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REPORT TO LEGISLATURE

Annual Grace Period Report: Subsidized Qualified Health Plan Enrollees

RCW 48.43.039
Chapter 84, Laws of 2014

December 1, 2016

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TABLE OF CONTENTS

INTRODUCTION

Section 4 of Second Engrossed Senate Bill 6089, 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 payment deadline. A grace period lasts 90 days for QHP enrollees who are applying monthly advance payments of health insurance premium tax credits (subsidized QHP enrollees).

These reports began December 1, 2014 and are required to be submitted annually. Previous reports are available on the Exchange corporate website under Legislative Reports & Presentations.

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 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 2016 calendar year, which includes data from January 1, 2016 through October, 31, 2016.

Note: At the end of September, 2015 premium aggregation functionality for qualified health plans offered in the individual market was removed from *Washington Healthplanfinder*. At that point, issuers of qualified health plans became responsible for managing enrollee payments, including monitoring and notifying enrollees in the grace period. As a result, all of the data required for this report is now generated by issuers of qualified health plans and is provided to the Exchange on an annual basis.

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 payment deadline (varies by carrier). 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).

Before subsidized QHP enrollees are disenrolled, they receive invoices from their issuer stating the premium amount owed, and delinquency notices from their issuer stating the impact of nonpayment of premiums on access to coverage and health care services. Additional detail about the information issuers must include in each delinquency notice is included in Section 4 of Second Engrossed Senate Bill 6089. See Appendix A.

FINDINGS

Grace period information on subsidized QHP enrollees (total of 153,952) as required by RCW 48.43.039 is as follows:

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

- Data provided by issuers indicates that 34,172 QHP enrollees receiving the advanced premium tax credit entered a grace period between January 1, 2016 and October 31, 2016.

  Note: Due to issuer reporting limitations, this total does not include subsidized Premera and LifeWise enrollees who entered the grace period then made a subsequent payment.

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

- Of the 34,172 reported subsidized QHP enrollees who entered a grace period, approximately 18,621 or 54% 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 24 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:

- Data provided by issuers indicates that 8,723 subsidized QHP enrollees were terminated for non-payment of premium.

COMPARISON: 2015 vs. 2016

Element	2015 Report (Jan. 1 – Sept. 25)	2016 Report (Jan. 1 – Oct. 31)
Total Subsidized QHP enrollees	152,725	153,952
Entered Grace Period	77,890 (51%)	34,172 (22%)*
Paid Premium After Entering Grace Period	48,011 (62%)	18,621 (54%)*
Average Number of Days Prior to Paying Premium	20	24*
Terminated for Non-Payment	10,926	8,723

** Due to issuer reporting limitations, totals do not include subsidized Premera and LifeWise enrollees who entered the grace period then made a subsequent payment.*

Notes:
- Total Subsidized QHP Enrollees is cumulative (reflects those enrolled at any point during the reporting period).
- For 2016, all data was generated by qualified health plan issuers and provided to the Exchange.
- Subsidized QHP enrollees who entered grace period after August were still within their 90-day grace period as of Oct. 31.
- Subsidized QHP enrollees who enter the grace period may voluntarily terminate their coverage within their 90-day grace period.

CONCLUSIONS

In summary, data from QHP issuers indicates that about a quarter of subsidized QHP enrollees missed a payment deadline and entered a grace period in 2016. However, half of enrollees who entered a grace period made at least one payment. On average, this payment continued to be about three weeks into the first month of a grace period, when appropriate claims for services rendered would be covered by their health insurance carrier.

A reported 8,723 subsidized QHP enrollees were terminated for non-payment following a 90-day grace period.

The Exchange will continue to use these findings to inform outreach activities related to consumer awareness of payment deadlines and grace periods. Per its Strategic Plan, the Exchange will also continue to analyze affordability issues for QHP consumers and use the information to shape future operational and policy direction.

APPENDIX: Text Second Engrossed Senate Bill 6089

SECOND ENGROSSED SENATE BILL 6089

ACT Relating to the health benefit exchange; amending RCW143.71.030, 43.71.090, and 48.43.039; and adding a new section to chapter 43.71 RCW.

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

Sec. 1. RCW 43.71.030 and 2012 c 87 s 4 are each amended to read as follows:

(1) The exchange may, consistent with the purposes of this chapter: (a) Sue and be sued in its own name; (b) make and execute agreements, contracts, and other instruments, with any public or private person or entity; (c) employ, contract with, or engage personnel; (d) pay administrative costs;(e) accept grants, donations, loans of funds, and contributions in money, services, materials or otherwise, from the United States or any of its agencies, from the state of Washington and its agencies or from any other source, and use or expend those moneys, services, materials, or other contributions; (f) aggregate or delegate the aggregation of funds that comprise the premium for a health plan; and (g) complete other duties necessary to begin open enrollment in qualified health plans through the exchange beginning October 1, 2013.

(2) The board shall develop a methodology to ensure the exchange is self-sustaining after December 31, 2014. The board shall seek input from health carriers to develop funding mechanisms that fairly and equitably apportion among carriers the reasonable administrative costs and expenses incurred to implement the provisions of this chapter. The board shall submit its recommendations to the legislature by December 1, 2012. If the legislature does not enact legislation during the 2013 regular session to modify or reject the 6 board's recommendations, the board may proceed with implementation of the recommendations.

(3) The board shall establish policies that permit city and county governments, Indian tribes, tribal organizations, urban Indian organizations, private foundations, and other entities to pay premiums on behalf of qualified individuals.

(4) The employees of the exchange may participate in the public employees' retirement system under chapter 41.40 RCW and the public employees' benefits board under chapter 41.05 RCW.

(5) Qualified employers may access coverage for their employees through the exchange for small groups under section 1311 of P.L.17111-148 of 2010, as amended. The exchange shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the small group exchange at the specified level of coverage.

(6) The exchange shall report its activities and status to the governor and the legislature as requested, and no less often than annually.

APPENDIX: Text Second Engrossed Senate Bill 6089 (Continued)

(7) By January 1, 2016, the exchange must submit to the legislature, the governor's office, and the board a five-year spending plan that identifies potential reductions in exchange per member per month spending below the per member per month levels based on a calculation from the 2015-2017 biennium appropriation. The report must identify specific reductions in spending in the following areas: Call center, information technology, and staffing. The exchange must provide annual updates on the reduction identified in the spending plan.

(8) By January 1, 2016, the exchange must develop metrics, with actuarial support and input from the health care authority, office of insurance commissioner, office of financial management, and other relevant agencies, that capture current spending levels that include a per member per month metric; establish five-year benchmarks for spending reductions; monitor ongoing progress toward achieving those benchmarks; and post progress to date toward achieving the established benchmark on the exchange public corporate web site. Quarterly updates must be provided to relevant legislative committees and the board.

(9) For biennia following 2015-2017, the exchange must include additional detail capturing the annual cost of operating the exchange, per qualified health plan enrollee and apple health enrollee per month, as calculated by dividing funds allocated for the exchange over the 2015-2017 biennium by the number of enrollees in both qualified health plans and apple health during the year. The data must be tracked and reported to the legislature and the board on an annual basis.

(10)(a) The exchange shall prepare and annually update a strategic plan for the development, maintenance, and improvement of exchange operations for the purpose of assisting the exchange in establishing priorities to better serve the needs of its specific constituency and the public in general. The strategic plan is the exchange's process for defining its methodology for achieving optimal outcomes, for complying with applicable state and federal statutes, rules, regulations, and mandatory policies, and for guaranteeing an appropriate level of transparency in its dealings. The strategic plan must include, but is not limited to:

(i) Comprehensive five-year and ten-year plans for the exchange's direction with clearly defined outcomes and goals;
(ii) Concrete plans for achieving or surpassing desired outcomes and goals;
(iii) Strategy for achieving enrollment and reenrollment targets;
(iv) Detailed stakeholder and external communication plans;
(v) Identification of funding sources, and a plan for how it will28fund and allocate resources to pursue desired goals and outcomes; and
(vi) A detailed report including:
(A) Salaries of all current employees of the exchange, including starting salary, any increases received, and the basis for any increases;
(B) Salary, overtime, and compensation policies for staff of the exchange;
(C) A report of all expenses;
(D) Beginning and ending fund balances, by fund source;
(E) Any contracts or contract amendments signed by the exchange; and
(F) An accounting of staff required to operate the exchange1broken out by full-time equivalent positions, contracted employees,2temporary staff, and any other relevant designation that indicates3the staffing level of the exchange.

APPENDIX: Text Second Engrossed Senate Bill 6089 (Continued)

(b) The strategic plan and its updates must be submitted to the authority, the appropriate committees of the legislature, and the board by September 30th of each year beginning September 30, 2015;the report of expenses for items identified in (a)(vi)(C) through (F) of this subsection must be submitted to the appropriate committees of the legislature and the board on a quarterly basis.

NEW SECTION. Sec. 2. A new section is added to chapter 43.71 RCW to read as follows:

As part of eligibility verification responsibilities, the exchange shall verify that a person seeking to enroll in a qualified health plan or qualified dental plan during a special enrollment period has experienced a qualifying event as established by the office of the insurance commissioner and shall require reasonable proof or documentation of the qualifying event.

Sec. 3. RCW 43.71.090 and 2014 c 84 s 1 are each amended 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. 156.27023(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.

(3) The exchange shall perform eligibility checks on enrollees who are in the grace period to determine eligibility for medicaid. The exchange, in collaboration with the health care authority, shall conduct outreach to eligible individuals with information regarding medicaid.

Sec. 4. RCW 48.43.039 and 2014 c 84 s 3 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;

(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; and

(c) If the health care provider or health care facility is providing care to an enrollee in the grace period, the provider or facility shall, wherever possible, encourage the enrollee to pay11delinquent premiums to the issuer and provide information regarding the impact of nonpayment of premiums on access to services.

(2) The information or notification required under subsection (1)14of 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.

APPENDIX: Text Second Engrossed Senate Bill 6089 (Continued)

(3) No earlier than January 1, 2016, and once the exchange has terminated premium aggregation functionality for qualified health plans offered in the individual exchange and issuers are accepting all payments from enrollees directly, an issuer of a qualified health plan shall:

(a) For an enrollee in the grace period, include a statement in a delinquency notice that concisely explains the impact of nonpayment of premiums on access to coverage and health care services and28encourages the enrollee to contact the issuer regarding coverage options that may be available; and

(b) For an enrollee who has exhausted the grace period, include a statement in a termination notice for nonpayment of premium informing the enrollee that other coverage options such as medicaid may be available and to contact the issuer or the exchange for additional information;

(c) For a delinquency notice described in this subsection, the issuer shall include concise information on how a subsidized enrollee may report to the exchange a change in income or circumstances, including any deadline for doing so, and an explanation that it may result in a change in premium or cost-sharing amount or program eligibility.

(4) 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 of11premium. The report must include as much data as is available for the calendar year.

(5) Upon the transfer of premium collection to the qualified health plan, each qualified health plan must provide detailed reports to the exchange to support the legislative reporting requirements.

(6) 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.