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REPORT TO LEGISLATURE

Subsidized Qualified Health Plan Enrollees: A Grace Period

ENGROSSED SUBSTITUTE SENATE BILL 6016
Chapter 84, Laws of 2014

December 1, 2014

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TABLE OF CONTENTS

INTRODUCTION

Section 3 of Engrossed Substitute Senate Bill 6016, enacted as Chapter 84, Laws of 2014, RCW 48.43.039, directs the Health Benefit Exchange to provide a report related to subsidized Qualified Health Plan (QHP) enrollees who enter a grace period. Customers enter a grace period when they are receiving coverage they did not pay for by the 23rd of the previous month. A grace period lasts 90 days for Qualified Health Plan enrollees who are applying monthly advance payments of health insurance premium tax credits (subsidized QHP enrollees).

These reports begin December 1, 2014 and are required to be submitted annually thereafter.

The aforementioned bill states, *"By December 1, 2014, and annually each December 1st thereafter, the health benefit exchange shall provide a report to the appropriate committees of the legislature with the following information for the calendar year:*

(a) The number of exchange enrollees who entered the grace period;
(b) the number of enrollees who subsequently paid premium after entering the grace period;
(c) the average number of days enrollees were in the grace period prior to paying premium; and
(d) the number of enrollees who were in the grace period and whose coverage was terminated due to nonpayment of premium."

The statute specifies that only subsidized QHP enrollees are to be included in the report: *"For purposes of this section, "grace period" means nonpayment of premiums by an enrollee receiving advance payments of the premium tax credit".*

This initial report presents grace period information on subsidized QHP enrollees as required by RCW 48.43.039. It includes as much data as is available for the 2014 calendar year, which includes data from January 1, 2014 through November 18, 2014.

Section 4 of Engrossed Substitute Senate Bill 6016 further states that, *"Section 3 of this act takes effect January 1st following the issuance of a report under section 2(3) of this act indicating that coverage was terminated due to nonpayment of premium for ten thousand or more enrollees who were in the grace period in that calendar year. In no case may section 3 of this act take effect before January 1, 2015. The health benefit exchange must provide notice of the effective date of section 3 of this act to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the health benefit exchange." This report provides the required notice that Section 3 of this act takes effect January 1, 2015.*

BACKGROUND

The federal Affordable Care Act regulations provide a 90-day grace period to enrollees in Exchange Qualified Health Plans who are receiving monthly advance payments of the premium tax credits but fail to pay their premiums, if they have paid at least one full month's premium during the benefit year. See 45 C.F.R. 156.270(d).

Subsidized QHP enrollees enter a grace period if they are receiving coverage they did not pay for by the 23rd of the previous month. During the first month of a grace period, the health insurance carrier must pay all appropriate claims for services rendered, and may pend claims for services rendered to subsidized QHP enrollees in the second and third months of a grace period. See 45 C.F.R. 156.270(d).

At the end of a grace period, the enrollee's coverage must be terminated if the enrollee has not paid all outstanding premiums. Federal regulations specify that the termination date is retroactive; the last day of coverage for subsidized QHP enrollees is the last day of the first month of the 3-month grace period. See 45 C.F.R. 155.430(d).

Currently the Exchange, in its role as a premium aggregator, terminates enrollees from coverage. The Exchange performs multiple checks before an enrollee is disenrolled. The Exchange performs multiple checks before an enrollee is disenrolled, including-excluding from the termination process enrollees with unresolved account issues (e.g. invoices with an incorrect balance).

Before subsidized QHP enrollees are disenrolled, they receive four invoices from the Exchange stating the premium amount owed, and three overdue payment notices that, per RCW 43.71.090 (2), include language that describes how to report a change that may trigger a change in their premium amount or program eligibility. These notices are sent according to consumer preference, either through email or mail. The Exchange also calls enrollees to inform them that they will be terminated from coverage unless payment is made in full.

FINDINGS

Grace period information on subsidized QHP enrollees (total of 150,147 as of November 18) as required by 48.43.039 is as follows:

Element (a): The number of exchange enrollees who entered a grace period:

- Approximately 80,499 QHP enrollees receiving the advanced premium tax credit entered a grace period between January 1, 2014 and November 18, 2014.

Element (b): the number of enrollees who subsequently paid premium after entering the a period:

- Of the 80,499 subsidized QHP enrollees who entered a grace period, approximately 61,350 or 76% made at least one payment after entering the grace period.

Element (c): the average number of days enrollees were in a grace period prior to paying premium:

- On average, premium payments were made 23 days into a grace period.

Element (d): the number of enrollees who were in a grace period and whose coverage was terminated due to nonpayment of premium:

- Of the 80,499 subsidized QHP enrollees who entered a grace period, approximately 10,535 were terminated for non-payment of premium. Note: individuals who entered a grace period after August were still within their 90-day grace period as of Nov. 18.

CONCLUSIONS

In summary, about half of subsidized QHP enrollees missed a payment deadline in 2014 and entered a grace period. However, four out of five enrollees who entered a grace period made at least one payment. On average, this payment was three weeks into the first month of a grace period when appropriate claims for services rendered would be covered by their health insurance carrier.

To date, 10,535 subsidized QHP enrollees have been terminated for non-payment following a 90-day grace period. Because coverage was terminated for ten thousand or more subsidized QHP enrollees, Section 3 of ESSB 6016 will take effect January 1, 2015.

This report may raise several questions for policy makers to consider. The Exchange will continue to use these findings to inform outreach activities and operational needs related to consumer awareness of payments and grace periods.

APPENDIX: TEXT ENGROSSED SUBSTITUTE SENATE BILL 6016

ENGROSSED SUBSTITUTE SENATE BILL 6016

AN ACT Relating to the grace period for enrollees of the Washington health benefit exchange; amending RCW 48.43.---; adding a new section to chapter 43.71 RCW; adding a new section to chapter 48.43 RCW; and providing a contingent effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1**. A new section is added to chapter 43.71 RCW to read as follows:

(1) The exchange must support the grace period by providing electronic information to an issuer of a qualified health plan or a qualified dental plan that complies with 45 C.F.R. Sec. 156.270 (2013) and 45 C.F.R. Sec. 155.430 (2013).

(2) If the health benefit exchange notifies an enrollee that he or she is delinquent on payment of premium, the notice must include information on how to report a change in income or circumstances and an explanation that such a report may result in a change in the premium amount or program eligibility.

NEW SECTION. **Sec. 2**. A new section is added to chapter 48.43 RCW to read as follows:

(1) For an enrollee who is in the second or third month of the grace period, an issuer of a qualified health plan shall:

(a) Upon request by a health care provider or health care facility,provide information regarding the enrollee's eligibility status in real-time; and

(b) Notify a health care provider or health care facility that an enrollee is in the grace period within three business days after submittal of a claim or status request for services provided.

(2) The information or notification required under subsection (1) of this section must, at a minimum, indicate "grace period" or use the appropriate national coding standard as the reason for pending the claim if a claim is pended due to the enrollee's grace period status.

(3) By December 1, 2014, and annually each December 1st thereafter, the health benefit exchange shall provide a report to the appropriate committees of the legislature with the following information for the calendar year: (a) The number of exchange enrollees who entered the grace period; (b) the number of enrollees who subsequently paid premium after entering the grace period; (c) the average number of days enrollees were in the grace period prior to paying premium; and (d) the number of enrollees who were in the grace period and whose coverage was terminated due to nonpayment of premium. The report must include as much data as is available for the calendar year.

APPENDIX: TEXT ENGROSSED SUBSTITUTE SENATE BILL 6016 (CONTINUED)

(4) For purposes of this section, "grace period" means nonpayment of premiums by an enrollee receiving advance payments of the premium tax credit, as defined in section 1412 of the patient protection and affordable care act, P.L. 111-148, as amended by the health care and education reconciliation act, P.L. 111-152, and implementing regulations issued by the federal department of health and human services.

Sec. 3. RCW 48.43.--- and 2014 c . . . s 2 (section 2 of this act) are each amended to read as follows:

(1) For an enrollee who is in the second or third month of the grace period, an issuer of a qualified health plan shall:

(a) Upon request by a health care provider or health care facility provide information regarding the enrollee's eligibility status in real-time; and

(b) Notify a health care provider or health care facility that an enrollee is in the grace period within three business days after submittal of a claim or status request for services provided.

(2) The information or notification required under subsection (1) of this section must, at a minimum:

(a) Indicate "grace period" or use the appropriate national coding standard as the reason for pending the claim if a claim is pended due to the enrollee's grace period status; and

(b) Except for notifications provided electronically, indicate that enrollee is in the second or third month of the grace period.

(3) By December 1, 2014, and annually each December 1st thereafter, the health benefit exchange shall provide a report to the appropriate committees of the legislature with the following information for the calendar year: (a) The number of exchange enrollees who entered the grace period; (b) the number of enrollees who subsequently paid premium after entering the grace period; (c) the average number of days enrollees were in the grace period prior to paying premium; and (d) the number of enrollees who were in the grace period and whose coverage was terminated due to nonpayment of premium. The report must include as much data as is available for the calendar year.

(4) For purposes of this section, "grace period" means nonpayment of premiums by an enrollee receiving advance payments of the premium tax credit, as defined in section 1412 of the patient protection and affordable care act, P.L. 111-148, as amended by the health care and education reconciliation act, P.L. 111-152, and implementing regulations issued by the federal department of health and human services.

NEW SECTION. **Sec. 4**. Section 3 of this act takes effect January 1st following the issuance of a report under section 2(3) of this act indicating that coverage was terminated due to nonpayment of premium for ten thousand or more enrollees who were in the grace period in that calendar year. In no case may section 3 of this act take effect before January 1, 2015. The health benefit exchange must provide notice of the effective date of section 3 of this act to affected parties, the chief clerk of the house of representatives, the secretary of the senate, the office of the code reviser, and others as deemed appropriate by the health benefit exchange.


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