Federally Facilitated Healthcare Exchanges

What You Need to Know When Serving Healthcare Exchange Members

As a contracted supplier of behavioral health care management services to Healthcare Exchange plans, a product of the Patient Protection and Affordable Care Act (ACA), Magellan manages the behavioral health benefits for some Exchange plan enrollees. As a Healthcare Exchange contractor for Qualified Health Plans (QHPs), Magellan, along with our contracted provider network, is subject to the standards and procedures established by the Centers for Medicare and Medicaid Services (CMS).

Termination of Coverage for Qualified Individuals (156.270)*

The ACA requires QHP issuers to observe a three-month grace period before terminating coverage for those enrollees who are receiving advance payments of the premium tax credits (APTCs) if they have paid the full premium for at least one month. Certain individuals are eligible to receive advance payments of the premium tax credit under the terms of this regulation. The QHP has to provide these individuals with a grace period of at least three consecutive months if they have previously paid in full at least one month's premium for their insurance. During this grace period the plan must pay all appropriate claims for services provided during the first month of the grace period. Claims for the second and third months may be pended. If the member settles all outstanding premium payments before the end of the grace period, then any pended claims must be paid as appropriate. If the premium is not paid before the end of the grace period, plans may deny the pended claims. Plans may still decide to pay claims for services delivered during that period for reasons related to either state law or company policy. The coverage termination date is retroactive to the end of the first month of the grace period. **Providers may seek payment from the member for services performed in months two and three that are denied due to nonpayment of premium, even if your provider agreement contains hold harmless language.**

The timeframes apply based on the date the service was rendered and not the date the claim was submitted.

In order to protect providers from potential unpaid claims in months two and three, the regulation requires that the plan notify providers who submit claims for services rendered during the second and third months of the grace period that any such claims may be pended and potentially not reimbursed by the plan if the individual does not pay their premium before the end of the grace period. This notice may be provided through an automated electronic process. Notices must contain:

- Purpose of the notice;
- A notice unique identification number;
- The name of the QHP and affiliated issuer;

- The names of all individuals affected under the policy and possibly under the care of this provider;
- An explanation of the three-month grace period, including applicable dates, including whether the enrollee is in the second or third month of the grace period and the consequences of grace period exhaustion for the enrollee and provider and options for the provider; and
- The customer service phone number for provider calls.

**Note that some plans may elect to pay claims for months two and three when received, and then recoup funds at a later date if plan premium remains unpaid and the member's coverage terminates effective at the end of month one of the grace period. In this situation the required grace period notification discussed above will be given to alert the provider to this possibility.*