FINAL BILL REPORT
ESSB 6016

C 84 L 14
Synopsis as Enacted

Brief Description: Concerning the grace period for enrollees of the Washington health benefit exchange.

Sponsors: Senate Committee on Health Care (originally sponsored by Senators Rivers, Keiser, Cleveland, Tom, Kline and McAuliffe).

Senate Committee on Health Care
House Committee on Health Care & Wellness

Background: The federal Affordable Care Act regulations provide a 90-day grace period to enrollees in Exchange qualified health plans who receive an advance premium tax credit but fail to pay their premiums, if they have paid at least one full month's premium during the benefit year.

The first month of the grace period, the health insurance carrier must pay all appropriate claims for services rendered, and may pend claims for services rendered to the enrollee in the second and third months of the grace period. The carriers must notify providers of the possibility for denied claims when the enrollee is in the second and third months of the grace period.

At the end of the grace period, the health insurance carrier must terminate the enrollee's coverage if the enrollee has not paid all out-standing premiums.

Summary: The Exchange must support the grace period by providing electronic information to issuers of qualified health and dental plans that complies with federal rules on termination of coverage. If the Exchange notifies an enrollee of a delinquency in paying premiums, the notice must include information on how to report a change in income or circumstances, as well as an explanation that such a report may result in a change in the premium amount or program eligibility.

A health insurance carrier offering a qualified health plan in the Exchange must notify a provider or facility that an enrollee is in a grace period as follows:

- With respect to an enrollee in the second or third month of the grace period, the issuer, upon request by a provider or facility, must provide information regarding the enrollee's eligibility status in real-time, and notify a provider or facility that the

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enrollee is in the grace period within three business days after submittal of a claim or status request for services provided; and

- The information or notification must, at a minimum, indicate "grace period" or a national coding standard as the reason for pending the claim if a claim is pended due to the grace period.

By December 1, 2014, and annually thereafter, the Exchange must provide the Legislature with a report indicating the number of enrollees who entered the grace period; the number of enrollees who paid premium after entering the grace period; the average number of days enrollees were in the grace period prior to paying premium; and the number of enrollees who were in the grace period and whose coverage was terminated due to nonpayment of premiums.

If the Exchange report indicates that coverage was terminated due to nonpayment of premium for 10,000 or more enrollees who were in the grace period, the issuer's notification to the provider or facility must also indicate whether the enrollee is in the second or third month of the grace period, unless the notification is provided electronically. This requirement is effective January 1 following issuance of the report, but in no case before January 1, 2015. The Exchange must notify affected parties and the Legislature if the contingency occurs.

The grace period is defined to mean nonpayment of premiums by an enrollee receiving advance payments of the premium tax credit as defined by the Affordable Care Act, and implementing regulations issued by the U.S. Department of Health and Human Services.

Votes on Final Passage:

Senate	48	0	
House	92	6	(House amended)
Senate	45	4	(Senate concurred)

Effective: June 12, 2014
Contingent (Section 3)