DIVISION 1

PROCEDURAL RULES

442-001-0000
Notice

The Office of Private Health Partnerships will give notice before adoption, amendment or repeal of any permanent rule:

(1) In the Secretary of State's Bulletin referred to in ORS 183.360 at least twenty-one (21) days before the hearing or intended action's effective date;

(2) By mailing copies of the notice to people on the mailing list and publications and organizations listed in policy, at least thirty (30) days prior to the rule's effective date; and

(3) By mailing a notice copy to the legislators specified in ORS 183.335(15) at least 49 days before the rule's effective date.

Stat. Auth.: ORS 183 & 653
Stats. Implemented: ORS 183
Hist.: IP 2-1989(Temp), f. 1-13-89, cert. ef. 1-18-89; IP 4-1989, f. & cert. ef. 9-29-89; IPGB 1-2004, f. & cert. ef. 11-1-04; OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0005
Model Rules of Procedure

In agreement with the provisions of ORS 183.341, OPHP adopts the entire Attorney General's Model Rules of Procedure under the Administrative Procedures Act effective January 1, 2008.

[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 Insurance Pool Governing Board.]

Stat. Auth.: ORS 183, 653.735 & 653.835
Stats. Implemented: ORS 183
Hist.: IP 1-1989, f. & cert. ef. 1-13-89; IPGB 1-1998, f. 2-18-98, cert. ef. 3-1-98; IPGB 1-2004, f. & cert. ef. 11-1-04; OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0050
Statement of Purpose and Statutory Authority

OARs 442-001-0050 through 442-001-0160 are adopted to carry out ORS 735.711 Criminal Records Checks (CRC), for the purpose of checking criminal history in Oregon or anywhere in the United States under 181.534.

Stat. Auth. ORS 735.707
Stats. Implemented: ORS 735.700 - 735.714
Hist.: OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0060
Definitions

(1) "Criminal Records Check (CRC)" means one of the following three processes used to check a subject individual's criminal history:

(a) Law Enforcement Data Systems (LEDS) uses names to check criminal offender information using the rules and procedures created by the Oregon Department of State Police (ODSP);

(b) An Oregon Criminal Records Check uses fingerprint identification to check criminal offender information in Oregon. Fingerprinting is done by ODSP; or

(c) A Nationwide Criminal Records Check uses fingerprint identification to check records for national criminal offender information. The Oregon Department of State Police does the fingerprinting. The Federal Bureau of Investigation does the search.

(2) "Fitness Determination" is the process used to find out if a subject individual is or is not fit to be an Office employee, volunteer, contractor, or vendor as described in OAR 442-001-0070.

(3) "Office" is the Office of Private Health Partnerships or any program within the agency.

(4) "Subject Individual" is described in OAR 442-001-0070.

Stat. Auth. ORS 735.707
Stats. Implemented: ORS 735.700 - 735.714
Hist.: OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0070
Subject Individual

A subject individual is a person who:

(1) Works or is applying to work for the Office;

(2) Provides a service to the Office as a:

(a) Volunteer;

(b) Contractor; or

(c) Vendor; or

(3) Has or will have access to confidential information based on state or federal laws or rules as described in the OPHP Internal Operating Policy "Criminal Records Check."

Stat. Auth. ORS 735.707
Stats. Implemented: ORS 735.700 - 735.714
Hist.: OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0080
Criminal Records Check Required

The Office may perform, or request ODSP to perform a CRC when:

(1) A person meets the definition of subject individual as described in OAR 442-001-0070; or

(2) It is required by federal law, state or administrative rule, or by contract or written agreement with the Office.

Stat. Auth. ORS 735.707
Stats. Implemented: ORS 735.700 - 735.714
Hist.: OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0090
Criminal Records Check Process

The written CRC process, along with the Internal Operating Policy, can be found in the Agency Resources section of the Office's Procedure Manual.

Stat. Auth. ORS 735.707
Stats. Implemented: ORS 735.700 - 735.714
Hist.: OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0100
Potentially Disqualifying Crimes

(1) A guilty verdict may disqualify a subject individual from being hired or promoted within the Office or being allowed to provide services to the Office as a volunteer, contractor or vendor.

(2) Crimes Relevant to a Fitness Determination include:

(a) All felonies;

(b) All misdemeanors; and

(c) Any Federal crime, United States Military crime or international crime.

(3) Assigned Office staff will review each crime identified in a CRC based on:

(a) Oregon law;

(b) Federal law; or

(c) The laws of any other area that are valid and in effect at the time of the fitness determination.

(4) At no time will a subject individual be denied under these rules because of a juvenile record that has been sealed or deleted in agreement with ORS 419A.260 and 419A.262.

Stat. Auth. ORS 735.707
Stats. Implemented: ORS 735.700 - 735.714
Hist.: OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0110
Final Fitness Determination

(1) If the Office decides to conduct a CRC, three factors will be considered in making a final fitness determination:

(a) Information given to the Office by the subject individual;

(b) Information received as a result of the CRC; and

(c) Any false statements made by the subject individual and found during the fitness determination process.

(2) When considering these factors, the Office may ask for other information from the subject individual or any other source inside or outside Oregon, including:

(a) Law enforcement;

(b) Criminal justice agencies; or

(c) Courts.

(3) To get other criminal offender information from the subject individual, the Office may request:

(a) To meet with the person;

(b) Written materials from the person; or

(c) Authorization from the person to get related information from other sources.

(4) If requested, the subject individual must meet with or provide the requested information to the Office within a reasonable period of time as determined by the Office. The Office will use this information to:

(a) Consider special circumstances about the nature of a crime. Special circumstances are defined in the OPHP Internal Operating Policy "Criminal Records Check."

(b) Evaluate any crime. During this review the Office will consider:

(A) The nature of the crime;

(B) Facts that support the conviction or pending charge or possible false statement; and

(C) If there is one, the connection of the crime or false statement to the specific requirements of the subject individual's current or future job, services, or general employment.

(c) Consider other facts related to the subject individual's job or services' responsibilities. "Other facts" are defined in the OPHP Internal Operating Policy, "Criminal Records Check".

(5) If a subject individual refuses to consent to a CRC, including fingerprint identification, the Office will not:

(a) Promote;

(b) Hire; or

(c) Allow the person the right to provide services. The person may not appeal this decision if it was made based on a refusal to consent to the CRC.

(6) If a subject individual is determined unfit, the Office will not:

(a) Hire;

(b) Promote; or

(c) Allow the person to provide services as a:

(A) Volunteer;

(B) Contractor; or

(C) Vendor in a position described in the OPHP Internal Operating Policy "Criminal Records Check."

(7) A completed fitness determination is a final order of the Office unless the subject individual requests:

(a) A contested case hearing as provided by OAR 442-001-0130(2); or

(b) An alternative appeals process as provided by OAR 442-001-0130(8).

(8) The Office will inform the subject individual determined unfit because of a CRC, of its decision, by:

(a) Personal service; or

(b) Registered or certified mail to the most current address provided by the subject individual.

Stat. Auth. ORS 735.707
Stats. Implemented: ORS 735.700 - 735.714
Hist.: OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0120
Incomplete Fitness Determination

(1) The department will consider a fitness determination incomplete and close it when:

(a) Circumstances change and a person no longer meets the definition of a "subject individual" under OAR 442-001-0070;

(b) The subject individual does not provide materials or information described in agency policy and procedure under OAR 442-001-0090 within the rule time frames;

(c) The department cannot locate or contact the subject individual;

(d) The subject individual fails or refuses to cooperate with the department's attempts to acquire other relevant information described in agency policy and procedure under OAR 442-001-0090;

(e) The department determines that the subject individual is ineligible or unqualified for the position for a reason unrelated to the fitness determination process; or

(f) The position is no longer open.

(2) A subject individual does not have a right to challenge a fitness determination closing because it's incomplete using:

(a) A contested case hearing under OAR 442-001-0130(2); or

(b) An alternate appeals process under OAR 442-001-0130(8).

Stat. Auth. ORS 735.707
Stats. Implemented: ORS 735.700 - 735.714
Hist.: OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0130
Contesting a Fitness Determination

The contested case hearing process describing how a subject individual may appeal a fitness determination made under OAR 442-007-0110 is outlined in agency policy and procedure.

(1) The Attorney General's Model Rules of Procedure, OAR 137-003-0001 through 137-003-0092, apply unless the Office refers the matter to the Office of Administrative Hearings to assign an Administrative Law Judge. If the Office refers the matter to the Office of Administrative Hearings, 137-003-0501 through 137-003-0700 will apply.

(2) A subject individual who is currently an Office employee and is denied as unfit because of a final fitness determination may appeal the fitness determination either:

(a) Under this rule's contested case process; or

(b) Through applicable personnel rules and policy processes.

(3) A subject individual's decision to appeal a fitness determination using applicable personnel rules and policies waives the right to a contested case hearing.

(4) The only decision that may be made is whether or not the subject individual is fit or unfit. The office will not be required to place a subject individual in any position, nor accept services from or enter into a contractual agreement with a subject individual under any circumstance.

(5) A subject individual may not use the appeals process established by this rule to challenge the accuracy or completeness of information provided by:

(a) The Oregon Department of State Police;

(b) The Federal Bureau of Investigation, or

(c) Agencies reporting information to the Oregon Department of State Police or the Federal Bureau of Investigation.

(6) A subject individual may use any process made available by the agency providing the information to challenge the accuracy or completeness of information identified in this section.

(7) The Office's hiring process or employment decisions will not be delayed by:

(a) Appealing a fitness determination;

(b) Challenging criminal offender information with the agency providing the information; or

(c) Requesting a new criminal records check and re-evaluation of the original fitness determination.

Stat. Auth. ORS 735.707
Stats. Implemented: ORS 735.700 - 735.714
Hist.: OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0140
Agency Representation

(1) The Administrator may designate an agency manager or employee to appear on behalf of the Office in contested case hearings conducted based on these rules.

(2) Office managers, employees, or other authorized personnel may not present legal argument as defined under OAR 137-003-0008 on behalf of the Office in contested case hearings that are conducted based on these rules.

(3) When the Office decides it is necessary to consult with the Attorney General's office, the hearings officer will provide a reasonable period of time for an agency representative to do so in order to obtain either written or oral legal argument or advice, if needed.

Stat. Auth. ORS 735.707
Stats. Implemented: ORS 735.700 - 735.714
Hist.: OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0150
Record Keeping, Confidentiality

(1) Any information obtained in the criminal records check is confidential.

(2) The Office must restrict giving out information obtained in the criminal records check. Only people identified by the agency, with a valid need to know the information, may have access to criminal records check documents.

Stat. Auth. ORS 735.707
Stats. Implemented: ORS 735.700 - 735.714
Hist.: OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

442-001-0160
Fees

The agency may charge a fee for getting criminal offender information used in making a fitness determination.

(1) The fee will not exceed the fee(s) charged the department by the Oregon Department of State Police and the Federal Bureau of Investigation to get criminal offender information on the subject individual.

(2) The agency may charge the subject individual the fee; or

(3) If the subject individual is an employee of an Office contractor and is undergoing a fitness determination in that capacity, the agency may charge the subject individual's employer for the fee.

Stat. Auth. ORS 735.707
Stats. Implemented: ORS 735.700 - 735.714
Hist.: OPHP 4-2008, f. 12-31-08, cert. ef. 1-1-09

DIVISION 5

THE FAMILY HEALTH INSURANCE ASSISTANCE PROGRAM

442-005-0000
Purpose and Statutory Authority

(1) OAR 442-005-0000 to 442-005-0350 are adopted to carry out the purpose of ORS 735.720 to 735.740, establishing within the Office of Private Health Partnerships a Family Health Insurance Assistance Program for Oregon residents who earn up to 185 percent of the federal poverty level.

(2) OAR 442-005-0000 to 442-005-0350 are adopted pursuant to the general authority of the Office of Private Health Partnerships under ORS 735.734 and the specific authority in ORS 735.720 to 735.740.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0010
Definitions

(1) "Alien Status Requirement." A qualified non-citizen meets the alien status requirement for FHIAP if the individual is one of the following:

(a) A person who was admitted as a qualified non-citizen on or before August 22, 1996;

(b) A person who entered the U.S. on or after August 22, 1996 and it has been five years since he or she became a qualified non-citizen;

(c) A person who has obtained their qualified non-citizen status less than five years ago, but entered the U.S. prior to August 22, 1996. The non-citizen must show that he or she has been living in the U.S. continuously for five years from a date prior to August 22, 1996 to the date the non-citizen obtained their qualified status and did not leave during that five year period. If the non-citizen cannot establish the five-year continuous residence before he or she obtained their qualified status, the person is not considered to have entered the U.S. prior to August 22, 1996;

(d) Regardless when they were admitted, a person with one of the following designated statuses:

(A) A person who is admitted as a refugee under section 207 of the INA;

(B) A person who is granted asylum under section 208 of the INA;

(C) A person whose deportation is being withheld under section 243(h) of the INA;

(D) A Cuban or Haitian entrant who is either a public interest or humanitarian parolee;

(E) A person who was granted immigration status according to the Foreign Operations Export Financing and Related Program Appropriation Act of 1988;

(F) A person who is a victim of a severe form of trafficking.

(e) Regardless of when they were admitted, a qualified non-citizen who is:

(A) A veteran of the U.S. Armed Forces, who was honorably discharged not on account of alien status and who fulfills the minimum active-duty service requirement; or

(B) On active duty in the U.S. Armed Forces (other than active duty for training);

(C) The spouse or unmarried dependent child of the veteran or person on active duty described in (e)(A) and (B).

(f) An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (8 U.S.C. 1359) apply; or

(g) A member of an Indian tribe (as described in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e));

(h) Any legal non-citizen who was approved for a FHIAP subsidy prior to November 1, 2004.

(2) "Appeal" means the opportunity for an applicant to request and receive administrative review by Office staff of a decision made or action taken by the Third Party Administrator (TPA) or state office regarding program eligibility, subsidy level, termination, re-enrollment, overpayments, misrepresentation, or any other decision adverse to the applicant (ref. 442-005-0320).

(3) "Applicant" means a person who has initially applied or a member who is applying for continuation of FHIAP subsidy payments, but who has not yet been determined to be eligible to receive such subsidy or continued subsidy. "Applicant" also includes dependents as defined in OAR 442-005-0010(7).

(4) "Benchmark" means an identified minimum level of health insurance benefits qualifying for subsidy eligibility. The benchmark is established by the Office in consultation with the Health Insurance Reform Advisory Committee and is submitted to and approved by the federal government.

(5) "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services that authorizes the transaction of health insurance. Carrier also includes the Oregon Medical Insurance Pool established under ORS 735.610.

(6) "Certified carrier" means a carrier that has been certified by the Office to participate in FHIAP. Certified carrier also includes the Oregon Medical Insurance Pool established under ORS 735.610.

(7) "Citizen" for the purposes of FHIAP means a native or naturalized member of the United States who can show proof of identity and citizenship as required in the Deficit Reduction Act (DRA) of 2005 (Pub. L. No. 109–171).

(8) "Dependent" for the purposes of FHIAP may include:

(a) An applicant's spouse, but not when deemed separated pursuant to OAR 442-005-0050(4) or 442-005-0070(5)(c);

(b) All of the applicant's and applicant's spouse's unmarried children, step children,-legally adopted children or children placed under the legal guardianship of the applicant or applicant's spouse who are under the age of 23 and reside with the applicant, and all dependent children of a dependent child;

(c) An unborn child of any applicant or applicant's dependent as verified by written correspondence from a licensed medical practitioner;

(d) An elderly relative or an adult disabled child, regardless of age, who lives in the home of the applicant, may be included as a dependent:

(A) For the purpose of FHIAP administration as it relates to ORS 735.720(3)(b), dependent elderly relative means any person 55 and older.

(B) For the purpose of FHIAP administration as it relates to ORS 735.720(3)(b) adult disabled child means:

(i) A child of the applicant or applicant's spouse who is unmarried, a step child, a legally adopted child, or a child placed under the legal guardianship of the applicant or applicant's spouse who is over the age of 18 and resides with the applicant; and

(ii) A child who is disabled with a physical or mental impairment that:

(I) Is likely to continue without substantial improvement for no less than 12 months or to result in death; and

(II) Prevents performance of substantially all the ordinary duties of occupations in which a person not having the physical or mental impairment is capable of engaging, having due regard to the training, experience and circumstances of the individual with the physical or mental impairment.

(9) "Federal poverty level" means the poverty income guidelines as defined by the United States Department of Health and Human Services. These guidelines will be adopted by FHIAP no later than May 1 each year.

(10) "FHIAP" means the Family Health Insurance Assistance Program established by ORS 735.720 to 735.740.

(11) "Group" means insurance offered through an employer or an association.

(12) "Health insurance producer" means a person who holds a current, valid license pursuant to ORS 774.052 to 774.089 as an insurance producer, where such producer is authorized to transact health insurance.

(13) "Incarcerated" means a person living in a correctional facility, such as:

(a) Individuals who are legally confined to a correctional facility such as jail, prison, penitentiary, or juvenile detention center; or

(b) Individuals temporarily released from a correctional facility to perform court-imposed community service work; or

(c) Individuals on leave of less than 30 days from a correctional facility; or

(d) Individuals released from a correctional facility for the sole purpose of obtaining medical care.

(14) "Income" includes, but is not limited to, earned and unearned gross income received by adults and unearned income received by children. Income includes bartering, or working in exchange for goods and services, discounts on goods and services, working in exchange for rent, and payments made for personal living expenses from business funds:

(a) For purposes of determining average monthly income, an applicant may deduct child or spousal support payments made by the applicant for a child or spouse that FHIAP does not consider a dependent. No deduction is allowed for support that is owed but not paid and collected through an offset against the applicant's state income tax refund;

(b) Income does not include educational grants or scholarships.

(15) "Investments and savings" include, but are not limited to: cash, checking accounts, savings accounts, time certificates, stocks, bonds, non-retirement qualified annuities, other securities easily converted to cash, and the tax-assessed value, as indicated by the county assessor, of any real property. Any of the above investments and savings that are owned by or in which a beneficial interest is held by the applicant or any member of the applicant's family will be considered investments and savings of the applicant:

(a) "Investments and savings" does not include one piece of real property maintained by the applicant or the applicant's family as a primary residence. If the applicant or applicant's family maintain multiple residences or own real property as residential rentals, those properties (other than one single primary residence) are included within the definition of "investments and savings;"

(b) "Investments and savings" excludes 529 Educational Savings Plans and qualified retirement accounts, including but not limited to IRAs and 401(k) plans.

(16) "Medicaid," see OHP.

(17) "Medicare" means coverage under either parts A or B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et. seq., as amended.

(18) "Member" means a person approved for FHIAP and enrolled in a health insurance plan using the subsidy, or a Homecare Union Benefits Board (HUBB) applicant enrolled in a health benefit plan and approved for, but not yet enrolled in FHIAP.

(19) "Misrepresentation" means making an inaccurate or deliberately false statement of material fact, by word, action, or omission.

(20) "OHP" means the Oregon Health Plan Medicaid program and all programs that include medical assistance provided under 42 U.S.C. section 396a (section 1902 of the Social Security Act).

(21) "Overpayment" means any subsidy payment made that exceeds the amount a member is eligible for, and has been received by, or on behalf of, that member, as well as any civil penalty assessed by the Office.

(22) "Qualified non-citizen" for the purposes of FHIAP. A person is a "qualified non-citizen" if he or she is any of the following:

(a) A non-citizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (8 U.S.C. 1101 et seq);

(b) A refugee who is admitted to the United States as a refugee under section 207 of the INA (8 U.S.C. 1157);

(c) A non-citizen who is granted asylum under section 208 of the INA (8 U.S.C. 1158);

(d) A non-citizen whose deportation is being withheld under section 243(h) of the INA (8 U.S.C. 1523(h)) (as in effect immediately before April 1, 1997) or section 241(b)(3) of the INA (8 U.S.C. 251(b)(3) (as amended by section 305(a) of division C of the Omnibus Consolidated Appropriations Act of 1997, Pub. L. No. 104-208, 110 Stat. 3009-597 (1996));

(e) A non-citizen who is paroled into the United States under section 212(d)(5) of the INA (8 U.S.C. 1182(d)(5)) for a period of at least one year;

(f) A non-citizen who is granted conditional entry pursuant to section 203(a)(7) of the INA (8 U.S.C. 1153(a)(7)) as in effect prior to April 1, 1980;

(g) A non-citizen who is a "Cuban and Haitian entrant" (as defined in section 501(3) of the Refugee Education Assistance Act of 1980);

(h) A battered spouse or dependent child who meets the requirements of 8 U.S.C. 1641(c) and is in the United States on a conditional resident status, as determined by the United States Immigration and Naturalization Service;

(i) American Indians born in Canada to whom the provision of section 289 of the INA (8 U.S.C. 1359) apply;

(j) Members of an Indian tribe, as defined in section 4(e) of the Indian Self-Determination and Education Act (25 U.S.C. 450b(e));

(k) A veteran of the U.S. Armed Forces who was honorably discharged for reasons other than alien status and who fulfilled the minimum active-duty requirements described in 38 U.S.C. 5303A(d);

(l) A member of the U.S. Armed Forces on active duty (other than active duty for training);

(m) The spouse or dependent child of a person described in either (k) or (l) above;

(n) A legal non-citizen approved for FHIAP subsidy prior to November 1, 2004.

(23) "Reapplication" means the periodic review and determination of a member's continued eligibility or subsidy level.

(24) "Reservation list" means a list of potential applicants for FHIAP, entered onto a register maintained by the TPA or state office as authorized by ORS 735.724.

(25) "Resident" means a citizen or qualified non-citizen who resides in Oregon or a full-time college student who is a citizen or qualified non-citizen with a parent who resides in Oregon.

(26) "Self-employment" means gross receipts received from a business owned, in whole or in part, by a FHIAP applicant or dependent if the gross receipts are reported on an Internal Revenue Service (IRS) Schedule C or 1099. Self employed income also includes income received for providing adult foster care if the recipient of the care lives in the applicant's home. Self-employment does not include income received from a partnership, S-corporation, C-corporation, or adult foster care if the care is not provided in the caregiver's home. Self-employment does not include income received from a Limited Liability Company except in the following situations:

(a) If an applicant or their dependent have income from a Limited Liability Company and file an IRS schedule C for said income, that income will be treated as self-employment and subject to business deductions;

(b) If an applicant or their dependent have income from a Limited Liability Company and file an IRS schedule F or J for said income, that income will be treated as Farming, Fishing or Ranching and subject to business deductions.

(27) "Support" means any court-ordered monetary payment for a child or former spouse or domestic partner whom FHIAP does not count in the applicant's family.

(28) "Voluntary payroll deduction" means an amount the employee has authorized the employer to deduct from the employee's income to pay expenses not required by law.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 735.724, 735-734 & 735.720 - 735.740

Stats. Implemented: ORS 735.720 - 735.740

Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06; OPHP 2-2007, f. 6-18-07, cert. ef. 7-9-07

442-005-0020
Reservation Lists

(1) To manage enrollment and ensure that funds are available to cover subsidy payments for those enrolled, two reservation lists will be established and maintained for FHIAP. One list will be for prospective applicants who have or will have access to group health benefit coverage. One list will be for prospective applicants who do not have access to group health benefit coverage.

(2) The Office will establish procedures to manage the reservation lists with the goal of equal distribution of funds between the group health benefit market and the individual health benefit market. This may require FHIAP to release applications from one reservation list ahead of the other.

(3) An applicant may obtain an individual or group application by first getting on the reservation list; or may access a group application via FHIAP's website; or from an employer or insurance producer.

(4) Prospective applicants will be added to the appropriate reservation list or assigned a reservation number in order of the date FHIAP receives a completed reservation request either in writing or over the telephone. A completed application form may be deemed a reservation request if no prior request was made.

(5) Each request will be assigned a reservation number, which will also function as confirmation of placement on the appropriate reservation list.

(6) Prospective applicants on the reservation list will be notified of their right to apply for FHIAP, as program funds are available.

(7) When enrollment in FHIAP reaches the maximum that funding will allow, additional enrollment may occur as current members terminate or if additional program funding becomes available.

(8) A prospective applicant has 75 calendar days from the date the Office mails the application form, or notifies the prospective applicant that they may apply for a FHIAP subsidy, to return a completed application form to the Office. If the Office does not receive a completed application form postmarked within 60 calendar days from the date it mails the application form, or notifies the applicant, the Office will mail a notice to the prospective applicant reminding them to complete and submit the application form.

(9) If a prospective applicant does not return an application form within 75 calendar days from the original date of mailing or notification, the Office will remove the prospective applicant's name from the reservation list.

(10) A prospective applicant may enroll in a health benefit plan while on the reservation list as long as they have met the six-month period of uninsurance requirement or exceptions to the period of uninsurance requirement prior to enrolling in the plan.

(11) FHIAP applicants may add new dependents to an existing insurance plan or their FHIAP application without adding them to the reservation list first.

(12) Members who have terminated from FHIAP cannot re-enroll in the program without first being placed on the appropriate reservation list unless they have a family member who is still enrolled in FHIAP.

Stat. Auth.: ORS 735.734, 735.722(2) & 735.728(2)

Stats. Implemented: ORS 735.720 - 735.740

Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0030
Application Process

(1) An application form developed by the Office, and any documentation required on the form, will be used to determine eligibility and subsidy level.

(2) The Office will establish procedures for the application process with the goal of more equally distributing funds between the group health benefit market and the individual health benefit market. This may require the Office to release applications from one reservation list ahead of the other.

(3) The application process is the only time when applicants may submit information proving their program eligibility. Information not submitted during this process will not be accepted for purposes of audit, appeal or contested case hearing except as provided in OARs 442-005-0310, 442-005-0320, 442-005-0330 and 442-005-0340.

(4) As program funds are available, prospective applicants on a reservation list are notified in writing of their eligibility to apply for FHIAP. An application form is included with the notice.

(5) Once the completed application is received, FHIAP will take action on it. Action may be approval, denial or a request for further information from the applicant.

(6) FHIAP may screen applications for FHIAP for potential eligibility for OHP. If FHIAP discovers that such potential eligibility exists, FHIAP will advise the applicant in writing of this possibility.

(7) Documents that verify required information requested on the application must be provided with the application if FHIAP is not able to verify the information electronically. Required documentation includes but is not limited to:

(a) A copy of a current Oregon identification or other proof of Oregon residency for all adult applicants;

(b) For non-United States citizens, a copy of documentation from INS showing their status and when they arrived in the United States.

(c) Documents verifying all adult applicant's and spouse's earned and unearned income and children's unearned income for the three months prior to the month in which the application is signed. Documentation may include, but is not limited to, pay stubs, award letters, support printouts and unemployment benefit stubs or printouts;

(d) A completed Self-Employment Income Worksheet and documents verifying income from self-employment for the six months prior to the signature date on the application, if applicable. Documentation may include, but is not limited to, business ledgers, profit and loss statements and bank statements;

(e) A completed Farming, Ranching and Fishing Income Worksheet and documents verifying income from farming, fishing and ranching for the 12 months prior to the signature date on the application, if applicable. Documentation may include, but is not limited to, business ledgers, profit and loss statements and bank statements;

(f) The most recently filed federal tax return and all schedules for applicants who have income from self-employment or farming, fishing or ranching.

(g) A copy of any group insurance handbook, summary, or contract that is available to any applicant.

(h) A completed Group Insurance Information (GII) form, if the applicant has group insurance available to them.

(i) For applicants with no income, the completed No Income form or other signed statement explaining how the applicant is meeting their basic needs, such as food, clothing and shelter.

(8) Additional verification must be provided when FHIAP requests it.

(9) FHIAP may verify any factors affecting eligibility, benefit levels or any information reported, such as:

(a) Data received by FHIAP that is inconsistent with information on the FHIAP application.

(b) Information provided on the application is inconsistent;

(c) Other information received by FHIAP is inconsistent with information on the FHIAP application;

(d) Information reported on previous applications is inconsistent with a current FHIAP application.

(10) FHIAP may decide at any time during the application process that additional eligibility factors must be verified.

(11) FHIAP may deny an application or end ongoing subsidy when acceptable verification or required documentation is not provided.

Stat. Auth.: ORS 735.734, 735.722(2) & 735.728(2)
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0040
Pending Applications

(1) Whenever additional information is requested by FHIAP during the application process the application will be placed in a "pend" status.

(2) Whenever further information is requested by FHIAP during the application process, the applicant has 45 calendar days from the date on the request to provide the additional information. If the information requested by FHIAP is not rpostmarked within 30 calendar days from the date on the request, the Office will mail a "15-day notice" to the applicant advising that only 15 days remain in which to provide the additional information.

(3) If an applicant does not provide all requested information within 45 days of the initial request, the application will be denied.

(4) Once an applicant has been denied because the applicant failed to respond to the request for further information, the applicant must make a new reservation request to FHIAP to be sent an application in the future. Their name may be placed on the reservation list in the manner prescribed in OAR 442-005-0020.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0050
Eligibility

In order for an applicant to qualify for a FHIAP subsidy, applicants must:

(1) Be a resident of Oregon or a full-time college student with a parent who is a resident of Oregon.

(2) Be a United States citizen or a qualified non-citizen who meets the alien status requirement.

(3) Not be eligible for or receiving Medicare benefits.

(4) Have investments and savings that are available of no more than $10,000 on the last day of the month prior to the month the application is signed. Investments and Savings are not available if owned by or a beneficial interest in them is held by a separated spouse. FHIAP will determine when an applicant's spouse is deemed separated for the purposes of this subsection (4).

(5) Have income of less than 185% of the Federal Poverty Level in effect at the time of determination. Income determination is outlined in OAR 442-005-0070.

(6) Meet one of the statutory definitions of family in ORS 735.720(2) at the time of eligibility determination. To be included in the family size for FHIAP eligibility determination, the applicant's family members must meet the definition of dependent under OAR 442-005-0010(8):

(a) A dependent may be counted in two separate households for the purposes of determining eligibility for FHIAP and any other state assistance program;

(b) A dependent may be counted in two separate households for the purpose of determining eligibility for both families in FHIAP;

(c) A dependent may not be enrolled in FHIAP and OHP (or any other state medical assistance program) at the same time;

(d) A dependent may be enrolled in FHIAP and any other state assistance program (except medical) at the same time;

(e) If a dependent is counted in two separate households for the purpose of determining eligibility in two different assistance programs, enrollment will be determined by criteria established in procedure.

(7) Meet either a period of uninsurance requirement or exceptions listed in OAR 442-005-0060.

(8) Not be incarcerated for more than 30 days or be a ward of the State.

(9) Provide necessary materials in order to allow for eligibility determination. If information submitted is inconsistent, and applicant may be denied.

(10) If applying for subsidy in the group market, must be able to enroll in a group insurance plan that meets the benchmark standard established by the Office within twelve months of eligibility determination. If an applicant to the group market does not have access to a group plan, the group plan they have access to does not meet the benchmark standard, or they cannot enroll into their group plan within twelve months of eligibility determination, the applicant will be denied and placed on the reservation list for an individual subsidy using the same date they were placed on the group reservation list.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06; IPGB 3-2006(Temp), f. & cert. ef. 11-27-06 thru 5-25-07; Administrative Correction, 6-16-07; OPHP 1-2007, f. & cert. ef. 6-18-07

442-005-0060
Period of Uninsurance Requirement

In order for an applicant to be eligible for a FHIAP subsidy, an applicant must have been without any health insurance coverage for six months immediately prior to either the signature date on the application, the date of eligibility determination, or any reservation entry date. This requirement does not apply if any applicant:

(1) Is currently enrolled in the OHP.

(2) Was enrolled in the OHP within the last 120 days.

(3) Is a former FHIAP member.

(4) Has enrolled in an insurance plan while on the reservation list as long as they have met the six-month period of uninsurance immediately prior to enrolling in the insurance plan.

(5) Has coverage through the Kaiser Child Health Program or any benefit plan authorized by ORS 735.700–735.714.

(6) Has a military insurance plan.

(7) Has enrolled in group coverage within the 120 days prior to getting on the FHIAP reservation list, as long as the applicant had been without any insurance coverage for six consecutive months immediately prior to becoming insured under the group plan.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0070
Income Determination

In order to qualify for FHIAP, an applicant must have average monthly gross income, from all sources, of up to 185 percent of the federal poverty level in effect at the time of determination. Subsidies will be approved on a sliding scale determined by income and family size.

(1) Average income from all sources, except income received from farming, fishing, ranching, or self-employment, will be determined using income received in the three-calendar months prior to the month in which the application was signed.

(2) FHIAP will determine if income received is considered farming, fishing or ranching by whether the income is reported on an IRS schedule F or J form. FHIAP will determine average income from farming, fishing or ranching by using gross receipts for the 12 months prior to the month the application was signed less deductions by either method (a or b) below. Average adjusted income will be determined by either method below (a or b) as specified by the applicant on the Farming, Ranching and Fishing Income Worksheet. Whichever method the applicant chooses to use will be the method used throughout that year's eligibility determination, including appeal and contested case hearing processes.

(3) FHIAP will determine if the applicant or applicant's spouse meets the definition of self-employment. Upon meeting the definition of self-employment, the average monthly gross receipts from self-employment and prior to FHIAP deductions will be determined using gross receipts received from the self-employed business during the six months prior to the month in which the application was signed. If the average gross monthly self-employment income during the six months prior to the month the application was signed exceeds $10,000.00, the applicant will be ineligible for FHIAP. Average adjusted income will be determined by either method below (a or b) as specified by the applicant on the Self-Employment Worksheet. Whichever method the applicant chooses to use will be the method used throughout that year's eligibility determination, including appeal and contested case hearing processes.

(a) Income received from farming, fishing, ranching and self-employment will be reduced by 50 percent for business expenses; or

(b) Income received from farming, fishing, ranching and self-employment will be reduced by the actual allowable expenses incurred during the six or twelve months prior to the date the application was signed.

(A) The following are considered allowable expenses:

(i) Labor (wages paid to an employee or work contracted out) except when paid to the applicant, anyone in the applicant's family, or a business partner.

(ii) Raw materials, equipment, machinery or other durable goods used to make a product or provide a service, excluding personal vehicles and real property. FHIAP will determine whether a vehicle is considered a personal vehicle based upon information submitted by the applicant and information obtained from the Department of Motor Vehicles.

(iii) Interest paid to purchase income-producing property, such as equipment or capital assets.

(iv) Insurance premiums, taxes, assessments, and utilities paid on income-producing property.

(v) Service, repair, and rental of business equipment (including motor vehicles) and property that is owned, leased or rented, excluding personal vehicles. FHIAP will determine whether a vehicle is considered a personal vehicle based upon information submitted by the applicant and information obtained from the Department of Motor Vehicles.

(vi) Advertisements and business supplies.

(vii) Licenses, permits, legal, or professional fees.

(viii) Transportation costs at 20 cents per mile, if the cost is part of the business expense. Commuting expenses to and from the worksite are not considered part of the business expense. If applicant is able to prove actual expenses for fuel and maintenance on business vehicles, those amounts can be deducted in lieu of the mileage calculation. In no instance will both deductions be allowed.

(ix) Charges for telephone services that can be verified as a necessary expense for self-employment.

(x) One-third (33.3%) of utility costs when the business shares a physical address with the applicant's residence.

(xi) Costs related to traveling to another area only when there is a reasonable possibility of deriving income from the trip, except for the cost of meals.

(xii) Business related bank and credit card fees.

(xiii) Bad debt.

(B) The following are not allowed as costs of producing self-employment income:

(i) Meals for the applicant or their family.

(ii) Payments on the principal of the purchase price of income-producing real estate.

(iii) Federal, state, and local income taxes, draws, or salaries paid to any family member, money set aside for personal retirement, and other work-related personal expenses (such as transportation, personal business, and entertainment expenses).

(iv) Depreciation.

(v) Costs related to traveling to another area when there is no reasonable possibility of deriving income from the trip.

(vi) Interest paid on credit card accounts.

(vii) Personal telephone charges.

(viii) Interest or principal payments on a mortgage when the business shares an address with the applicant's residence.

(ix) Rental payments for real property when the business shares a physical address with the applicant's residence.

(x) Losses incurred by another business.

(4) Income is available immediately upon receipt, or when the applicant has a legal interest in the income and the legal ability to make the income available, except in the following situations when it is considered available as indicated:

(a) For earned and unearned income:

(A) Income available prior to any deductions such as garnishments, taxes, payroll deductions, or voluntary payroll deductions will be considered as available; however, support payments as defined in OAR 442-005-0010(34) may be deducted from gross income if the applicant is able to prove the payments were made.

(B) Income usually paid monthly or on some other regular schedule, but paid early or late is treated as available on the regular payday.

(C) Payments made in a "lump-sum" will be divided out over the number of months the payment is for. "Lump sum" payments will only be divided if the applicant can provide proof of the period for which the payment was made.

(b) Earned income is available as follows:

(A) Income withheld or diverted at the request of an employee is considered available in the month the wages would have been paid;

(B) An advance or draw that will be subtracted from later wages is available when received.

(c) Payments that should legally be made directly to an applicant, but are paid to a third party on behalf of an applicant, are considered available the date that is on the check or stub.

(5) Income is not available if:

(a) The wages are withheld by an employer, with the exception of garnishment, even if in violation of the law;

(b) The income is paid jointly to the applicant and other individuals and the other individuals do not pay the applicant his/her share.

(c) It is received by a separated spouse. FHIAP will determine when an applicant's spouse is deemed separated for purposes of this subsection (5)(c).

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0080
Additional Eligibility Requirements in the Group Market

(1) Applicants on the group reservation list will be approved for a FHIAP subsidy only if a group plan that meets the benchmark standard is available to them or someone in their family at the time of application, even if enrollment in the plan is not immediate.

(2) If an applicant is sent an application based on availability of group insurance and does not have a group plan available to them or anyone in their family within 12 months of application, the application will be denied. The applicant will automatically be placed on the individual reservation list using the same date they were placed on the group reservation list.

(3) If an applicant on the group reservation list has access to a group insurance plan, but it does not meet the benchmark, the application will be denied and the applicant will be placed on the individual reservation list using the same date they were placed on the group reservation list.

(4) In the instance when FHIAP is not allowed as a qualifying event, the applicant must enroll during the employer's open enrollment period. The applicant will remain eligible for subsidy through their group insurance for 12 months.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0090
Determination — Approvals and Denials

(1) If the applicant is denied subsidy during the application process, FHIAP will send a letter advising the applicant of the decision. The letter will include information regarding the applicant of the decision. The letter will include information regarding the applicant's right to appeal or request a contested case hearing and the steps necessary to do so (ref. 442-005-0330). Applicants whose entire family are denied and wish to reapply must first get on the appropriate reservation list.

(2) If the applicant is approved for subsidy, FHIAP will send a letter advising the applicant of the decision. The letter will include information about who has been approved for subsidy and the level of subsidy to be paid.

(3) The subsidy eligibility period will be based on the subsidy approval date, not the effective date of enrolment in the insurance plan.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0100
Subsidy Levels

(1) When a family has average gross monthly income up to 125 percent of federal poverty level in effect at the time of determination, they will receive a subsidy of:

(a) 95 percent of the member's monthly premium amount in the individual health benefit plan market; or

(b) 95 percent of the member's share of the monthly premium amount in the group health benefit plan market.

(2) When a family has average gross monthly income from 125 up to 150 percent of federal poverty level in effect at the time of determination, they will receive a subsidy of:

(a) 90 percent of the member's monthly premium amount in the individual health benefit plan market; or

(b) 90 percent of the member's share of the monthly premium amount in the group health benefit plan market.

(3) When a family has average gross monthly income from 150 up to 170 percent of federal poverty level in effect at the time of determination, they will receive a subsidy of:

(a) 70 percent of the member's monthly premium amount in the individual health benefit plan market; or

(b) 70 percent of the member's share of the monthly premium amount in the group health benefit plan market.

(4) When a family has average gross monthly income from 170 up to 185 percent of federal poverty level in effect at the time of determination, they will receive a subsidy of:

(a) 50 percent of the member's monthly premium amount in the individual health benefit plan market; or

(b) 50 percent of the member's share of the monthly premium amount in the group health benefit plan market.

(5) The subsidy amounts will never exceed 50 percent, 70 percent, 90 percent, or 95 percent of the total premium based on percentage of federal poverty level in effect at the time of eligibility determination.

(6) With the exception of administrative error or audit, subsidy percentage levels will only be re-evaluated at reapplication. Subsidy dollar amounts may change, however, if the actual premium being subsidized changes.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0110
Applicant Referral to Health Insurance Producers

(1) FHIAP will provide assistance to FHIAP applicants requesting help with health benefit plan decisions.

(2) Applicants who wish to purchase an individual health benefit plan will be referred, upon their request, to participating producers.

(3) To qualify for referrals from FHIAP, health insurance producers must:

(a) Have a current Oregon resident health insurance, general lines producer license, or a nonresident health insurance or general lines producer license, if the nonresident licensee can service the member face to face;

(b) Complete training as required by FHIAP;

(c) Have Errors and Omissions Insurance, with limits of at least $500,000 per occurrence and $1,000,000 aggregate annually, in force during their participation in the Producer Referral Program and agree to notify FHIAP if Errors and Omissions coverage is no longer in force;

(d) Agree to provide the same level of client contact and service to customers receiving a FHIAP subsidy as is provided to other customers;

(e) Agree to help customers fill out an entire Oregon Medical Insurance Pool application if necessary;

(f) Agree to advise FHIAP when the sale of a health benefit plan to FHIAP applicants is completed, whether or not the coverage is a certified plan, or the prospective purchaser decides not to purchase any health benefit plan if requested by the Office; and

(g) Agree to inform customers if they or their dependents may be eligible for OHP.

(4) FHIAP reserves the right to remove any agent from the referral program at any time.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0120
Enrollment In Health Benefit Plans — Individual Market

(1) To remain eligible for subsidy assistance, an applicant must apply for coverage with an insurance plan within the timeframes outlined by FHIAP on the Certificate of Eligibility. The following rule (previously 442-004-0090(2) has been incorporated in section 442-005-0190, Enrollment in FHIAP — Group Market

(2) Approved applicants will no longer be eligible for a FHIAP subsidy if they fail to enroll into an insurance plan as outlined by FHIAP on the Certificate of Eligibility. Approved applicants who fail to enroll must get on a reservation list in order to receive an application to reapply for a FHIAP subsidy. The following rule (previously 442-004-0090(3) has been incorporated in section 442-005-0190, Enrollment in FHIAP — Group Market

(3) Applicants approved for a subsidy in the individual market must use the subsidy to purchase a plan offered by a FHIAP-certified carrier that meets the benchmark standard. The following rule (previously 442-004-0090(4)(a) through (d) has been incorporated in section 442-005-0200, Vendor Set-up/State Accounting System — Group Market

(4) A family approved for a FHIAP subsidy may choose to enroll family members into different plans, including enrolling some family members in a group plan, some family members in an individual plan and some family members in the OHP as long as no family member is enrolled in OHP and FHIAP at the same time.

(5) If a person is enrolled in two insurance plans, FHIAP will subsidize only one plan.

(a) If one of the plans is a group plan that meets the benchmark, FHIAP will subsidize the group plan. If both plans are group plans that meet the benchmark standard, FHIAP will subsidize the plan that is most cost-effective to the Office.

(b) If both of the plans are individual, FHIAP will subsidize only a plan offered by a FHIAP-certified carrier that meets the benchmark standard. If both plans meet the benchmark standard, FHIAP will subsidize the plan that is most cost-effective to the Office.

(6) Any FHIAP applicant or member who is enrolled in an individual plan and being subsidized by FHIAP must enroll into a group plan if one becomes available to them, provided the group plan meets the benchmark standard. Members who fail to enroll into such a plan are no longer eligible for a FHIAP subsidy in the individual market.

(7) If the applicant is approved for individual insurance subsidy and has not yet enrolled in an individual insurance plan, FHIAP will begin to subsidize premiums no earlier than the first of the month following the date of the approval letter.

(8) If the applicant is approved for individual insurance subsidy and is already enrolled in the insurance plan, FHIAP may begin subsidizing premiums from the first of the month in which they are approved for subsidy. The subsidy eligibility period will be based on the subsidy approval date

(9) If a carrier elects to discontinue participation in the program, members served by that carrier will have to reapply for insurance coverage with another FHIAP-certified carrier and maintain continuous coverage in order to remain eligible for the subsidy. For the purposes of this section, continuous coverage may include a 120 calendar-day break in coverage.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0130
Member Invoicing — Individual Market

(1) Except for the first billing period, FHIAP will not pay the carrier until the member's portion of the premium has been received.

(2) Invoices are mailed to members one month in advance of the carrier due date to ensure timely payment to the carrier.

(3) Member payments are due to FHIAP by the date provided on the monthly invoice.

(4) Unpaid balances greater than $3.00 are mailed a reminder and given an extension on the original due date.

(5) If the payment is not postmarked by the due date on the reminder, FHIAP subsidy may be cancelled.

(6) If FHIAP fails to send a reminder, the member will be billed for two months during the next billing cycle. In these instances:

(a) FHIAP will not pay the carrier until the amount due has been paid.

(b) FHIAP will not be responsible for carrier non-payment terminations.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0140
Member Payments — Individual Market

(1) Member payments will be processed no less than each business day.

(2) Members will be notified of payments returned by the bank for Non-Sufficient Funds (NSF).

(a) A check that is returned for Non-Sufficient Funds is considered the same as non-payment.

(b) Replacement funds must be sent within 10 days of the date on the notification letter.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0150
Carrier Payments — Individual Market

(1) Member payments must be received before payment to the carrier will be made, except for the first billing period.

(2) In the event the member does not pay their portion of the first months' premiums, FHIAP will disenroll the member and apply normal overpayment collection practices for the member's portion only.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06; OPHP 3-2007(Temp), f. & cert. ef. 10-29-07 thru 4-26-08; Administrative correction 5-20-08

442-005-0160
Carrier Refunds — Individual Market

(1) FHIAP will resolve member overpayments by requesting a refund from the carrier; except for overpayments older than three months and overpayments resulting from member misrepresentation.

(2) FHIAP will seek carrier refunds within 30 days of overpayment determination.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0170
Member Refunds — Individual Market

(1) Member refunds will be processed no less than weekly.

(2) Member refunds will not be processed for amounts under $25.00 unless it is the final payment on a termed account.

(3) Members will receive refunds for their portion of any overpaid premium.

(4) Member refunds of premiums paid to a carrier will be processed upon receipt of the refund from the carrier.

(5) Current members billed incorrectly may request a refund or take a credit on their active account for refunds over $25.00.

(6) Member refunds for premium not yet sent to the carrier will be paid weekly even if an additional refund is due from the carrier as long as both refunds are over $25.00.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0180
Selection of Certified Carriers in the Individual Health Benefit Plan Market

Carriers may request to go through the certification process at any time. Selection criteria used to determine which carriers may be certified includes but is not limited to:

(1) Agree to a three-year commitment to be a FHIAP-certified carrier.

(2) Agree to electronic transferring of invoices and payments.

(3) Accept the Certificate of Eligibility in lieu of a first month's payment.

(4) Be an Oregon licensed health insurance company or health care service contractor holding a valid certificate of authority from the Department of Consumer and Business Services authorizing the transaction of health insurance.

(5) Be in the Oregon small employer-sponsored health benefit plan market (2-50 employees) and Oregon individual health benefit plan market.

(6) Have been in the individual or portability market for at least the last three consecutive years.

(7) Agree to accept FHIAP payment grace periods.

(8) The carrier shall remain responsible for notifying its FHIAP membership of premium rate increases.

(9) Offer one or more health benefit plans that meet FHIAP's benchmark requirements.

(10) Agree to give the Office of Private Health Partnerships a written 180-day notice of intent to withdraw from being a certified carrier.

(11) Agree that the Office of Private Health Partnerships may cancel partnership with cause by giving 180-day written notice.

(12) If the Office determines at any time that an insufficient number of individual health benefit plan options are available, it may request additional Individual Health Benefit Plan carriers to be certified.

(13) The carrier discontinuing participation must notify each insured FHIAP member 90 calendar days before their coverage will be discontinued and inform each insured to contact FHIAP for assistance in obtaining new coverage.

(14) May give preference to carriers with statewide coverage.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0190
Enrollment in FHIAP — Group Market

(1) Any applicant approved for a subsidy in the group market must enroll in a group plan that meets the benchmark standard within 12 months of being approved for FHIAP. Applicants that do not enroll in a group plan within 12 months will have to get back on the reservation list in order to reapply for a subsidy.

(2) Any FHIAP applicant or member who is enrolled in an individual plan and being subsidized by FHIAP must enroll into a group plan if one becomes available to them, provided the group plan meets the benchmark standard. Members who fail to enroll into such a plan are no longer eligible for a FHIAP subsidy in the individual market.

(3) If the applicant is approved for a group insurance subsidy, FHIAP will subsidize premiums that pay for the full approval month, no matter what day in the approval month the decision is made. The subsidy eligibility period will be based on the subsidy approval date.

(4) Once enrolled, if a member loses their group coverage due to loss of employment, or the employer discontinues the group plan, FHIAP will subsidize a COBRA, portability or individual plan. FHIAP will also subsidize a COBRA, portability, or individual plan for approved HUBB applicants who have not yet enrolled in the program.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06; OPHP 2-2007, f. 6-18-07, cert. ef. 7-9-07

442-005-0200
Vendor Set-up/State Accounting System — Group Market

Subsidy payments may be payable to:

(1) The member or member's employed spouse from whose pay check the premium is being deducted.

(2) Parents of member children.

(3) Carriers.

(a) Member payments must be received before payment to the carrier will be made, except for the first billing period.

(b) In the event the member does not pay their portion of the first months' premiums, FHIAP will disenroll the member and apply normal overpayment collection practices for the member's portion only.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0210
Employer Verification — Group Market

(1) Employer contribution changes — Members must report changes in circumstances to FHIAP as provided in 442-005-0260.

(2) Subsidy changes — FHIAP will request a new employer verification form if plan changes become evident through payroll deduction changes, member notification, etc. FHIAP will continue to subsidize the member at the documented rate until new rates are received. Underpayments will be paid to members when new rates are documented.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0220
Subsidy Payments — Group Market

(1) The amount FHIAP will subsidize is based on the monthly insurance premium less the employer's contribution.

(2) FHIAP will reimburse the eligible members' portion of the premium in the group market using submitted payment verification. Verification can include, but is not limited to payroll records, paycheck stubs, employer letters, carrier invoices, receipts, and cancelled check copies.

(3) FHIAP subsidies for HUBB will be paid in accordance with Individual Market OARs 442-005-0130, 442-005-0140, 442-005-0150, 442-005-0160, and 442-005-0170.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06; OPHP 2-2007, f. 6-18-07, cert. ef. 7-9-07

442-005-0230
COBRA/Portability

(1) Potential applicants with a COBRA or Portability plan are placed on FHIAP's reservation list.

(2) Members receiving group subsidy who lose their insurance coverage may opt for COBRA, Portability, or an Individual insurance plan and FHIAP will continue to provide premium subsidy.

(3) Members approved for group subsidy who lose their insurance coverage prior to paying premiums are only eligible for COBRA or portability plan subsidy assistance.

(4) Members approved for group subsidy who lose their insurance coverage prior to using the FHIAP subsidy may opt to use their FHIAP subsidy toward COBRA, state continuation, or portability.

(5) HUBB applicants approved for group subsidy who lose their insurance may also use their FHIAP subsidy for an individual plan, in addition to COBRA, state continuation, or portability

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06; OPHP 2-2007, f. 6-18-07, cert. ef. 7-9-07

442-005-0240
Reapplication for Health Insurance Subsidy

(1) Eligibility for subsidy lasts for a maximum of twelve months.

(2) Members must reapply for subsidy once every 12 months after receiving their initial approval.

(3) FHIAP will send members an application at least 60 calendar days before their subsidy eligibility ends. The application will be mailed to the last known address of the member. The information provided by the member on this application will be used to determine the family's eligibility for the next 12 months.

(4) FHIAP will review eligibility during the reapplication process using the same requirements as outlined in OAR 442-005-0020.

(5) The application is mailed with a letter, outlining the review process and the due date for return of the reapplication materials.

(6) The member will have at least 45 calendar days from the date the application is mailed to return the reapplication materials. If the reapplication materials are not postmarked within 30 calendar days, the Office will mail a notice to the member Reminding them to return their application to FHIAP by the due date.

(7) If the reapplication materials are not postmarked by the due date, the application is denied and the applicant must make a new reservation in order to receive an application as space permits.

(8) Once the completed application materials are received FHIAP will take action on it. The action may be approval, denial, or a request for further information from the applicant.

(a) Reapplications that require more information to determine FHIAP eligibility will be placed in a "pend" status.

(b) Whenever further information is requested by FHIAP during the reapplication process, the applicant has 45 calendar days following the date of the request to provide the additional information. If the information requested by FHIAP is not postmarked within 30 calendar days from the date on the request, the Office will mail a notice to the member advising that only 15 days remain in which to provide the additional information.

(c) If a member does not provide all requested information within 45 calendar days of the initial request, the reapplication will be denied.

(d) Once a member has been denied because they failed to respond to the request for further information, the member must make a new reservation request to FHIAP to be sent an application in the future. Their name may be placed on the reservation list in the manner prescribed in OAR 442-005-0020.

(9) If a member is denied continued eligibility during the reapplication process, FHIAP will notify the member in writing of the reason for the denial, the effective date of the action, a phone number and resource for questions, and appeal and contested case hearing rights.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0250
Adding Dependents

(1) Members may add dependents to their FHIAP enrollment at any time throughout the 12-month eligibility period as long as the dependent meets the period of uninsurance requirement or exceptions outlined in OAR 442-005-0060.

(2) FHIAP may limit or prohibit the ability to add dependents when doing so would cause projected program costs to exceed the funding available to cover subsidy payments for those enrolled.

(3) Premium rates and the member's portion of the premium could change as a result of adding dependents.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06; OPHP 2-2008(Temp), f. & cert. ef. 5-19-08 thru 11-14-08; OPHP 3-2008, f. 11-10-08, cert. ef. 11-11-08

442-005-0260
Member Reporting

(1) Members must report changes in circumstance to FHIAP within 30 calendar days of their occurrence by phone or in writing. These circumstances include the following:

(a) Change of Name;

(b) Change in Employers;

(c) Changes to family composition including death, divorce, any family member becoming a ward of the state or being incarcerated for more than 30 continuous days;

(d) Change of home or mailing address, even if temporarily away (more than 30 days):

(e) If any FHIAP member drops health benefit coverage;

(f) Obtaining different or additional health benefit coverage;

(g) Any family member becomes ineligible for health benefit plan;

(h) Change in employer contribution for FHIAP members receiving subsidy in the group market;

(i) If group insurance becomes available to a member enrolled in the individual market as stipulated in OAR 442-005-0190(2).

(2) Failure to report any of the above changes may result in termination from the program, subsidy suspension, loss of insurance coverage or an overpayment.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0270
Termination of Subsidy

Termination from the FHIAP program occurs when:

(1) Payment of the member's share of the insurance premium is not postmarked by the date stipulated in correspondence from FHIAP;

(2) The member is no longer a resident of Oregon;

(3) The member terminates or is terminated from the member's health benefit plan and fails to notify FHIAP;

(4) The insurance plan that covers an eligible child of any member terminates or is terminated, and the member does not replace the eligible child's health insurance within 120 calendar days from the date FHIAP notifies the member to replace the child's coverage.

(5) The member is determined to be ineligible at reapplication or any time during the subsidy year. Ineligibility results if:

(a) A member is eligible for or receiving Medicare on or before the date the application was signed. Subsidy may remain in force for the remainder of the applicant's 12-month eligibility period if the applicant became eligible for Medicare after signing the application.

(b) A member is incarcerated beyond 30 continuous calendar days.

(c) Any member is enrolled in OHP and FHIAP simultaneously and fails to timely terminate from one program after being notified by FHIAP that they must do so.

(d) Any information submitted is inconsistent and does not allow for eligibility determination.

(e) FHIAP staff makes an administrative error when determining eligibility and the applicant should have been denied and error is identified during an audit of the member's file.

(f) An applicant or member in the individual market becomes eligible for a benchmark-approved group plan with an employer contribution and doesn't enroll within 30 days of the first opportunity of enrollment in the group plan.

(g) The member failed to submit required or requested information or submitted inadequate or unclear information such that FHIAP cannot make an eligibility determination.

(6) In the group market, the member fails to provide monthly verification of coverage, premiums, and employer contribution within 30 days from the date FHIAP requests such documentation.

(7) The member fails to pay an overpayment amount as per OAR 442-005-0280.

(8) The member fails to return their reapplication within 45 days from the date it was mailed to them.

(9) A member is found to have committed misrepresentation on the FHIAP application. If a civil penalty is imposed, the member is ineligible to enroll or re-enroll in FHIAP.

(10) Projected program costs exceed the funding available to cover subsidy payments for those enrolled.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740

Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06; OPHP 1-2008(Temp), f. & cert. ef. 3-31-08 thru 9-26-08; Administrative correction 10-21-08; OPHP 3-2008, f. 11-10-08, cert. ef. 11-11-08

442-005-0275
Misrepresentation/Civil Penalty

(1) FHIAP may investigate any applicant, member or former member for misrepresentation in obtaining subsidy benefits. Such investigations may be through random file audits or by management request.

(2) FHIAP may ask appropriate legal authorities to initiate civil or criminal action under Oregon laws when, in FHIAP's judgment, available evidence warrants such action.

(3) FHIAP may issue an intent to take disciplinary action against a member by giving notice of the opportunity for a contested case hearing.

(4) When a finding is made that an applicant or member has committed misrepresentation:

(a) The member is terminated from FHIAP and ineligible to re-enroll in FHIAP;

(b) The member is liable for repayment to FHIAP the full amount of overpayment FHIAP has established, regardless of any restitution amount ordered by a court;

(c) The applicant or member is liable for any civil penalty set by FHIAP up to a statutory limit of $1,000. The civil penalty amount will be set by using a sliding scale based on the amount of subsidy paid on the member's behalf.

Stat. Auth.: ORS 735.734, 735.740, & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0280
Overpayments

(1) Any overpayment amount is a debt owed to the State of Oregon and may be subject to collection. An overpayment may result from administrative error, member error, misrepresentation, or civil penalty.

(2) An overpayment is considered to be member error if it is caused by the member's misunderstanding or error. Examples include, but are not limited to, instances where the member intentionally or unintentionally:

(a) Did not provide correct or complete information to FHIAP;

(b) Did not report changes in circumstances to FHIAP;

(c) Claimed and was reimbursed for an ineligible subsidy period.

(3) An administrative error overpayment may be caused by any of the following circumstances:

(a) FHIAP committed a calculation, procedural, or typing error that was no fault of the member;

(b) FHIAP failed to compute or process a subsidy payment correctly.

(4) A misrepresentation error includes but is not limited to the member giving an inaccurate or deliberately false statement of fact that results in an inappropriate eligibility determination or an incorrect subsidy level calculation. Misrepresentation may result in a civil penalty.

(5) The FHIAP member is having the health insurance premium subsidized by another state government program, such as, but not limited to OHP, and such subsidy results in a double payment for the same health insurance premium.

(6) FHIAP will mail notification of overpayments to the member. This written notice shall:

(a) Inform the member of the amount of and the reason for the overpayment;

(b) Inform members of their appeal and contested case hearing rights.

(7) FHIAP will collect overpayment amounts in one lump sum if the member is financially able to repay the overpayment amount in that manner.

(8) If the member is financially unable to pay the amount due in one lump sum, FHIAP will accept regular installment payments as outlined in 442-005-0290 — Payment Plans.

(9) If FHIAP is unable to recover the overpayment amount from the member within overpayment guidelines:

(a) FHIAP may renegotiate the payment plan agreement or refer the balance to the Department of Revenue, the Department of Justice, or another outside agency for collection. If an account is referred to an outside agency for collection, any expenses incurred for collection will be added to the member's balance due.

(b) FHIAP may file civil action to obtain a court ordered judgment for the amount of the debt. FHIAP may also assert a claim for costs and fees associated with obtaining a court judgment for the debt. When a judgment for costs is awarded, FHIAP will collect this amount in addition to the overpayment amount, using the methods of recovery allowable under state law and administrative rule.

(10) If the member submits an appeal or contested case hearing request, FHIAP will discontinue any attempts at collection until the conclusion of the appeal or hearing.

(11) If the appeal decision is in the member's favor, FHIAP will refund any money collected as overpayment recovery as outlined in OAR 442-005-0280, 442-005-0290 and 442-005-0300.

(12) Any former FHIAP member with an outstanding overpayment balance who is reapplying for FHIAP subsidy must meet the regular eligibility criteria and be repaying their outstanding overpayment as follows:

(a) A minimum of $10 per month or the amount necessary to collect the overpayment amount in one year, whichever is greater, or

(b) An offset against any future monthly subsidy payment in the amount necessary to collect the overpayment amount in one year.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0290
Payment Plans

Subsidy overpayments that are paid on the member's behalf are the member's responsibility. Members may be eligible to establish a payment plan to reimburse FHIAP.

(1) Payment plans for Individual members who are currently enrolled:

(a) Members who have been billed at an incorrect subsidy level or premium rate will be responsible for repayment of their portion of the amount FHIAP overpaid the insurance carrier on their behalf.

(b) Members will have an option to either repay the overpayment amount in full or establish a payment arrangement.

(c) Payments established under a payment arrangement will consist of no less than the regular monthly member portion plus an amount sufficient to reduce the overpayment to zero within 120 days.

(d) If the overpayment cannot be paid within 120 days, special payment arrangements may be coordinated. Consideration for the payment plan will be the time remaining before the next reapplication period. The overpayment must be paid in full to FHIAP within 12 months unless an exception is negotiated.

(e) Once a payment plan is approved FHIAP sends the member a letter. The letter:

(A) Outlines the payment arrangement and informs members that they are responsible for making timely payments according to the established payment plan.

(B) Informs the member of what action FHIAP will take to collect the overpayment.

(f) If the member fails to follow the payment plan, the member may be terminated for non-payment. The unpaid balance will then be transferred to collections.

(2) Payment plans for group members who are currently enrolled:

(a) Members have an option to either repay the overpayment amount in full or establish a payment arrangement.

(b) Group member overpayments will be collected by reducing subsidy reimbursements on active accounts until the full overpayment is repaid,

(c) Group overpayments must be repaid within 120 days unless alternate timeframes are negotiated.

(d) Consideration for the payment plan will be the time remaining before the next reapplication period.

(e) The overpayment must be repaid within 12 months unless an exception is negotiated.

(3) Payment plans for inactive members: See Collections Section 442-005-0300.

(4) Terminated members with an outstanding unpaid balance, who are reapplying to the program, must establish payment arrangements in order to be eligible for re-enrollment.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0300
Collections

(1) FHIAP staff will reconcile terminated accounts with unpaid balances.

(2) FHIAP staff will notify the member in writing of the collection amount. The terminated member will have 21 days to appeal before further collection action is taken, unless appeal rights were already extended in other FHIAP correspondence.

(3) Terminated members may be eligible to establish a payment plan as outlined in OAR 442-005-0290.

(4) If FHIAP is unable to recover the unpaid balance from the terminated member or no payment is made within 90 days:

(a) FHIAP may renegotiate the collection agreement or refer the balance to the Department of Revenue, the Department of Justice, or another outside agency for collection. If an account is referred to an outside agency for collection, any expenses incurred for collection will be added to the member's balance due.

(b) FHIAP may file civil action to obtain a court ordered judgment for the amount of the debt. FHIAP may also assert a claim for costs and fees associated with obtaining a court judgment for the debt. When a judgment for costs is awarded, FHIAP will collect this amount in addition to the overpayment amount, using the methods of recovery allowable under state law and administrative rule.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0310
Audits

(1) Quality assurance audits will be performed to verify:

(a) FHIAP statutes, rules, policies and procedures are followed correctly.

(b) FHIAP procedures are effective.

(c) Eligibility is determined correctly.

(2) Audits may be performed on a directed or random basis.

(3) As a result of an audit:

(a) A member or former member may be determined ineligible for a FHIAP subsidy.

(b) A member or former member may be determined ineligible retroactively for a prior subsidy eligibility period.

(c) A subsidy level adjustment may be necessary for a current or previous determination period.

(4) An audit determination could result in an overpayment or underpayment to a member or former member.

(5) The member or former member must submit additional verification when FHIAP requests it.

(a) FHIAP may verify any factors affecting eligibility, benefit levels or any reported information. Such information includes, but is not limited to:

(A) Any information submitted by the member that is inconsistent.

(B) Information provided on the application that is inconsistent.

(C) Other information that is used as verification but is inconsistent with the information on the application.

(D) Information reported on previous application that is inconsistent with the current FHIAP application.

(b) FHIAP may decide at any time that additional eligibility factors must be verified.

(c) FHIAP may deny an application or end ongoing subsidy when requested verification is not provided.

(6) Requested verification includes the same information as listed in OAR 442-005-0030 as well as any other information that will verify information already submitted.

(7) If additional information is requested during a directed or random audit, the member has 30 days from the date of the Request for Information letter to submit the information. FHIAP will use the postmark date to determine timeliness. If a FHIAP member fails to cooperate with a FHIAP audit, the member may be disenrolled.

(8) If a decision differs from the original eligibility determination, FHIAP will notify the member in writing of the reason for the denial or change in determination, the effective date of the action, and the member's appeal and contested case hearing rights.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0320
Appeals

(1) All FHIAP correspondence that notifies applicants or members of decisions and determinations will include appeal language and outline the steps necessary to file an appeal.

(2) An applicant or member may appeal any decision made or action taken by FHIAP.

(3) To appeal a decision or action, the applicant or member must advise FHIAP in writing of their desire to appeal. The written appeal request must be postmarked within 21 calendar days of the date on the notice or action.

(4) The appeal request must include the reasons for the appeal, which shall be limited to the issue(s) cited in the decision or determination.

(5) On its own or if asked by an applicant or member, FHIAP may consider additional information during the appeal process. If further information is requested by FHIAP, the applicant or member has 15 calendar days from the date on the request to provide the additional information. If the information requested by FHIAP is not postmarked within 15 calendar days from the date on the request, the original decision will be upheld.

(6) Once FHIAP has made a decision on appeal, the applicant or member will be notified of the appeal decision.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0330
Contested Case Hearings

(1) An applicant or member may request a hearing on FHIAP's appeal decision.

(2) To receive a hearing, the hearing request must be in writing, signed by either the applicant, member, or their attorney and be postmarked no later than 21 calendar days following the date of the appeal decision notice.

(3) The hearing request must include the reasons for the hearing, which shall be limited to the issue(s) cited in the appeal decision notice.

(4) FHIAP will conduct a contested case hearing pursuant to ORS 183.413 to 183.470.

(5) Once a hearing is requested, FHIAP will not pursue collection of any alleged overpayment until FHIAP has issued a final order affirming the overpayment.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0340
Extenuating Circumstances

The Agency Administrator or designee will appoint a case management panel to review extenuating circumstance requests that may result in exceptions to application of the administrative rules. Requests relating to life circumstances beyond the applicant's control will be considered.

(1) Exceptions will not be granted for any eligibility requirements except the extension of timeframes associated with submitting information, including, but not limited to the application, income

verification, appeal or hearing request and information specifically requested by FHIAP staff.

(2) Exceptions will also be considered for non-payment of the member's portion of the insurance premium.

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

442-005-0350
Rule Authorizing Agency Representative

(1) Subject to the approval of the Attorney General, a FHIAP officer or employee is authorized to appear on behalf of the agency in a hearing that may result in the change or termination of program benefits as well as in some cases imposing civil penalties.

(2) The agency representative may not make legal argument on behalf of the agency.

(a) "Legal argument" includes arguments on:

(A) The jurisdiction of the agency to hear the contested case;

(B) The constitutionality of a statute or rule or the application of a constitutional requirement to an agency; and

(C) The application of court precedent to the facts of the particular contested case proceeding.

(b) "Legal argument" does not include presentation of evidence, examination and cross-examination of witnesses, or presentation of factual arguments or arguments on:

(A) The application of the facts to the statutes or rules directly applicable to the issues in the contested case;

(B) Comparison of prior actions of the agency in handling similar situations;

(C) The literal meaning of the statutes or rules directly applicable to the issues in the contested case; and

(D) The admissibility of evidence or the correctness of procedures being followed.

(3) When an agency officer or employee represents the agency, the presiding officer shall advise such representative of the manner in which objections may be made and matters preserved for appeal. Such advice is of a procedural nature and does not change applicable law on waiver or the duty to make timely objection. Where such objections involve legal argument, the presiding officer shall provide reasonable opportunity for the agency officer or employee to consult legal counsel and permit such legal counsel to file written legal argument within a reasonable time after conclusion of the hearing.

(4) The presiding officer may limit an authorized representative's presentation of evidence, examination and cross-examination of witnesses, or presentation of factual arguments to insure the orderly and timely development of the hearing record, and shall not allow an authorized representative to present legal argument as defined in subsection (2)(a).

Stat. Auth.: ORS 735.734 & 735.720 - 735.740
Stats. Implemented: ORS 735.720 - 735.740
Hist.: IPGB 2-2006, f. & cert. ef. 6-1-06

DIVISION 6

SMALL EMPLOYER HEALTH PLANS

442-006-0000
Purpose and Statutory Authority

(1) OAR 442-006-0000 to 442-006-0040 are adopted to carry out the purposes of ORS 735.700 through 735.714 to increase access to health insurance and health care by providing health benefit plans for small employers.

(2) OAR 442-006-0000 to 442-006-0050 are adopted pursuant to the authority of the Insurance Pool Governing Board under ORS 735.708(5).

Stat. Auth.: ORS 735.708
Stats. Implemented: ORS 735.700 & 735.714
Hist.: IPGB 1-2005, f. & cert. ef. 3-1-05

442-006-0010
Definitions

(1) "Alternative Group Plan" (AGP) is a health benefit plan designed for adults only and excludes four state mandates under the Insurance Pool Governing Board's statutory authority found in ORS 735.710(7).

(2) "Children's Group Plan" (CGP) is a comprehensive benefit plan that covers children only. The CGP can be purchased by any employer in conjunction with the AGP or as a stand-alone product.

(3) "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 which is a federal mandate that requires employers sponsoring group health plans for twenty (20) or more employees to offer continuation of coverage to employees, their spouses, and dependent children who become unemployed.

(4) "Creditable coverage" is defined in ORS 743.730(8).

(5) "Dependent" means an eligible employee's spouse, eligible child or an adult disabled child.

(6) "Eligible Child" means an employee's unmarried child under the age of 23 including stepchild, legally adopted child, or a child under the employee's guardianship. A dependent child of a dependent child is not eligible for the CGP unless the employee has guardianship of the grandchild.

(7) "Eligible Employee" is defined in ORS 735.700(4).

(8) "Guaranteed Issue" requires contracted carriers to offer health benefit plans under this IPGB program without consideration of health status, claims experience, or geographic location if it is within the carrier's service area.

(9) "Guaranteed Renewal" means that a carrier shall not discontinue any policy during or at the termination of the contact period except in the circumstance specified in ORS 743.754(6).

(10) "Health Maintenance Organization" (HMO) means a health plan delivery system that provides comprehensive medical services to its members for a fixed, prepaid premium.

(11) "Opt Out" means the employee has met criteria that allow them to be excluded from the participation calculation. This criterion includes having other group coverage, Medicare, Medicaid, Indian Health Service (HIS), Tri-Care, or the Oregon Health Plan. Opt Out criterion does not include individual health benefit plans.

(12) "Participation Rate" is the percentage of eligible participants that a carrier requires an employer to enroll in order to qualify for a group policy.

(13) "Portability Coverage" is defined in ORS 743.760(1)(c).

(14) "Pre-existing Condition" is defined in ORS 743.731(27).

(15) "Preferred Provider Organization" (PPO) is a health plan delivery system in which providers are under contract with insurance company to provide medical care at a discounted or negotiated price for the health care services.

(16) "Premium" is defined in ORS 735.700(7).

(17) "Small Employer" is a person, firm, corporation, partnership or association actively engaged in business that, on at least 50 percent of the working days during the preceding year, employed no more than 50 eligible employees and no fewer than two eligible employees, the majority of whom are employed within this state, and in which a bonafide partnership or employer-employee relationship exists. 'Small Employer' includes corporations that are eligible to file a consolidated tax return pursuant to ORS 317.715.

(18) "Small Employer Health Plan" (SEHP) means the alternative group plan (AGP) and the children's group plan (CGP).

Stat. Auth.: ORS 735.708
Stats. Implemented: ORS 735.700 & 735.714
Hist.: IPGB 1-2005, f. & cert. ef. 3-1-05

442-006-0020
Program Duration

IPGB will offer the small employer health plans to employers for as long as authorized by the Oregon legislature.

Stat. Auth.: ORS 735.708
Stats. Implemented: ORS 735.700 & 735.714
Hist.: IPGB 1-2005, f. & cert. ef. 3-1-05

442-006-0030
Carrier and Plan Selection

(1) IPGB will select carriers to offer the SEHPs through a competitive bidding process. The process will be carried out by releasing a request for proposal (RFP). Selection criteria for the carriers includes, but is not limited to:

(a) Must meet all technical specifications as outlined in the RFP.

(b) Must offer both the Alternative Group Plan (AGP) and the Children's Group Plan (CGP) and may offer either or both as Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or other plan approved by IPGB.

(c) Must be able to administer the CGP independently without employees enrolled in the AGP, and must have the ability to track the children back to the employee and employer.

(d) Must be in the SEHI market and offer both plans throughout their SEHI service area.

(e) Must have the ability to extract an assessment fee from the premium and remit those funds to the IPGB quarterly for agent training and program marketing. This assessment is subject to legislative approval and shall not be implemented until notified by the IPGB that legislative approval has been granted.

(f) Must provide required data as developed by the IPGB.

(2) Carriers are selected for a three-year period. No new carriers will be allowed to participate during those three years, unless there is a loss of statewide coverage.

(3) Annually, the board will review proposed modifications to benefits and rates. Rate review may occur more frequently than annually if any contracted carrier terminates their participation in the program. Remaining carriers will then have the opportunity to negotiate new rates. Approved rate adjustments will take effect March 1 of each year for all carriers and employers regardless of their anniversary date.

(4) Carriers may withdraw from the program by giving formal written notice to the IPGB 180 days from the date of notice or the annual expiration date of its plans with employers, whichever is later. A carrier that withdraws may not reenter the program for a minimum of twenty-four (24) months. Upon completing the 24-month waiting period carriers will be eligible to submit a proposal at the next RFP.

(5) Carriers must use the following underwriting guidelines:

(a) Both plans must be Guaranteed Issue. Eligible employees/dependents currently insured by the Oregon Medical Insurance Pool (OMIP) will not be eligible for Opt-Out.

(b) Carriers shall develop a separate pool for the Small Employer Health Plans from their other small employer pool(s).

(c) Once an employer enrolls in either the AGP or the CGP they are only allowed to change carriers at annual renewal.

(A) Under the new plan, the member's lifetime maximum may be reduced by the benefit amount already paid under the previous plan.

(B) Benefit information shall be provided to the new carrier by the previous carrier within 100 calendar days.

(C) The carrier must use the same lifetime maximum reduction calculation for all employers enrolled in a SEHP.

(d) Both plans will be subject to standard state continuation, portability, and COBRA regulations. Reaching a lifetime maximum does not create portability eligibility.

(e) The pre-existing condition provisions used in the SEHI market shall apply as well as credits for prior creditable coverage.

(f) An employer may only select benefit plans on their plan anniversary, except when the employer group had no eligible children when they purchased the AGP. In this situation the employer may purchase the CGP within 30 days of a qualifying event.

(g) An employer must use the same carrier for both the AGP and CGP.

(h) A small employer health benefit plan shall be renewable at the option of the policyholder and shall not be discontinued by the carrier during or at the termination of the contract period except in the circumstances specified in ORS 743.737(5) and (6).

Stat. Auth.: ORS 735.708
Stats. Implemented: ORS 735.700 & 735.714
Hist.: IPGB 1-2005, f. & cert. ef. 3-1-05

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Employer Eligibility

(1) In order for an employer to be eligible to purchase one or both of the SEHPs, an employer must meet the following criteria:

(a) The employer must have at last two and no more than 50 employees working at least either 17.5 hours per week, or a higher threshold established by the carrier/employer, whichever is more.

(b) All eligible employees must be offered the selected plan or plans.

(c) The employer must meet the following uninsured criteria:

(A) Existing businesses may not have been insured on or after July 1, 2003.

(B) New businesses formed after July 1, 2003 and never offered insurance.

(2) The employer shall have exclusive control of the plan(s) that will be offered to their employees. They will be able to select from the following menu:

(3) Employee only — Alternative Group Plan.

(4) Eligible Children only — Children's Group Plan.

(5) Employee and Spouse Only — Alternative Group Plan.

(6) Employee and Dependents — Adults/Alternative Group Plan; Eligible Children/Children's Group Plan.

(7) The employer shall make a minimum contribution of $50.00 per eligible employee but may contribute up to 100% of the total premium. If the employer selects only the Children's Group Plan, the $50.00 contribution per eligible employee will be applied to the family group but the employer may contribute up to 100% of the total premium. Employer contribution may be modified by the IPGB during the annual rate and benefit review.

(8) The Alternative Group Plan requires 100% participation of all eligible employees.

(9) The Children's Group Plan requires 75% participation of the eligible employees and 100% of a family group.

(10) An employer may only change carriers effective March 1 of each calendar year. An employer may change carriers with a different effective date only if their current carrier withdraws from the program.

Stat. Auth.: ORS 735.708
Stats. Implemented: ORS 735.700 & 735.714
Hist.: IPGB 1-2005, f. & cert. ef. 3-1-05