



# Step-by-step guide to the ACA grace period

This resource does not create an attorney-client relationship between the American Medical Association and the reader. The AMA is not providing legal advice in this resource. The reader should receive legal advice from retained legal counsel concerning any issues raised in this resource.

This resource outlines key questions to ask health insurers about how your practice will be notified of grace period status, your rights with respect to payment and recoupment and more. It also covers frequent issues that physicians raise about the grace period.

Visit [ama-assn.org/go/aca](http://ama-assn.org/go/aca) for additional information and resources on the Affordable Care Act (ACA) and the grace period.

## I. Insurer-related issues

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### A. Notice. Determine how the health insurance issuer will notify you when one of your patients (and his/her dependents) has entered the grace period.

1. **You ARE entitled to receive notice.** Federal regulations require health insurance issuers to notify providers of the possibility for denied claims when a patient is in the grace period.<sup>1</sup>
2. **What specific information will you receive?** Ask the health insurance issuer what specific information its notices will contain. You will, for example, want to find out if the issuer's notice contains the following kinds of information:
  - (a) Language conspicuously identifying the purpose of the notice
  - (b) A notice-unique identification number
  - (c) The name of the qualified health plan (QHP) and affiliated health insurance issuer
  - (d) The QHP's unique health plan identifier
  - (e) The full legal names of the patient and any of the patient's dependents, if applicable
  - (f) An explanation of the three-month grace period, and applicable dates, including:
    - (i) The specific date upon which the grace period for the patient (and any dependents) began, and the specific date upon which the grace period will expire
    - (ii) Whether the enrollee is in the first, second or third month of the grace period
    - (iii) The consequences for you and your patient if the grace period is exhausted
    - (iv) Your options during, and upon exhaustion of, the grace period

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<sup>1</sup> 45 C.F.R. § 156.270(d)(3)

(g) A QHP customer service telephone number where you can have your questions answered<sup>2</sup>

**3. How will you be notified?** The Centers for Medicare & Medicaid Services (CMS) regulations do not specify how the health insurance issuer must notify you when one of your patients enters the grace period. For example, will the health insurance issuer send notice to you via email or mail? Will the health insurance issuer provide notice on its website (e.g., via a provider portal)? Will the health insurance issuer notify you via standard transactions when you do an eligibility check or submit a claim? However, the CMS encourages issuers to provide this notice whenever responding to an eligibility verification request from a health or dental care provider.<sup>3</sup> The effectiveness of a timely and detailed grace period notice may be undermined if the notice provided is not likely to attract your attention. For example, if the health insurance issuer will provide you with notice via mail, are you more likely to immediately read correspondence that conspicuously indicates that it contains important grace period information concerning your patients? If the notice uses standard transactions, then your vendor will need to be sure to capture that information and flag it to your staff. Be sure you understand how you will be notified of your patients' grace period status.<sup>4</sup>

**4. Timing.** Federal regulations do not specify when health insurance issuers must provide grace period notice to providers. However, the CMS expects issuers to provide such notice within the first month of the grace period and throughout months two and three.<sup>5</sup> Be sure to ask the health insurance issuer when it will provide you with grace period notifications. For example, will the issuer alert you as soon as it learns that a patient has entered the first month of the grace period? Or, will you receive notification only when a patient has entered the second or third grace period month? Obviously, the more timely notice you receive concerning your patients' entry into the grace period, the earlier you can discuss grace period issues with patients and take appropriate steps to proactively address financial concerns.

**5. Closely track receipt of and review your grace period notifications.** Closely review your grace period notifications to make sure that they comply with federal requirements and any other specifics mandated by a state-based exchange or department of insurance. Keep copies of any noncompliant notifications, and document any instances of delinquent notifications. If noncompliance or delinquency occurs regularly, immediately inform the health insurance issuer and the applicable exchange and department of insurance. You also can alert the AMA at [ExchangePlans@ama-assn.org](mailto:ExchangePlans@ama-assn.org).

**6. Will you be notified when a patient is removed from the grace period?** It will be important to know when a patient has paid his or her premiums in full and is no longer in the grace period. Ask if and how a health insurance issuer will notify you when such a patient has been taken out of the grace period.

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<sup>2</sup> The American Medical Association's (AMA) Advocacy Resource Center has developed a model state grace period bill entitled the "Physician and Provider Notification of Patients in Health Insurance Exchange Grace Period Act," which would require health insurance issuers to provide this specific notice. The model bill may be accessed at [ama-assn.org/go/stateaca](http://ama-assn.org/go/stateaca).

<sup>3</sup> CMS Federally Facilitated Marketplace Enrollment Operational Policy and Guidance, October 3, 2013 ("Draft Manual"), page 29, which can be accessed at [http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR\\_OperationsPolicyandGuidance\\_5CR\\_100313.pdf](http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/ENR_OperationsPolicyandGuidance_5CR_100313.pdf)

<sup>4</sup> The AMA's technical resource, "Health insurance exchange premium payment grace period: Best practice for electronic notifications," outlines best practices to help ensure that physicians receive this critical notification in a standard, electronic format. It is intended for electronic data interchange staff, vendors, regulators, and physician practice technical staff.

<sup>5</sup> Id.

**B. Policy with respect to pending and denial.** Make sure you know whether the health insurance issuer will pend claims for services you provide during the second or third month of the grace period, and whether the health insurance issuer will deny those claims if the patient's coverage terminates due to nonpayment of premiums. Having this information in writing (along with accurate, timely and complete information concerning the patient's grace period status) will be essential for several reasons. It can be an opportunity for you to help educate your patient on the importance of paying his or her premiums. And it is also important to inform the patient that he or she may be financially obligated to pay in full for services received during the second or third month of the grace period. The AMA offers a [sample grace period notice to patients](#) that explains what the grace period is and what patients need to do if they are in the grace period.

**1. Find out whether your state prompt pay laws limit issuers' ability to pend claims.** Your state prompt pay laws may limit a health insurance issuer's ability to pend or deny your claims. For example, the California Department of Managed Health Care decided that the state's prompt pay law, which requires health plans to process claims within 30 to 45 days of receipt, did not allow issuers to pend claims for the full 60 days permitted by federal law.<sup>6</sup> Other states (e.g., Virginia) have decided that the 90-day grace period supersedes state prompt pay requirements.<sup>7</sup> Every state has a prompt pay law. Consult your state medical association or insurance department concerning what, if any, limitations your state's prompt pay law may place on an issuer's ability to pend claims during the second or third month of the grace period. It is important to note, however, that even if an issuer does not pend the claim, they may seek recoupment later.

**C. Payment and recoupment.** Some health insurance issuers have stated that they will pay, rather than pend, claims for services provided during the second and third months of the grace period. If one of your health insurance issuers takes this approach, find out if and how the health insurance issuer may attempt to recover any such payments made to you if the patient ultimately fails to pay his or her premiums in full. Consider the following:

**1. Remittance advice.** Find out what, if any, reason and remark codes and associated terminology the health insurance issuer will include in its electronic remittance advice (the ASC X12 835 Health Care Claim Payment/Remittance Advice) to convey grace period information. For example, what, if any, codes and terminology will indicate that the patient is in the first month of the grace period, the second month of the grace period or the third month of the grace period?

**2. Effect of state laws limiting overpayment recoveries.** Your state may limit the time period within which health insurance issuers may request refunds or recoup overpayments. For example, both Maryland and Texas mandate that generally a health insurance issuer cannot recover an overpayment from a provider after six months from the date on which the health insurance issuer paid the claim. Be sure you know what, if any, limits your state may have because those limits may provide significant protection concerning recoupments. Ask your state medical society or department of insurance for the time period during which the issuer is allowed to recoup payment.<sup>8</sup>

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<sup>6</sup> <http://www.cpc.org/cpc2013/assets/File/Announcements/2013-09-02-DMHC-email-to-plans-re-grace-period.pdf>

<sup>7</sup> [http://www.scc.virginia.gov/boi/faq/aca\\_hi.pdf](http://www.scc.virginia.gov/boi/faq/aca_hi.pdf)

<sup>8</sup> The AMA's Physician and Provider Notification of Patients in Health Insurance Exchange Grace Period Act states that overpayment recovery efforts must commence no later than 60 days after the grace period expires. The model bill can be accessed at [ama-assn.org/go/stateaca](http://ama-assn.org/go/stateaca).

**3. Review your contract.** Most managed care contracts allow health insurance issuers to recoup overpayments, so review your contracts to make sure you understand the issuer's recoupment rights. Understanding these rights can help you:

- (a) Reduce the "surprise" factor if and when an issuer requests a refund or pursues recoupment
- (b) Anticipate how long you will need to keep your payment records in case you want to contest a refund request or recoupment action
- (c) Determine whether the issuer's contractual overpayment recovery rights extend beyond time frames permitted by state law; if the issuer pursues an overpayment under this clause contrary to state deadlines, you should immediately notify the issuer that it is in violation of state law and, if the issuer continues, you will alert your state medical society and insurance department

#### **D. Eligibility verification.**

**1. Method of verification.** Ask the health insurance issuer how you will be able to verify eligibility (e.g., telephonically or via the ASC X12 270 Health Care Eligibility Benefit Inquiry/ASC X12 271 Response).

**2. Will the verification response contain key grace period information?** Ask the health insurer if and how its verification responses will communicate grace period information concerning the patient. For example, will the response indicate when the patient entered the grace period or whether or not the patient is in the second or third month of the grace period?

**(a) Codes and terminology used by the ASC X12 271 Response.** Specifically with regard to the ASC X12 271 Response, you should understand any specific codes and associated terminology through which the health insurer may convey information concerning the patient's grace period status. For example, some health insurers may indicate that the patient's status is "7–Pending Eligibility Update." or "8–Inactive–Pending Investigation." Additional information that may be conveyed includes the premium paid to date, the starting and end dates of the grace period and a textual message identifying that the dates are related to the grace period.

**3. Checking eligibility status as a matter of course.** Be sure that, as a matter of course, you check and document the patient's eligibility status prior to each visit. Checking and documenting eligibility status regularly is particularly important for patients involved in an ongoing course of treatment that may impose significant financial obligations on the patient for your services if the patient loses coverage because of a failure to pay premiums in full during the three-month grace period.

**4. Keep records and track accuracy.** All grace period information included in verification responses should be accurate. It is vital that you keep electronic and document telephonic verification responses. If a question later arises concerning a patient's grace period status, you can review those responses to confirm the issuer's eligibility verification and evaluate the accuracy of grace period information that the verification contains. You should inform your state medical association, exchange and department of insurance if you determine that a health insurance issuer repeatedly fails to provide you with accurate grace period information.

## **E. What happens if the health insurance issuer fails to provide you with accurate information concerning grace period status?**

**1. Who bears the cost for inaccurate grace period information?** For example, suppose a health insurance issuer that has adopted a “pend and deny” policy pays a claim based on inaccurate information indicating that the patient is still in the first month of the grace period. Later, the issuer updates its records and discovers that the patient was in the second month of the grace period. Will the health insurance issuer be allowed to recover that mistaken payment? This is a key question that should be posed to the state-based exchange and/or state department of insurance.

### **2. Possible state law protections.**

**(a) Does your state limit the basis for overpayment recoveries?** In addition to placing deadlines within which health insurance issuers must pursue overpayments, some states limit the circumstances under which overpayment may be pursued. A state may, for example, permit overpayment recoveries on limited grounds (e.g., if the issuer made a duplicate payment, another payer was financially obligated to pay under coordination of benefits, etc.), but not merely because the health insurer issuer simply paid in error. Be sure you know whether or not your state law limits the grounds for overpayment recovery, as mere mistaken payments may not be a sufficient basis for recovery.

**(b) Binding verifications.** A few states have laws that make eligibility determinations binding on health insurance issuers. Under such laws, if a health insurance issuer verifies eligibility, it cannot later revoke that verification and attempt to recover any associated payments. Find out if your state has enacted such a law because that law could in some cases protect your practice from having to accept the financial consequences of an issuer’s mistaken eligibility determinations.<sup>9</sup>

**3. Review your contract.** Under most managed care contracts, health insurance issuers retain the right to recover mistaken payments (e.g., payments resulting from erroneous eligibility determinations). Similarly, issuers may likely reserve the right to recover payments made in spite of providing you with inaccurate grace period information. It is, therefore, crucial that you review any exchange contract to make sure you understand any obligation on your part to return payments resulting from issuers’ mistakes. Such a review will not only help you evaluate whether or not you want to sign the contract, it will also help you determine whether or not contract language complies with limitations imposed by state law.

**F. Prior authorization and grace period information.** The health insurance issuer will likely require prior authorization for certain items and services for grace period patients (e.g., using facsimile, email, mail, telephonic means or the ASC X12 Health Care Services Review and Response). If so, ask the issuer if its responses will convey information concerning the patient’s grace period status. Some health insurance issuers have indicated that their responses to prior authorization requests will not contain information concerning grace period status on the grounds that such responses only report information concerning the medical necessity of the item or service involved.

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<sup>9</sup> The AMA’s Physician and Provider Notification of Patients in Health Insurance Exchange Grace Period Act binds health insurance issuers to their eligibility determinations. The model bill can be accessed at [ama-assn.org/go/stateaca](http://ama-assn.org/go/stateaca).

## II. Issues concerning patients

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**A. Be prepared to discuss grace period issues with patients.** When you learn that a patient has entered the grace period, be prepared to talk with the patient about what it means to be in the grace period and the potential consequences for failing to catch up on premium payments. You should not assume that the patient has received, read or fully understood any grace period notifications received from the health insurance issuer or other sources. If the patient is scheduled for an appointment, ask the patient to bring any grace period correspondence he or she may have received as this will help you or your office manager explain the meaning of the correspondence and ensure that information received from the health insurance issuer is consistent with your patient communications. The AMA offers a [sample grace period notice to patients](#) that explains what the grace period is and what patients need to do if they are in the grace period.

**B. Ask the patient about his or her financial circumstances.** Ask the patient why he or she has fallen behind on premiums. Has a change in financial circumstances (e.g., job loss, divorce, death of a spouse) been the cause? If so, the patient may not be able to catch up on premiums. However, even if it is likely that the health insurance issuer will terminate the patient's coverage for premium nonpayment at the grace period's end, you may be able to help the patient identify and enroll in other coverage for which the patient may be eligible. And if the patient is signed up for coverage in the exchange, the job loss or other change in financial circumstances may entitle the patient to an increase in the premium credit subsidy.

**1. Potential ethical considerations.** With respect to helping patients obtain other coverage, a potentially relevant ethical consideration has been expressed by the AMA's Council on Ethical and Judicial Affairs (CEJA). More specifically, CEJA Ethical Opinion E.9.0651, Financial Barriers to Health Care Access, provides in part that:

Physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means. In view of this obligation:

- (a) Individual physician should take steps to promote access to care for individual patients.
- (b) Individual physicians should help patients obtain needed care through public or charitable programs when physicians cannot do so themselves....<sup>10</sup>

**C. Can you help your grace period patients pay their premiums?** Based on guidance and a rule issued by the U.S. Department of Health and Human Services (HHS), HHS has repeatedly discouraged physicians, hospitals and other health care providers from paying patients' premiums. On Nov. 4, 2013, HHS issued a frequently asked question (FAQ) concerning this issue.<sup>11</sup> In the FAQ, HHS stated:

It has been suggested that hospitals, other healthcare providers, and other commercial entities may be considering supporting premium payments and cost-sharing obligations with respect to qualified health plans purchased by patients in the Marketplaces. HHS has significant concerns with this practice because it could skew the insurance risk pool and create an unlevel field in the Marketplaces. HHS discourages this practice and encourages issuers to reject such third-party payments. HHS intends to monitor this practice and to take appropriate action, if necessary.

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<sup>10</sup> <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion90651.page>

<sup>11</sup> <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf>



On Feb. 7, 2014, HHS issued a further clarification in another FAQ.<sup>12</sup> HHS indicated that its FAQ from Nov. 4 was not meant to preclude state and federal government programs or grantees, including Ryan White HIV/AIDS programs, from making such payments (see the March 14 rule below requiring health insurance issuers to accept such payments). It also clarified that private, not-for-profit foundations can pay premiums for a patient who meets financial need criteria (which are not defined) as long as the payment is not based on health status considerations and any premium payments that cover the entire policy year.<sup>13</sup> On May 21, HHS again stated that private, not-for-profit foundations may pay patients' premiums as previously discussed in the February 7 FAQ.

On March 14, HHS published an Interim Final Rule (IFR) again addressing the issue of premium payments made by third-party payers. Under the IFR, health insurance issuers offering individual market QHPs, including stand-alone dental plans (SADPs), must accept premium and cost-sharing payments from the following third-party entities on behalf of plan enrollees: (a) Ryan White HIV/AIDS program; (b) Indian tribes, tribal organizations or urban Indian organizations; and (c) state and federal government programs.<sup>14</sup> Also, the CMS restated its concerns about other types of third-party premium payments:

Our new standard does not prevent QHPs and SADPs from having contractual prohibitions on accepting payments of premium and cost-sharing from third-party payers other than those specified in this interim final regulation. In particular, as stated in our November FAQ, we remain concerned that third-party payments of premium and cost-sharing provided by hospitals, other healthcare providers, and other commercial entities could skew the insurance risk pool and create an unlevel competitive field in the insurance market. We continue to discourage such third-party payments of premiums and cost-sharing, and we encourage QHPs and SADPs to reject these payments.<sup>15</sup>

Based on this guidance, physicians should exercise extreme caution prior to discussing with patients the possibility of premium assistance. You should also read your contract very carefully as it might prohibit you from providing premium support or other financial assistance. Even if your contract does not address the issue, find out if the health insurance issuer's provider manual or other policies and procedures preclude you from providing financial assistance. Finally, state law requirements may limit your ability to help patients financially, so it may be advisable to check with an experienced health care attorney prior to discussing financial support with patients.

**D. Can you reschedule grace period patients until they catch up on their premiums?** If you have a contract with a health insurance issuer, that contract may prohibit you from rescheduling grace period patients. This is because most managed care agreements contain very broad anti-discrimination clauses. These provisions prohibit providers from treating patients differently based not only on issues such as race, national origin, ethnicity, disability, etc., but also on grounds such as source of payment or type of insurance coverage. Rescheduling grace period patients, therefore, may be a breach of your contract. Even if rescheduling is not contractually prohibited, great care must be taken to ensure that rescheduling cannot be interpreted as a type of discrimination that is prohibited under state or federal law.

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<sup>12</sup> On March 14, CMS also published an interim final rule requiring QHP issuers to accept premium and cost sharing payments made by the Ryan White HIV/AIDS Program and other, specific state and federal programs.

<sup>13</sup> <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-payments-of-premiums-for-qualified-health-plans-in-the-marketplaces-2-7-14.pdf>

<sup>14</sup> [http://www.ofr.gov/OFRUpload/OFRData/2014-06031\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2014-06031_PI.pdf)

<sup>15</sup> Id.

**E. Termination issues.** Typically, if a health insurance issuer rescinds a patient's *coverage*, you are no longer contractually obligated to see the patient. In most cases, this means that you are free to terminate the patient-physician relationship. You may, of course, continue the relationship if you and the patient agree to do so (e.g., if the patient is able to pay you adequately for your services on a self-pay basis). It is important to clarify, however, that an issuer cannot terminate the coverage of patients in the grace period until after the expiration of the grace period, including any additional processes that the issuer may be required to follow.

If an issuer cancels a patient's coverage and you are considering terminating the patient-physician relationship, you should always exercise care when doing so, since terminating the patient-physician relationship can raise serious ethical and medical liability considerations for patients with special medical conditions (e.g., patients who are in the late stages of pregnancy or have serious chronic illnesses). Ethically speaking, CEJA Ethical Opinion E-8.115 "Termination of the Physician-Patient Relationship" states:

Physicians have an obligation to support continuity of care for their patients. While physicians have the option of withdrawing from a case, they cannot do so without giving notice to the patient, the relatives, or responsible friends sufficiently long in advance of withdrawal to permit another medical attendant to be secured.<sup>16</sup>

Physicians must also provide sufficient notice to avoid potential medical liability or professional licensure board action resulting from claims of patient abandonment. What constitutes sufficient notice will depend on the facts of each case, your state's laws, professional rules of conduct and court decisions. If you are caring for a patient with a special medical condition and you are unsure what constitutes appropriate notice, it may be prudent to consult an experienced health care attorney in your state and your medical liability carrier regarding how best to handle termination.

**1. Review your contract.** You should review your contract carefully to find out what obligation you have to provide ongoing care to patients with special medical conditions whose coverage has been terminated at the grace period's end. Most managed care agreements contain continuation of coverage provisions that require physicians to treat patients with special medical conditions for specific periods of time after coverage has ended. Also, it is vital that you find out if the issuer will pay for providing such care until you can appropriately end the patient-physician relationship or the patient can secure other coverage.

## **F. Financial considerations.**

**1. Financial agreements.** Chances are your practice already requires patients to sign agreements that make the patient financially responsible for cost-sharing obligations and non-covered services. You should review your agreement to make sure it also obligates the patient to timely pay you in full for services you provide during the second and third months of the grace period if the patient loses coverage due to premium nonpayment. The AMA offers [model financial agreement language for patients receiving Advance Premium Tax Credits](#) that you can modify for use in your practice.

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<sup>16</sup> <https://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8115.page>



**a. Ethical considerations.** When reviewing your financial agreements, keep in mind that specific ethical considerations may apply. More specifically, CEJA Ethical Opinion E-6.08, Interest Charges and Finance Charges, permits physicians to request that payment be made at the time of service or add interest/other charges to delinquent accounts. The opinion also provides that: "The patient must be notified in advance of the interest or other reasonable finance or services charges . . ." and "Physicians are encouraged to review their accounting/collection policies to ensure that no patient's account is sent to collection without the physician's knowledge."<sup>17</sup>

**2. Track negative impact.** Closely track any negative impact that claim denials for services provided during the second or third month of the grace period may have on your practice revenue. Pay particular attention to the extent to which you are able to obtain timely payment in full from patients to whom you provided services during the second or third month of the grace period but who lost coverage due to premium nonpayment. Being able to show the health insurance issuer that its pend-and-deny policy has had a significant adverse effect on your practice due to unsuccessful attempts to receive timely payment in full from patients may:

- (a) Be useful in future negotiations with the health insurance issuer
- (b) Encourage the issuer to reconsider its pend-and-deny policy
- (c) Persuade the issuer to defray the negative impact, e.g., by making payments to you to offset at least a portion of lost revenue
- (d) Help you evaluate whether or not you should continue contracting with the health insurance issuer
- (e) Be useful in convincing the CMS to change its regulations and state health policy makers and legislators to enact legislation mitigating the effects of the grace period for all physicians in your state

Visit [ama-assn.org/go/aca](http://ama-assn.org/go/aca) for additional information and resources on the Affordable Care Act and the grace period.

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17 <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion608.page>