This presentation is intended as a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, and formal policy guidance that it is based upon. This presentation summarizes policy and operations current as of the date it was presented. Links to certain source documents have been provided for reference. We encourage audience members to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information about the requirements that apply to them. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.
Today’s Topics

- Enrollment Effectuation
- Binder Payments
- Enrollment Cancellation
- Premium Payment Grace Periods
Steps to Effectuate Coverage Through the Federally-facilitated Marketplace

1. Consumer completes an application.
2. Consumer selects a plan.
3. Consumer makes a timely payment of the binder payment, if applicable, to the insurance company.
4. Insurance company informs the Federally-facilitated Marketplace (FFM) of effectuated coverage, if applicable.
Binder Payment and Effectuation

- Consumers must pay their binder payment (often the first month’s premium) for enrollment to be effectuated.

- The deadline to make the binder payment to effectuate enrollment* must be:
  - No earlier than the coverage effective date.
  - No later than 30 calendar days from the coverage effective date.

*This is for regular coverage effective dates, as special effective dates have a different range of deadlines.
Many insurance companies adhere to a “threshold” payment policy. This policy allows a consumer to make a binder payment that is less than the entire premium but greater than the “threshold” amount, usually 95 percent.

Example: John Doe’s monthly premium is $100. He pays a timely binder payment of $97, which is 97 percent of the monthly premium and therefore greater than the insurance company’s 95 percent threshold. His enrollment is effectuated by the insurance company and the FFM.
Scenario #1 – Consumer Pays Premium Before Deadline

On December 15, 2021, Stephanie selects a plan.

She pays the binder payment fully or within the tolerance of an applicable premium payment threshold by the deadline of January 1, 2022.

On January 1, Stephanie’s coverage starts.
Coverage Cancellation

- A cancellation is an action or request to “cancel” coverage, which usually occurs before the coverage effective date. Cancellation may be initiated by:
  - The consumer, voluntarily.
  - The insurance company when a binder payment is not made by the payment deadline.

- Free-look Exception
  - Allows an enrollee to retroactively cancel coverage within a certain period of time, following existing state-specific guidelines.
Scenario #2 – Consumer Does Not Pay Full Premium Before Deadline

On November 4, 2021, Nicholas selects a plan with a January 1, 2022, effective date.

He does not pay his binder payment fully or within the tolerance of an applicable premium payment threshold by the deadline of January 30, 2022.

His coverage is cancelled retroactively to January 1, 2022.
Grace Periods

A grace period is an extension set by state or federal rules that gives enrollees with effectuated coverage additional time to pay the portion of the monthly health insurance premiums for which they are responsible before the coverage is terminated for non-payment of premium.
Grace Periods (Cont.)

The length of a grace period depends on the enrollee’s eligibility according to the following guidelines:

- Enrollees receiving advance payments of the premium tax credit (APTC) when they first fail to timely pay premiums have a grace period of three consecutive months.
  - The grace period starts the first month an enrollee fails to pay, even if they make payments for following months.

- All other enrollees not receiving APTC when they first fail to timely pay premiums have a grace period determined by state rules.
  - Consumers should contact their state Department of Insurance for state-specific information on grace periods for enrollees not receiving APTC.

TIP: Remind consumers that it is important to pay all outstanding insurance premiums during a grace period so their health insurance company doesn’t end their coverage.
Claims During Grace Periods for Consumers who are Receiving APTC

- During the first month of a three-month grace period for enrollees receiving APTC, the insurance company must pay all appropriate claims for services rendered to the enrollee.

- During the second and third months of the grace period for enrollees receiving APTC, the insurance company may pend claims for services rendered, if permitted by state law.

- If an enrollee fails to pay all outstanding premiums or an amount that satisfies any applicable premium threshold before the end of the grace period:
  - The insurance company will terminate the enrollee’s coverage for non-payment of their premium, effective on the last day of the first month of the grace period.
  - The insurance company will deny any claims that were pended during the second and third months of the three-month grace period.
Scenario #3 – A Consumer Does Not Pay Premiums During a Grace Period

- John, who’s eligible for and chooses to receive APTC, selects his plan during the Open Enrollment Period (OEP).
- John makes his binder payment on time to effectuate his coverage.
- John does not make a premium payment for May.
- By the end of the three-month grace period, John has not paid all outstanding premium owed (within the tolerance of any applicable premium payment threshold).
Scenario #3 – A Consumer Does Not Pay Premiums During a Grace Period:
Question #1

When does John’s grace period expire?

A. July 31
B. August 31
C. September 30
D. October 31
Scenario #3 – A Consumer Does Not Pay Premiums During a Grace Period:
Answer #1

When does John’s grace period expire?

A. July 31
B. August 31
C. September 30
D. October 31

Answer: A. July 31, the final day of the third month after his grace period started on May 1.
If John still has outstanding premium beyond any applicable threshold after July 31, may the insurance company of John’s Marketplace plan deny any pended claims during June and July?

Yes or No?
Answer: Yes

Since John will lose coverage retroactively to the last day of May (May 31), if he does not pay all outstanding premium owed (within the tolerance of any applicable premium payment threshold) by the end of the grace period, John’s insurance company may deny all pended claims from June and July, although it may keep the APTC paid on John’s behalf and any premium John paid for May coverage. This insurance company must generally refund any premium that John paid for coverage in June or July, in accordance with applicable state law.
Termination for Non-payment of Premiums

- If enrollees do not pay all outstanding premium amounts or an amount sufficient to satisfy any premium payment threshold before the end of the applicable grace period, the insurance company will terminate the enrollee’s coverage for non-payment of premiums.
- A grace period does not “reset” when an enrollee makes a partial payment.
- When an enrollee’s coverage is terminated for non-payment of premiums, the consumer does not qualify for a Special Enrollment Period (SEP) for the resulting loss of minimum essential coverage (MEC).
An enrollee who is eligible for but elects not to receive APTC is not eligible for a three-month grace period, but they are eligible for the grace period required by the enrollee’s state for consumers who fail to timely pay their premiums.

An enrollee can appeal an insurance company’s decision if they believe their coverage was wrongly terminated. A consumer has the right to appeal all terminations or failure to provide or make payments (in whole or in part) for a benefit, including rescissions. However, terminations are not appealable to the Marketplace. Additional information on when to appeal to either the health insurance company or the Marketplace is located at Marketplace.cms.gov/technical-assistance-resources/how-to-appeal-a-decision.pdf.
Scenario #4 – Termination for Non-payment

- Patrick, who’s eligible for and elects to receive APTC, selects his plan during Open Enrollment.
- Patrick fails to make his August payment.
- Patrick fails to make his September payment.
- Patrick pays his August and September premium in full at the end of September.
- Patrick fails to make an October payment.
Scenario #4 – Termination for Non-payment:

Question

Is Patrick still within his grace period if he pays his August and September premiums in full, before October’s premium is due?

Yes or No?
Scenario #4 – Termination for Non-payment:

Answer: No

Patrick paid his August and September premiums in full before the October premium was due, ending his grace period. If he does not pay his October premium by the deadline, he will enter a new grace period that will end on December 31.
Re-enrollment in a Marketplace Plan After Coverage is Terminated Due to Non-Payment of Premium

Consumers whose previous coverage was terminated due to non-payment of premiums can enroll in coverage, if otherwise eligible, during the OEP:

- Consumers can receive a new eligibility determination and, if eligible, enroll in a Marketplace plan for the next plan year.
- Consumers with grace periods expiring at the end of the current plan year and who actively complete a plan selection for the upcoming plan year during the OEP may enroll in new coverage in certain scenarios, if otherwise eligible.
Re-enrollment in a Marketplace Plan After Coverage is Terminated Due to Non-Payment of Premium (Cont.)

- Some consumers may experience a gap in coverage if:
  - They select a different plan through a different insurance company during the OEP and pay their binder payment, so the new coverage is effectuated January 1; and
  - Their previous coverage was terminated effective prior to January 1.

- Note: If consumers aren’t enrolled in Marketplace coverage in mid-December, they aren't eligible to be automatically re-enrolled by the FFM for the following year.
  - Enrollees with grace periods expiring on December 31 or extending beyond the current plan year may still be eligible for auto-re-enrollment in a plan for the upcoming plan year.
Final Market Stabilization Rule

To the extent permitted by state law, an insurance company who has provided proper notice to its enrollees, in paper or electronic form, of the consequences of non-payment of premium on future enrollment, can require an individual or employer to pay all past-due premiums for coverage in the preceding 12-month period before they will effectuate new coverage.

- An insurance company that adopts such a payment policy is required to apply it uniformly to all employers or individuals in similar circumstances, regardless of health status and consistent with non-discrimination requirements.

- This payment policy also applies to insurance companies that do not adopt the policy but are within an adopting insurance company's controlled group.
This means that an insurance company may, without violating guaranteed availability requirements:

- Attribute a premium payment to premiums due to that insurance company for coverage under a product offered by that insurance company or another insurance company in the same controlled group within the prior 12 months, and
- Refuse to effectuate new coverage for failure to pay the binder payment for the new coverage.

This interpretation does **not** allow an insurance company to:

- Condition effectuation of new coverage on payment of premiums owed to a different insurance company*, or
- Condition the effectuation of coverage on payment of past-due premiums by an individual other than the person contractually responsible for the premium payment.

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* An insurance company may be able to collect past-due premiums for a different insurance company if both insurance companies are in the same controlled group.
Marketplace Plan Non-renewal for Medicare Entitlement

- An insurance company is prohibited from selling or issuing individual market coverage to a consumer entitled to Medicare Part A or enrolled in Medicare Part B if the insurance company knows the coverage would duplicate Medicare benefits to which the enrollee is entitled.

  Exception: If the renewal is under the same policy or contract of insurance, which would be determined using state rules.