefit plan coverage;

(b) The effective date of pool coverage shall be the effective date of prior health benefit plan termination date. Benefits will begin accruing upon effective date of pool coverage;

(c) The eligible insured must pay premiums from the date of the prior health benefit plan coverage termination.

(4) In cases where prior health benefit plan coverage has been terminated and waiting lists exist, credit toward the six-month pre-existing condition exclusion will be granted for both the time the eli-

gible insured was covered under a previous health benefit plan and time spent on the waiting list as follows:

(a) The eligible insured must make application for pool coverage within 63 days of the effective date of prior health benefit plan termination;

(b) The effective date of pool coverage shall be the effective date of enrollment. Benefits will begin accruing upon enrollment and the acceptance of premium payment;

(c) The eligible insured must pay premiums from the date of enrollment.

(5) In cases where an approved application has been placed on a waiting list, credit toward the six-month pre-existing condition exclusion will be granted for the time spent on the waiting list as follows:

(a) The effective date of pool coverage shall be the effective date of enrollment. Benefits will begin accruing upon enrollment and the acceptance of premium;

(b) The amount of credit granted shall be based on the number of months the approved applicant was on the waiting list;

(c) The eligible insured must pay premiums from the date of enrollment.

Stat. Auth.: ORS 183.341 & ORS 705.135
Stats. Implemented: ORS 735.610(4)(d) & (6)
Hist.: MIP 1-1992, f. & cert. ef. 4-28-92; MIP 4-1993, f. & cert. ef. 4-1-93; MIP 1-1996, f. 8-1-96, cert. ef. 10-1-96; OMIPB 1-2000, f. 2-29-00, cert. ef. 3-1-00

443-005-0070
Criteria for Assessment Reduction Consideration

(1) Licensed health insurance carriers and health care service contractors, herein referred to as insurers, participating in the Oregon individual health insurance market (non-Medicare, non-Medicaid) may voluntarily choose to apply for the assessment reduction. Such insurers are eligible for OMIP assessment reductions if, and only if, all the following criteria are met:

(a)(A) If the insurer is active in the group health insurance market and the individual health insurance market, the insurer must offer individual health insurance in the same or greater geographic area as its group health insurance; or,

(B) If the insurer is ONLY in the individual market, it must offer coverage statewide.

(b) The insurer must offer at least one individual health benefit plan that has a scope of benefits similar to OMIP with member cost sharing actuarially equivalent to at least one OMIP plan. The insurer shall attach along with their Assessment Reduction Application (Exhibit 1) the health benefit plan and its associated member cost sharing for OMIP to review for purposes of determining if actuarial equivalency exists.

(c) The rate schedule for the plan noted in subparagraph (b) must be, when averaged over a two year period, less than the OMIP surcharged rate.

(d) The insurer must demonstrate an active marketing plan for all individual plans and all individual plans must be continuously available. This includes plans offered only in a specific market segment. The plans must be continuously available to that market segment. Data and information to confirm that coverage is continuously available may be gathered by any method deemed appropriate by OMIP, including, but not limited to, direct audit by OMIP staff or inclusion as part of an Insurance Division general market conduct examination, or a targeted Insurance Division market conduct examination.

(2) When data and information demonstrating compliance with section (1) are reviewed and approved by OMIP, an insurer's assessment shall be reduced based upon the following schedule: [Table not included. See ED. NOTE]. The allowed exception to the rejection rate is Existing Pregnancy.

(a) Rejection rates will be calculated based on a three-year rolling average beginning October 1, 1996. Rejection rates will be submitted quarterly by any insurer that elects to participate in the OMIP Assessment Reduction Program. If an insurer initially elects not to participate and later chooses to do so, or a new insurer enters the individual health insurance market after October 1, 1996 and elects to participate, a minimum of six months of rejection rate data must be submitted to OMIP.

(b) A "rejection" for the purposes of OMIP assessment reduction is defined as: rejection of an application for individual coverage occurs when an application for an individual health benefit plan is denied because of the health status of the applicant or any other individual to be covered by the plan applied for. Health status includes previous claims history, previously treated conditions, current conditions, and anticipated claims. A rejection because of an existing pregnancy shall not be counted as a rejection nor as an acceptance under this definition. An application not acted upon by the insurer within thirty days from when the application was first received or thirty days from the first request for additional information, shall be deemed a "rejection."

(c) The "rejection rate" equals the number of "rejected applications" divided by the sum of "accepted applications" plus "rejected applications." An "accepted application" is an offer to insure the person for any individual health benefit plan offered by the insurer. Applications denied coverage or had applications returned for reasons other than health status (i.e. failure to include required premium payments, failure to provide information as requested by the insurer or incomplete or false applications, or other non-health related reasons) will not be used when computing an insurers rejection rate.

(d) The data and information for OMIP to confirm this rejection rate may be gathered by any method deemed appropriate by OMIP, including, but not limited to, direct audit by OMIP staff or inclusion as part of an Insurance Division general market conduct examination, or a targeted Insurance Division market conduct examination.

(3) Implementation Timeline:

(a) The assessment reduction program will be implemented at the July 1, 1997 assessment.

(b) Implementation will be phased in over the next five regularly scheduled assessments as follows: [Table not included. See ED. NOTE]

(4) Election to Participate:

(a) Participation in the Assessment Reduction Program is voluntary and only those insurers that elect to participate must provide OMIP with quarterly information on rejection and acceptance rates and information required to determine whether an insurer meets the criteria established under the program.

(b) An insurer that chooses to participate must complete and send in the Assessment Reduction Application Form shown in Exhibit 1 of this rule.

(c) An insurer that chooses not to participate in the Assessment Reduction Program is not required to complete or file Exhibit 1.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 183.341
Stats. Implemented: ORS 735.614(9)(a) & (b)
Hist.: MIP 1-1996, f. 8-1-96, cert. ef. 10-1-96; MIP 1-1997(Temp), f. & cert. ef. 7-11-97; OMIPB 1-1998, f. 1-6-98, cert. ef. 1-8-98; OMIPB 1-2000, f. 2-29-00, cert. ef. 3-1-00

DIVISION 10

APPEAL RULES

443-010-0010
Appeals Procedure

(1) Appeal of Determination Unrelated to Benefit or Claim Issues: An individual who has received an adverse determination related to the Oregon Medical Insurance Pool (OMIP) may appeal the determination as follows:

(a) An individual who is dissatisfied with the determination of the Third Party Pool Administrator may make a written appeal to the Administrator of the OMIP Board within 30 days from the date of determination explaining why the appellant believes the determination should be different. The appellant must include copies of the original application, supporting documentation, correspondence from the Third Party Pool Administrator, and any other pertinent information;

(b) The Administrator of the OMIP Board shall review the appeal based on information provided by the appellant, program eligibility criteria, information obtained from the Third Party Pool Administrator, established precedence, and Oregon Revised Statutes. The Administrator of the OMIP Board shall complete an Appeal Summary Form to document findings and the determination, provide a written response to the appellant and the Third Party Pool Administrator within 30 days of receiving the appeal, and provide the OMIP Board with a copy of the Appeal Summary Form;

(c) If the Administrator of the OMIP Board finds that circumstances of the appeal fall outside of parameters used to make determinations, the Administrator shall bring the appeal before the OMIP Case Management Committee. The Committee shall meet immediately before the next scheduled Board meeting or at other times as necessary;

(d) The OMIP Case Management Committee shall review the appeal and any pertinent information provided and determine whether an exception will be granted to the OMIP policy and guidelines. The OMIP Case Management Committee shall provide the appellant and the Third Party Pool Administrator with a written response within 60 days from the receipt date of the appeal;

(e) The decision of the OMIP Case Management Committee shall be final.

(2) Appeal of Benefit or Claim Issues: An individual may appeal insurance benefit or claim issues as follows;

(a) An individual shall follow the appeal process outlined in the benefit book for the plan in which the individual is enrolled, either Plan I, II, III, or IV;

(b) An individual who is dissatisfied with the decision of the Third Party Pool Administrator may make a written appeal to the Administrator of the OMIP Board within 30 days of the date of the Third Party Pool Administrator's decision. The appellant must include copies of supporting documentation;

(c) The Administrator of the OMIP Board shall review the appeal based on information provided by the appellant, provisions of the contract, information obtained for the Third Party Pool Administrator, and established precedence. The Administrator of the OMIP Board shall complete an Appeal Summary Form to document findings and the determination, provide a written response to the appellant and the Third Party Pool Administrator within 30 days of receiving the appeal, and provide the OMIP Board with a copy of the Appeal Summary Form;

(d) If the Administrator of the OMIP Board finds that circumstances of the appeal fall outside of parameters used to make benefit or claim determinations, the Administrator shall bring the appeal before the OMIP Case Management Committee. The Committee shall meet immediately before the next scheduled Board meeting or at other times as necessary;

(e) The OMIP Case Management Committee shall review the appeal and any pertinent information provided and determine whether an exception will be granted to the contract provisions. The OMIP Case Management Committee shall provide the appellant and the Third Party Pool Administrator with a written response within 60 days following the receipt date of the appeal;

(f) The decision of the OMIP Case Management Committee shall be final.

(3) OMIP Case Management Committee: The OMIP Case Management Committee shall be appointed by the OMIP Board Chair and be comprised of at least three members of the OMIP Board:

(a) The OMIP Board Chair shall designate a chairperson and one consumer representative;

(b) The Committee shall review and act upon all appeals which cannot be resolved by the Administrator of the OMIP Board;

(c) The Chairperson of the OMIP Case Management Committee shall request the participation of additional Board members when the nature of the appeal requires their expertise in analyzing the case and making a decision.

Stat. Auth.: ORS 183.341 & ORS 705.135
Stats. Implemented:
Hist.: MIP 3-1990(Temp), f. & cert. ef. 6-19-90; MIP 1-1992, f. & cert. ef. 4-28-92; MIP 3-1992, f. 10-30-92, cert. ef. 11-1-92; OMIPB 1-2000, f. 2-29-00, cert. ef. 3-1-00

DIVISION 15

ASSESSMENT RULES

443-015-0010
Assessment for Operating Expenses

(1) An assessment of insurers and reinsurers shall be made by the Oregon Medical Insurance Pool Board for the purpose of collecting monies to cover expenses and losses of the Pool which are not or will not be sufficiently covered by funds in the Oregon Medical Insurance Pool Account.

(2) The frequency of such assessments shall be determined by the Board based on projected cash balances and operating revenues and expenditures.

(3) The projected cash balance shall take into account a reserve intended to cover claims incurred but not reported or paid. The reserve shall be reviewed quarterly by the Board to determine its adequacy and adjusted as needed.

(4) The amount assessed to each insurer or reinsurer shall depend on each insurer's or reinsurer's proportion of the total of all Oregon insureds and certificate holders insured or reinsured and the amount of deficiency:

(a) Each insurer's or reinsurer's proportion of the total of all Oregon insureds and certificate holders insured or reinsured will be based on reports submitted to the Board stating the number of insureds as of December 31st of the previous year;

(b) Total Oregon insureds and certificate holders insured or reinsured shall be determined as follows:

(A) The count of insureds and certificate holders insured or reinsured shall be limited to medical insurance as defined in ORS 735.605(5);

(B) The count shall include all insureds and certificate holders, including dependents, other individuals whose medical insurance coverage is insured or reinsured in whole or in part, and individuals covered under excess loss coverage written on self-funded medical plans;

(C) Reinsurers may exclude from the number reported those individuals that have been counted by the primary insurer or the primary reinsurers;

(D) Insurers and reinsurers are permitted to reduce their estimate of the number of covered dependents by ten percent to account for dual coverage;

(E) The insurer and reinsurer may use any reasonable method of estimating or may use actual counts of the number of individuals for whom coverage is provided.

(5) If assessment collections exceed the amount needed to meet Pool expenses and losses, excess funds shall be held and invested and, with the earnings and interest, used by the Board to offset future net losses or to reduce Pool premiums. For the purposes of this section, "future net losses" include reserves for incurred but not reported claims.

Stat. Auth.: ORS 183.341 & ORS 705.135
Stats. Implemented:
Hist.: MIP 2-1990(Temp), f. & cert. ef. 5-15-90; MIP 1-1992, f. & cert. ef. 4-28-92