

Findings & Recommendations Pertaining to:

**Retroactive Denial of Eligibility with
Subsequent Payment Recovery**

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Executive Summary

As called for in Senate Bill 5346 (SB5346), the WorkSMART Institute engaged 13 providers organizations and 11 health plans in a structured process to arrive at a shared understanding of the ‘retroactive denial of eligibility’ problem and recommendations for protecting provider organizations and health plans from its impact. Findings and recommendations are documented in this paper, which is being submitted to the OneHealthPort Board of Directors and the Office of the Insurance Commissioner.

When it happens, retroactive denial of eligibility can be burdensome to providers.

Retroactive denial of eligibility results when a health plan indicates that a patient is eligible for coverage, that patient receives treatment from a provider, and it is later determined that the patient was not eligible at the time of service. If a claim for those services was paid to the provider, that payment is subsequently recovered. Provider organizations must then pursue the patient, and/or another insurer, for payment.

Retroactive denial of eligibility occurs relatively infrequently. There is general agreement that retroactive eligibility denial with subsequent payment recovery occurs with less than .1% of claim volume. The situation most typically arises for one of the following reasons; 1) an employer group, or member, defaulted on premium payments that were already delinquent, or 2) an employer group, Medicare or Medicaid retroactively disenrolls the patient from coverage.

Meaningful impact towards resolving this situation will require changes in national policy and legislation. Retroactive denial of eligibility is most problematic with Medicare, Medicaid and self-insured health plans. Federal policy allows Medicare and Medicaid programs to retroactively terminate and disenroll. ERISA legislation governs premium payment and termination practices of self-insured plans.

Having at-risk health plans implement changes MAY RELIEVE SOME of the providers' burden. Retroactive denial of eligibility occurs to a lesser extent with commercial at-risk health plans. These health plans could make some impact by:

- Reducing the time period within which an employer group can be delinquent on their premium payments or can retroactively disenroll an employee/beneficiary.
- Enhancing the communication between health plans-provider organizations about delinquent premium payments and the intent to recover claim payments.

Employer groups lack a compelling incentive to voluntarily adopt these changes. Standardizing these practices across at-risk health plans may require Washington State regulations that mandate specific language in health plan contracts with employer groups. And even with these regulations in place, retroactive denial of eligibility will still continue to occur with Medicare, Medicaid and self-insured health plans.

Straining the employer group – health plan relationship and completely restricting premium payment delinquency or retroactive disenrollment is not recommended. Prematurely shifting the payment responsibility to the patient will burden provider organizations and patients even worse than the current situation.

Introduction

Senate Bill 5346 (SB5346) calls for the lead private sector organization to "Recommend a standard or common process to the commissioner to protect providers and hospitals from the costs of, and payors from claims for, services to patients who are ineligible for insurance coverage in circumstances where a payor provides eligibility verification based on best information available to the payor at the date of the request;"

This paper presents an understanding of the problem referenced in SB5346 and recommends steps that can be taken to ease its burden on provider organizations. The good news is there appears to be agreement that this problem happens infrequently relative to the number of patients treated by a provider. The bad news is that the ability of the local health care community and Washington State legislative/regulatory agencies to further reduce the frequency and impact of the problem is likely to be limited. Broad base, comprehensive improvements will only be achieved through corresponding steps at the national level.

The content of this paper was distilled from conversations with provider organizations and health plans that are representative of the Washington State healthcare community (see Appendix). Those organizations were also invited to review this document in draft form. Their comments have been incorporated into this final version.

This paper will address the following topics:

1. Problem Definition & Scope
2. Magnitude of the Problem and the Four Causes
3. Burden on Provider Organizations
3. Assessment and Recommendations

Problem Definition & Scope

Within this document, the problem will be referred to as 'retroactive denial of eligibility with subsequent payment recovery'. It can be simply described as follows. A health plan determines that a patient is eligible for coverage based upon receipt of premium payment (or the promise of payment) from a policy subscriber, employer or funding program. The provider organization may verify that the patient is eligible, treats the patient, submits a claim for services, and receives payment from the health plan. At a later point in time, the health plan determines that the patient was not eligible for coverage by them at the time of treatment and recovers their payments from the provider organization. (A variation of the same problem is when the provider verifies eligibility and treats the patient but, before a claim is submitted, the health plan determines that the patient was not eligible for coverage by them and denies any future claims.)

Providers experience this problem to varying degrees with three types of health plans -- commercial full risk plans, commercial self-funded plans and publically funded programs, e.g. Medicaid and Medicare. Commercial full risk plans are subject to

Washington state insurance regulations. Commercial self-funded plans and publicly funded programs are not subject to state insurance regulations.

Like all problems, this one too has complicating factors. These factors oftentimes come up in discussions about retroactive denial of eligibility, but are only tangentially related to it. These factors are mentioned here for sake of completeness and to help establish context and boundaries around the problem. Since these factors fall outside the scope of the problem as it is defined above, they will not be further addressed in this document.

- Pre-Authorizations by Health Plans: In Washington State, (per WAC 284-43-410 (3)(h)), the health plan cannot recover payment from a provider organization if those services were pre-authorized, even in the case of retroactive denial of eligibility. Put another way, once pre-authorization is given by a health plan, recovery efforts cannot be undertaken due to retroactive denial of eligibility.
- Provider's process to verify eligibility: By definition, retroactive denial of eligibility only presents itself AFTER the provider organization has verified eligibility coverage and/or AFTER the claim has been paid. As such, this paper will not focus on issues and practices related to eligibility determination by the provider organizations as these practices will not mitigate the risk of retroactive denial of eligibility.
- Coordination of Benefits: A patient may have coverage from multiple health plans. In some situations, the wrong health plan 'paid as primary' for the services delivered to a patient. When this is discovered, that health plan recovers payments from the provider organization. This situation is unrelated to retroactive denial of eligibility. Practices to prevent and address this type of situation are discussed within the Best Practice Recommendation related to Coordination of Benefits. As such, it is outside the scope of this document.

Magnitude of the Problem and the Four Causes

Anecdotal evidence reported by all organizations suggests that the frequency of occurrence of the problem is very low. The exact magnitude of the problem is difficult to determine. Of all the provider organizations and health plans that were interviewed, only the Healthy Options plans and Medicaid could provide specific statistics about the frequency of occurrence. Health plans estimated that retroactive eligibility denial with subsequent recovery occurs with less than .1% of their claim volume. Provider organizations reported that the frequency of payment recovery ranged from extremely rare (primary care clinic) to 25-30 times per month (large medical center).

The four primary causes of retroactive denial of eligibility with subsequent recovery of payment are listed below and briefly described. (For the sake of brevity, all possible nuances within each cause are not described, e.g. delays caused by TPA/broker, health plan backlogs, etc. These nuances may add to the complexity or timeframe but do not

alter the fundamental characteristics of each cause.) The first three causes involve commercial full risk and commercial self-insured health plans. The fourth cause involves publically funded healthcare programs.

1. Employer group defaults on their premium payments to the health plan.

An employer group will submit to the health plan a roster of enrolled employees*¹. This roster of employees, along with premium payment amounts, rolls forward from month to month unless changes are made to it. At the beginning of each month, employees are added and removed from the roster by the employer and premiums are paid. Employees on the roster become eligible for healthcare coverage.

In the best case, employer groups will submit premium payment to the health plan for their employees prior to the beginning of the month of coverage. Often times these payments are delayed into the current month of coverage and, at times, even later than that. Commercial health plans give employer groups varying degrees of latitude in how long payments can be delayed before their employees are no longer eligible for healthcare coverage (30 to 90 days depending upon health plan).

During the period that an employer group's premiums have not yet been paid, health plans have different policies for informing providers about this situation and for paying claims.

- a. Informing providers about pending premium payments: Some health plans communicate this to providers and some don't.
- b. Processing provider claims for employees. Some health plans pend claims until premiums are received. Some health plans pay claims.

When provider organizations are aware that an employer's premiums have not yet been paid, they have different policies for holding the affected patient financially responsible and for submitting claims.

- a. Holding the patient financially responsible: Some providers have patients sign waivers that state they will pay for the services if the health plan doesn't. Some providers don't.
- b. Submitting claims for patients without current eligibility: Some providers pend claims until they know the premiums have been paid. Some submit claims.

When a health plan determines that an employer group has defaulted on their premium payments, the health plan terminates eligibility for the employees. An employee's eligibility is terminated retroactively to the last month of coverage for which premium payments were received. If the health plan paid claims for services for an employee during a month in which premiums were not paid, those payments are recovered from the provider organization. Some health plans send recovery letters to provider organizations requesting a refund check. Others automatically "take back" or deduct the money from future payments to the provider until the full amount is recovered.

Magnitude: Commercial health plans indicate that default on premium payments by employers is rare and accounts for less than 10% of the .1% of the claim volume where eligibility has been retroactively denied leading to subsequent payment recovery.

*1 - Roster and premium payments are for employees and their dependents

2. *Individual/family defaults on their premium payments to the health plan.*

For individual and family plans, premiums are paid by an individual and not by an employer group. Premiums are typically due before the beginning of the month of coverage or within the first 10 days. Commercial health plans give individuals much less latitude than they do employer groups in how long payments can be delayed before eligibility is terminated. Typically it is no later than the current month of service. In most cases, information about individual/family premium payments are not communicated to providers and health plans pend claims that are received for an individual/family whose premiums are not paid. In some cases, the health plan may give the individual the benefit of the doubt and pay a claim for service before a premium was paid.

When a health plan determines that an individual has defaulted on their premium payments, the health plan terminates eligibility for the individual/family. Eligibility is terminated retroactively to the last month of coverage for which premium payments were received. If the health plan paid claims for services for the individual/family during a month in which premiums were not paid, those payments are recovered from the provider organization. Some health plans send recovery letters to provider organizations requesting a refund check. Others automatically "take back"/deduct the money from pending claim payments.

Magnitude: Commercial health plans indicate that default on premium payments by individuals is uncommon. Some suggest that its occurrence is beginning to increase in frequency as a) the burden of coverage shifts from employers to individuals who may not have the financial strength to pay premiums on a timely basis, and b) individuals change plans without informing the health plan that they are leaving.

3. *Employers retroactively remove an employee from their enrollment roster.*

Ideally, the enrollment roster provided to the health plan on a monthly basis accurately reflects the list of employees that are eligible for coverage. All newly hired employees would be added to the roster and all employees not eligible for benefits (e.g. terminated employees, hourly employees with insufficient hours of work, etc.) would be deleted from the roster^{*2}. Unfortunately, employer groups rarely notify health plans of roster deletions even within 30-45 days after those terminations

take effect. In fact, roster terminations are oftentimes communicated to the health plan well after the terminations were effective.

Union-based plans and COBRA appear to be the most problematic in regards to retroactive disenrollment. Union-based plans, e.g. Boeing, Retail Clerks, etc. can take months to review their records to determine which members worked enough hours to qualify for coverage. As for COBRA, since participants are no longer employees, employers (or their Third Party Administrator - TPA) can lose track of whether premiums were sent in, status of dependents, end of eligibility dates, etc. In all of these cases, health plans initially receive premium payments from the employer group and are later asked to retroactively delete the member.

When health plans receive retroactive roster deletions, they return paid premiums to the employer group for those terminated members and update their automated claim system to make those members ineligible for the appropriate month(s). Some, though not all, health plans have time limits within which premiums will be returned, e.g. premiums will only returned for the most recent 3 months. If claims had been paid to a provider for services that were delivered during the month(s) that premiums were returned to the employer group, those payments will be recovered from the provider. To recover payments, some health plans send recovery letters to provider organizations requesting a refund check. Others automatically 'take back' the money from pending claim payments.

Magnitude: Commercial health plans indicate retroactive termination from an employer group accounts for almost 90% of the .1% of the claim volume where eligibility has been retroactively denied leading to subsequent payment recovery.

A variation of this situation is when a health plan receives an enrollment roster containing an employee termination but, due to data entry backlogs or loading errors, does not update the patient's eligibility until after they visit a provider. If the patient doesn't inform the provider about their change in employment status, the provider assumes that the previous coverage is still in place and submits the claim to the health plan, which is later denied. Though this combination of events can occur, it is extremely atypical.

*2 - Roster deletions include an employee's dependents

4. *Medicaid and Medicare review member cases and retroactively move a member to another program.*

Members enrolled in one publically funded healthcare program may have been entitled to benefits offered through an alternative publically funded program. This entitlement is always determined after services have been delivered. Specific situations where this occurs includes:

- a. A Healthy Options member is determined to qualify for Medicaid - SSI (disability) benefits. OR A Healthy Options member switches, during a month of Healthy Options coverage, to Fee-For-Service (FFS) Medicaid "Open Coupons".

Medicaid notifies the Healthy Options plan when a Healthy Options member

- Is determined to qualify for Medicaid-SSI, or
- Requests to opt out of the Healthy Options program in favor of Open Coupons.

In both cases, the Healthy Options plan will continue to pay for services for this member until they have received official notice of disenrollment from Medicaid. Medicaid will recoup premiums retroactively to the eligibility termination date. Once the member has been dis-enrolled from the Healthy Options plan, a 'refund letter ' is sent to the affected providers to alert them to this issue and to the fact that they can bill Medicaid for these services. Payments made to providers for the member after they became eligible for Medicaid-SSI/Open Coupons are recovered by the Healthy Options plan.

Magnitude:

One Healthy Options plan reports retroactive enrollment in Medicaid-SSI typically affects .01% of their membership. On average, payments are recovered for 6-12 months of service with an average monthly recovery at \$500,000 and an annual average recovery of \$6M.

One Healthy Options plan reports that the number of members that switch to Open Coupons is 175 per month (though not all have paid claims). This plan's average monthly recovery is \$70,000 with an annual average recovery of \$840,000.

- b. A Medicaid-SSI (disability) member is determined to qualify for Medicare benefits.

Medicaid clients receiving SSI (disability) are subject to periodic review by Social Security Administration (SSA) for Medicare entitlement. If SSA determines that a patient is Medicare entitled, they notify the appropriate Medicaid agency. Medicaid informs the respective providers that payments made by Medicaid will be recovered and sends the providers a "buy back" letter to substantiate their retrospective billing of the Medicare intermediary. When included with a provider's claim for services, this buy back letter should trigger the Medicare intermediary to waive any timely filing requirements.

There are no time limitations on how far in the past SSA can determine that a patient was Medicare entitled. However, providers can only bill the Medicare intermediary for services provided within the last 24 months in some circumstances and within the last 36 months in others.

Washington State Medicaid only recovers payments from providers for the period of time in which the provider is allowed to bill Medicare, i.e. within the past 24 months or 36 months depending upon the circumstance. For payments made to providers outside those time periods, Medicaid attempts to recover other monies from the federal government through multi-state lawsuits.

Magnitude: Over the past 15-16 months, Medicaid has recovered \$20 million from providers for patients who were retroactively covered by Medicare. Medicaid has also determined that an additional \$34 million needs to be recovered.

All four causes of retroactively denied eligibility outlined above can result in payment recovery from the provider. Those same causes may also result in the following variation of the problem. A patient's eligibility is retroactively denied after the provider verifies eligibility but before their claim is paid. As a result, the provider never receives payment from the health plan. This variation of the problem is less problematic since the provider becomes aware of retroactive denial almost immediately after submitting the claim. The patient can then be pursued in a timely manner in order to acquire the correct insurance information and submit a claim, or to start the process of collecting from the patient.

The frequency of occurrence of this variation of the problem is much more difficult to quantify since there is no good way to track if/when the provider verified eligibility in relation to when the eligibility was actually terminated.

Burden on Provider Organizations

Payment recovery as a result of retroactive denial of a patient's eligibility can be burdensome to providers. The process of returning payments to health plans and pursuing alternative billing options brings with it a number of challenges, as outlined below.

1. *Automatic take-backs rather than recovery letters lead to manually intensive research efforts.*

When recovering payments, providers prefer that health plans send recovery letters as required by RCW 48.43.600 that is presented below.

Overpayment recovery — Carrier (1) Except in the case of fraud, or as provided in subsections (2) and (3) of this section, a carrier may not: (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within twenty-four months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

Some health plans that are not subject to RCW 48.43.600 automatically 'take-back' the money from claim payments that are pending for the provider organization. The provider is only made aware of this recovery by monitoring their remittance advice. Upon noticing the take-back, the provider must manually research the situation to find out why the money was recovered. If the provider does not notice the take back, they will not know to pursue alternative billing.

2. *The longer the retroactive recovery period, the more difficult it is to contact the patient and the possibility of alternative coverage options becomes less likely.*

Gathering up-to-date billing information from patients is always problematic for providers. It is hard enough to get this information from patients before and at the point of service, when the patient is making an effort to be in contact with the provider organization. The difficulty increases significantly after the patient has been treated and accounts have been settled. As time passes, the patient's contact information changes, e.g. phone disconnected, moved, etc., and in some cases the patient dies. Significant staff time can be required to track patients down to determine if they had other insurance coverage and to set up payment arrangements if they didn't.

In cases where the patient did not have insurance coverage, the patient may be eligible for Medicaid. However, a Medicaid application must be submitted within 90 days of date of service. Depending upon the recovery timeframe, the patient may no longer be eligible to apply for Medicaid.

3. *The longer the retroactive recovery period, the probability of claim denials for no pre-authorization and untimely billing increases.*

In retroactive denial of eligibility situations, some health plans recover payments from providers for up to 2 years from the date of payment. Providers must then locate the patient, find out if other coverage was in force and submit claims for service. The health plans receiving those claims may deny them for lack of pre-authorization^{*3} or for untimely filing. The provider must then go through the appeals process to secure their revenue.

*3 - Denials for lack of pre-authorization is addressed in the Best Practice Recommendation - Extenuating Circumstance. If the provider contacts the health plan BEFORE the claim is submitted to explain the circumstances, the health plan will process the claim AS IF a pre-authorization had been obtained.

Assessment and Recommendations

Payment recovery from providers as a result of retroactive denial of eligibility occurs relatively infrequently in relation to the number of claims that are submitted and paid. When this situation does occur, it is most likely to affect providers who see a large number of patients and providers who treat patients with employer self-insured coverage

and patients with Medicaid, Medicare and federally funded program patients. The provider organizations are burdened with trying to track down the patient, determine if other coverage was in effect and then dealing with delayed billing and appeal issues.

The roots of retroactive denial of eligibility and subsequent payment recovery can be traced to the employer group for commercial plans and to Medicaid and Medicare for public programs. However, it is almost impossible to fix the problem at its source. Challenges such as handling benefits for hourly employees, managing cash flow, administrative inefficiencies, etc., make it difficult for employer groups to pay their premiums on a timely basis and/or to give roster update information to the health plan in a timely manner. Penalizing the employer groups too harshly could have undesirable and unintended consequences on their employees, e.g. an employee would be unable to get health care because their employer didn't pay the premiums on time. Federal policy allows Medicaid and Medicare programs to retroactively terminate and enroll. Medicare and Medicaid shouldn't be penalized because they are doing what they are required to do.

In some cases, the patient themselves contribute to the problem. All employees know when their employment has been terminated. Many employees know when they have worked insufficient hours to maintain insurance coverage. Yet these employees fail to ask their providers to change their insurance status when they go in for treatment. Providers play a very small part in this situation by not asking the patient about current employment at every visit.

In order to minimize the unintended consequence of a patient going without insurance for short periods of time due to no fault of their own, health plans give leeway to the employer groups. The health plan provide "bridge coverage" when an employer group is delinquent in premium payments. When this "bridge" coverage fails or when the employer retroactively deletes employee, providers take up the slack. They spend the time tracking down the patient and billing either the patient or alternative insurance coverage, if and when applicable.

In crafting a solution to this problem, three things must be considered:

1. *There is no silver bullet.* There is no perfect solution without change in Federal regulation. Whatever solution is crafted by the local healthcare community and/or Washington state regulatory agencies, the major contributors to the problem, i.e. self-funded plans, Medicaid and Medicare will not be subject to it.
2. *The cost and breadth of the solution should not outweigh the magnitude and burden of the problem.* The scope of the solution should be commensurate to the part of the problem that can reasonably be addressed.
3. *The solution should solve the problem, without creating new ones.* From a provider's perspective, it is easier and much more efficient to submit claims to health plans than it is to bill patients. A certain amount of "reasonable latitude" built into a strong employer group-health plan relationship keeps the provider-health plan relationship

intact. Restricting that latitude too aggressively may have the unintended consequence of putting even worse burdens on providers and patients. e.g., if timeframes for making premium payments are too stringent (especially in this economic environment) and the employer group is defaulted too quickly, employees would not have insurance coverage and providers would be billing patients. Later reinstatement of the employer group's coverage would introduce new complexity for the employer group, health plan, providers and patients.

Bottom line, the solution must be appropriate to the problem and to the likelihood of solving it. This problem occurs relatively infrequently and any non-Federally mandated solution will only solve part of it. A reasonable solution will have the following characteristics:

1. Health plans should be encouraged to continue to give employers leeway, but the "timeframe" should be tightened. Timeframe limits should be used to discourage employer groups from unreasonably, inefficient practices where they benefit at the expense of the provider.

Timeframe limits should be applied in a standard way by all health plans across all employer groups. Employer groups lack a compelling incentive to voluntarily adopt more stringent timeframe limits. Standardizing these limits across health plans may require Washington State regulations that mandate specific language in health plan contracts with employer groups.

2. Health plans and provider organizations should leverage any "positive" consequences of timeframe limits in relation to the risk that they each take. In cases of extremely tardy roster deletions, employer groups should be restricted from recouping monthly premiums. When health plans keep premiums, providers should keep claim payments for those months when they treated the employee. The health plan benefits in those cases when the employee isn't treated and the provider benefits in those cases when the employee is treated.
3. Administrative burdens on providers should be minimized along with the timeframe that they are at-risk for payment recovery.

Recommended practices that contribute to a reasonable solution are:

1. In their contracts with employer groups/funding sources, require health plans to limit premium payment delinquency to 2 months of coverage. The following information about delinquent payments will be available to providers when they verify eligibility with the health plan, i.e. before treatment and over the course of treatment, as in the case of concurrent reviews.
 - a. In no later than 45 days of the premium payment becoming delinquent, health plans will update their eligibility system(s) with 'delinquent payment' information for all affected employees so that providers can determine whether or not to hold

the affected patient financially responsible and whether or not to submit claims for that patient.

- b. After premium payment has been delinquent for 2 months of coverage, health plans will update their eligibility system(s), within 15 days, to indicate that the eligibility for all affected employees have been terminated.

For example, premium payments due for coverage starting April 1st must be paid by June 1st. As of May 15th, the health plan's eligibility system will have been updated with 'delinquent payment' information if the payment has not yet been made. If the payment is not made by June 1st, the health plan will update their eligibility system, by June 15th, to show that eligibility has been terminated.

2. In their contracts with employer groups/funding sources, require health plans to limit the group's ability to recoup premiums paid for retroactive roster deletions to the most recent 2 full months of coverage^{*4}. (See examples 2a & 2b) Employer groups must notify health plans of retroactive deletions within the first 15 days of the current month in order for premiums to be returned for the month just before the prior month. (See example 2c)

Examples:

- a. If on June 15th an employer group notified the health plan that an employee had been terminated in January, only the premiums for the months of April and May can be returned.
- b. If on June 15th an employer group notified the health plan that an employee didn't have enough hours for coverage in March, no premiums would be returned.
- c. If on June 15th, an employer group notified the health plan that an employee didn't have enough hours for coverage in April, premiums would be returned for April. If the health plan was notified on June 16th, no premiums would be returned for April.

^{*4} - Not all employer billing cycles start on the first of the month. These recommended time periods start at day 1 of the billing cycle, which could be the 1st of the month, the 10th of the month, the 15th of the month, etc.

3. In compliance with RCW 48.43.600, a health plan will notify providers, via a recovery letter, of their intent to recover payments for services. The letter should allow the provider 45 days to choose between sending a refund check to the health plan, having the health plan take-back the money from current claim payments or appealing the recovery. If the provider doesn't respond to the health plan, the health plan can take-back the payment.
4. Limit health plan recovery of payments from providers to those months of coverage when premium payments were either not made by the employer group or were refunded to the employer group. Recovery letters for payments-made will be sent to providers no later than 45 days of the employer group notifying the health plan of retroactive roster deletion or of the date of claim payment, whichever is later.

5. When a retroactive COBRA enrollment is received for a member, the health plan will reprocess any claims that had been denied for that member during the period between the termination of the previous coverage and the date that the COBRA coverage was activated.

This recommendation is intended to address the following:

COBRA allows an employee to wait up to 60 days after termination of their employer paid insurance coverage to select COBRA coverage. In that period of time, a provider could submit a claim that was denied due to no eligibility. However, that claim would be eligible for coverage once COBRA is retroactively activated.

Providers are not always aware that COBRA is retroactively activated, and thus may not resubmit the claim.

6. Allow health plans to treat certain cases of retroactive termination of eligibility as a Coordination of Benefit (COB) situation, if they choose to do so. These cases would have to meet the following criteria:
 - a. *Health plan paid a provider's claim for a patient.* As a benefit of their employment, an employee was eligible for coverage by Health Plan 'A'. The employee terminated their employment and secured coverage with Health Plan 'B'. They later received care, but did not inform the provider of the change in coverage. The provider submitted a claim to Health Plan 'A', who paid the claim.
 - b. *The patient was retroactively terminated and payment to the provider cannot be recovered.* At a later point in time, the employer group retroactively notified Health Plan 'A' of the employee's termination. The notification was outside of the time limit for notifying the health plan (as defined in #2 above) so that the employer group could not recoup their previously paid premium from Health Plan 'A'. Thus, Health Plan 'A' cannot recover payment from the provider^{*5}
 - c. *The patient had other coverage at the time of service.* Health Plan 'A' discovers that the ex-employee had secured coverage for the date of service from Health Plan 'B'.

In these cases, the relationship between the health plans will be considered a COB situation with health plan 'A' as the secondary payer. Health plan 'A' can pursue health plan 'B' for recovery of monies paid as primary and will notify the provider of the patient's coverage with Health Plan 'B', so that the provider can update their records.

^{*5} - If the employer group notified Health Plan 'A' within the time limit and recouped their premium payment, Health Plan 'A' could recover payments from the provider (as defined in #4 above).

Even with these practices in place, there needs to be realistic expectations about the impact of any proposed solutions. Since retroactive denial of eligibility with payment recovery occurs most frequently with self-funded plans, COBRA, Healthy Options, Medicaid and Medicare, changes to federal regulations are likely to be required in order to achieve widespread adoption. These plans/programs are outside the exclusive purview

of Washington State regulatory activities and will not be subject to any solution. As such, in concert with the implementation of these or similar practices, outreach and ongoing educational efforts should be planned in order to respond to provider confusion about why the problem continues to occur.

In the event the Office of the Insurance Commissioner elects to proceed with a regulatory approach to implement some of the recommendations in this section, proposed regulatory language has been included in Appendix B to help guide the drafting of such regulations.

Appendix A
Representatives of Healthcare Community Invited to Participate

Clinics/Physician Groups

- Everett Clinic
- Northwest Physician's Network
- Physician's Clinic of Spokane
- Puget Sound Family Physicians
- Sound Family Medicine
- University of Washington Physicians
- Washington State Medical Association
- Yakima Urology Associates

Hospitals/Medical Centers

- Children's Hospital
- Health Services Northwest (for Providence & Swedish)
- Multicare
- Sacred Heart Medical Center
- Virginia Mason

Health Plans

- Association of Washington Health Plans
- Cigna
- Columbia United Providers
- First Choice
- Group Health Cooperative
- Kaiser Permanente
- KPS Health Plans
- Medicaid/HRSA
- Molina
- Premera
- Regence

Appendix B
Proposed Regulatory Language

WAC 284-165-010 Purpose and Applicability

WAC 284-165-020 Definitions

WAC 284-165-040 Retroactive Changes to an Individual's Coverage under a Health Plan

WAC 284-165-010 **Purpose and applicability.** The purpose of this chapter is to establish streamlined and uniform procedures for the carriers and health care providers for the effectuation of chapter 48.165 RCW.

WAC 284-165-020 **Definitions**

- (1) Carrier means an entity licensed under chapters 48.20, 48.21, 48.44, 48.46 and 48.62 RCW.
- (2) Group contract means a contract for health care services which by its terms limits eligibility to members of a specific group.
- (3) Health care providers or provider has the same meaning as in RCW 48.43.005 and shall include facilities licensed under chapter 70.41 RCW.
- (4) Health plan or health benefit plan has the same meaning as in RCW 48.43.005(19).
- (5) Payor has the same meaning as in RCW 48.65.010(5).
- (6) Premium has the same meaning as in RCW 48.43.005(22)
- (7) Purchaser means an individual or entity, whether private or public, that purchases a health plan from a carrier.
- (8) Refund has the same meaning as in RCW 48.43.600(5).

WAC 284-165-040 **Retroactive Termination of an Individual's Coverage for Delinquent Premium Payment or Ineligibility Under the Health Plan**

- (1) If a purchaser fails to pay a carrier the premium for an individual covered by a health plan, the carrier must:
 - (a) within 45 days of the premium due date, update its eligibility system to reflect that premium is delinquent to enable a provider to establish other payment options with the individual; and
 - (b) retroactively terminate that individual from coverage once premium is delinquent for 61 days past the premium due date, or a shorter time period at the discretion of the carrier consistent with the terms of the health plan; and
 - (c) update its eligibility system to reflect the effective date of the retroactive termination within 15 days of the date the carrier retroactively terminated such coverage.
- (2) If a purchaser of a group contract notifies a carrier that an individual, for whom premiums were previously paid to the carrier, should be retroactively terminated because that

individual did not meet eligibility requirements under the group contract and either requests that the carrier reimburse the premium or attempts to recoup premium from the carrier by offset or other mechanism to future premium amounts due, the carrier must:

(a) continue the individual's coverage and retain the applicable premium, if such notice was received more than 75 days following the premium due date; or

(b) terminate the coverage for that individual and refund the applicable premium, if such notice was received within 75 days of the premium due date.

(3) If a carrier previously made payment to a provider for services rendered to an individual whose coverage is retroactively terminated under subsections (1) or (2) above, the carrier must request in writing a refund from a provider within 45 days of the later of: (i) the date the carrier received notification from the purchaser of the request for retroactive termination or (ii) the date of claim payment.

(4) If a provider fails to contest the refund request in writing to the carrier within 30 days of the provider's receipt, the request is deemed accepted and the provider must pay the carrier the refund. If the carrier has not received such payment within 60 days of the date of the refund request, the carrier may offset to a future claim of some or all of a payment already received by a provider.

(5) If an individual eligible for COBRA continuation coverage under the group contract elects such coverage retroactively consistent with federal law and the carrier receives full payment of all premium due, the carrier must reprocess any clean claim (as defined in WAC 284-43-321) previously received by the carrier and denied prior to the individual becoming enrolled under the group contract as a COBRA member. The date that the carrier receives payment in full for all premium due shall be the applicable date of receipt for purposes of WAC 284-43-321.

(6) The section shall be effective for retroactive terminations made by carriers beginning [DATE]. Carriers must amend group contracts to outline the requirements of section (2); however such amendment may be handled by endorsement. No amendment to health plans are required for section (1). Carriers and providers are not required to amend provider contracts to incorporate sections (3), (4) or (5).