This Best Practice is intended for use with the corresponding MN Uniform Companion Guide(s), **Version 5010**

1. Title of best practice:

Best Practice to Meet Requirements for Health Insurance Exchange Grace Period Notifications (per 45 CFR 156.270(d)(2))

2. Who does the best practice apply to:

Qualified Health Plan Issuers (Insurers, Payers)

3. Narrative description as to what is being addressed by this best practice:

Federal regulations 45 CFR 156.270 specify requirements that must be followed for terminating the coverage of Health Insurance Exchange enrollees who are receiving advance payments of premium tax credits (APTC). For additional information and background regarding applicable federal regulations and the need for this best practice, refer to AUC Best Practices to Meet Requirements for Health Insurance Exchange Grace Period Notifications (per 45 CRF 156.270(d)(2).

This best practice describes how to provide notification in response to submission of a claim from a health care provider, using the ASC X12N/005010X221A1 Health Care Claim Remittance/Advice (835) electronic transaction. It is based upon and incorporates a draft best practice that was prepared and made available for review by ASC X12 in early 2014. In order for this best practice to have the greatest positive benefit, it is important that claims be filed and processed quickly, so that providers may have the most advance notice possible of an enrollee's grace period and the possibility that the enrollee's claims may be pended during the grace period or retroactively denied following the grace period.

4. The loops, segments and elements, etc. that the best practice applies to:
CAS, MIA, MOA, and LQ of the ASC X12 005010X221A1 Health Care Claim Payment/Advice 835.

5. Describe how to do the best practice:

The best practice is organized as a series of three tables below for the three month premium payment grace period.

Table 1. Services in Grace Period Month 1

Table 1 shows the special case of first month of the grace period. Pursuant to 45 CFR 156.270, claims submitted for the first month of the grace period must be paid as if the premium were paid in full. As a result, the first table shows the simple case of claims for the first month of the grace period as being paid, with accompanying RARC alerts to indicate that the enrollee is in the first month of the grace period, and that claims for services rendered to the enrollee in the second and third months of the grace period may be pended.

Table 1. Services in Grace Period Month 1	
Issuer (insurer) action upon receipt of claim	**835**
Paid	• Report *RARC "N615"*, meaning "Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under the Code of Federal Regulations, Title 45, Part 156.270, a Qualified Health Plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period." • Report *RARC "N616"*, Meaning "Alert: This enrollee is in the first month of the advance premium tax credit grace period."

See also Tables 2 and 3, following.

Table 2. Services in Grace Period Months 2 and 3

Table 2 takes into account that in months 2 and 3 of the grace period the issuer (insurer) may pay or pend claims. It also takes into account that, depending on whether the issuer paid or pended the claim, and whether the enrollee paid the premium in full during the grace period, a second 835 may be needed to report a reversal and correction of the first claim. Table 2 below is a high-level summary showing the possible scenarios to be considered. Table 3 is a more detailed version of Table 2, showing in more detail the notifications that are to be used for each of the scenarios.

Table 2. Summary Table for Services in Grace Period Months 2 and 3

Issuer (insurer) action upon receipt of claim	Initial 835	Subsequent 835	
		If Premium Paid During Grace Period	If Premium Not Paid During Grace Period
Paid	835 reflects paid claim	• No correction needed	• Reversal of paid claim • Correction will be a denied claim • Ultimately a recoupment will be taken
Pended/Soft denied	835 reflects pended claim	• Reversal of pended claim • Correction will be a paid claim	• Reversal of pended claim • Correction will be a denied claim • No recoupment needed

Table 3. Detailed Table for Services in Grace Period Months 2 and 3

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Issuer (insurer) action upon receipt of claim	**Initial 835**	**Subsequent 835**	
		If Premium Paid During Grace Period	**If Premium Not Paid During Grace Period**
Paid	• Report *RARC "N615"*, meaning "Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under the Code of Federal Regulations, Title 45, Part 156.270, a Qualified Health Plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period." • Report *RARC "N617"*, Meaning "This enrollee is in the second or third month of the advance premium tax credit grace period."	• No correction needed	• Reversal of paid claim • Correction will be a denied claim using CARC "27", meaning "Expenses incurred after coverage terminated." • Ultimately a recoupment will be taken
Pended/Soft denied	• *CAS01 equals "OA"*, meaning "Other Adjustment" • *CAS02 equals "257"*, –meaning "The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)"	• Reversal of pended claim • Correction will be a paid claim	• Reversal of pended claim • Correction will be a denied claim using CARC "27", meaning "Expenses incurred after coverage terminated." • No recoupment needed

Table 3. Detailed Table for Services in Grace Period Months 2 and 3			
Issuer (insurer) action upon receipt of claim	**Initial 835**	**Subsequent 835**	
		If Premium Paid During Grace Period	**If Premium Not Paid During Grace Period**
	• CAS03 equals the total charge amount • Report *RARC "N615"*, meaning "Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under the Code of Federal Regulations, Title 45, Part 156.270, a Qualified Health Plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period." • Report *RARC "N617"*, Meaning "This enrollee is in the second or third month of the advance premium tax credit grace period."		

6. Effective date:

June 23, 2014

7. Last revision date:

April 21, 2014