

Understanding Your Health Plan Coverage: Effectuations, Reporting Changes, and Ending Enrollment

November 2025

This information is intended only for the use of entities and individuals certified to serve as Navigators, certified application counselors, or non-Navigator assistance personnel in a Federally-facilitated Marketplace. The terms "Federally-facilitated Marketplace" and "FFM," as used in this document, include FFM where the state performs plan management functions. Some information in this presentation may also be of interest to individuals helping consumers in State-based Marketplaces and State-based Marketplaces using the Federal Platform. This material was produced and disseminated at U.S. tax filer expense.

CSG-202511



Agenda

- Enrollment Effectuation
- Binder Payments
- Enrollment Cancellation
- Premium Payment Grace Periods
- Consumer Options for Ending Coverage
- Reporting Changes to the Marketplace



Steps to Effectuate Coverage Through the Federally-facilitated Marketplace

Effectuation is when an individual's plan selection is finalized and their coverage becomes active after they have paid their first month's premium, often called a "binder payment."

1. Consumer completes an application.
2. Consumer selects a plan.
3. Consumer makes a timely payment of the binder payment, if applicable, to the insurance company.
4. Insurance company informs the Federally-facilitated Marketplace (FFM) of effectuated coverage, if applicable.

Binder Payment and Effectuation



- Consumers must pay their binder payment (often the first month's premium) for enrollment to be effectuated.
- The deadline to make the binder payment to effectuate enrollment* must be:
 - No earlier than the coverage effective date.
 - No later than 30 calendar days from the coverage effective date.
 - If the consumer's net premium is \$0, then the consumer will not be required to make a payment to effectuate coverage.

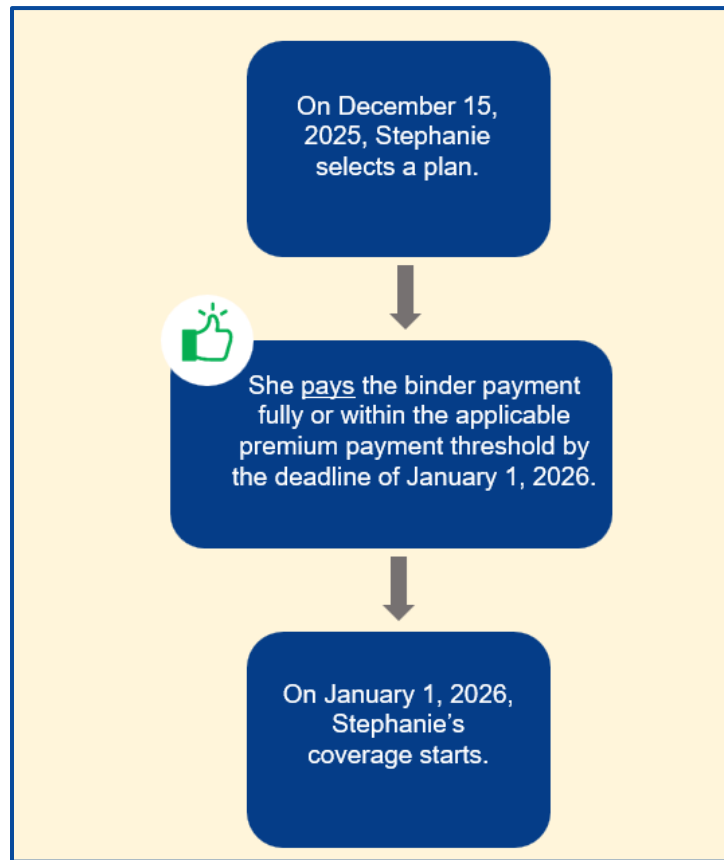
*This is for regular coverage effective dates, as special effective dates have a different range of deadlines.

Binder Payment and Effectuation (Cont.)

New Payment Threshold Policy – The 2025 Marketplace Integrity and Affordability Final Rule Requirement:

- Effective through plan year (PY) 2026, CMS is finalizing elimination of the fixed-dollar and gross percentage-based premium payment thresholds, allowing issuers to only adopt the net percentage-based threshold.
- This change will help ensure that consumers are aware of their initial or continued enrollment. Many insurance companies offering Marketplace plans adhere to a “threshold” payment policy.
 - This policy allows a consumer to make a binder payment (or other payment) that is less than the full premium, but greater than a “threshold” amount, such as 95 percent of the premium after application of any advanced payments of the premium tax credit (APTC).
 - Example: John Doe’s monthly premium after APTC is \$100. He pays a timely binder payment of \$97, which is 97 percent of the net monthly premium and therefore greater than the insurance company’s 95 percent threshold. His enrollment is effectuated by the insurance company and the FFM.

Scenario #1 – Consumer Pays Premium Before Deadline



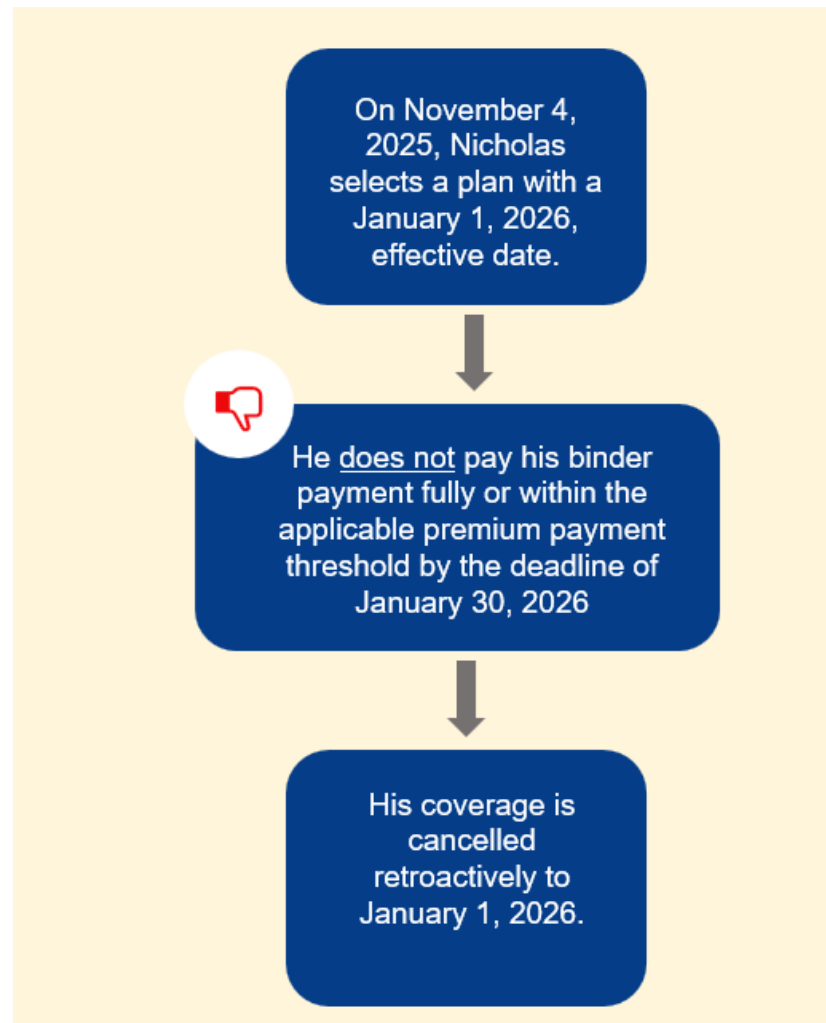
The applicable premium payment threshold is less than the full premium, but greater than a reasonable “threshold” amount, such as 95 percent of the premium after application of any APTC. This allows a consumer to effectuate coverage.

Coverage Cancellation

- A cancellation is an action or request to cancel Marketplace coverage before the coverage effective date, or back to the start date. Cancellation may be initiated by:
 - The consumer, voluntarily.
 - The insurance company when a binder payment is not made by the payment deadline.
- Free-look Exception:
 - Allows a consumer to retroactively cancel coverage within a certain period of time, following existing state-specific guidelines.



Scenario #2 – Coverage Cancellation When Consumer Does Not Pay Full Premium Before Deadline



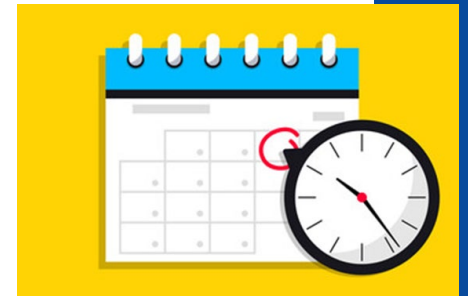
Grace Periods

- A grace period is an extension set by state or federal rules that gives Marketplace consumers with effectuated coverage additional time to pay their portion of the monthly health insurance premiums before the coverage is terminated for non-payment of premium.
- The length of a grace period depends on the enrollee's eligibility, according to the following guidelines:
 - Consumers receiving APTC when they first fail to timely pay premiums and who have made a binder payment have a grace period of three consecutive months.
 - The grace period starts the first month an enrollee fails to pay, even if they make payments for following months.
 - All other Marketplace consumers not receiving APTC when they first fail to timely pay premiums have a grace period determined by state rules.
 - Consumers should contact their state Department of Insurance for state-specific information on grace periods for Marketplace consumers not receiving APTC. (Refer to [State Insurance Departments](#) for more information.)

Assister Tip

Remind consumers that:

- It is important to pay all outstanding insurance premiums during a grace period, so their health insurance company does not end their Marketplace coverage.



Claims During Grace Periods for Consumers Who are Receiving APTC

- During the first month of a three-month grace period for consumers receiving APTC, the insurance company must pay all appropriate claims for services rendered to the enrollee.
- During the second and third months of the grace period for consumers receiving APTC, the insurance company may pend claims for services rendered, if permitted by state law.
- If an enrollee fails to pay all outstanding premiums or an amount that satisfies any applicable premium threshold before the end of the grace period:
 - At the end of the grace period, the insurance company will terminate the enrollee's coverage for non-payment of their premium, retroactively effective to the last day of the first month of the grace period.
 - For example, if a consumer's grace period ends on September 30, the last day of coverage will be July 31.
 - The insurance company will deny any claims that were pended during the second and third months of the three-month grace period.

Scenario #3 – A Consumer Does Not Pay Premiums During a Grace Period

- Johnna, who's eligible for and chooses to receive APTC, selects her plan during the Open Enrollment Period (OEP).
- Johnna makes her binder payment on time to effectuate her coverage beginning on January 1.
- Johnna makes full payments for January through April but does not make a premium payment for May.
- By the end of the three-month grace period, Johnna has not paid all outstanding premiums owed (within the applicable premium payment threshold).
 - Therefore, Johnna's last day of coverage is May 31.



Scenario #3 – A Consumer Does Not Pay Premiums During a Grace Period: Question #1

When does Johnna's grace period expire?

- A. July 31
- B. August 31
- C. September 30
- D. October 31



Scenario #3 – A Consumer Does Not Pay Premiums During a Grace Period: Answer #1

A. July 31.

This is the final day of the third month after her grace period started on May 1.



Scenario #3 – A Consumer Does Not Pay Premiums During a Grace Period: Question #2

If Johnna still has outstanding premiums beyond any applicable threshold after July 31, may the insurance company offering Johnna's Marketplace plan deny any pended claims during June and July?



Scenario #3 – A Consumer Does Not Pay Premiums During a Grace Period: Answer #2

Yes.

- Since Johnna will lose coverage retroactively to the last day of May (May 31), if she does not pay all outstanding premium owed (within the applicable premium payment threshold) by the end of the grace period, Johnna's insurance company may deny all pended claims from June and July.
- The insurance company may keep for May coverage the APTC paid on Johnna's behalf and any premium Johnna paid.
- The insurance company must generally refund any premium that Johnna paid for coverage for June or July, in accordance with applicable state law, as well as any APTC received for those months.



Termination for Non-Payment of Premiums

- If consumers do not pay all outstanding premium amounts or an amount sufficient to satisfy any premium payment threshold before the end of the applicable grace period, the insurance company will terminate the consumer's coverage for non-payment of premiums.
- A grace period does not “reset” when a consumer makes a partial payment.
- When a consumer's coverage is terminated for non-payment of premiums, the formerly enrolled consumer does not qualify for a Special Enrollment Period (SEP) for the resulting loss of minimum essential coverage (MEC).



Termination for Non-Payment of Premiums (Cont.)

- A consumer who is eligible for but elects not to receive APTC is not eligible for a three-month grace period, but they are eligible for any grace period required by the consumer's state.
- A consumer has the right to appeal to an insurance company's decision to terminate for nonpayment if they believe their coverage was wrongly terminated.
- However, terminations are not appealable to the Marketplace, only to the insurance company.

Additional information on when and how to appeal a decision to either the health insurance company or the Marketplace, as appropriate, is located at [How to Appeal a Decision](#).

Scenario #4 – Termination for Non-Payment

- Patrick, who is eligible for and elects to receive APTC, selects his plan during OEP and effectuates his coverage by paying the first month's premium.
- Patrick fails to make his August payment.
- Patrick fails to make his September payment.
- Patrick pays his August and September premium in full at the end of September.
- Patrick fails to make an October payment.

Scenario #4 – Termination for Non-Payment: Question

On October 1, is Patrick still within his grace period if he pays his August and September premiums in full at the end of September?



Scenario #4 – Termination for Non-Payment: Answer

No.

Patrick paid his August and September premiums in full before the October premium was due, ending his grace period. If he does not pay his October premium by the deadline, he will enter a new grace period that will end on December 31.



Re-Enrollment in a Marketplace Plan After Coverage is Terminated Due to Non-Payment of Premium

Consumers whose previous coverage was terminated due to non-payment of premiums can re-enroll in Marketplace coverage, if otherwise eligible, if they qualify for a SEP for a reason that is not loss of MEC or during the OEP:

- During the OEP, consumers can receive a new eligibility determination and, if eligible, enroll in a Marketplace plan for the next plan year.
- Consumers with grace periods expiring at the end of the current plan year and who actively complete a plan selection for the upcoming plan year during the OEP may enroll in new coverage, if otherwise eligible.



Re-Enrollment in a Marketplace Plan After Coverage is Terminated Due to Non-Payment of Premium (Cont.)

- Some consumers may experience a gap in coverage if:
 - They select and enroll in a plan during a qualified SEP, or during the OEP and pay their binder payment, so the new coverage is effectuated January 1; and
 - Their previous coverage was terminated prior to December 31.
- Note: If consumers are not enrolled in Marketplace coverage when auto re-enrollment occurs, which is usually in mid-December, they are not eligible to be automatically re-enrolled by the FFM for the following year.
- **Reminder:** Consumers do not qualify for the loss of MEC SEP if their coverage ends due to non-payment of premiums.

Consumer Options for Ending Coverage



- Consumers may voluntarily end their enrollment upon request for any reason.
- Common reasons include:
 - Obtaining other MEC such as Medicare, Medicaid, or job-based coverage; or
 - Simply wanting to end coverage.

Source: 45 CFR § 155.430

Ending Coverage: Terminating Coverage vs. Canceling Coverage

- When terminating coverage:
 - The consumer has enrolled and paid at least one month's premium (i.e., coverage has been effectuated).
- If the consumer is ending coverage for some, but not all, members on the application, their coverage will end immediately in most cases.
- When canceling coverage:
 - The consumer generally has not yet effectuated coverage with their first premium payment.



Process for Ending Coverage

In some cases, consumers will need to end Marketplace coverage by calling the Marketplace Call Center. In other cases, consumers can end their coverage online using [HealthCare.gov](https://www.healthcare.gov) (as in the example in the previous slides). This depends on:

- If everyone on the application is ending their coverage or just some people
- If someone is ending coverage because they're starting Medicare



Process for Ending Coverage (Cont.)

If the person who is ending their Marketplace coverage is not starting Medicare, and is the primary contact (the person who created the account) on the application, then the household contact should call the Marketplace Call Center to:

- End the primary contact's Marketplace coverage.
- Designate a new primary contact.
- Ensure that those remaining on their Marketplace plan don't lose their coverage. Note: When the subscriber is being removed from the policy, a new policy for the remaining household members will be created. This will require payment of binder to effectuate coverage.



Ending Coverage for Some but Not All Family Members

- If a consumer wishes to remove someone from the enrollment group to terminate that person's coverage but does not wish to remove everyone from the enrollment group, the consumer should call the Marketplace Call Center.
 - In order to avoid unintentionally ending coverage for all consumers, any requests to end coverage for just some consumers on the application must be done through the Marketplace Call Center.

Note: Once an individual is removed from the policy, if the person removed is the primary contact policyholder or if the removal results in another change to the policy (e.g., it changes from a family plan to a self-only plan or a standard plan to a child-only plan), the remaining consumers on the application may need to enroll in a new policy.

Ending Coverage for Consumers Who Are Starting Medicare

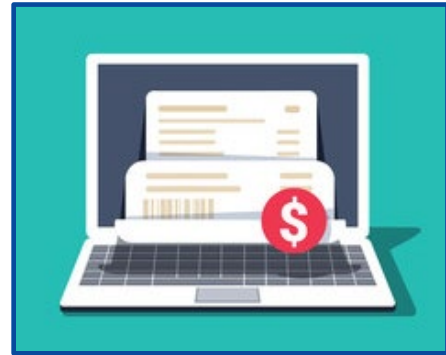
- Starting in March 2025, the Marketplaces on the Federal platform introduced new functionality in the eligibility application that lets consumers report when they're starting Medicare.
- The Marketplace can end those consumers' Marketplace coverage at the appropriate time, while other consumers in their households can keep their Marketplace coverage.
- Marketplace consumers can report Medicare coverage that has already started, or Medicare coverage that will start up to three months in the future.

Note: To remove a household member completely from an application who is also the primary contact due to death, divorce, or a different reason, consumers should call the Marketplace Call Center.

For more information, refer to [Assisting Consumers Who Are Starting Medicare webinar](#).

Ending Coverage for the Entire Enrollment Group

- To end coverage for the entire enrollment group, consumers should:
 - Log into their [HealthCare.gov](https://www.healthcare.gov) account and select “My Applications & Coverage;”
 - Navigate to “My plans & programs;”
 - Select the END (TERMINATE) ALL COVERAGE button; then
 - Select the END (TERMINATE) COVERAGE button.
- A red “Status: terminated” bar should then appear above the plan that was terminated.
- Following these steps will end every health and dental policy for the entire enrollment group.



Removing a Household Member Completely



- To remove a household member completely from an application due to death, divorce, or a different reason, consumers should:
 - Log into their [HealthCare.gov](https://www.healthcare.gov) account;
 - Go to “My Applications & Coverage;”
 - Select the desired application under “Your existing applications;”
 - Select the “Report a life change” option in the menu;
 - Select the type of life change they are reporting; and
 - Select the Continue button.
- Once they proceed through the application to the “Who needs health coverage?” screen, they should select **Remove** next to the name of the member they want to remove.

Removing a Household Member Completely (Cont.)



- Once the consumer selects **Remove**, they will confirm on the next screen whether they want to remove the member from the application, the reason they are removing the member (e.g., death, divorce, or a different reason), and the date of the change; or keep them on the application as a non-applicant.
- Additional information may still be needed for determining eligibility for cost savings. Each removal scenarios (e.g., death, divorce, a different reason) will have slightly different text alerting the consumer of the option to keep the member on the application in non-applicant status rather than removing them.
- After selecting the **Save & Continue** button, the consumer can proceed through the rest of the application.

Ending Coverage Key Takeaways

- Consumers should not try to change or remove the household contact online unless they're ending coverage for everyone on the plan.
- If one of the consumers is ending coverage due to enrolling in Medicare, they can report a life change and provide their Medicare start date and the Marketplace will automatically end their Marketplace coverage the day before their Medicare starts.
- Instructions on ending Marketplace coverage are available at [HealthCare.gov: Cancel your Marketplace plan.](https://www.healthcare.gov/cancel-your-marketplace-plan/)



Reporting Changes to the Marketplace

- The process to remove some, but not all, members from Marketplace coverage is the same process that you will advise consumers to follow when helping them report other important life changes to the Marketplace.
- For more information on reporting changes to the Marketplace, visit:
 - [When your income or household changes.](#)



Examples of Other Changes Consumers Should Report to the Marketplace

Type of Life Change/Change in Circumstances

- | | |
|--|---|
| <ul style="list-style-type: none">▪ New person on the application (e.g., birth, marriage)▪ Removal of a person from the application (e.g., death, divorce, dependent turning 26)▪ Relocation to a new address (e.g., new service area/county or state)▪ Loss of access to other coverage (e.g., employer coverage)▪ New access to other coverage (e.g., employer coverage)▪ New access to coverage from a public program [e.g., Medicaid, the Children's Health Insurance Program (CHIP)]▪ Release from incarceration▪ Become incarcerated▪ Change in citizenship or immigration status▪ Pregnancy▪ To remove a dependent child who is turning 26
(NOTE: Dependent children who turn 26 during the plan year are permitted to stay on their parents' Marketplace plan until December 31 of the plan year in which they turn 26 (or the maximum age under state law)) | <ul style="list-style-type: none">▪ Change in tax filing status/tax household composition▪ Change in status as an American Indian/Alaska Native or tribal status▪ Change in disability status▪ Correction to name, date of birth (DOB), or Social Security Number (SSN)▪ Increase or decrease in income for anyone on the application▪ Communication preferences:<ul style="list-style-type: none">➤ Email address➤ Phone number➤ Language preferences➤ Add or remove phone text alert➤ Mailing of paper notices |
|--|---|

Important Reminders



- Steps for terminating and canceling coverage are the same in most cases.
- When ending coverage for some, but not all, family members; removing someone from the consumer's application; or reporting qualifying life changes, the applicant will receive a new eligibility determination notice.
- Deleting an application DOES NOT cancel the policy.
- Remind consumers to return to their application to report changes throughout the year.
- Note: The Marketplace Appeals Center does not review appeals for termination disputes (i.e., a consumer who wants a retroactive termination—this is not appealable). Retroactive terminations due to Marketplace error or technical issue may be reviewed by caseworkers and evaluated, but if the retroactive termination is denied, there are no appeal rights.

Consumers can visit [HealthCare.gov: How do I cancel my Marketplace Plan?](#) for more information or call the Marketplace Call Center for help: 1-800-318-2596.

Resources

- [How do you appeal a decision?](#)
- [Coverage Appeals](#)
- [How to apply & enroll: Premium payments, grace periods, & losing coverage](#)
- [State Insurance Departments](#)
- [Assisting Consumers Who Are Starting Medicare webinar](#)
- [Turning 26? What You Need to Know About the Marketplace](#)
- Marketplace Assister Microlearning Courseware:
 - [Application Walkthrough: Helping Consumers Enroll in Marketplace Coverage](#)
 - [Post-enrollment Assistance: Making Health Plan Premium Payments](#)
 - [Terminating a Marketplace Plan](#)