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Bulletin 228

HANDLING OF CLEAN CLAIMS DURING THE ACA GRACE PERIOD

This Bulletin is directed to all insurers issuing accident and sickness insurance policies, as defined at IC 27-8-5.7-1; all HMOs as defined at IC 27-13-36.2-2, and all health care providers submitting claims to those insurers and HMOs (collectively, insurers and HMOs are referred to in this Bulletin as "Plans"). The purpose of this Bulletin is to clarify how to comply with Indiana's Clean Claims Law in light of the Affordable Care Act's (ACA's) Grace Period.

Indiana's Clean Claims Laws (IC 27-8-5.7 for insurers and IC 27-13-36.2 for HMOs) require insurers and HMOs to pay claims promptly or face interest payments to providers for claims paid outside the law's parameters. Under Indiana law, a clean claim means a claim "submitted by a provider for payment . . . that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment." IC 27-8-5.7-2 and IC 27-13-36.2-1.

Under 45 CFR 156.270, insureds covered by a Marketplace plan and receiving Advanced Premium Tax Credits (APTC) who have paid at least one full month's premium have a ninety-day grace period (the Grace Period) for payment of premiums. If a claim is eligible for payment, plans must pay it during the first thirty days of the Grace Period and provide certain notices. After the first thirty days of the Grace Period, plans have the option to pay or hold the claim until the insured pays the premium.

The Department considers claims submitted for services rendered during days 31 to 90 of the Grace Period to fall under a particular circumstance requiring special treatment preventing payment and, therefore, not a clean claim under Indiana law so long as the provisions of this Bulletin are followed. Plans will not be subject to Clean Claim interest and potential fines for claims pended during days 31 through 90 of the Grace Period. Plans should use the date of service in determining where a claim falls in the Grace Period.

Plans that hold claims during the Grace Period must, when a provider submits a claim for services rendered during days 31 through 90 of the Grace Period, give written notice to the provider that the claim is pended and potentially will not be reimbursed by the plan if the insured does not pay outstanding premiums. This notice may be provided electronically. If all outstanding premium is paid during the Grace Period, the Plan must adjudicate all pended claims. Claims must be processed automatically without the need for the provider to resubmit the claim.

If the premium is not paid in full during the grace period and the Plan terminates the insured's policy retroactive to one month after the last day premiums were paid, pended claims may be denied. Plans must, in the denial notice, provide notification to providers that coverage was terminated retroactively.

If the Department receives a complaint and forwards it to the Plan, and the Plan determines the non-payment of the claim is due to the application of a Grace Period, the Plan's response should include the APTC status of the policy and whether the claim was for a date of service after the initial thirty days of the Grace Period. If a Plan receives a complaint directly from an insured, enrollee, or authorized representative regarding non-payment of a claim, the Plan should provide this same information.

Questions regarding this Bulletin should be directed to compliance@idoi.IN.gov.

INDIANA DEPARTMENT OF INSURANCE

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