



# Enrollment & Transaction Frequently Asked Questions

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## Frequently Asked Questions (FAQ) # 6

Release Date: July 22, 2013

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- Q1: The April 2013 Annual Letter to Issuers indicated that Issuers must notify providers that may be affected by an enrollee entering a grace period for non-payment (providers who submit claims for services they have provided to individuals during the grace period and for which they risk not being reimbursed). When should the QHP Issuer send the notice to providers? Should it be sent as soon as the enrollee enters the grace period or in response to a submitted claim? If the latter, does notice need to be re-issued for each claim submitted by a single provider? Does the notice need to be sent at some regular interval (i.e., each month of the grace period?)**
- A1:** CMS does not intend to regulate on the timing or detailed procedures for the grace period notifications to providers. However, we are developing guidance regarding timing and content for this provider notification, as well as and recommendations for communication about claims processing or claim status for an enrollee in the three month grace period.



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- Q2: As per 45 CFR 156.270(d)(2), when someone who receives APTC has fallen into the delinquency grace period, the Issuer must “notify Health and Human Services (HHS) of such non-payment.” The regulation does not specify the means by which the Issuer is to provide the notification to HHS, but some Issuers would like to send the termination transaction to the Federally-facilitated Marketplace (FFM) at the conclusion of the grace period. Is this permissible?**
- A2: If an enrollee fails to *pay in full* his or her portion of any premium due prior to the end of the applicable grace period, QHP Issuers **must** send an 834 termination transaction to the Marketplace. In addition, Issuers must participate in a reconciliation process with the Federally-facilitated Marketplace (FFM). Each month, Issuers will submit a reconciliation audit file with certain data elements for every current enrollee, including the “premium paid through date.” This will identify the FFM enrollees who are in a payment delinquency status, thus meeting the notification requirement for non-paying enrollees.
- Q3: In the April, 2013 Letter to Issuers there is mention that “...the QHP Issuer must report current and accurate information on the status of qualified individual and enrollee premium payments.” The letter says: “QHP Issuers will provide up-to-date information on the last premium payment date for every enrollee.” How are QHP Issuers to report this information?**
- A3: Issuers must participate in a reconciliation process with the Federally-facilitated Marketplace (FFM). In the monthly reconciliation audit file, Issuers will submit the “premium paid through date” for every current enrollee. This will identify for the FFM, enrollees who are in a payment delinquency status, thus meeting the notification requirement for non-paying enrollees.



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**Q4:** In the final Exchange Rule, the provision at §156.270(b)(1) requires that a QHP Issuer provide an enrollee with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage. Does the date of the notice dictate the date of termination, or does the notice simply give 30 days for the enrollee to make the payment? Which of the following scenarios would be in compliance with the above?

*Scenario 1: Premium payment for the month of March is due 3/1; enrollee does not pay by 3/31. Health Plan sends a termination of coverage notice to the enrollee on April 1st. Member does not pay premium. Health Plan terminates the enrollee effective 2/28. 2: As above, enrollee does not pay premium for month of March. Health Plan sends a termination of coverage notice to the enrollee on April 1st. Member does not pay premium. Health Plan terminates the enrollee effective 4/30.*

**A4:** On July 15, 2013, CMS published the Eligibility and Enrollment Final rule (CMS-2334-F), which streamlines a number of provisions in the Affordable Care Act, including those related to termination. In this Final rule, the termination of coverage notice provision at §156.270(b) states if the QHP Issuer terminates an enrollee's coverage in accordance with §155.430(b)(1)(i), (ii), or (iii), the Issuer must, "**promptly and without undue delay:** (1) Provide the enrollee with a notice of termination of coverage that includes the termination effective date and reason for termination. " This regulatory clarification does not alter the rules for the effective date of termination for non-payment of premium. For enrollees receiving APTC, termination will continue to be the last day of the first month of the three month grace period. For enrollees not receiving APTC, the effective date of termination must be in accordance with the standard policy established by the QHP Issuer in accordance with §156.270(c).

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- Q5: According to the CMS Enrollment Companion Guide, three possible qualifiers for 2100G (Responsible Person Loop) are: 1) E1 Person or Other Entity Legally Responsible for a Child (QMCSO), 2) QD Responsible Person, and 3) S1 Parent. However, per the ASC X12 834 Implementation Guide, Power of Attorney should have a qualifier J6. What qualifier will be sent in 2100G for Power of Attorney data?**
- A5: The CMS Enrollment Companion Guide explicitly uses only two of the 13 available qualifier codes from the ASC X12 834 Implementation Guide for use in the 2100G Segment. These two qualifiers are: QD for Responsible Person and S1 for Parent. These are the only two codes CMS plans to use in the Federally-facilitated Marketplace. If QHP Issuers feel that other qualifier codes such as Power of Attorney are necessary, recommendations may be submitted to [Comments834guide@cms.hhs.gov](mailto:Comments834guide@cms.hhs.gov). The policy and technical team at CCIIO will consider the requests for future development schedules.
- Q6: Race and Ethnicity questions are asked separately, as two distinct questions on the Federally-facilitated Marketplace (FFM) enrollment application, but there is only one field in ASC X12 834 Enrollment transaction to represent both data elements (DMG05-01 in 2100A). What are the rules to combine the race/ethnicity into one data element? (AHIP 65)**
- A6: Federal law sees race and ethnicity as distinct, and that is why there are two separate questions on the Federally-facilitated Marketplace application. The ASC X12 834 Implementation Guide provides a situational field for race *or* ethnicity, with the notation that the data “is normally self-reported and under certain circumstances is collected for United States Government statistical purposes.” There are no other rules or regulatory guidance beyond the constraints of the ASC X12 834 Implementation Guide.
- Q7: An individual is eligible and takes Advance Premium Tax Credit (APTC) on his medical QHP plan. However, there is not enough APTC to also apply to their dental plan. CCIIO indicated on a 6/17 enrollment technical call that that the enrollee would still be considered an APTC recipient and the 90 day grace period would apply to the dental plan. However, since the indicator on the dental plan would reflect \$0, how would the dental plan know the enrollee is APTC eligible to give them the 90 day grace on the dental plan, particularly if an individual has medical coverage with one Issuer and dental coverage with a Stand Alone Dental Plan?**
- A7: Consistent with the policy regarding Advance Premium Tax Credit (APTC) and eligibility for the grace period for individuals on a standard medical plan, if no APTC is applied to the dental plan, the enrollee would not be eligible to receive a grace period for three consecutive months for that (dental) plan.