

Coordination of Benefits

Benefit and Plan Calculations

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Often when medical billers are being taught about coordination of benefits, the focus seems to be on determining who pays primary. In reality, most plan benefit determination of primary payer has already been established. Where it gets complicated is after a claim is submitted to both carriers, and you have an EOB from both plans. We still have to determine how much the patient should be billed, and what adjustments are to be posted to a patient's account. Coordination of benefits is one of the most important issues for a medical biller and very few courses cover the actual calculations of dual plan benefits. Medical billers must pay special attention to participating carrier contracts as well as making certain benefits are verified for all plans that the patient is enrolled in. In this paper, we will briefly go over determining the order of benefit determination, but the main focus in this paper, will be calculating the payments, adjustments and final determination of patient balances. This guide assumes that you have general knowledge of both coordination of benefits, order of determining primary carrier, and general medical billing knowledge.



Determining the order of payment (Who pays primary)

The National Association of Insurance Commissioners (NAIC) released its first set of **model COB** guidelines back in the early 1970's. The model was created to serve as a guideline for employers and state legislature to adopt as a consistent set of rules for coordinating benefits. These rules have been amended a few times and many carriers still use this model in their coordination provisions. You can find the latest (2013) [NAIC guidelines on COB here](#).

COB provisions of a group health plan usually include the following:

- **General rules for employee's and their spouses with two group health plans.**
The plan that covers the employee of a group health plan is generally primary over that individual; a spouse's employer sponsored health plan would be primary for them.
- **For plans with children covered by two employer group health plans** the general rule is that the parent whose birthday falls first in the year will pay primary on the children. (Birthday Rule)
The plans consider only the parent's birth date, not the year. For example, if the father's birthday is 1/1/1966, and the mother's birth date is 4/10/1965, the father's plan would be primary since his birthday falls first in the calendar year.
- **For those parents with children that are divorced**, payment order can be affected by the divorce decree. If the divorce decree does not specify responsibility, and parents have joint custody, the birthday rule applies. If there is a court order that specifies which parent is responsible for health care coverage and/or costs, that group health plan is primary and supersedes any other provision.

With divorce, the coordination of benefit determination can become difficult in determining the primary payer. There are general guidelines that can be followed:

- > The plan of the custodial parent is primary
- > Next, the plan of the spouse of the custodial parent pays

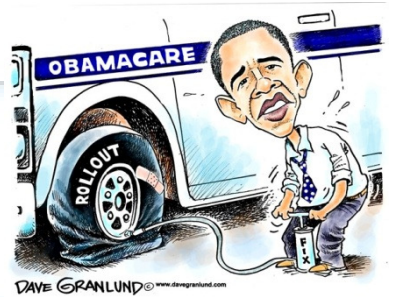
- > Next, the plan of the non custodial parent pays
- > And finally, the plan of a non-custodial parent's spouse pays

It is not unusual for a medical practice to request any divorce decree or custody agreement to be added to the patient's file.

- **If a person has COBRA continuation coverage or any state mandated continuation coverage**, the continuation coverage (COBRA) is always the last payer.
- **If a plan does not specify coordination of benefit rules**, the plan that covered the person for the longest period of time is primary.
- **A plan that does not contain a Coordination of Benefits clause consistent with these rules is always primary.**

The Affordable Care Act and Changes to the NAIC Model COB Regulation

In August of 2013, NAIC added a clause to the rules on duplicate coverage of children to incorporate when a child is covered by a parent's plan and an employer's plan at the same time. An additional change, the NAIC stated that if a person has health coverage under an insured or self-funded health plan as well as a "fault" or "no-fault" auto liability policy, the auto liability policy is to be primary payer on auto accident injuries. In a third change to section 3(K)(3), adds a new paragraph (h) that defines a plan which includes group and non group insurance contracts as well as subscriber contracts that pay or reimburse for the cost of dental care. As noted above, you can find the latest (2013) [NAIC guidelines on COB here](#) which contain all of the updated changes.



Health insurance plans will often establish their own rules for coordinating benefits in cases of dual coverage. These rules are typically found in the patient's summary plan description and/or policy benefits book. There are generally a few different situations where Coordination of Benefits (COB) applies.

- Standard or model coordination of benefits between group health plans.
- Standard coordination rules between group health plans and government plans. (Medicare, TRICARE, etc)
- Standard coordination between group health plans and auto insurance carriers.

Note: As a general rule, patients should understand the coordination of benefits clause included in their plan policy. As a medical biller, it can be helpful to learn how to determine the primary carrier as well as how to process a secondary claim to determine the patients out of pocket responsibility, as well as understanding how secondary claims are processed in a coordination of benefit situation.

Methods of calculating benefits

Once the primary carrier has been established, and claims have been processed by the primary and the secondary plans, this is where things get tricky. It's now time to coordinate the benefits using the EOB's. This is where it is determined what the patient owes, if the patient owes, and what part of our billed charges is to be adjusted off. COB does not allow a claimant to receive more than 100% of the eligible charges between two group health plans payments. There are instances where a Medicare beneficiary may have an individual plan to which they contribute 100% of the premiums and that can result in payment to the patient for more than the billed charges.



The following are descriptions and examples are of the common COB methods carriers use to calculate their benefit in a COB situation. **How benefits are calculated can vary depending on the plan**, which is why you want to be sure benefits are verified for each plan the patient is covered by. You also want to review your plan contracts for any specific benefit provisions.

NOTE: The secondary plan will determine the method of COB used to calculate its benefits.

In cases where a primary plan has not been established, carriers will often use the "Right of Recovery" or ROR approach. Under this approach, carriers may make a determination after a claim is paid, that another party, had primary responsibility. When this happens, a plan may recoup any benefits they paid previously where the other carrier may have had primary responsibility. Plans may also send inquiries to their insured party to determine if there are any other plans with responsibility. Claims may be pended for this information from their insured or they may pay the claim but inform the patient and the provider that if determined that another carrier had primary or full responsibility they have the right to recover any reimbursements. When running across a patient with more than one payer, it is important to determine the COB approach the carrier takes. There are even many plans that do not coordinate benefits at all.

There are generally three approaches plans take when they calculate coordination of benefit payments.

1. **Full COB** - Also called "**traditional COB**". If a plan indicates they have a full or traditional COB method, the primary plan calculates the claim payment without any consideration of additional benefits. The secondary carrier also calculates their benefit according to what they would normally pay if they were the primary carrier. The primary plan would pay the benefit as calculated and according to any plan provisions. The secondary, would then pay the balance if its calculation shows at least that amount **would have been normally paid** with no other coverage in place. For example, let us assume a patient is covered by two group health plans that both have a \$250 deductible. The patient incurs a healthcare cost of \$100. The primary applies the full cost of the plan allowable to the patient's deductible. For this example we will say that the plan allowable was \$100. The secondary carrier would also apply their plan allowable up to the cost of \$100 to the patients' deductible with their plan and no benefit would be payable. The patient would need to meet their deductible with both plans before any benefits are payable.

Example #1 Full/Traditional COB Example:

In this sample, patient has a \$100 deductible on both plans which has not been met, and 20% coinsurance, with both plans. Physician is participating with both primary and secondary plans.

	Primary Plan	Secondary Plan
Billed Charges	\$2000.00	\$2000.00
Plan Allowable	\$1550.00	*\$1925.00
Less Deductible	\$100.00	\$100.00
Eligible expenses before coinsurance	\$1450.00	\$1825.00
Eligible expenses AFTER coinsurance	\$1160.00	\$1460.00 (would have paid if primary) \$1825 X .80%
Benefit Paid	\$1160.00	\$300.00
Benefit Paid	\$1160.00	\$300.00
Total Paid All Plans		*\$1460.00

Par Adjustment: - *\$75.00

Total Plan Payments: \$1460.00

Patient Responsibility: \$465.00 **

*= higher allowable - As you post payments, it's important to remember that the higher allowable determines the participating adjustment you take with two plans that the practice participates with.

** Patient is responsible for \$465.00 which is the difference between the higher allowable and the total amount paid by both plans together.

Use the section below if needed to do your own calculations:

NOTES:



2. **Non-Duplication of Benefits** - under this method, the secondary plan does not reimburse any more on the claim than it would have paid if it were the primary payer. The secondary plan would review the payment of the primary plan, and if the primary payment is equal to or more than what the secondary payer would have paid on its own, no benefit would be payable. This approach is also sometimes considered "maintenance of benefits approach" or a "carve-out" benefits approach. This is normally the type of COB provision a self-funded plan would utilize. For example, if both the primary and secondary health plan had the exact same plan structure, there would be no benefit to having dual coverage. Both plans would calculate the benefit as if no other plan existed. Another example is if the primary plan covers 80% of covered charges, and the secondary carrier covers 80% as well, the secondary carrier would not make any additional payment. However, if the primary plan had a coinsurance rate of 50%, and the secondary plan had a coinsurance rate of 80%, the secondary plan would consider the remaining 30% of covered charges. In other words, the secondary carrier looks only at the benefit paid by the primary carrier.

Example: #2 - Non Duplication of Benefits/ Carve Out

In this sample, physician is participating with both plans. patient has a \$10 copay with the primary plan and \$15 copay with the secondary plan, with 0 coinsurance. Patient's secondary plan has a "Non duplication of benefits" method. (NO COB)

	Primary Plan	Secondary Plan
Billed Charges	\$2000.00	\$2000.000
Plan Allowable	\$1900.00	\$1885.00**
Less Copay	\$10.00	\$15.00
Balance eligible expenses	\$1890.00	\$1885.00
Benefit Payable	\$1890.00	\$0.00 *

Par Adjustment: - \$100.00**
 Total Plan Payments: - \$1890.00
 Patient Responsibility: = \$10.00*

*Since the secondary plan has a "non duplication of benefits" specified with its plan, the Secondary calculates their LIABILITY, as if no other insurance existed. In the example **above the secondary would have paid \$1885.00**. Since the primary plan paid more than the secondary would have paid if they were the only carrier, no payment is due from secondary.

** Remember, the plan with the higher allowable, determines the amount of the participating provider adjustment. In the example above, the primary plan allowable of \$1900.00 is higher than the secondary allowable of \$1885.00, leaving \$100 to be the amount of the adjustment that would be posted to this account.

* Patient responsibility is \$10.00, which is the lower copayment and the difference between the primary plan payment and the higher allowable.

Use the section below if needed to do your own calculations:

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- 3. Supplemental COB** - under this method, the primary plan calculates the amount it will pay, and the secondary plan pays the **balance of allowable expenses** after any deductible and coinsurance. This method is less common.

Example #3: Supplemental COB

In this sample, patient has a \$100 deductible and 20% coinsurance with the primary plan. Secondary plan has a \$10 copay, and 0% coinsurance. Physician is not participating with primary plan, but is participating with the patient's secondary plan. Patient's secondary plan has a **"Non duplication of benefits" method. (NO COB)**

	Primary Plan	Secondary Plan
Billed Charges	\$2000.00	\$2000.000
Plan Allowable	\$1800.00**	\$1900.00
Less Deductible/Copay	\$100.00	\$10.00
Balance eligible expenses	\$1700.00	\$1890.00
Benefit Payable	\$1360.00	\$530.00 *

Par Adjustment: - \$100.00

Total Plan Payments: - \$1890.00

Patient Responsibility: = \$10.00*

*Secondary payment is based on the allowable of the secondary since the provider is participating with the secondary. Total payments by both plans combined, equal \$1890.00 using the secondary allowable as the higher allowable. The secondary payment of \$530.00 is the supplemental payment.

** Since the provider is non-participating with the primary carrier, the primary has reduced the billed charges due to U&C (Usual and Customary). This would not affect a secondary plan in a supplemental COB situation. If the secondary plan were non participating, and reduced the charges due to U&C, then the patient would be responsible for the difference between the higher allowable and the amounts paid.

* Patient responsibility is \$10 which is the lower copayment and the difference between the higher allowable of \$1900, minus total plan benefits paid by both carriers.

Use the notes section below to do your own calculations

NOTES:

Automobile Accidents and Coordination of Benefits

In many states a patient may be covered by both a group health plan and an auto carrier plan. No-fault states can be tricky, as the state regulates the payment order for medical services required due to an auto accident. The payment order depends on how the patients plan is funded. If a plan is self-funded and governed by ERISA, it is exempt per ERISA from complying with state law. Your plan may reserve a secondary payer for auto accident expenses. A plan can also choose not to cover auto accident related expenses at all.

If a plan covers employees in other states, state laws can dictate the payment order. It is typical of states with no-fault provisions to not have mandated payment order, and it is left up to the plan to determine the payment status. If not obligated by law, the plan may reserve a secondary stance for auto accidents, meaning the auto carrier insurance would be primary and group plan would be secondary.



Coordination of Benefits with Medicare and TRICARE

Medicare or TRICARE is the secondary payer to **all** of the following:

- All Workers' Compensation Claims
- Automobile and no-fault claims.
- Group health claims covering end-stage renal disease (ESRD) Patients with ESRD, and coverage with a group health plan, Medicare pays secondary for the first 30 months. After 30 months, Medicare becomes primary.
- Any group health benefit claim of a plan that has 20 or more employees that cover current employees and/or their spouses after age 65
- Any large group health claim sponsored by employers with more than 100 employees that cover currently employed Medicare eligible individuals.





How Medicare and Workers Compensation Coordinate Benefits

If payment has not been made or cannot be expected to be made promptly by a workers' compensation plan, liability insurance, or no-fault insurance, Medicare may make a conditional payment, under some circumstances, subject to Medicare payment rules. Conditional payments are made subject to repayment when the primary plan makes payment. When Medicare is secondary payer, the order of payment is the reverse of what it is when Medicare is primary. The other payer pays first and Medicare pays second. When Medicare is the secondary payer, the provider, physician, or other supplier, or beneficiary must first submit the claim to the primary payer. The primary payer is required to process and make primary payment on the claim in accordance with the coverage provisions of its contract. The primary payer may not decline to make primary payment on the grounds that its contract calls for Medicare to pay first. If, after the primary payer processes the claim, it does not pay in full for the services, [Medicare secondary benefits may be paid for the services as prescribed in §10.8](#). Generally, the beneficiary is not disadvantaged where Medicare is the secondary payer because the combined payment by a primary payer and by Medicare as the secondary payer is the same as or greater than the combined payment when Medicare is the primary payer.

Medicare “Set Aside”

Under [Section 1862 42 U.S.C. §1395y\(b\)\(2\) and § 1862\(b\)\(2\)\(A\)\(ii\) of the Social Security Act](#), Medicare is not responsible for paying a qualified injured person's medical expenses when payment “has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance.” If the medical expenses are disputed in a personal injury situation, the provider, physician, or other supplier may bill Medicare as the primary payer. If the product or service is normally reimbursable under Medicare rules, Medicare may pay the expenses conditionally. Then if there is a subsequent settlement, judgment, award, or other payment, Medicare requires reimbursement of the expenses.



How Medicare “Set Aside” Works

Some workers compensation claimants are eligible for Medicare benefits, or will become eligible in the near future. By law, Medicare is always the secondary payer for work-related injuries—workers compensation should pay for medical services for such injuries. Workers compensation insurers (including self-insured's) are therefore required to protect Medicare's interests when settling claims. Workers compensation Medicare Set-Asides are funds established to pay future work-related-injury medical costs that might otherwise be paid by Medicare. A Medicare Set Aside (MSA) can be funded as a lump sum, an annuity, or a combination of both. An MSA can be “self-administered,” meaning that the claimant administers the MSA, or the MSA can be professionally administered. For total workers compensation settlements meeting certain criteria, CMS will review the proposed MSA. Having CMS review a proposed MSA is optional. There is no requirement that carriers submit proposed MSAs to CMS for review. However, there is a “safe-harbor” aspect to having CMS review a proposed MSA. If certain

conditions are met and the MSA funds are not sufficient to pay for the medical care needed for the work-related injury, then Medicare will pay for any further (otherwise Medicare covered) medical services needed to treat the work-related injury. CMS has two thresholds for reviewing MSAs, often called the “\$25,000 threshold” and the “\$250,000 threshold.” Specifically, CMS will review a proposed MSA when:

- The claimant is currently Medicare-eligible and the proposed total settlement is at least \$25,000. The claimant might be Medicare-eligible because:

they are 65 years old or older

they have been on Social Security Disability for at least two years

- The claimant is likely to become Medicare-eligible within 30 months and the proposed total settlement is at least \$250,000. The claimant might be likely to become Medicare-eligible within the next 30 months because:

- They are at least 62½ years old but not yet 65 years old

- They have been on Social Security Disability for less than two years or are likely to become eligible for Social Security Disability within the next six months.

In conclusion, we hope that as a medical biller, you have a better understanding of coordination of benefits and the various models of COB a secondary plan carrier may have. Remember, when verifying benefits, you want to ask the secondary carrier which method of COB is included in the patients plan. PMRNC members have access to this paper as well as other resources in our members only area. Find COB information located in our Learning Center.



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