350 Winter Street NE, P.O. Box 14480, Salem, Oregon 97309-0405 503-378-4140 dfr.oregon.gov

Health insurance order FAQs
May 8, 2020

1. **What types of insurance are subject to the health insurance order?**

The order applies to all policies of health insurance in Oregon, with the exception of accidental death and dismemberment, disability, and long-term care polices. This includes all fully-insured commercial health insurance policies, including individual and group health benefit plans, limited benefit, short-term limited-duration, and Medicare Supplement policies. However, to the extent that federal requirements for Medicare Supplement plans conflict with the order, federal requirements supersede the order.
The order does not apply to self-insured employer plans. However, the division strongly encourages self-insured employers to take steps to provide similar relief and flexibility to employee benefit plan members.

2. **How does the order apply to health insurance policies that were in a grace period on the date of the order?**

With the exception of qualified health plans purchased with tax credits through the Health Insurance Marketplace (see Question 3), health insurance policies that were in a grace period as of the March 25 order must be provided a grace period of at least 60 total days. For example, if a policy was provided a 30-day grace period ending March 31, the grace period for that policy must be extended by at least 30 days to provide a total of 60 days.

3. **How does the order apply to the three-month grace period for people who receive advance premium tax credits (APTC) through the Oregon Health Insurance Marketplace?**

The three-month grace period must be applied as specified by federal law. The order does not lengthen, shorten, or delay the grace period required for policies purchased using APTCs.

4. **Is an insurer permitted to cancel a policy if the policyholder does not pay the entire premium amount due by the end of the 60-day grace period?**

Yes. For example, if a policy enters the grace period April 1, and by the end of 60 days, only one month's premium has been paid, the policy may be terminated. However, the cancellation may not be retroactive to a date earlier than the last day of the first month of the grace period.

5. **The order requires insurers to pay claims for services provided in the first month of the grace period. Who is responsible for claims for services provided after that?**

If the insurer does not receive the required premium payment by the end of the 60-day grace period, the insurer may terminate the policy as of the last day of the first month of the grace period, and may deny claims for services provided after that date.
Patients may be eligible for other coverage to help cover these claims, including the Oregon Health Plan or coverage through the Oregon Health Insurance Marketplace, where they may be eligible for financial assistance. The division strongly encourages businesses and people struggling to pay premiums to consider all their options and seek expert assistance from a licensed insurance agent, if appropriate.

6. **The order requires insurers to extend deadlines for policyholders to report claims or submit other communications related to claims. Does this extension apply to claims or other communications from health care providers?**

Yes. The division expects insurers to provide comparable flexibility for health care providers submitting claims or other communications on behalf of insureds.
The division also expects health insurers to provide appropriate flexibility to health care providers in situations where claims submissions may be delayed or affected by uncertainty about the patient's health insurance coverage, since many people may be transitioning between sources of health coverage at this time.

7. **How does the order apply in situations where an employer offering a health benefit plan is no longer eligible for its group plan due to a change in group size?**

Insurers offering health benefit plans are reminded that the division's guidance on employee counting is based on the average number of employees during the preceding calendar year (see https://dfr.oregon.gov/laws-rules/Documents/OAR/div53-0015_exA.pdf).
Consistent with that guidance, insurers offering health benefit plans should consider group size only at the time of renewal. These insurers may not cancel a group health benefit plan policy based on a change in the number of employees during a contract year.
At the time of renewal, the insurer may review the number of people employed over the preceding year to assign the group to the appropriate market, consistent with the division's guidance on employee counting.
Insurers offering health benefit plans are also reminded, even if an employer's market size has changed, the employer is still entitled to guaranteed issue in the small or large employer market. Accordingly, the insurer must still offer to renew the employer onto any plans the insurer offers in the appropriate market.

8. **Does the order require insurers to offer all means of telephonic and electronic reporting of claims and other communications?**

No, it requires insurers to take all practicable steps to make reporting and communication methods available that are compatible with physical distancing recommendations. It does not require insurers to adopt all possible methods for all forms of reporting and communication. For example, it does not require insurers to accept claims submitted solely by telephone call, without supporting documentation that may be necessary to substantiate the claim.