

90-DAY GRACE PERIOD FAQ

Background

The *Affordable Care Act*, and subsequent regulations released by the Centers for Medicare and Medicaid Services (CMS), made numerous changes to the health insurance marketplace. One area of concern for family physicians is new regulations that extend the time that services are deemed covered in the event that a lapse in payment occurs. The ACA provision extends, to 90 days, the grace period in which patients have to “true up” any past payments prior to the insurance coverage being terminated.

Current laws and regulations on late and outstanding premium payments vary by state, with some states allowing insurers to drop consumers’ policies without advance notice. Other states require insurers to offer a 30-day grace period before dropping customers’ plans. Under rules issued by the Centers for Medicare and Medicaid Services (CMS), consumers will get a 90-day grace period to pay their outstanding premiums before insurers are permitted to drop their coverage. The rule applies to all consumers, in all states, who purchase subsidized coverage through the Affordable Care Act’s (ACA) health insurance marketplace.

The rule also requires insurers to reimburse providers during the first 30 days of the 90-day grace period. If a consumer still fails to make a payment after 90 days and his or her coverage is dropped, depending on most state laws, insurers will not be required to pay for claims incurred during the last 60 days of the grace period. If coverage is dropped for nonpayment, physicians must work directly with patients to collect payments for the balance incurred during days 31-90 of the grace period.

Which patients are impacted?

The grace period issue only applies to individuals who receive tax subsidies to purchase insurance through the health insurance marketplace. Please note that information on whether or not the patient is receiving subsidies will not be noted on their insurance cards.

How does the 90-day grace period work?

If an enrollee’s premium is due on May first, the 90-day grace period begins. If he or she pays their full share of the premium, the 90 day grace period is not needed. If he or she fails to pay their required amount, the 90-day period begins. The insurer **MUST** pay a claim incurred during the first 30 days of the period (1st through 30th day). Claims during the unpaid 31st through the 90th day may be pended. If the enrollee never pays his or her share, the claim is not payable by the insurer.

What does it mean for family physicians?

Trust but verify. Make any appropriate changes to your current procedure to verify eligibility for every visit, especially for those patients who have coverage through an exchange plan. If your EHR accommodates electronic transactions under HIPAA, you may be able to check a patient’s eligibility on the date of the appointment, but this may require a change in your standard front office check-in procedures.

How does this regulation impact my state’s prompt pay law?

Some states have prompt pay laws that may require payment of claims in a period of time which proceeds the grace period (e.g. 15 days for an electronic claim) and may influence the application of this policy. Physicians should consult with their state chapters on laws and regulations in their states.

Am I required to provide care if the insurance plan is suspended?

If the patient’s eligibility verification states that coverage is suspended, the physician may choose to treat the situation as it would any other patient who has had a lapse in health insurance coverage. For non-emergency services, patients would have the option to either pay cash or not be seen.

What should I do if a claim that is unpaid due to non-payment of premium?

Follow your existing policy on non-payment of patient bills.

