Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form

FILED
4-14-17 4:00 PM
ARCHIVES DIVISION
SECRETARY OF STATE

Oregon Health Authority, Oregon Educators Benefit Board — 111
Agency and Division — Administrative Rules Chapter Number

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Rules Coordinator — Telephone

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Address

RULE CAPTION

Amendments clarify OEBB policy and processes that are currently in place

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

Hearing Date	Time	Location	Hearings Officer
5-23-17	10:30 a.m.	500 Summer St NE, Rm 137B, Salem, OR 97301	OEBB Staff

RULEMAKING ACTION

Secure approval of rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND:
111-040-0001, 111-040-0015, 111-040-0040, 111-040-0050

REPEAL:

RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

AMEND AND RENUMBER: Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

Statutory Authority:
ORS 243.860 to 243.886

Other Authority:

Statutes Implemented:
ORS 243.864(1)(a)

RULE SUMMARY

Amendments to this rule are to clarify OEBB policy and processes that are currently in place. Clarifications include opt-outs, newborn coverage effective dates, Medicare and TRICARE. In addition, the proposed rule changes are to clean up language used in this rule to make the language consistent with all other OEBB administrative rules.

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

05-31-2017 5:00 p.m. — April Kelly — april.kelly@oregon.gov
Last Day *(m/d/yyyy)* and Time for public comment — Rules Coordinator Name — Email Address

*The Oregon Bulletin is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation.

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

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Oregon Health Authority, Oregon Educators Benefit Board — 111
Agency and Division — Administrative Rules Chapter Number

Amendments clarify OEBB policy and processes that are currently in place

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of:

111-040-0001, 111-040-0015, 111-040-0025, 111-040-0040, 111-040-0050

Statutory Authority:
ORS 243.860 to 243.886

Other Authority:

Statutes Implemented:
ORS 243.864(1)(a)

Need for the Rule(s):

After an annual review, it was determined that there were some small changes needed to this rule. We are cleaning up language used in Division 40 so that the language is consistent throughout all OEBB administrative rules. In addition, amendments to this rule are to clarify OEBB policy and processes that are currently in place. Clarifications include opt-outs, newborn coverage effective dates, Medicare and TRICARE.

Documents Relied Upon, and where they are available:

ORS 243.860 to 243.886, 2007 Oregon laws available online or by request of the OEBB staff.

OEBB Board Public Meeting minutes from March 7, 2017 are available online at
http://www.oregon.gov/oha/OEBB/Pages/OEBB-Board-Meetings.aspx

Fiscal and Economic Impact:

These proposed administrative rules are not predicted to have a fiscal or economic impact.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

No fiscal impact was identified.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small business and types of businesses and industries with small businesses subject to the rule:

Not applicable. There are no OEBB entities that can be considered a small business in Oregon.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

Not applicable. There are no OEBB entities that can be considered a small business in Oregon.

c. Equipment, supplies, labor and increased administration required for compliance:

Not applicable. There are no OEBB entities that can be considered a small business in Oregon.

How were small businesses involved in the development of this rule?

Since small businesses are not impacted by the proposed rule changes, none were invited to participate in the development of this proposed rule.

Administrative Rule Advisory Committee consulted?: Yes
If not, why?:

05-31-2017 5:00 p.m. — April Kelly — april.kelly@oregon.gov

Last Day (m/d/yyyy) and Time for public comment	Printed Name	Email Address

DIVISION 40

ENROLLMENT

111-040-0001

Effective Dates

(1) Effective Dates for Newly Eligible Employees. Initial benefit elections, unless otherwise specified in a collective bargaining agreement or documented Entity policy in effect on June 30, 2008, are effective on the later of:

(a) The first of the month following a completed online enrollment in the OEBB benefit management system or submission of a paper enrollment or change form, or

(b)(A) The first of the month following the date of hire or the date of eligibility; with the following exception:

(B) The first of the month following approval of Evidence of Insurability for Optional Life Insurance above the guarantee issue amount, Long Term Disability, or Long Term Care insurance.

(2) Effective Dates for Qualified Status Changes. Covered dependent changes are effective the first of the month following the date of the event causing the dependent to be eligible under OEBB administrative rules with the following exceptions:

(a) Coverage for a newborn child is effective on the date of birth. The active eligible employee must add the newborn child to their benefit plans within 60 calendar days from the date of birth in order for the newborn child to be eligible for benefit coverage. **If the newborn is born between the first and the fifteenth of the month, the baby is added to the plan the first of the month in which the baby is born. If the newborn is born between the sixteenth of the month and the end of the month, the baby is added to the plan the first of the following month. With a newborn, the baby begins incurring their own expenses from their date of birth and since premiums are not pro-rated, this balances premiums.**

(b) Coverage for a newly adopted child is effective the date of the adoption decree or date of placement for adoption. The active eligible employee must add the adopted child to their benefit plans within 60 calendar days from the date of the decree or placement in order for the newly adopted child to be eligible for benefit coverage; and

(A) The active eligible employee must submit the adoption agreement with the enrollment forms to the Entity.

(B) Claims payments will not be made for expenses incurred prior to the date of decree or placement.

(c) Coverage for an eligible grandchild is as follows:

(A) If the legal guardianship is finalized within the first 60 days following the birth of the grandchild, coverage will be effective retroactive to the date of the birth.

(B) If the legal guardianship is finalized 61 or more days from the date of birth of the grandchild, the coverage will be effective the first of the month following the date the guardianship documents are finalized.

(C) If the legal guardianship is finalized 61 to 180 days from the date of birth of the grandchild, and the effective date of legal guardianship is retroactive to the grandchild's date of birth, coverage will be effective retroactive to the date of birth. If legal guardianship is finalized after 180 days coverage will be effective the first of the month following the date the guardianship documents are finalized.

(d) The first of the month following approval of Evidence of Insurability for Optional Spouse/Domestic Partner Life insurance above the guaranteed issue amount, if applicable, or Long Term Care Insurance.

(3) Elections made during an open enrollment period are effective on the first day of the new plan year. There will be a 12-month waiting period for services other than preventive dental exams and cleanings and/or routine vision exams for coverage added during the open enrollment period if enrolling in a dental or vision plan in which the employee and/or dependents were previously eligible.

111-040-0015

Removing an Ineligible Individual from Benefit Plans

(1) An ~~active~~ **eligible** employee who enrolls them self and/or an eligible person is responsible for removing spouses, domestic partners and children from their OEBB-sponsored benefit plans by submitting completed, applicable forms to their Entity benefits administrator within 31 calendar days after the date the individual becomes ineligible. Coverage ends on the date identified under OAR 111-040-0005.

(2) An Entity is responsible for removing ineligible individuals from the OEBB benefits management system. The Entity must complete such removal within 14 calendar days after:

(a) An event resulting in loss of the employee's eligibility, or

(b) The receipt of notification of an event resulting in loss of eligibility of the employee's spouse, domestic partner or child.

(3) If coverage of an employee's spouse, domestic partner or child is terminated retroactively then:

(a) The employee may be responsible for claims previously paid by the benefit plans to the providers during the period of ineligibility at the carrier's discretion; and

(b) Premium adjustments will be made retroactively based on the coverage end date.

(4) OEBB shall conduct eligibility verifications and reviews to monitor compliance with OEBB administrative rules governing eligibility and enrollment. Eligibility reviews may occur at different times throughout the plan year. The member is responsible to submit documentation upon request. In the event the member does not provide the required documentation in a timely manner to sufficiently prove the dependent meets eligibility requirements, or the documentation provided is insufficient, the dependent's coverage will be terminated. Retroactive terminations may occur if the documentation provided shows the dependent was not eligible for coverage and the member misrepresented the dependent as being an eligible dependent as defined by OAR 111-080-0045.

111-040-0025

Correcting Enrollment and Processing Errors

(1) Employee Enrollment Errors. Enrollment errors occur when an eligible employee provides incorrect information or fails to make correct selections when making benefit plan elections. The eligible employee is responsible for identifying enrollment errors or omissions.

(a) OEBB authorizes Entities to correct enrollment errors reported by the eligible employee within 45 calendar days of the original eligibility date, open enrollment period end date, or Qualified Status Change date.

(b) Enrollment errors identified after 45 calendar days of the eligibility date, open enrollment period end date or Qualified Status Change date must be submitted to OEBB for review and approval based on OAR 111-080-0030.

(2) Benefit Administrator Processing Errors. Processing errors or omissions occur when benefit plan elections are processed incorrectly in the benefit system or when a newly eligible employee does not receive correct enrollment information.

(a) OEBB authorizes Entities to correct processing errors identified within 45 calendar days of the eligibility date, open enrollment period end date, or Qualified Status Change date. The Entity must reconcile all premium discrepancies.

(b) Processing errors identified after 45 calendar days of the eligibility date, open enrollment period end date, or Qualified Status Change date must be submitted to OEBB for review and approval based on OAR 111-080-0030. The ~~Educational~~ Entity must reconcile all premium discrepancies within 30 calendar days of any adjustments made in the system.

(3) The effective date for the correction of either an employee enrollment error or benefit administrator error is retroactive to the original effective date as identified in OAR 111-040-0001.

(4) The OEBB Administrator has the authority to grant exceptions to OEBB's Administrative Rules when there are extenuating circumstances which can be supported by documentation and verified by OEBB staff.

111-040-0040

Qualified Status Changes (QSCs)

(1) An Eligible Employee experiencing a change in family or work status as noted below after an annual open enrollment, or anytime during the plan year, has 31 calendar days beginning on the date of the event to make allowable changes. If the event is gaining a child, as defined by 111-040-0040(4)(c), or results in a loss of eligibility, the Eligible Employee has 60 calendar days after the event to make allowable changes.

(2) An Eligible Employee can only make changes that are consistent with the event for them self and/or dependents.

(3) An Eligible Employee must report the Qualified Status Change (QSC) to the employee's Entity within the specified timeframe. Failure to report a QSC that will result in removal of a spouse, domestic partner, or child within the timeframe stated in 111-040-0040(1) may be considered intentional misrepresentation, and OEBB may rescind the individual's coverage back to the last day of the month in which the individual lost eligibility. Please refer to the QSC matrix for details on what changes can occur with each event.

(4) Qualified Status Changes which allow an employee to make changes to his or her coverage are:

(a) Gaining a spouse by marriage or domestic partner by meeting domestic partner eligibility;

(b) Loss of spouse or domestic partner by divorce, annulment, death or termination of domestic partnership,

(c) Gaining a child by birth, placement for/or adoption, or Domestic Partner's children (by affidavit of domestic partnership),

(d) Change in employee group which affects plan option availability;

(e) Spouse, domestic partner or child starts new employment or other change in employment status which affects eligibility for benefits;

(f) Spouse, domestic partner's or child's employment ends or other change in employment status resulting in a loss of eligibility for benefits under their employer's plan;

(g) Event by which a child satisfies eligibility requirements under OEBB plans;

(h) Event by which a child ceases to satisfy eligibility requirements under OEBB plans;

(i) Changes in the residence of the active eligible employee, spouse, domestic partner, or child (i.e., moving out of the service area of an HMO or limited network service area plan);

(j) Significant changes in cost of the Eligible Employee's or Early Retiree's current plan and tier level that result in a negative **or positive** impact of 10 percent or more to:

(A) The amount an active Eligible Employee or Early Retiree must contribute toward benefits.

(B) The amount a spouse or domestic partner must contribute toward his or her group health insurance plan cost.

(k) Different Open Enrollment/Plan Year under a spouse/domestic partner's employer plan.

(l) Related laws or court orders. For example: Qualified Medical Child Support Order (QMSCO), Entitlement to Medicare or Medicaid, HIPAA, or Children's Health Insurance Program (CHIP) Changes are determined by the applicable law or court order.

(5) Changes in coverage, or contribution amounts that result in a reduced amount that an employee or eligible dependent must contribute toward benefits, do not constitute a Qualified Status Change.

(6) The following applies to the Long Term Care benefit plans only:

(a) Cancel the plan at any time without a QSC event.

(b) Plan additions or changes require a QSC event as defined 111-040-0040(2). The addition of a plan or change in plans with a QSC is subject to a medical evidence review by the LTC carrier.

111-040-0050

Declination of Coverage

(1) As used in this section:

(a) “Opting out of coverage” means that an otherwise Eligible Employee elects not to enroll in a medical plan and is eligible to receive a portion of the cash contribution or other type of remuneration as provided for under a collective bargaining agreement, documented Entity policy, or employment contract.

(b) “Waiving benefits” means that an otherwise Eligible Employee elects not to enroll in any one of the benefit plans available under the OEBB-sponsored benefits program and is not eligible to receive any portion of a cash contribution or other type of remuneration.

(2) Unless otherwise specified in a collective bargaining agreement, documented Entity policy or employment contract in effect on July 1, 2008, an Eligible Employee may opt out of the OEBB-sponsored medical benefit plans. Eligible Employees electing to opt out must:

~~(a) Maintain coverage under another employer-sponsored group medical benefit plan;~~

(a) Maintain minimum essential medical coverage for themselves and all other individuals for whom the employee can reasonably expect to claim a personal tax exemption deduction for. The medical coverage must be another employer-sponsored group medical benefit plan. The employee must attest to the coverage at initial enrollment and annually thereafter, or

(b) Be enrolled in Medicare or TRICARE coverage and be employed by an Entity that administers their benefits program in compliance with the requirements of Section 125 of the Federal Internal Revenue Code (IRC);

(**c**~~b~~) Meet the requirements of the Entity opt out program in which they are participating;

(**d**~~c~~) Submit their election to opt out through the OEBB benefit management system; and

(**e**~~d~~) If requested, provide proof of current coverage under another employer-sponsored group medical benefit plan.

(3) An Eligible Employee participating with or enrolled in coverage bought on the individual market, the Oregon Health Plan/Medicaid, Veterans’ Administration Health Benefit Program, Student Health Insurance market may not elect to opt out of OEBB-sponsored medical benefit plans. The Eligible Employee may elect to waive benefits or enroll in an OEBB-sponsored medical benefit plan.

(~~3~~**4**) Eligible Employees electing to opt out of the OEBB-sponsored medical benefit plans may enroll in the dental benefit plans, vision benefit plans, and optional benefit plans.

(4**5**) The level and type of funds and allowances retained by Eligible Employees and Entities as a result of opt out programs are determined through collective bargaining agreements and documented Entity policies.

(~~5~~**6**) An Entity will provide OEBB with a written description of its opt-out program upon request.

(~~6~~**7**) An otherwise Eligible Employee may opt-out of medical if the criteria above are met, decline dental and/or vision, or elect any combination of benefits provided under the OEBB-sponsored benefits program, unless otherwise stated in a collective bargaining agreement or documented Entity policy.

(~~7~~**8**) Elections to opt out of the medical benefit plans or waive benefits must be made at the time of hire, when initially meeting eligibility, during an open enrollment period, or following a QSC event whereby the OEBB QSC Matrix allows this as an option.

(a) Coverage for previously OEBB-eligible employees or a previously OEBB-eligible dependent enrolling in the dental and/or vision plans during an open enrollment period will be limited to routine and preventive care for the first 12 months and subject to a 12-month waiting period for orthodontia coverage.

(b) An Eligible Employee who enrolls in the dental or vision plans, or adds previously OEBB- eligible dependents to the dental and vision plans following and consistent with a QSC event will not be subject to waiting periods.

(~~8~~**9**) An Eligible Employee electing to not enroll when initially eligible for optional insurance plans, or enrolling for more than the guarantee issue amount, will have to go through a medical review. Failure to remit a medical history statement or complete other requirements will result in a declination of requested amounts, or the amount above the guaranteed amount, if applicable.

(~~9~~**10**) An Eligible Employee electing to not enroll when initially eligible for optional short term disability will be subject to a late enrollment penalty upon enrollment.