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Health Policy Brief

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The Ninety-Day Grace Period. Under the ACA, insurers must wait three months before cancelling the policies of subsidized enrollees who are delinquent on premium payments.

WHAT'S THE ISSUE?

From October 2013 through March 2014 more than eight million Americans enrolled in a new health plan through the Affordable Care Act's (ACA's) insurance Marketplaces. The law recognizes that for some enrollees this represents a significant period of transition, with many gaining regular health coverage for the first time in their lives. To help enrollees new to the system keep their insurance, the ACA provides a ninety-day grace period before an insurer can discontinue someone's coverage for failure to pay a monthly premium. This applies only to those who have received an advance premium tax credit to purchase health insurance through the Marketplaces and have previously paid at least one month's full premium in that benefit year.

The grace period allows for continuity of care for patients by preventing people from shifting or "churning" in and out of coverage when they fail to make a monthly premium payment. Health care providers, however, have argued that the way in which the Centers for Medicare and Medicaid Services (CMS) has implemented the grace-period requirement could expose them to significant financial risk.

This Health Policy Brief focuses on CMS's implementation of the ACA grace period and concerns from hospitals and physicians about potential financial liability now that millions of people have signed up for subsidized health insurance on the Marketplace exchanges.

WHAT'S THE BACKGROUND?

Before the ACA, state laws and regulations on outstanding premium payments varied, and this continues to be the case for nonsubsidized consumers. According to the National Association of Insurance Commissioners (NAIC), most state laws provide for a thirty-day grace period, and state law will continue to apply for those not receiving subsidies through a Marketplace. However, the ACA established a uniform timeframe for subsidized consumers. The grace-period requirement applies to all consumers receiving advance payment of premium tax credits, regardless of whether the insurance Marketplace in their state is operated by the state or by the federal government.

The most recent report on enrollment through the state-based and federally facilitated Marketplaces from the Department of Health and Human Services (HHS) found that more than eight million people chose plans between October 1, 2013, and April 19,

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85%

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2014, and 85 percent of them qualified for premium tax credits. This percentage shows that the impact of the grace period could be significant because most of the people who enrolled qualified for subsidies to help afford their premiums. As of mid-August, 7.3 million people enrolled in the Marketplaces had paid their premiums.

Furthermore, many subsidy-eligible people have yet to enroll, and they could add to the magnitude of the issue if they enroll but are unable to pay their premiums.

WHAT'S IN THE LAW?

The ACA outlines the responsibilities of insurers to enrollees who are receiving advanced payments of premium tax credits. The grace period is only briefly discussed. The statute states that if a subsidized enrollee does not pay his or her premium, the insurance issuer must notify HHS of such nonpayment and allow a three-month grace period for nonpayment of premiums before the insurer discontinues coverage. Again, an individual only qualifies for the grace period if he or she has paid at least one month's premium.

CMS regulations have expanded upon the law's language. In final regulations, CMS said issuers must pay all appropriate claims for medical services rendered to the enrollee during the first month of the grace period, and the insurer may put on hold claims for services rendered to the enrollee in the second and third months. Issuers must also notify HHS of such nonpayment and notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.

There is no requirement on when this notice must be sent to a physician, although CMS has subsequently said it expects providers to be notified within the first month. Federal rules also do not address the grace period for the ACA's Small Business Health Options Program, or SHOP exchanges. Under an NAIC model law and other laws of many states, for small businesses there is a thirty-day grace period.

Some states have taken action to enact additional requirements on health plans for grace-period purposes. Louisiana Gov. Bobby Jindal signed into law on May 22 certain provider notification requirements. The law says that if a provider requests information regarding an enrollee about eligibility, benefits, or claims status, and the request or service is for a date within the last two months of the grace period, the issuer is required to clearly identify that the enrollee is in the grace period. Information provided about the enrollee's grace-period status is binding. If the insurer does not tell the provider that the enrollee is in the grace period, the plan must pay claims for covered services, and it is precluded from trying to recoup payment.

Washington Gov. Jay Inslee on March 27 signed a bill that addresses provider notification. That statute says that for an enrollee who is in the last sixty days of the grace period upon provider request the insurer must provide real-time information regarding that person's status and notify the provider that an enrollee is in the grace period within three business days after a claim is submitted. Legislation has also been introduced in Connecticut.

Under CMS guidance, if an individual does not pay premiums within the grace period, that enrollee is terminated from coverage and cannot re-enroll until the next open enrollment period, which currently would be November 15, 2014, to February 15, 2015, unless the individual experiences a qualifying life event such as marriage, residency change, or loss of health coverage and then a special enrollment period applies. If the individual then pays his or her first month's premium at the start of the next open enrollment period, coverage is reinstated, and the insurer cannot put 2015 premium payments toward the balance due from 2014, although the insurer can try to collect otherwise.

In its final regulation, CMS writes that during the three-month grace period an issuer must continue to collect advance payments of premium tax credits on behalf of the enrollee from the Treasury Department, and it must return those advance payments for the second and third months of the grace period if the enrollee exhausts the entire grace period. The regulation also states that if an enrollee is delinquent on premium payments, the insurer must provide written notice to the individual.

WHAT'S THE DEBATE?

Most criticism about the ninety-day grace period has come from provider organizations, such as hospital and physician groups. Some policy makers and insurance industry leaders have suggested that because patients delinquent on their premiums are not charged with

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a rate increase, issued a repayment order, or banned from obtaining other coverage, they can jump from one plan on the Marketplace to another after a termination. However, in fact, this is only the case when the plan ends on December 31. For example, an enrollee could stop paying premiums in September, receive a ninety-day grace period through December, and then during the open enrollment period enroll in a plan effective January 1. But if an enrollee is terminated from a plan in May, absent a special enrollment period, the enrollee would have to wait until the next open enrollment period for coverage effective January 1, essentially going without coverage for seven months.

Some provider associations have already begun tracking how CMS's regulations on the grace period are affecting physician practices. For example, a May 2014 survey from the Medical Group Management Association (MGMA) stated, "Practices cited some of the main reasons for not participating with ACA exchange products were related to concerns about financial burdens from patient collections (such as burdens related to collecting high deductibles from patients and concerns about financial liability from the 90-day grace period)." Specifically, 48 percent of practices not participating with any ACA Marketplace products cited worries about assuming financial liability during the grace period as a reason for their decision.

In proposed regulations issued by CMS on July 15, 2011, the agency initially said that qualified health plan issuers would continue to pay all appropriate claims submitted on behalf of the enrollee during the ninety-day period. Implementing the grace period in this way would ensure that providers are reimbursed for care provided to those patients during those three months, CMS said. Physicians and hospitals supported this approach.

Insurers, on the other hand, were concerned about the effect on plan premiums if they were required to pay claims for the entire ninety days. In the proposed regulations, enrollees could stop paying premiums in September, and issuers would still have to pay claims between October and December, even if the covered individuals never paid another premium payment for that year. And then, in the next open enrollment period those enrollees would be able to re-enroll in the same plan or choose another plan and pay the premium for January, granting them continuous coverage. Insurers argued that this would ultimately raise premiums because they would price for nine months of premium collection rather than for twelve.

CMS also proposed that if an eligible enrollee is more than one month behind on payments, any subsequent payments made to the insurer would be applied to the first billing cycle in which the enrollee was delinquent. An enrollee would only exit the grace period once he or she has fully paid all outstanding premiums.

After insurers argued that nothing in the text of the ACA required plans to pay medical claims if an enrollee was behind on his or her premium payments, CMS said, in final regulations issued on March 27, 2012, that insurers would be required to pay claims during the first month of the grace period but allowed to delay paying claims for any services rendered during the second and third months of the grace period. The claims could eventually be rejected if the enrollee's coverage was terminated.

CMS noted that there is no federal standard requiring issuers to extend the grace period to enrollees who are not receiving advance payments of premium tax credits, but any Marketplace exchange could itself choose to require issuers to provide all enrollees with such a grace period, regardless of advance payment status. These people, however, are still protected by any state laws around grace periods, as mentioned previously.

Several hospital and physician groups, including the American Hospital Association (AHA), MGMA, and the American Medical Association (AMA), have come out against CMS's implementation of the grace period, saying that the regulations effectively shorten the statutorily mandated ninety days to thirty days—potentially leaving them on the hook for the cost of services rendered from days thirty-one to ninety.

During these second and third months of the grace period, because the patient is still insured, he or she cannot be billed by the provider for any remainder that is owed for medical services that the enrollee received. But if an enrollee fails to pay his or her premiums and the entire grace period elapses, providers are allowed to seek payment for the medical services they gave to that patient and for which the insurance company did not reimburse claims.

Many states have "prompt payment" laws that set timeframes for insurers to reimburse pro-

48%

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viders for claims. In an August 2013 American Bar Association newsletter article, California Medical Association official Brett Johnson wrote, "States currently require health insurers to pay clean claims within anywhere from 15 to 45 days, depending on the means of submission (e.g., electronic or paper), and impose penalty interest where insurers fail to pay within the prescribed time period. Such payment requirements would certainly inhibit an issuer's ability to pend claims over a two-month period."

State rescission restrictions that dictate when an issuer can end an enrollee's coverage could also pose preemption issues, Johnson said. Some states had restrictions in place that prevented the rescission of a policy unless there was evidence of fraud, which could be seen as preventing the application of federal statute.

It is possible that an insurer may pay a physician or hospital for care provided to a patient during the grace period, and then later drop that patient's coverage if he or she fails to pay premiums in full during the rest of the ninety-day grace period. In this scenario, insurers might pursue, as overpayment, the claims it paid out for care provided during the grace period. Those providers, however, may be protected from having to return those payments: Some states have laws that make initial eligibility determinations binding on health insurance issuers.

WHAT'S NEXT?

The earliest that any Marketplace exchange coverage could have gone into effect was January 2014, and policyholders must have paid at least one month's premium before becoming eligible for the grace period.

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Some statistics have been released on the number of enrollees caught in the grace period, though they are state-specific. According to a July 2014 report from Vermont's state-based Marketplace, 1,980 people were in the 90-day grace period. Most of those enrollees—1,266—were within the first 30 days. The report adds that this year to date 644 enrollees had been terminated from their plans for nonpayment.

The larger ramifications of the grace-period policy, if any, will likely not be evident for several months, because some people who enrolled in a health plan during the first open enrollment period may have not had their coverage become effective until April or even May.

Provider education: The AMA, the largest trade group for physicians, has released a number of resources for its members to deal with potential consequences of a patient entering the ACA grace period. For example, one document lists questions physician practices should ask insurers about how their practice will be notified of patient grace-period status and rights with respect to payment and recoupment. The AMA says physician practices should determine how and when an insurer will notify them if a patient and any dependents have entered the grace period, what information the notices will include, how the practice will be notified, and whether the insurer will tell the practice if a patient has subsequently paid his or her late premiums in full.

Patient assistance programs: Some providers have expressed interest in providing premium and cost-sharing assistance for their patients enrolled in coverage through the Marketplaces. By helping their patients maintain coverage and avoid the grace period in the first place, providers hope to reduce the risk that medical claims for care they provide will go unpaid.

However, questions continue to swirl about the legality of such an approach. Although federal anti-kickback regulations might seem to prohibit this type of practice, HHS has stated that such regulations do not apply to the Marketplaces, their plans, and premium tax credits because they are not considered "federal health care programs." Nevertheless, federal regulators have sought to discourage the practice of providers and other commercial entities directly subsidizing patients' health insurance costs.

HHS, though, has suggested that nonprofit charities providing this type of financial assistance to Marketplace plan enrollees is permissible. Hospitals support that view, although the industry wants issuers to be required to accept such financial assistance.

Because of mixed signals from the federal government, the AMA has told its members to "exercise extreme caution prior to discussing with patients the possibility of premium assistance." But the resource the association developed for its members suggests that physicians should be prepared to discuss the grace period with their patients as well as other issues, such as the patient's financial circumstances. The AMA has developed model language for physi-

cians' collection policies with regard to grace-period patients.

The ACA's uniform grace period could prove to play an important role in keeping people enrolled in their plans. But big questions remain unanswered about the financial risks to which physician practices or hospitals could be exposed, as well as how much risk insurers face for claims in the grace period and how that might affect premium growth for all enrollees over time. The issue is likely to evolve in the coming months and years, as it becomes clearer how likely patients who have signed up for subsidized Marketplace exchange coverage are delinquent on their payments. ■

About Health Policy Briefs

Written by
Rachana Dixit Pradhan
Health Care Reporter
Politico

Editorial review by
Timothy Jost
Robert L. Willett Family Professor of Law
Washington and Lee University School of Law

Jennifer Kowalski
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Health Affairs

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