



August 15, 2013

Ms. Marilyn B. Tavenner
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Qualified Health Plan Payment for Services during Grace Period for Nonpayment of Premiums

We, the undersigned organizations, respectfully request that the Centers for Medicare & Medicaid Services (CMS) reconsider and revise its policy implementing a provision under the Patient Protection and Affordable Care Act (ACA) regarding termination of coverage for non-payment of insurance premiums by individuals who qualify for advance payment of premium tax credits. Specifically, we urge CMS to ensure compliance with the ACA by requiring qualified health plans (QHPs) to provide health insurance coverage for a full three-month grace period.

Under section 1412(c)(B)(iv)(II) of the ACA, if an insured individual who qualifies for advance payment of premium tax credits does not pay his/her portion of the premium, QHPs are required to “allow a 3-month grace period of nonpayment of premiums before discontinuing coverage.” (Emphasis added.) This grace period protects low-income individuals who wish to purchase health insurance, but who may experience temporary difficulty in paying premiums during a given time period, giving them an opportunity to catch up. Under this protective measure, an individual’s inability to pay insurance premiums must be sustained before the ACA will permit QHPs to terminate coverage.

In July 2011, CMS issued a proposed rule to implement this ACA provision. (76 *Fed.Reg.* 41,865 [Jul. 15, 2011].) CMS proposed that a QHP issuer must provide a grace period of at least three consecutive months before terminating coverage, provided an enrollee receiving advance payments of the premium tax credit previously has paid at least one month’s premium. Thus, CMS’s proposal went

further than the required statutory minimum of a three-month grace period, presumably to afford QHPs and states the flexibility to provide additional consumer protections as desired.

In a recent final rule, however, CMS reversed course and promulgated a final policy that permits QHPs to terminate coverage after 30 days of non-payment of premiums for this category of enrollees. (*See 77 Fed.Reg.* at 18426-28.) Specifically, QHPs would be required only to pay all appropriate claims for services provided during the first month of the grace period, and could suspend claims for services furnished during the second and third months. If a consumer does not pay his/her outstanding premiums by the end of the three-month grace period, the QHP may deny all pending claims for services rendered during the second and third months.

The effect of this policy is to allow QHPs to retroactively terminate coverage for the second two months of the grace period. This shifts the burden related to patient protections during most of the grace period from QHPs to health care providers. In the final rule, CMS acknowledged its lack of authority to change the grace period, when it responded to a commenter's request for a six-month grace period by stating "[w]e do not believe the statute provides the flexibility to alter the grace period timeframe." (*See 77 Fed.Reg.* at 18,427-28.) But then CMS adopted a policy that effectively shortens the grace period to one month by allowing retroactive termination simply by waiting three months to execute the termination.

While plans may terminate coverage for non-payment of premiums more quickly in the current commercial insurance market, the ACA clearly sought to protect low-income enrollees in QHPs in a way that affords them a greater opportunity to maintain continuous health insurance coverage. Additionally, CMS promulgated this final policy without any indication of such a possibility in the proposed rule. Thus, affected stakeholders had no meaningful opportunity to comment.

The final policy has another notable disparate impact. The final rule stated that it is "critical that the Federal government establish a uniform grace period policy." (*Id.*) However, the final policy does not comport with this basic principle because it essentially creates two different grace period policies: one for the first month and another for the remaining two months. In doing so, this policy will subject enrollees to significant personal liability for services received during the second two months, which was not contemplated by a statute clearly intended to provide coverage protection to low-income individuals for an entire three-month period.

CMS's approach also unfairly burdens providers who treat these patients because they will not get paid by the QHP for covered services and will have to wait to try to obtain direct payment from the patient. The reality is that it will be extremely difficult to collect payment from low-income patients who already are having trouble paying their QHP premiums.

Accordingly, we strongly urge CMS to revise section 45 C.F.R. 156.270(d) to reflect the ACA-mandated minimum three-month grace period, and require QHPs to pay for all services rendered during that time period. If a revised policy adopts the statutory minimum grace period, it must not allow QHPs to suspend claims. Patients only are protected when the statute is implemented as Congress intended. Without payment for covered services, there is only an illusion of continued coverage during the 90-day grace period, not the actual continued coverage required by law.

Thank you for your consideration. We look forward to continuing our work with CMS to ensure that ACA implementation protects patients' broad access to medical services.

Sincerely,

/s/

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Executive Vice President
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/s/

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/s/

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cc: Gary Cohen, DHSS/CMS/OA/CCIIO