Demystifying Coordination of Benefits

There are times when someone may have more than one health plan in effect. How do you know which plan pays benefits first (primary plan) and which pays next (secondary plan)? How does coordination of benefits work? Below is information on how coordination is determined and what information may be needed in order to make that determination. Part one discusses employer-based coverage while part two discusses non-employer-based coverage, including Medicaid, Medicare, and TriHealth. Additional information can be found in the Coordination of Benefits section of your plan document.

Part 1: Employer Based Coordination of Benefits

There are two parts to account for when coordinating benefits; determining in what order the plans pay and how they work together.

In order to determine which plan will pay first, we need to know how many plans (or policies) the member is covered under, the date each took effect, and the member's relationship to the policy holder of each plan or policy. Generally, a group health plan or policy through the member's employer will be primary for that member.

The following examples show how coordination of benefits is determined in the most common situations:

Example 1: Julie and John, a married couple, are each covered under their own employer's plan and each other's coverage. Julie will be primary under her employer's plan and secondary under John's plan. Similarly, John will be primary under his employer's plan and have secondary coverage under Julie's plan.

Example 2: Sarah and Sam are a married couple. Sarah is under age 26 and covered under her parent's plan as well as Sam's employer plan. Since she is not the policy holder of either coverage, the plan that pays first is the one that has been in effect longest. If she also has coverage through her own employer, her employer-sponsored coverage will pay first, then the coverage that has been in effect longest for her (of the remaining two plans) will apply as secondary coverage.

Example 3: Tina and Tyler are a couple in a relationship who have children together (whether they are married or not). Their children are covered under both parents' employer's plans. In this example the birthday rule would determine which plan is primary for the children. If Tina's birthday is in January and Tyler's is in June, the children will be primary on Tina's plan and secondary under Tyler's plan since Tina's birthday falls earlier in the year. The ages of the parents do not matter.

In situations where there are children and a divorce is involved, or where there are court documents in place when the parents were never married, it is important that all applicable court documents, such as decrees and shared parenting plans, be reviewed to determine which parent's plan is to pay first. Court documents can be submitted to MedBen who will review them to determine if a particular parent has been ordered to provide health coverage for a child and/or to determine which coordination rule to apply. Remember, stepparents may also be providing coverage.

It is not necessary to send in the entire court document. The needed sections of a court document include:

- the portion that shows the names of the parents/children involved (generally the first page)
- the portion that states who the residential/custodial parent is
- the portion that states which parent may be required to carry insurance
- the section that shows a shared parenting agreement/plan has been approved or incorporated into the decree
- the page with the judge's signature or seal.

If all documents are not submitted there could be a delay in processing claims since the review cannot be completed.

The below examples show how coordination of benefits are determined when a divorce decree is involved.

Example 1: Emily and Eric are a divorced couple with a child who is 21 years old and is covered under both parent's plans. There was previously a court order in place; however, it expired when the child turned age 18. Emily's plan has covered the child since January 1, 2000 and Eric's plan has covered the child since January 1, 2008. In this scenario the coverage in effect longer rule will apply, so Emily's plan will be primary, and Eric's will be secondary.

Example 2: Barb and Bob are a divorced couple with a court document ordering Bob to carry health coverage on their teenage children. Both Barb and Bob provide coverage for their children. In this example, Bob's plan would be primary since he is ordered to carry the coverage.

Example 3: Ashley and Aaron are divorced with a young son and both cover him on their separate plans. There is a divorce decree, but it does not address health coverage for the child. In this case the custodial rule would apply. The plan of the primary custodian of their son will be primary.

Generally, a court decree will remain active until a child turns 18 years old. If he or she is still in high school, it may remain in effect until the earlier of the date the child graduates from high school or age 19. Court documents expire as determined by the court and can therefore differ by county and state.

Part 2: Non-Employer Based Coordination of Benefits

Sometimes members have other coverage through a government program, or another non-employer-based health plan. Below we will discuss coordination of benefits through Tricare, Medicaid and Medicare.

Tricare

Tricare will never be primary for a dependent spouse or child of a service member. It will be primary for the service member only when he or she is on Active Duty or for services related to injuries incurred while serving in the military.

Medicaid

Medicaid will always pay benefits after any employer-based coverages. Medicaid is always the payer of last resort.

Medicare

Individuals of any age can become eligible for Medicare if they qualify due to disability, including, but not limited to, End Stage Renal Disease (ESRD). Most individuals become eligible when they reach age 65.

When coordinating Medicare benefits with a group health plan, there are a few factors that come into play. If the covered person is "age eligible" (65 & older and not on Medicare due to disability), is still an employee and on the employer's health plan, and the employer has over 20 employees, Medicare will typically pay secondary to the employer's health plan, as long as that employee is considered to be "active at work." If such employee is on a Retiree Plan, Medicare Supplement Plan or being offered COBRA through an employer, the employer's size no longer determines coordination and Medicare will always pay primary. Medicare will also pay primary for groups with under 20 employees when the member is enrolled due to age.

If the employee/spouse/dependent is under the age of 65 and eligible for Medicare due to a disability (other than ESRD) the same coordination rules mentioned above apply except the group must have over 100 employees, instead of 20, in order to be the primary payor.

Special coordination rules apply for those who are eligible for Medicare due to "ESRD.". If the individual who has been diagnosed with ESRD is enrolled in both Medicare and a group health plan, the group health plan will always pay primary for the first 30 months of Medicare coverage. This first 30-month period is considered Medicare's "coordination period." After the coordination period, Medicare will switch to being the primary payor for at least 6 months as long as the individual is still entitled to Medicare due to ESRD and his or her Medicare entitlement reason hasn't changed to "disability."

Coordinating health insurance with Medicare can be complicated at times and, depending specific circumstances, can result in a different rule applying. Therefore, if you have questions or concerns regarding how your plan will coordinate with Medicare, or any other plan, please contact Customer Service for assistance. Plan administrators may also contact their assigned Account Representatives for further assistance.