Health insurance exchange

Premium payment grace period
Best practice for electronic notifications

Introduction

This document is a technical description relating health insurance exchange premium payment grace period (grace period) requirements to the Accredited Standards Committee (ASC) X12 Health Insurance Portability and Accountability Act (HIPAA)-mandated and other health care transactions. While it provides a general business description of the grace period requirements, it is intended for an audience that has at least a general technical knowledge of the related electronic transactions and that is comfortable with the general structure of those transactions. Potential readers include, but are not limited to, health plan electronic data interchange staff, vendors, regulators, and physician group and other health care provider technical staff.

The information contained in this document represents the best practices identified by the AMA's Administrative Simplification Initiatives group as part of its effort to ensure that physicians receive this critical notification in a standard, electronic format.

Abstract

Recent health insurance exchange (HIX)-related regulations include a provision for a premium payment grace period. When an HIX enrollee has received a federal subsidy and paid at least one month's premium, health plans are obligated to provide a three-month grace period to the enrollee if a subsequent payment is late or does not arrive at all. Some of the requirements related to this grace period are:

- Health plans must pay appropriate claims for services performed by health care providers in the first month of the grace period
- Health plans may suspend claims for services during the second and third month of the grace period until the receipt of premium payment or the expiration of the grace period
- Health plans must notify impacted health care providers when an HIX member is in the grace period

While the regulations do not provide any explicit statements as to the form that the health care provider notification must take, HIPAA-mandated electronic transactions are a viable notification method for multiple reasons:

- Transactions from a health care provider about an HIX patient within a premium payment grace period would indicate that the health care provider is impacted by the grace period
- Transactions would provide timely information about the grace period to health care providers
- Transactions would minimize the administrative burden of the grace period on health care providers

In order for these transactions to maximize the administrative simplification value to the industry, the grace period information must be provided in a consistent format across the entire industry. Variation from health plan to health plan is counter to effective delivery of grace period information to the health care provider community.

Grace period notification

This document identifies the HIPAA-mandated and related ASC X12 transactions that could be utilized by health plans to convey grace period information to health care providers, and provides a standardized usage compliant with the applicable implementation guides. Health plans are not obligated to utilize the transactions for the messaging described in this document. However, these best practices identify industry standard usage for any health plan that does choose to use the transactions for this reporting. In this way, health care providers and health care provider vendors can implement processes to identify and automate the handling of the HIX premium payment grace period information.

The related ASC X12 Technical Reports are:

- Health Care Eligibility Benefit Inquiry and Response (270/271) - 005010X279
- Health Care Claim Acknowledgment (277) - 005010X214 (aka 277CA)
- Health Care Claim Status Request and Response (276/277) - 005010X212
- Health Care Claim Payment/Advice (835) - 005010X221

Note: Many of the codes referenced in the technical solutions below are owned by organizations external to ASC X12 and are not listed in the related ASC X12 Technical Reports. The Health Care Claim Status Codes (277 STC01-02), Health Care Claim Status Category Codes (277 STC01-01), Remittance Advice Remark Codes (835 MIA05, 20, 21, 22, 23, MOA03, 04, 05, 06, 07, LQ02), and Claim Adjustment Reason Codes (835 CAS02, 05, 08, 11, 14, 17) referenced in this document were obtained from wpc-edi.com, and are distributed by Washington Publishing Company (WPC). Since the descriptions of these code values are subject to change by the owning organizations, access the WPC website to obtain the current up-to-date descriptions.

Health Care Eligibility and Benefit Inquiry and Response (270/271)

When a health plan receives a Health Care Eligibility and Benefit Inquiry (270) from a health care provider that requests eligibility and benefit information for a patient, and the requested date is within an active grace period, that is a clear indication that the health care provider is impacted by the grace period.

The inquiry will indicate the request date by:

- A 2100 or 2110 C/D loop DTP segment with a DTP01 qualifier of "291" – meaning Plan. The date will be conveyed in DTP03
- Absence of Plan date from the inquiry indicates that the Plan date for the inquiry is the date of the transaction

Note: During the grace period, the patient is considered to be covered until the grace period ends without premium payment.

Eligibility and benefit response detail

The Eligibility and Benefit Response (271) needs to convey specific information in order to clearly identify the business situation:

- Need to identify that coverage is active, but with an indication that there is an issue
- Need to identify the dates related to the grace period – premium paid to date, begin and end date of the grace period
- Need to identify explicitly that this is an HIX premium payment grace period

Since many health care provider systems look at the EB01 element in the response for the general status of the patient's eligibility, the value there must clearly indicate the action to be taken. A value of "1," meaning "Active," indicates a green light with normal coverage. A value of "6," meaning "Inactive," indicates a red light where the health care provider will seek other coverage or payment from the patient. Generally, any code containing the word "inactive" will result in the health care provider asking the patient to identify another active health plan, or provide payment for the services. Since the code value in EB01 is critical to the action of the health care provider, the value must convey that payment is not to be sought at this time and a claim should be submitted for any services during the grace period, but that there is a potential problem. Code "5," meaning "Active – Pending Investigation" conveys an appropriate message to garner the actions desired–notification of the grace period, with subsequent claim submission for any services rendered.

Within the response 271 transaction, report:

- In the 2100C/D DTP segment, identify the Premium Paid to Date by
  - DTP01 equals "343"- meaning "Premium Paid to End Date"
  - DTP02 equals "D8"- meaning that the date format will be CCYYMMDD
  - DTP03 equals (the premium paid to end date)
- In the initial 2110C/D loop report:
  - EB segment
    - EB01 equals "1" – meaning "Active" if the Plan date is in the first month of the Grace period
    - EB01equals "5" – meaning "Active – Pending Investigation" if the Plan date is in the second or third month of the grace period
    - EB03 equals "30" – meaning "Health Benefit Plan Coverage"
  - DTP segment – Grace period start
    - DTP01 equals "193" – meaning "Period Start"
    - DTP02 equals "D8" – meaning that the date will be in the format CCYYMMDD
    - DTP03 equals (the begin date of the grace period)
  - DTP segment – Grace period end
    - DTP01 equals "194" – meaning "Period End"
    - DTP02 equals "D8" – meaning that the date will be in the format CCYYMMDD
    - DTP03 equals (the end date of the grace period)
  - MSG segment – indicating that this is related to the HIX-specific grace period as the nature of the "investigation" indicated by EB01
    - MSG01 equals "HIX Grace Period." The health plan can append any additional textual message to the maximum length of the element (264 characters) as desired.

Note: The response must comply with all other guide or operating rule requirements beyond the specifics identified above.

Health care claim status

When a health plan has received a claim with service dates within an active grace period, all claim status information related to that claim should identify the existence of the grace period as long as the grace period is still in effect.

Claim acknowledgment (277CA)

When:

- a health plan responds to a submitted electronic claim with a Health Care Claim Acknowledgment (277CA), and
- the health plan can identify that the patient is in the grace period during editing of the received claim, and
- the response provides individual claim information, and
- an accepted for adjudication claim has one or more of the service dates within an active grace period

The health plan must return a 2200D loop STC segment with the following:

- STC01-01 (Health Care Claim Status Category Code) equals "A2" – meaning "Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system."
- STC01-02 (Health Care Claim Status Code) equals "766" – meaning "Services performed during a Health Insurance Exchange (HIX) premium payment grace period."
- STC02 equals (the effective date of the status)
- STC03 equals "WQ" – meaning "Accept"
- STC04 equals (Total Claim Charge Amount)

Claim status response detail – pended claims (277)

When the health plan receives a claim status request (276) for a claim where:

- One or more of the service dates is within the grace period, and
- the claim is being pended and has not completed adjudication (either because of the grace period or for other reasons)

The health plan must return a Health Care Information Status Notification (277) containing a 2200D/E loop STC segment with the following:

- STC01-01 (Health Care Claim Status Category Code) equals "P5" – meaning "Pending/Payer Administrative/System hold."
- STC01-02 (Health Care Claim Status Code) equals "766" – meaning "Services performed during a Health Insurance Exchange (HIX) premium payment grace period."
- STC02 equals (the effective date of the status)
- STC04 equals (Total Claim Charge Amount)

Note: Other applicable STC segments can be returned as dictated by the business when additional status information is available.

Claim status response detail – adjudicated claims (277)

When the health plan receives a claim status request for a claim where:

- One or more of the service dates is within the grace period, and
- the claim has completed current adjudication (as paid or denied until the grace period is resolved)

The health plan must return a 277 containing a 2200D/E loop STC segment with the following:

- STC01-01 (Health Care Claim Status Category Code) equals (the appropriate "Fx" Claim Status Category Code)
- STC01-02 (Health Care Claim Status Code) equals "766" – meaning "Services performed during a Health Insurance Exchange (HIX) premium payment grace period."
- STC02 equals (the effective date of the status)
- STC04 equals (Total Claim Charge Amount)
- Appropriate information in the remaining STC elements identifying paid amount, remittance and payment dates, and check/EFT number

Note: Other applicable STC segments can be returned as dictated by the business when additional status information is available.

Health Care Claim Payment/Advice (835)

When a health plan has received a claim with service dates within an active grace period, all remittance advice information related to that claim should identify the existence of the grace period as long as the grace period is still in effect, as well as when the grace period has ended and is resulting in recovery of a previous payment due to failure to pay the premium. In all cases, appropriate Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) must be included. Also, all other applicable 2100 and 2110 loop information must be reported as required by the ASC X12 Technical Report and applicable to the business of the specific claim or service.

Remittance advice detail – pended claims

Since there is no mandate for health plans to support the 277CA, and a health plan supporting the 277CA may not have edits that are able to identify the grace period at initial claim receipt, health plans that pend claims may choose to notify health care providers that the claim is in the second or third month of the grace period using the mandated Health Care Claim Payment/Advice (835). This scenario can also be looked at as the health plan performing a soft denial—one where the decision is not final. When this happens, specific codes must be used to clearly identify the relationship of the claim to the grace period.

For claims that normally pay at the claim level (such as inpatient institutional claims where a diagnosis-related group [DRG] contract applies):

- Report the claim payment in 2100 loop CLP04 as zero
- Report the patient responsibility in 2100 loop CLP05 as zero
- Report a 2100 loop CAS segment where:
  - CAS01 equals "OA" – meaning "Other Adjustment"
  - CAS02 (CARC) equals "257" – meaning "The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. (Use only with Group Code OA)"
  - CAS03 equals the total claim charge amount

- Report the related RARCs in the 2100 loop MOA segment (positions 3, 4, 5, 6, 7) or MIA segment (positions 5, 20, 21, 22, 23), as applicable
    - 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."

For claims that normally pay at the service level (such as professional, dental, and outpatient institutional claims):

- Report the claim payment in 2100 loop CLP04 as zero
- Report the patient responsibility in 2100 loop CLP05 as zero
- Report the related RARCs in the 2100 loop MOA segment (positions 3, 4, 5, 6, 7) or MIA segment (positions 5, 20, 21, 22, 23), as applicable
    - 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."
- Report a 2110 loop for each service line of the claim
- Report the service paid amount in 2110 loop SVC03 as zero
- Report a 2110 loop CAS segment where:
    - CAS01 equals "OA" – meaning "Other Adjustment"
    - CAS02 (CARC) equals "257" – meaning "The disposition of the claim/service is pending during the premium payment grace period, per Health Insurance Exchange requirements. (Use only with Group Code OA)"
    - CAS03 equals the service line charge amount

Remittance advice detail – payment of premium

If the patient does pay his or her premium for claims that have been pended during the grace period, the reversal and correction process must be followed and appropriate codes used to identify the situation. When this occurs, there is no special coding reported in the 835 other than to be sure to include the RARCs from the original adjudication in the reversal.

Remittance advice detail – adjudicated as paid claims during the grace period

Since the health plan is under no obligation to pend claims during the grace period, in some cases the health plan may choose to adjudicate and pay claims that fall in the grace period. This may be due to state prompt payment regulations or other requirements. When this happens, the fact that the claim is in the grace period must be conveyed to the health care provider using the coding of the 835.

- Report the related RARCs in the 2100 loop MOA segment (positions 3, 4, 5, 6, 7) or MIA segment (positions 5, 20, 21, 22, 23), as applicable
    - 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."

Remittance advice detail – expired grace period with no payment

If the patient does not pay his or her premium by the end of the grace period, an appropriate rejection claim must be sent. If the health plan previously sent either a pending claim notice or the adjudication in the 835, then a reversal of the previous information must be sent as well. If this is the first time that the claim is being sent in the 835, then the reversal is not included.

Reversal Claim (Note: All appropriate information from the original adjudication must be sent, as specified in the technical report, in addition to the following)

- Report the related RARC in the 2100 loop MOA segment (positions 3, 4, 5, 6, 7) or MIA segment (positions 5, 20, 21, 22, 23), as applicable
    - Report RARC "N698" – meaning "Alert: This reversal is due to non-payment of the Health Insurance Exchange premiums by the end of the premium payment grace period, resulting in loss of coverage. (Note: To be used with claim/service reversal)."

Rejection claim – inpatient paying at the claim level

- Report the 2100 loop CLP04 amount as zero
- Report the 2100 loop CLP05 amount as the full claim submitted charge
- Report the related RARC(s) in the 2100 loop MOA segment (positions 3, 4, 5, 6, 7) or MIA segment (positions 5, 20, 21, 22, 23), as applicable
    - Report RARC "N619" – meaning "Coverage terminated for non-payment of premium."
- Report the 2100 Loop CAS segment where
    - CAS01 equals "PR" – meaning "Patient Responsibility"
    - CAS02 (CARC) equals "27" – meaning "Expenses incurred after coverage terminated."
    - CAS03 equals the total claim submitted charge
- Report the 2100 loop DTM segment where
    - DTM01 equals "036" – meaning "Expiration"
    - DTM02 equals the expiration date of the coverage – the first day of the second month of the expired premium payment grace period

Rejection claim – professional, dental or outpatient claim paying at the service level

- Report the 2100 loop CLP04 amount as zero
- Report the 2100 loop CLP05 amount as the full claim submitted charge
- Report the related RARC(s) in the 2100 loop MOA segment (positions 3, 4, 5, 6, 7) or MIA segment (positions 5, 20, 21, 22, 23), as applicable
    - Report RARC "N619" – meaning "Coverage terminated for non-payment of premium."
- Report the 2100 loop DTM segment where
    - DTM01 equals "036" – meaning "Expiration"
    - DTM02 equals the expiration date of the coverage – the first day of the second month of the expired premium payment grace period
- Report the 2110 loop SVC03 equals zero
- Report the 2110 Loop CAS segment where
    - CAS01 equals "PR" – meaning "Patient Responsibility"
    - CAS02 (CARC) equals "27" – meaning "Expenses incurred after coverage terminated."
    - CAS03 equals the service line submitted charge

Optional remittance reporting – grace period first month

Optionally, the health plan can indicate to the health care provider that the patient is/was in the first month of the premium payment grace period when paying a claim with dates of service in the first month.

- Report the related RARC in the 2100 loop MOA segment (positions 3, 4, 5, 6, 7) or MIA segment (positions 5, 20, 21, 22, 23), as applicable
  - 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."

Conclusion

Standard implementation by health plans of electronic notifications regarding health insurance exchange premium payment grace period situations is the best way for physicians and other health care providers to be able to identify the grace period and take appropriate actions, with a minimum of manual intervention. Then, physicians, patients, and health plans will all have the same information about this sensitive situation. This minimizes telephone calls for all involved and maximizes the administrative simplification savings.

Visit ama-assn.org/go/aca for additional information and resources on the Affordable Care Act and the grace period.