

Chapter 443 Oregon Health Authority, Oregon Medical Insurance Pool

DIVISION 1

PROCEDURAL RULES

- 443-001-0000** Notice of Rulemaking
443-001-0005 Rules of Administrative Procedure
443-001-0010 Rules Governing Contracting Procedures

DIVISION 2

OREGON MEDICAL INSURANCE POOL

- 443-002-0010** Definitions
443-002-0020 Administering Insurer
443-002-0030 Assessment for Operating Expenses and Counting Insureds
443-002-0040 Adjustment of Assessment for Insurers in Individual Health Benefits Market
443-002-0050 Agent's Referral Fees
443-002-0060 Eligibility
443-002-0070 Benefits, Benefit Limitations, Benefit Exclusions and Claims Administration
443-002-0080 Premiums
443-002-0090 Member Termination
443-002-0100 Member Suspension and Resumption of Coverage
443-002-0110 Coordination of Benefits
443-002-0120 Effective Dates
443-002-0130 Enrollment Limitations
443-002-0150 Enrollment When Waiting Lists Exist
443-002-0160 Enrollment When No Waiting Lists Exist
443-002-0170 Pre-Existing Conditions
443-002-0180 Credit Towards the Six-Month Waiting Period for Pre-Existing Conditions
443-002-0190 Grievance, Appeals, External Review

DIVISION 1

PROCEDURAL RULES

443-001-0000
Notice of Rulemaking

Prior to adoption, amendment or repeal of any permanent 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 twenty-one (21) days before the effective date of the intended action.

(2) By mailing copies of the notice at least thirty (30) days prior to the effective date to persons on the mailing list established by the Board under ORS 183.335(8), and the following publications and organizations:

- (a) Publications:
(A) The Associated Press;
(B) The Daily Journal of Commerce; and
(C) The United Press International.
(b) Organizations:
(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 & 705

Stats. Implemented:

Hist.: MIP 2-1989(Temp), f. & cert. ef. 10-4-89; MIP 1-1990, f. & cert. ef. 3-23-90; OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05

443-001-0005

Rules of Administrative Procedure

The Model Rules of Procedure, OAR 137-001-0005 through 137-001-0080, in effect on December 9, 2003, as promulgated by the Attorney General of the State of Oregon under the Administrative Procedures Act are adopted as the rules of procedure for rulemaking actions of the Oregon Medical Insurance Pool.

[ED NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the Office of the Attorney General or the Oregon Medical Insurance Pool.]

Stat. Auth.: ORS 183 & 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; OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05

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 & 705

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

DIVISION 2

OREGON MEDICAL INSURANCE POOL

443-002-0010

Definitions

(1) "Administering Insurer" means the insurance company or third party administrator selected pursuant to ORS 735.620 to provide administrative services to operate OMIP on behalf of the OMIP Board.

(2) "Appeal" means a request to have an adverse grievance decision reviewed.

(3) "Applicant" means a person who is applying for OMIP coverage.

(4) "Benefit Enrollment Year" means a year beginning on the enrollee's effective date of OMIP coverage.

(5) "Calendar Year" means January 1st through December 31st each year.

(6) "Carrier" means an insurance company, a health maintenance organization or health care service contractor that has a valid certificate of authority from the Director of the Department of Consumer and Business Services that authorizes the transaction of health insurance.

(7) "Certificate of Coverage (COC)" means a certificate that is provided by an insurance carrier as proof of prior insurance coverage.

(8) "Children" means the applicant's natural, legally adopted child, or legal guardian, stepchildren living in the home or non-resident stepchildren if there is a qualified medical child support order that requires the applicant to provide health insurance.

(9) "Claim" means a request for payment under the terms of an insurance Contract.

(10) "Creditable Coverage" means prior health insurance coverage that reimburses for medical and hospital expenses without regards to a specific medical condition or disease and has comparable, similar benefits and payout amounts to OMIP's health benefit plans.

(11) "Dependent" means the contract holder's enrolled legal spouse, domestic partner, and unmarried children less than 23 years of age.

(12) "Eligibility" means meeting the Oregon residency and medical, portability, or federal Health Coverage Tax Credit (HCTC) requirements to qualify for the OMIP program as established in OAR 443-002-0060.

(13) "Enrollee" means an individual who is enrolled in one of the OMIP medical or portability benefit plans.

(14) "External Review" is a review performed by a state contracted independent review organization when an enrollee has exhausted all internal grievance and appeal procedures and wants the opinion of a medical professional who is separate from the patient's health insurance company. External review applies only to disputes about medical necessity, experimental or investigational treatment, or need for continuity of care.

(15) "Grievance" means a written complaint submitted to OMIP's administering insurer by or on behalf of an enrollee regarding:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and OMIP.

(16) Health Coverage Tax Credit (HCTC) is a federal tax credit that pays 65% of qualified health insurance premiums for eligible individuals and their family members. In order to receive the HCTC, you must meet certain requirements, such as being a:

(a) Trade Adjustment Assistance (TAA) or Alternative Trade Adjustment Assistance (ATAA) recipient; or

(b) Pension Benefit Guaranty Corporation (PBGC) benefits recipient.

(17) "Medicaid" means federal medical assistance provided under 42 U.S.C. section 396a administered by the Oregon Department of Human Services.

(18) "OMIP" means the Oregon Medical Insurance Pool.

(19) "Pre-existing Condition" means a condition for which professional medical advice, diagnosis, care, or treatment was recommended or received in the six months before coverage began. For purposes of the six month limitation period, the term pregnancy shall include: pre-and postnatal care, miscarriage, abortion, delivery (vaginal or surgical), and complication of pregnancy. Complication of pregnancy includes but is not limited to: intra-abdominal surgical procedures; placenta abruptio and placenta previa; acute exacerbations or heart conditions and or diabetes; toxemias.

(20) "Resident" means a person who is legally domiciled and maintains a principal place of residence in Oregon. Once a person is enrolled in OMIP coverage, he/she must also reside at this principle place of residence at least 180 days each benefit enrollment year.

(21) "Substantially Equivalent Health Benefits or Coverage" means health insurance coverage that reimburses for medical and hospital expenses without regards to a specific medical condition or disease and has comparable, similar benefits and payout amounts, to OMIP's health benefit plan.

Stat. Auth.: ORS 735.610(6)

Stats. Implemented: ORS 735.600 - 735.650

Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 2-2005, f. 12-30-05, cert. ef. 1-1-06; OMIPB 1-2008, f. & cert. ef. 1-2-08; OMIPB 5-2008(Temp), f. & cert. ef. 7-1-08 thru 12-27-08; OMIPB 8-2008, f. 11-14-08, cert. ef. 11-15-08

443-002-0020

Administering Insurer

(1) The OMIP Board shall select an insurer or insurers through a competitive bidding process as established in ORS 735.620 that utilizes a Request for Proposal (RFP).

(2) The Administering Insurer shall be responsible for all requirements set forth in the RFP.

Stat. Auth.: ORS 735.610(6) & 735.620

Stats. Implemented: ORS 735.600 - 735.650

Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05

443-002-0030

Assessment for Operating Expenses and Counting Insureds

(1) OMIP shall assess insurers and reinsurers, as defined in ORS 735.605, for the purpose of collecting monies to cover expenses and losses of OMIP in excess of premiums, which are not or will not be sufficiently covered by funds in the OMIP Account defined in 735.612.

(a) Pursuant to ORS 735.614(2), OMIP counts both the number of Oregon insureds and Oregon certificate holders for assessment purpose. Health insurance issued in other states for certificate holders in Oregon shall be subject to the assessment count.

(b) OMIP will assess insurance companies based on the number of persons insured in Oregon. The actual insurance transaction does not have to take place in the State of Oregon for it to be counted.

(c) All insurers that are authorized to transact health or medical insurance in Oregon and that insure persons residing in Oregon will be subject to the assessment. All reinsurers that reinsure medical insurance in Oregon on or after September 27, 1987, will be subject to assessment.

(2) The OMIP Board shall determine the frequency of such assessments 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 Board shall review the reserve quarterly to determine its adequacy and adjust it as needed.

(4) The amount for which OMIP assesses each insurer or reinsurer as defined in ORS 735.605 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 funds that OMIP needs to cover projected expenses and losses in excess of the premiums:

(a) Annually, OMIP will send a request to all insurers insuring or reinsuring health or medical insurance in Oregon to report the number of persons insured or reinsured in Oregon as of March 31 of the current year.

(A) The insurer or reinsurer will have 30 days from the date of the request to return the requested count.

(B) Based on the information obtained in the requested count, OMIP will issue bi-annual assessments. Insurers, including reinsurers, will have 30 days from the notice of assessment to make payment. Effective May 1st of 2006, if the insurer does not make payment in full to OMIP within 30 days from the notice of assessment, OMIP may add interest, fees, and other penalties as approved by the Board.

(C) If OMIP discovers that an insurer (including a reinsurer) has inaccurately reported the number of persons insured, OMIP may request that the insurer provide an accurate count and may reassess the insurer accordingly.

(b) OMIP shall determine the total number of Oregon insureds and certificate holders insured or reinsured as follows:

(A) OMIP shall limit the count of insureds and certificate holders insured or reinsured 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, to the extent permitted by federal law, individuals covered under excess loss coverage written on self-funded medical plans;

(C) Reinsurers may exclude from the number reported those individuals that the other insurers or reinsurers have counted;

(D) The insurers and reinsurers may use any reasonable method of estimating or may use actual counts of the number of individuals for whom coverage is provided. They must inform OMIP how they calculated any estimates.

(5) If assessment collections exceed the amount needed to meet OMIP expenses and losses, OMIP shall hold and invest the excess funds and use the earnings and interest, to offset future net losses or to reduce OMIP premiums. For the purposes of this section, "future net losses" include reserves for incurred-but-not-reported claims.

(6) OMIP allows a three-year look back period for adjusting assessments based on discrepancies reported to determine counts of covered lives. This rule applies retroactively from May of 2006.

(a) If OMIP discovers that a carrier over-reported the number of covered lives during the three-year look back period, OMIP may apply a credit to future assessments if applicable. If the actual count of covered lives drops to zero, OMIP may return the assessment payment to the carrier.

(b) If a carrier under-reported the number of covered lives during the three-year look back period, OMIP may charge the carrier the per member per month amount for each assessment applicable to each year. OMIP may also charge interest from the year of the discrepancy and for each additional year in the amount equivalent to what OMIP most recently earned on its cash account.

Stat. Auth.: ORS 735.610(6) & 735.614

Stats. Implemented: ORS 735.600 - 735.650

Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 2-2005, f. 12-30-05, cert. ef. 1-1-06; OMIPB 2-2008(Temp), f. & cert. ef. 1-2-08 thru 6-30-08; OMIPB 3-2008, f. & cert. ef. 4-15-08; OMIPB 4-2008(Temp), f. & cert. ef. 6-10-08 thru 12-5-08; OMIPB 8-2008, f. 11-14-08, cert. ef. 11-15-08

443-002-0040

Adjustment of Assessment for Insurers in Individual Health Benefits Market

(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, they meet all the following criteria:

(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, 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 its 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 it must make them continuously available. This includes plans that the insurer offers only in a specific market segment and it must make those plans continuously available to that market segment. OMIP may use any method that it deems appropriate to gather data and information to confirm that an insurer's coverage is continuously available, including, but not limited to, direct audit by OMIP staff or may rely upon an Insurance Division general or targeted market conduct examination.

(2) When OMIP has reviewed and approved data and information demonstrating compliance with section (1) OMIP may reduce an insurer's assessment based upon OMIP's determination of rates of rejection of individuals for coverage. The allowed exception to the rejection rate is existing pregnancy.

(a) OMIP will determine rejection rates based on a three-year rolling average. Insurers must submit rejection rates to OMIP quarterly in order 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, and elects to participate, it must submit a minimum of six months of rejection rate data to OMIP.

(b) A "rejection" or "rejected application" for the purposes of OMIP assessment reduction is such that rejection of an application for individual coverage occurs when the insurer denies an application for an individual health benefit plan because of the health status of the applicant or any other individual to be covered by the plan for which the individual applied. Health status includes previous claims history, previously treated conditions, current conditions, and anticipated claims. OMIP shall not count an insurer's rejection because of an existing pregnancy as a rejection nor as an acceptance under this definition. An application that the insurer does not act upon 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. OMIP will exclude from its calculation of the rejection rate any denials of coverage 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).

(d) The data and information to confirm an insurer's rejection rate includes, but is not limited to, direct audit by OMIP staff or an Insurance Division general or targeted market conduct examination.

(3) 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 OMIP Assessment Reduction Application Form.

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

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 735.610(6) & 735.614

Stats. Implemented: ORS 735.600 - 735.650

Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05

443-002-0050

Agent's Referral Fees

(1) OMIP will pay agent referral fees in the amount of \$75 for applications prepared and submitted by the agent and that the Administering Insurer accepts, approves and identifies as complete, and for which the member submits the first month's premium.

(2) OMIP reserves the right to refuse to pay the \$75 agent referral fee for applications submitted with incomplete or missing documentation.

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

Stats. Implemented: ORS 735.600 - 735.650

Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05

443-002-0060

Eligibility

(1) MEDICAL. Individuals applying for OMIP medical coverage must be a resident of the State of Oregon and meet one of the following eligibility requirements:

(a) Applicant was denied individual health insurance coverage within six months from the mailing date of the OMIP application; or

(b) Applicant has been diagnosed or treated within the last five years for one or more medical conditions listed on the most current OMIP application; or

(c) Applicant is now a resident of Oregon and has transferred from another state's high-risk pool; or

(d) Applicant was offered individual health insurance that contained a waiver which excluded coverage for a specific medical condition; or

(e) Applicant was offered individual health insurance but was limited by the choice of plans the carrier was willing to offer due to a specific medical condition; or

(f) Applicant is eligible for the health coverage tax credit (HCTC) under Section 35 of the Internal Revenue Code effective for taxable years beginning after December 31, 2001.

(2) PORTABILITY. Individuals applying for OMIP portability coverage must be a resident of the state of Oregon; apply to OMIP within 63 days of losing the prior group coverage, AND meet one of the following portability requirements:

(a) Applicant has had at least 180 days of group coverage, AND has exhausted all COBRA or state continuation coverage if available and no portability coverage is available through the previous group plan's health insurer; or

(b) Applicant is eligible for Oregon portability through the previous insurance carrier but has moved from the insurance carrier's service area or the insurance carrier no longer services the area in which the member currently lives; or

(c) Applicant has had at least 18 months of prior creditable health insurance coverage without a gap in coverage of greater than 63 days and the most recent was in a group plan, AND has exhausted COBRA or state continuation coverage if available, AND no portability coverage is available through the previous group plan's health insurer.

Stat. Auth.: ORS 735.610(6), 735.615 & 735.616

Stats. Implemented: ORS 735.600 - 735.650

Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 1-2005(Temp), f. & cert. ef. 8-26-05 thru 2-20-06; OMIPB 2-2005, f. 12-30-05, cert. ef. 1-1-06; OMIPB 1-2008, f. & cert. ef. 1-2-08; OMIPB 6-2008(Temp), f. & cert. ef. 7-1-08 thru 12-27-08; OMIPB 8-2008, f. 11-14-08, cert. ef. 11-15-08

443-002-0070

Benefits, Benefit Limitations, Benefit Exclusions and Claims Administration

Effective January 1, 2012, Benefits, Benefit Limitations, Benefit Exclusions and Claims Administration for the OMIP program are set forth in the OMIP individual benefit plan contracts as of January 1, 2012, the OMIP application as of January 1, 2012, the OMIP handbook as of January 1, 2012, the OMIP Premium Rates and Instructions pamphlet as of January 1, 2012, the OMIP Benefit Summary pamphlet as of January 1, 2012 and any applicable endorsements. These documents are hereby incorporated into this rule by reference.

Chapter 443 Oregon Health Authority, Oregon Medical Insurance Pool

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 735.610(6) & 735.625
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 2-2005, f. 12-30-05, cert. ef. 1-1-06; OMIPB 1-2007(Temp), f. & cert. ef. 7-23-07 thru 1-5-08; OMIPB 1-2008, f. & cert. ef. 1-2-08; OMIPB 1-2008(Temp), f. & cert. ef. 2-12-09 thru 8-10-09; OMIPB 2-2009, f. 3-30-09, cert. ef. 4-15-09; OMIPB 1-2010, f. & cert. ef. 2-9-10; OMIP 1-2011, f. & cert. ef. 1-26-11; OMIP 1-2012, f. 1-26-12, cert. ef. 2-6-12

443-002-0080 Premiums

(1) Individuals eligible for OMIP due to Medical Eligibility or are eligible because they qualify for the health insurance tax credit under the Federal Trade Act of 2002 must pay a premium rate determined by the OMIP Board in accordance with ORS 735.625(4)(c), but not more than 125% of the applicable rate.

(2) Individuals eligible for OMIP due to Portability Eligibility pursuant to OAR 443-002-0060 must pay a premium rate not to exceed 100% of the applicable rate as determined by the OMIP Board in accordance with ORS 735.625(4)(c) and 735.616(3)(c) provided that they apply to OMIP within 63 days of the prior health benefit coverage termination date and that they had the prior group coverage in place for not less than 180 days.

(3) The Board will review the premium rates on an annual basis as defined in ORS 735.625.

(4) Premiums will be based on the age of the oldest enrolled person under the OMIP policy and are rated incrementally with 5-year age bands.

(5) Premiums may also be based on the geographic location in which an enrolled member lives.

Stat. Auth.: ORS 735.610(6), 735.616 & 735.625
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 1-2005(Temp), f. & cert. ef. 8-26-05 thru 2-20-06; OMIPB 2-2005, f. 12-30-05, cert. ef. 1-1-06

443-002-0090 Enrollee Termination

OMIP will terminate an enrollee's OMIP coverage if any of the following occurs:

(1) An enrollee ceases to be an Oregon resident. Termination will become effective at the end of the month in which the enrollee is no longer an Oregon resident as determined by OMIP.

(2) An enrollee reaches 65 years of age or is disabled and becomes eligible for Medicare. OMIP may terminate coverage effective on the date on which the enrollee's coverage under Medicare becomes effective.

(3) An enrollee becomes eligible for and enrolled in a comprehensive health care benefit package under ORS Chapter 414 (Medicaid). OMIP may terminate coverage effective on the date on which the enrollee's coverage under Medicaid becomes effective.

(4) OMIP discovers that a public entity, employer, health care provider, or any other entity has paid or is paying the premiums for the enrollee or reimburses him/her for premium payments for the purpose of reducing its own financial loss or obligation. Termination may take effect the date the public entity or health care provider began paying, or reimbursing the enrollee for, the OMIP premium.

(5) An enrollee is employed by a business with two or more eligible employees as defined by ORS 743.730 and applied for OMIP coverage at the direction of an insurance agent, insurance company, employer or any other entity for the purpose of separating the enrollee from health insurance benefits that the business offers or provides to its employees. Termination may take effect as of the effective date of OMIP coverage.

(6) OMIP discovers that an enrollee had substantially equivalent health care benefits as of the effective date of OMIP coverage. Termination may take effect back to the effective date of OMIP coverage. The enrollee may be responsible for reimbursing OMIP for any claims paid.

(7) OMIP has paid \$2 million in benefits on behalf of an enrollee.

(8) An enrollee becomes an inpatient or inmate at a State of Oregon correctional or mental institution as defined under ORS 179.321. Termination may take effect the date in which the enrollee became an inpatient or inmate.

(9) OMIP discovers that an enrollee made a material misrepresentation, omission on the application or at anytime during his/her

enrollment, used fraudulent statements or misrepresentation, the coverage may terminate back to the effective date of coverage.

(10) An enrollee misuses the provider network by being disruptive, unruly or abusive in a way that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its providers to provide service to that enrollee. Termination may take effect at the end of the month for which the enrollee has paid premium.

(11) An enrolled dependent turns 23 years of age and is not mentally or physically incapacitated. Termination will take effect at the end of the month in which the dependent reached his/her 23rd birthday.

(12) Termination may take effect at the end of the month in which an enrolled dependent under 23 years of age, marries, is no longer an Oregon resident as defined by OMIP, or is no longer a full-time student in an accredited institution of higher education.

(13) Coverage may terminate on the last day of the month for enrolled dependents if the contract holder turns 65 and is eligible for Medicare, or dies.

(14) An enrollee fails to pay the premium by the premium due date. Termination may take effect at the end of the month for which the enrollee has paid premium.

(15) An enrollee may voluntarily request that OMIP terminate coverage at the end of any period during which the enrollee has paid premiums. The enrollee must submit to the Administering Insurer a 30-day advance written notice to terminate.

Stat. Auth.: ORS 735.610(6) & 735.615
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 2-2005, f. 12-30-05, cert. ef. 1-1-06; OMIPB 1-2010, f. & cert. ef. 2-9-10

443-002-0100 Member Suspension and Resumption of Coverage

(1) OMIP will suspend coverage if a member or dependent begins receiving health care benefits under Medicare or Medicaid for reasons other than turning 65 pursuant to ORS Chapter 414.

(2) If OMIP receives a request to suspend coverage as described above, OMIP shall suspend coverage effective at the first of the month in which the OMIP member or dependent began receiving their health care benefits for Medicare or Medicaid.

(a) OMIP will suspend coverage for a maximum of 12 months.

(b) OMIP will not collect premiums from the member or dependent during the period of suspended coverage.

(c) If the member does not request his/her OMIP coverage be suspended when becoming eligible for Medicare or Medicaid for the reasons listed above, OMIP may terminate coverage effective the first of the month in which the member began receiving Medicare or Medicaid benefits.

(d) If the member or dependent loses eligibility for Medicare or Medicaid, the member may request the OMIP coverage to be reinstated. The member must submit a written request to the administering insurer within 63 days of the termination date for the Medicare or Medicaid coverage.

(3) OMIP will suspend coverage if a member or dependent enrolled in OMIP began receiving group health care benefits and requests suspension of coverage in writing to the administering insurer within 30 days after the effective date of the group health care coverage.

(a) OMIP will suspend coverage effective at the first of the month in which the OMIP member or dependent began receiving their group health care benefits.

(b) OMIP will not collect premiums from the member or dependent during the period of suspended coverage.

(c) If the member or dependent loses eligibility for group health care coverage, the member may request their OMIP policy to be reinstated within 63 days of the termination date for the group insurance. The request must be in writing to the administering insurer.

(A) If the member was previously enrolled in an OMIP portability plan they will not be able to resume the previous OMIP portability coverage unless there were no COBRA or portability options available through the previous group insurance.

(B) If the member was enrolled in a portability plan and COBRA and/or portability is available through the previous group carrier and the member is unable to obtain individual health insurance because of his/her health status, the member can apply for an OMIP medical plan within 63 days from the end date of the previous group insurance.

(i) If the member is eligible for a medical plan the member will receive credit toward the six-month waiting period for pre-existing conditions based on the number of months previously covered by the OMIP contract and the number of months the person was covered by the other coverage.

(ii) The amount of the deductible met for the prior suspended coverage will carry over if the OMIP coverage was resumed within the same calendar year as the suspended coverage.

(4) If the member requests resumption of coverage, but OMIP no longer offers the same contract, OMIP will offer coverage available through the most similar current OMIP contract.

(5) A person pursuant to OAR 443-002-0100 for whom coverage was suspended and later resumed will receive credit toward the six-month waiting period for pre-existing conditions based on the number of months previously covered by the OMIP contract and the number of months the person was covered by the other coverage.

Stat. Auth.: ORS 735.610(6) & 735.615
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 1-2008, f. & cert. ef. 1-2-08; OMIPB 7-2008(Temp), f. & cert. ef. 9-29-08 thru 3-27-09; Administrative correction 4-20-09

**443-002-0110
Coordination of Benefits**

(1) In all instances, OMIP is the payer of last resort and any other health care coverage is the primary payer.

(2) The other insurance cannot be Medicaid (Oregon Health Plan/OHP). Enrollees are not eligible for OMIP coverage if they are enrolled or receiving Medicaid benefits.

(3) As the payer of last resort, OMIP may retroactively pursue claim payments that it made as the primary payer.

(4) This rule applies to all claims submitted to OMIP on or after January 1, 2009.

Stat. Auth.: ORS 735.610(6) & 735.625
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 2-2005, f. 12-30-05, cert. ef. 1-1-06; OMIPB 3-2009, f. & cert. ef. 10-5-09

**443-002-0120
Effective Dates**

(1) Effective dates for medical eligible applicants and their eligible dependents that are listed on the application shall be the first day of the month after the Administering Insurer has accepted and approved the application for enrollment.

(2) Effective dates for portability eligible applicants and federal Health Coverage Tax Credit (HCTC) applicants and their eligible dependents that are listed on the application shall be the first day after their previous group health plan ended.

(3) The Administering Insurer will inform applicants of their acceptance for OMIP coverage by sending a premium notice, identification card and policy contract.

(4) If an applicant fails to return the premium when requested, the Administering Insurer will reject the application as if the applicant were never effective or enrolled.

(5) If the Administering Insurer determines that an applicant or dependents of an applicant are not eligible for the program, the Administering Insurer will inform the applicant by sending the applicant a letter explaining the reason for the denial.

Stat. Auth.: ORS 735.610(6) & 735.625
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 2-2005, f. 12-30-05, cert. ef. 1-1-06

**443-002-0130
Enrollment Limitations**

In accordance with ORS 735.625(4)(d), OMIP may establish an enrollment schedule for new monthly enrollments and may establish 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 Administering Insurer 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 Administering Insurer 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 Board shall use the criteria for establishing the limitations and allocations to determine if it must make any modification.

Stat. Auth.: ORS 735.610(6) & 735.625
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05

**443-002-0140
Waiting Lists**

If the number of applications that OMIP approves exceeds the maximum number of policies in force or the monthly allocation, the Board shall close enrollment:

(1) OMIP may approve new applications but it shall not establish the effective date of coverage until openings occur.

(2) OMIP may establish a waiting list and notify applicants as follows:

(a) OMIP shall send a notification letter to the applicants informing them that it has approved their application but, because of enrollment limitations, OMIP has placed them on a waiting list and will notify them when an opening occurs;

(b) If an applicant sent an initial premium payment with the application, OMIP shall return the premium payment with the notification letter.

(3) OMIP shall establish a waiting list in chronological order of applications approved.

Stat. Auth.: ORS 735.610(6) & 735.625
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05

**443-002-0150
Enrollment When Waiting Lists Exist**

As openings occur, OMIP shall give first priority to approved applicants on the waiting lists and enroll them as follows:

(1) As an opening occurs, OMIP shall attempt to contact the next applicant on the waiting list and inform the applicant that there is an opening and that he/she must submit the initial premium payment to receive coverage.

(2) The applicant must submit the premium payment to the Administering Insurer within 15 calendar days from the date of the notice:

(a) If the applicant fails to submit the premium payment within the 15 calendar days, OMIP shall remove the applicant's name from the waiting list;

(b) If the applicant submits 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 735.610(6) & 735.625
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05

**443-002-0160
Enrollment When No Waiting Lists Exist**

(1) When enrollments are below the maximum allocated, priority for enrollment shall be as follows: Eligible applicants shall complete an original application and provide the requested documentation to the Administering Insurer. The Administering Insurer will date stamp the original application for verification of receipt. If the original application is received incomplete, the date stamp on the original application will serve only to indicate the date of receipt of the application. The date the application becomes complete will be used for determining eligibility for enrollment.

(a) The Administering Insurer shall pend for further information for up to 30 days incomplete applications or applications submitted without proper documentation. The Administering Insurer will send a notice to the applicant identifying the missing information or doc-

umentation and give the applicant 30 days to submit the requested information.

(b) Applicants whose applications have been pended and who fail to return the requested information within the 30 day time frame shall be rejected as if the applicant were never effective or enrolled.

(2) The Administering Insurer will process applications on a first come, first enrolled basis. The Administering Insurer has the authority to make exceptions to the application process.

Stat. Auth.: ORS 735.610(6) & 735.625
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05

443-002-0170

Pre-Existing Conditions

(1) A “pre-existing condition” is defined as “a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the insured’s OMIP effective date of coverage.”

(2) With respect to medically eligible applicants and dependents, during the first six months of the policy, OMIP will not pay claims for any condition that is a pre-existing condition.

(3) With respect to medically eligible applicants and dependents, pregnancy is a pre-existing condition and will not be a covered benefit for the first six months of an OMIP policy.

Stat. Auth.: ORS 735.610(6) & 735.625
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05

443-002-0180

Credit Towards the Six-Month Waiting Period for Pre-Existing Conditions

(1) OMIP may reduce the six month wait period for pre-existing conditions for each month of creditable coverage the enrollee had prior to applying to OMIP if:

(a) The enrollee’s application to OMIP was received by OMIP or OMIP’s third party administrator within 63 days from the prior health plan’s termination date; and

(b) The enrollee provided a Certificate of Coverage (COC) document reflecting the enrollee’s name, effective date of coverage, and termination date. In addition, the enrollee included a summary of benefits for the prior health plan, to determine if the plan was creditable.

(2) OMIP may not give credit for benefits, treatments, or services if the enrollee had not satisfied any of the prior health plan’s waiting periods or if the benefit, treatment, or services were excluded by the previous health plan.

Stat. Auth.: ORS 735.610(6) & 735.625
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 2-2009, f. 3-30-09, cert. ef. 4-15-09

443-002-0190

Grievance, Appeals, External Review

If an enrollee believes that a contract, action, or decision of OMIP is incorrect, the enrollee may file a written grievance.

(1) To file a grievance the enrollee must submit a written statement to the Administering Insurer within 180 days from the adverse contract, action, or decision, outlining the issue and any other supporting documentation.

(a) The Administering Insurer will respond to the enrollee within five business days from the date the grievance was received, to acknowledge receipt of the grievance.

(b) The Administering Insurer will send a written decision to the enrollee within 30 calendar days after receiving the grievance. In the event more extensive review is needed, the Administering Insurer will notify the enrollee of the delay and will send a written response to the enrollee within 45 calendar days after receiving the grievance.

(2) If, after filing a grievance, the enrollee is dissatisfied with the Administering Insurer’s response to the grievance, the enrollee may then file an appeal.

(a) The enrollee must file an appeal in writing to the Administering Insurer within 30 calendar days from the date of the written decision of the grievance.

(b) The Administering Insurer will respond to the enrollee within five business days to acknowledge receipt of the appeal.

(c) The Administering Insurer will mail a written decision to the enrollee within 30 calendar days after receiving the appeal.

(3) If the enrollee is dissatisfied with the outcome of the appeal determination, the enrollee may file a second appeal directly to OMIP.

(a) The enrollee must file an appeal in writing directly to OMIP within 30 days from the date of the determination letter regarding the first appeal decision (not grievance) made by the administrating insurer.

(b)(A) OMIP will review the appeal; however, if the dispute is regarding medical necessity, experimental or investigational procedures, or need for continuity of care, OMIP will request an External Review from and Independent Review Organization (I.R.O.) on your behalf.

(B) If OMIP chooses to send an appeal to External Review, it will be considered the final level of appeal. The I.R.O. will make its review and report its decision within 30 calendar yeas (3 days for expedited reviews).

(c) If the appeal is not regarding medical necessity, experimental or investigational procedures, or need for continuity, OMIP will mail a written decision to the enrollee within 30 calendar days after receiving the appeal.

Stat. Auth.: ORS 735.610(6)
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 2-2010(Temp), f. & cert. ef. 9-29-10 thru 3-27-11; OMIP 2-2011, f. & cert. ef. 1-26-11; OMIP 2-2012, f. 1-26-12, cert. ef. 2-6-12