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COORDINATING BENEFITS FOR PATIENTS WITH MORE THAN ONE SOURCE OF INSURANCE COVERAGE

If a patient is covered under his own employer-sponsored health insurance plan and is listed as a beneficiary on his spouse's plan, which plan do you bill first? If you are treating a child whose parents are divorced, which parent's plan do you bill? Coordination of benefits (COB) provides guidelines to help you answer these and other questions that arise when a patient is covered by more than one health plan. The primary goal of COB is to determine the order in which insurance plans pay and to ensure that the total payment does not exceed 100 percent of the billed expenses. COB also ensures that the primary plan pays as if it were the only plan. The secondary plan and any subsequent plans pay the difference between the billed amount and the payment made by the primary plan.

The National Association of Insurance Commissioners (NAIC) posted model COB regulations in 2013 (see http://www.naic.org/store/free/MDL-120.pdf) . These regulations form the basis for the majority of state laws on COB, providing some degree of consistency. The federal government, however, complicates the issue. ERISA (Employee Retirement Income Security Act, see Chapter 42), the federal legislation that covers employee benefit plans sponsored by self-insured employers, exempts such employers from state COB laws, allowing the plans to develop their own policies for COB. In addition, COB rules for Medicare and Medicaid that also preempt state laws are maintained by the Centers for Medicare and Medicaid Services (CMS). For the most part, health plans maintain detailed processes to ensure that COB occurs and is carried out correctly for patients who are covered under multiple plans.

As a physician, it is important for you to understand the general principles of COB and know how to identify potential COB issues to ensure that you and your patients receive prompt and accurate reimbursement.

GENERAL PRINCIPLES OF COB

As stated above, the main purpose of COB is to determine the order of payments when a patient is covered by more than one insurance plan. The first step in this process is to determine which plan is the primary payer, which is secondary, and so on. In general, the following guidelines are used to determine primacy:

- **Type of Plan:** If a patient is receiving treatment as a result of an accident, the insurance policy that covers the accident (workers' compensation, automobile, homeowner's) is generally the primary plan.
- **Family Member Coverage:** The subscriber's plan is primary for the subscriber. It will be secondary for any dependents of the subscriber who are subscribers themselves on other policies.
- **Plan Provisions:** Some plans specify their order of payment. For example, Medicaid is always considered the payer of last resort. Also, if the service provided is not considered a covered service by a plan, COB is not an issue. The plan that covers the service should be billed as the primary plan.
- **State of Residence:** Applicable state laws may offer some guidance in determining COB.
- **Employment Status:** For active employees, the employer-sponsored health plan is generally primary. Other plans, such as Medicare, may be primary for disabled or retired employees.
- **Legal Decrees:** Child custody agreements may specify which parent's plan is primary for the child. Such legal decrees take precedence over other methods of determining the primary plan.

IDENTIFYING POTENTIAL COB SITUATIONS

There are a number of triggers that should indicate to you that a patient may have more than one health plan and will require COB. These include:

- Patient is sixty-five or over (this may indicate Medicare coverage)
- Patient is under sixty-five but has end-stage renal disease or a disability (this may also indicate Medicare coverage)
- Patient and patient's spouse are both employed
- Patient is a child whose last name is different from the parent/subscriber
- Patient is being seen for an injury or condition related to employment
- Patient is being seen for an injury or condition resulting from an accident

If any of these apply, verify all insurance coverage with the patient and contact the insurers directly to confirm which is primary before submitting any claims. This will reduce the chance of delays and errors in claims processing.

RULES OF THUMB

Despite the complexity of COB legislation and regulations, there are a few rules of thumb that will help you facilitate processing and payment of claims in COB situations.

- **Subscriber:** The plan for which the patient is the subscriber, member, or active employee is almost always primary.
- **Spouse:** If the patient is a subscriber on one plan and a dependent on the spouse's plan, the spouse's plan is secondary. If the patient is only covered as a dependent on the spouse's plan, that plan is primary.
- **Dependent Children:** If the parents are married, unmarried and living together, or share joint custody, the primary plan is the one carried by the parent whose birthday falls earlier in the calendar year. If both parents have the same birthday, the primary plan is the one that has been in place longer. If the parents are divorced and a court decree specifies who is responsible for the child's healthcare coverage, this decree takes precedence over the "birthday rule."
- **Managed Care:** If the primary plan is managed, that plan is permitted to reduce the allowed payment amount if cost-containment policies are not followed (e.g., preauthorization). In general, if the secondary plan is managed, it cannot reduce the allowed amount for not following cost-containment policies unless the primary plan makes a reduction as a result of similar plan provisions. This means that if the patient's primary plan does not require preauthorization for services and the secondary plan does, the secondary plan cannot penalize you for not obtaining preauthorization. **Note**: Some managed care plans have changed this rule by including language in their benefit plans requiring preauthorization, even if the plan is a secondary payer.
- **Medicaid:** Medicaid is considered the payer of last resort and is never the primary plan unless it is the only coverage a patient has.
- **Medicare:** Medicare is generally secondary to workers' compensation plans and employer-sponsored plans if the patient is still an active employee. If a patient is no longer considered an active employee due to retirement or disability, Medicare is generally primary. **Note:** If a physician has opted out of Medicare (see Chapter 40) so that Medicare cannot be billed for her services, the patient's Medigap policy will not reimburse for the treatment either, although other Medicare supplementary policies may.

- **TRICARE:** TRICARE, the health plan for U.S. military personnel and their families (formerly known as CHAMPUS) is always a secondary payer, except when Medicaid is involved.

For additional information on COB for a specific patient, the patient's health plans are the best source of information, particularly the one you believe to be primary.