BULLETIN

To: **Health Insurers**
Health Maintenance Organizations
Private Review Agents

Re: **Group Contracts: Retroactive Termination and Adverse Decisions**

Date: **November 19, 1999**

Bulletin: **Life and Health 99-20**

Legislation was enacted during the 1999 Session of the Maryland General Assembly to address complaints by providers that, after services have been preauthorized and rendered, payment would be denied for the services because the patient was not covered by the health plan at the time the services were rendered.

Retroactive Termination

An individual who ceases to be a member of a group to which a group health insurance contract has been issued loses eligibility to receive benefits under the contract. Legislation effective October 1, 1999 establishes when loss of eligibility takes effect.

Chapter 554 of the Acts of the General Assembly of 1999 (Senate Bill 350), codifies §15-303(f) of the Insurance Article, to require each contract for group health insurance to contain a provision requiring the group policyholder to continue to pay the premium for an employee, member, or dependent under the contract until notice of termination of coverage has been received by the insurer or health maintenance organization. As a result, when an individual ceases to be a member of a group, the insurer or HMO will pay for health services rendered in accordance with the contract until the day that notice of termination has been received or, if notice is received before the date of termination, the date coverage terminates under the contract. The group policyholder will be under a contractual obligation to pay the premiums owed until notice is received. This ensures the insurer or HMO will not be obligated to provide services for which no premium has been collected.

Retrospective Adverse Decisions

Senate Bill 350 also amends Title 15, Subtitle 10B of the Insurance Article. In that Subtitle, an adverse decision is a determination, made after consideration of appropriate and efficient allocation of a health care service, that the service *is not medically necessary, appropriate, or*

efficient and therefore may result in noncoverage. This language clearly indicates an adverse decision relates to denials on the basis of medical necessity, not coverage status. The language defining adverse decision in Subtitle 10B is also used in the definition of adverse decision for Subtitle 10A. As defined in §15-10A-01(b)(2) of the Insurance Article, an "adverse decision" specifically does not include a decision concerning membership status. Thus, although the term "adverse decision" is defined somewhat differently in §15-10B-01(b), the variations in the two definitions of the same term must be read to be consistent, and both indicate a membership determination is not part of an adverse decision.

Senate Bill 350 amends Title 15, Subtitle 10B by repealing, from §15-10B-07(c)(2), two of the permissible circumstances under which a private review agent could "retrospectively render an adverse decision" regarding preauthorized or approved services delivered to a patient. As stated in the repealed language, those grounds were :1) "the patient, on the date the services were rendered, was not insured by or an enrollee, subscriber, or member of" the plan on whose behalf the private review agent made the preauthorization, and (2) "except for determinations of appropriateness or medical necessity of the covered services that were preauthorized, the services would not be covered in whole or in part under the policy or contract".

The language repealed prevents a PRA from making a retroactive adverse decision because the patient was not a member, or the service was determined not to be covered. For the reasons described above, neither of the circumstances repealed is related to whether a service is medically necessary, a statutory element of a determination to render an adverse decision. Nonetheless, a PRA is now prohibited from basing a retrospective adverse decision on those circumstances. However, Section 15-10B-01 applies to PRAs and the adverse decisions they make, but not to the decisions of HMOs or insurers which do not constitute adverse decisions as defined by statute. An HMO, insurer, or third party administrator may deny reimbursement based on membership or contract coverage. Since Chapter 554 did not limit that authority, absent further statutory changes, they may continue to do so.

<u>Inquiries by Providers</u>

Carriers should encourage providers to confirm membership before a preauthorized service is actually delivered. If a provider contacts a carrier before rendering a preauthorized service to determine whether, on that day, the patient currently maintains coverage under the group health insurance contract, the carrier should give accurate information.

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Donna B. Imhoff, Associate Commissioner
Life and Health