

REPORT TO LEGISLATURE

Annual Grace Period Report: Subsidized Qualified Health Plan Enrollees

RCW 48.43.039
Chapter 84, Laws of 2014

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TABLE OF CONTENTS

Introduction	1
Background	2
Findings	3
Conclusion	4

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 an annual 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).

This report includes the following grace period information on subsidized QHP enrollees as required by RCW 48.43.039(4):

- (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.

It includes as much data as is available for the 2017 calendar year, which includes data from January 1, 2017 through October, 31, 2017.

These annual reports began on December 1, 2014. Previous reports are available on the Exchange corporate website under [Legislative Reports & Presentations](#).

Note: The requirement that the Exchange submit this report was established in 2014. At that time, the Exchange was responsible for managing enrollee payments, including monitoring and notifying enrollees in the grace period. In September 2015, payment related responsibilities were transitioned from the Exchange to issuers of qualified health plans (following the removal of premium aggregation functionality from Washington Healthplanfinder). As a result, issuers of qualified health plans generate all of the data required for this report and provide it to the Exchange on an annual basis.

BACKGROUND

The federal Affordable Care Act regulations provide a 90-day grace period to QHP enrollees in the Exchange 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 RCW 48.43.039. See Appendix A.

FINDINGS

Grace period information on subsidized QHP enrollees (total of 149,628) as required by RCW 48.43.039(4) is as follows:

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

- Data provided by issuers indicates that 36,935 QHP enrollees receiving the advanced premium tax credit entered a grace period between January 1, 2017 and October 31, 2017.

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

- Of the 36,935 reported subsidized QHP enrollees who entered a grace period, approximately 28,512 or 77% 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 18 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 5,077 subsidized QHP enrollees were terminated for non-payment of premium.

COMPARISON: 2016 vs. 2017

Element	2016 Report (Jan. 1 – Oct. 31)	2017 Report (Jan. 1 – Oct. 31)
Total Subsidized QHP enrollees	153,952	149,628
Entered Grace Period	34,172 (22%)	36,935 (25%)
Paid Premium After Entering Grace Period	18,621 (54%)	28,512 (77%)
Average Number of Days Prior to Paying Premium	24	18
Terminated for Non-Payment	8,723	5,077

Notes:

- Total Subsidized QHP Enrollees is cumulative (reflects those enrolled at any point during the reporting period).
- For 2016 and 2017, 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, 2017 data from QHP issuers continues to show that about a quarter of subsidized QHP enrollees miss a payment deadline and enter a grace period, and that an increasing majority of these enrollees make at least one payment. On average, this payment continues 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. The data also indicates that the total annual number of QHP enrollees terminated for non-payment following a 90-day grace period has continued to decline.

It is not expected that these results will vary significantly from year to year. Until the underlying statute is updated to reflect that the Exchange no longer collects or monitors grace period information, the Exchange will solicit data from insurers on an annual basis and compile it for this report.

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 RCW 48.43.039

Grace period—Notification or information—Information concerning delinquencies or nonpayment of premiums—Reports—Defined.

- (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 pay delinquent 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) 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 pending 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) 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 and encourages 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 of premium. 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.