COMMUNITY Health Options®

Coordination of Benefits

Reimbursement Policy

Purpose

To provide guidelines that define the order of coverage where insurance and managed care companies coordinate coverage and payment of medical claims for Members covered under more than one plan.

Policy

Coordination of Benefits (COB) is a provision that establishes the order in which insurance plans pay claims when an individual has coverage under more than one plan. The insurance industry has developed a consistent and orderly way to determine which plan pays its full benefits and which plan pays a reduced amount (if any), which, when added together, equal more than a single plan's benefit, but not more than the total amount of the allowable charges incurred. When there is coverage under more than one plan, it is intended that Members and/or Providers receive the appropriate amount of reimbursement for medical services.

Community Health Options will coordinate benefits payable in accordance with state law, federal regulations, and National Association of Insurance Commissioners (NAIC) guidelines.

Definitions

Coordination of Benefits (COB): A provision used to establish the order in which plans pay claims when more than one plan provides coverage.

Primary Carrier: The carrier that has been determined to be responsible for primary payment by applying the criteria to determine the order of benefits.

Secondary Carrier: The carrier that has been determined to be responsible for secondary payment (also referred to as paying as secondary).

Tertiary Carrier: The carrier that has been determined to be responsible for payment after the primary and secondary payment (if any).

Procedure

When a Member is covered by two or more plans, the rules for determining the order of benefit payments, as defined by NAIC, 2013 as follows:

- (A) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan.
- (B) (1) Except as provided in paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state the complying plan is primary.
- (B) (2) Coverage that is obtained by membership in a group that is designed to supplement a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed

over base plan hospital and surgical benefits, and insurance-type coverages that are written in connection with a closed panel plan to provide out-of-network. benefits.

- (C) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- (D) Each Plan determines its order of benefits using the first of the following rules that apply:
    - (1) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.
    - (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:
        - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
            - The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
            - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
        - (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
            - (i) If a court decree states that one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
            - (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits;
            - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or
            - (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or healthcare coverage, the order of benefits for the child are as follows:
                - The plan covering the custodial parent;
                - The plan covering the spouse of the custodial parent;
                - The plan covering the non-custodial parent; and then
                - The plan covering the spouse of the non-custodial parent.
        - (c) For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
    - (3) Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

- (4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other Plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (5) Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that covered the person the shorter period of time is the secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, This plan will not pay more than it would have paid had it been the primary plan. (pp. 13-75)

For COB rules surrounding Member liability coverage (worker's compensation, auto insurance, etc.) reference Community Health Options' policy and procedure - Subrogation Process.

Reimbursement Guidelines

Community Health Options as Primary:

- When Community Health Options is the primary payer, claims pay according to the Member Benefit Agreement and Provider contracted reimbursement.

Community Health Options as Secondary:

- If it is determined that Community Health Options is secondary (or tertiary) to another commercial plan, Community Health Options will pay up to its contracted allowed amount minus the primary insurance payment. Members' cost sharing will still apply.
- If it is determined that Community Health Options is secondary to Medicare, Community Health Options will only approve up to the Medicare allowed amount, and the Member responsibility carried over from Medicare will be subject to the Member's cost share under their Community Health Options plan.

References

National Association of Insurance Commissioners (NAIC). (Oct 2013). Coordination of Benefits Model Regulation. Retrieved from https://content.naic.org/

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