

CONSIDERING INSURANCE BILLING FOR COLLEGE HEALTH PROGRAMS

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ABSTRACT

The advantages for successful insurance billing for the health care components of a College Health Programs can be compelling. It can result in reduced tuition/fee costs, lower out-of-pocket costs for students, and increased awareness of the availability of services provided by the College Health Programs. Conversely, adopting insurance billing when the circumstances are not favorable can result in increased administrative burdens with nominal improvements in revenue. In the worst-case outcomes, students experience a severe loss of access to health care.

Colleges continue to receive information about insurance billing that is likely to constitute impermissible practices in most state jurisdictions. Adopting insurance billing without fully understanding the regulatory environment and compliance requirements can result in liability for possible violation of insurance fraud statutes, and/or for noncompliance with insurance participating provider agreements. Given the variability of insurance billing regulation by state jurisdiction, it is essential to consult with legal counsel with expertise in insurance regulatory law for the state in which the College Health Program is located.

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KEYWORDS:

- Affordable Care Act (ACA)
 - Bridge Plans
 - College Health Programs
 - Coordination of Benefits (COB)
 - Primary and Secondary Payor
 - Student Administrative Health Fees (SAHF)
 - Student Health Insurance/Benefit Programs (SHIBPs).
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UPDATED PUBLICATION FROM 2013

This document provides an update for our publication on insurance billing from January 2013. An important first change is to the title. Since 2013 we note the creation of new leadership positions and departments to oversee the major components of services related to the health and well-being of students, such as the Associate Vice President for Student Health and Wellbeing at the University of Alabama,^{1,2} as well as increased adoption of integrated and highly collaborative health and counseling services.³ Because the previous

title could be construed to infer that there is a common separation between health and counseling services, we chose to use the term “College Health Programs” for the title as used by the [Lookout Mountain Group](#) in its recent publication, “An Eight-Year Update for the Lookout Mountain Group’s Review of College Health Programs.”

As a precursor to reading this publication it will be important for recipients to review [Appendix](#)

[A](#) to understand key concepts for coordination of benefits (COB) and the secondary payor concept

for student administrative health fees (SAHF). This Appendix explains how COB works when a person is covered by more than one health insurance plan, and how SAHF can be used in certain state jurisdictions to fund all or some of the charges not covered by students’ personal health insurance.

We do not include an update for the continued trend for public university College Health Programs to move away from traditional prepaid funding sources toward insurance billing. Nor do we discuss the viability of SHIBPs, which was an important topic at the time of our 2013 publication. Results for the American College Health Association’s (ACHA) 2017 survey, presented at the ACHA annual meeting in Washington, DC, on June 8, 2018,⁵ and other readily available articles and presentations, provide information on these subjects from 2013 to present. Similarly, a discussion of the trend for increased utilization for College Health Programs is not included since this information is also readily available from other sources. Finally, we do not include analysis or recommendations for maximizing insurance revenue for College Health Programs due to the highly technical and complex nature of medical coding and ever-changing regulatory environment.

“A College Health Program describes the constellation of services, strategies, policies, and facilities an institution of higher education assembles to advance the health of its students. While some College Health Programs are also intended to provide extensive services for faculty and staff, most of the components are intended to provide services exclusively for eligible students. On many campuses, College Health Programs are wholly focused on the provision of health care in the form of medical and psychological services and may include a variety of health care related services including sports medicine services for intercollegiate athletes, student health insurance/benefit programs, crisis intervention and public safety services.”⁴

— *Lookout Mountain Group*

VARIABILITY OF FINANCIAL RESULTS FOR INSURANCE BILLING

While many colleges have achieved long-term success funding a substantial portion of health services operations through insurance billing revenue, the overall results remain highly variable. This same outcome also applies to a smaller number of colleges that have engaged in insurance billing for counseling services (refer to [Billing for Medical Visits and Not Psychological Counseling](#)). Our focus in this section is on insurance billing for health services but much of the analysis also applies to billing for counseling services, intercollegiate sports medicine, health promotion, and other College Health Program components that deliver health care services.

The reason for the variability of success for insurance billing mainly stems from environmental factors associated with College Health Programs. Some of the major elements for optimal results for insurance billing include the following.

- The college is located in a state jurisdiction that allows SAHF to take an always-secondary payor position in COB with students' personal health insurance (refer to "[Mitigating the Impact of Cost Sharing Provisions on Students' Access to Care](#)").
- The college has an effective insurance requirement as a condition of enrollment in compliance with ACHA's insurance standards (i.e., a "restrictive waiver" insurance requirement results in relatively few students without access to care).^{6 7}
- There are few completely uninsured students who are eligible to use the health service (e.g., part-time students).
- Billing for Affordable Care Act (ACA) preventive care services is a priority for the health service, and the insurance status of students and reimbursement policies of commercial insurers are favorable.
- The SHIBP provides comprehensive benefits (including full coverage for health service charges or only has nominal copayments), has a favorable cost, and is effectively marketed, often resulting in 40 percent or more of eligible students being covered.
- The health service is a participating provider with almost all students' personal health insurance plans and/or it offers a successful [bridge plan](#) (e.g., the plan provides meaningful benefits and is a good insurance value from a cost-benefit perspective) that provides access to care for students who are insured by HMOs or other provider networks that will not contract with the health service as a participating provider.
- In-network provider reimbursement rates for primary care visits and other services are favorable (e.g., at 120 percent of Medicare or higher).
- The college is in a geographic area where employer-sponsored health plans have relatively low copayments for primary care visits for illness or injury (even if there is a high deductible health plan).

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Viewed collectively, the above list is daunting relative to the probability of achieving optimal results from insurance billing. When all of the above variables do exist, the expected high range for insurance reimbursements from third party payors often equates to 30 to 45 percent of the operating cost of a health service (not including pharmacy and other major ancillary services). While this is significantly less than what would otherwise be required for profitability for a primary care practice, it is important to recognize that most college health services will continue to require significant SAHF subsidization after insurance billing has been successfully implemented. This is because College Health Programs have circumstances that are more economically disadvantageous than is common for community primary care practices. These include the requirements to be open for extended periods when there are relatively few patients either on the campus and/or wanting to access services, employee benefits costs that are higher than common for community providers, and relatively low levels of provider productivity compared to community providers.

It is noteworthy that profitability is also highly variable among community physician practices. Hospital-owned primary care physician practices are generally not profitable. A Medical Group Management Association (MGMA) study, reported in *Harvard Business Review*, shows that the loss was \$196,000 per employed physician in 2016.⁸ Urgent care clinics, however, are more likely to be profitable, but they also operate on a different model than most primary care practices and college health services.⁹

It is a certainty there will continue to be significant changes in primary care reimbursements. There will be movement to outcomes-based compensation, as well as changes for provider reimbursements for telemedicine, required increased data reporting, and other payment-related modifications that will increase the complexity of insurance billing.¹⁰ In short, College Health Programs that have adopted insurance billing are likely to experience increasing complexity for both contracting and delivery of care, as well as the probability of increased volatility for costs and revenue. From a positive perspective, insurance billing may result in earlier adoption of best practices in the delivery of health care services to students.

To be economically viable, insurance billing for most College Health Programs usually requires that new revenue exceeds 15 percent of billed charges. If this threshold is not met, then administrative and staffing costs are likely to exceed new revenue. When insurance billing fails, the most severe outcome is that a significant number of students are effectively disenfranchised from care. In these situations, it is not uncommon to find that insurance billing results in the health service primarily providing care to the students covered by the SHIBP. This is because the SHIBP may be the only insurance plan that has extensive first-dollar benefits for charges at the health service and/or large numbers of students are underinsured or uninsured (or other factors exist that are listed above).

For many students not covered by the SHIBP, losing access to the on-campus health service, because there are now significant charges following the adoption of insurance billing, is not resolved by obtaining services from community health care providers. There are often transportation and accessibility barriers (e.g., lengthy wait times), in addition to cost, with community health care providers that makes access to College Health Program services essential for many students.

BILLING FOR ACA PREVENTIVE CARE SERVICES

Students and parents/guardians, like many consumers, are becoming increasingly aware of the broad spectrum of ACA preventive care services that all ACA-governed health insurance plans must provide without any patient cost sharing (i.e., copayments, deductibles, and coinsurance).¹¹ If a College Health Program does not bill insurance, it is likely that routinely provided preventive care services* funded from tuition/fees will be unnecessarily duplicated by many students' personal health insurance. The circumstances for ACA preventive care services being a major factor for insurance billing revenue are variable, but still well worth considering in evaluating whether insurance billing is appropriate for a College Health Program.

Many college health administrators would contend that preventive care services account for a small percentage of current health services expenditures, and, therefore, any duplication of private insurance is nominal. This view may, however, be incomplete as the revenue opportunity for preventive care services from students' insurance can be significant, and entirely appropriate given the focus of the ACA on providing preventive care services to consumers (discussion of the long-term medical effectiveness and economic return for providing preventive care services is beyond the scope of this publication).¹²

* Examples of ACA preventive care services for adults that would commonly be provided to college students include the following.

These services are free only when delivered by a doctor or other provider in your plan's network.

- Alcohol misuse screening and counseling
- Depression screening
- Diet counseling
- HIV screening
- Immunization vaccines
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling
- Syphilis screening
- Tobacco use screening¹³

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ACA preventive care services that are commonly provided in college health services for women also include contraception, cervical cancer screening, chlamydia infection screening, and well-woman visits.¹⁴

In addition to billing for stand-alone visits for ACA preventive care services, in some locations it is common for commercial insurers to reimburse health care providers for billing ACA preventive services using current procedural terminology (CPT) code modifier 25 as an addition to an evaluation and management (E&M) office visit charge for care for an illness or injury. For example, a nurse practitioner seeing a student for a recurring upper respiratory condition ultimately concludes that sleep deprivation and other behaviors are contributing factors. Under this scenario, the medical office visit for the upper respiratory infection could be extended to provide the student with ACA preventive care services for alcohol misuse screening and counseling, depression screening, or other elements of a wellness exam. With appropriate documentation in the medical record and applicable coding, the students' insurance plan may reimburse this portion of the visit's cost at 100 percent under ACA preventive care benefits.

While the ACA mandates preventive care benefits, commercial insurers have discretion as to how they cover them.¹⁵ Also, as noted in the quote from the HHS website, ACA preventive care services are only required to be provided for in-network participating providers (e.g., an HMO is not required to provide ACA preventive care benefits at a college health service that is not an in-network participating provider).

There are wide variances in the revenue reported from insurance billing from providing ACA preventive care services among college health services that have a long history of insurance billing. There are undoubtedly multiple causes for these variances, including the likelihood that some health services are serving a significant number of students who have personal health insurance, with which they cannot pragmatically become in-network participating providers (e.g., Medicaid, Medicare, or group model HMOs). There can also be resistance among staff toward completing the additional documentation and coding that is required for providing preventive care services. These problems are not unique to college health services that are self-operated. In several instances, we have also observed health services that have been outsourced or have community partner arrangements whereby billing for ACA preventive care services does not account for a significant portion of insurance billing revenue, despite the insurance status of students and local commercial insurer reimbursement policies appearing favorable.

FEDERAL RECOGNITION FOR THE EXISTENCE OF COLLEGE HEALTH PROGRAMS

Student administrative health fees (SAHF) were first recognized in federal regulations issued in March 2012 by the US Department of Health and Human Services (HHS) for the operation of student health insurance programs (CMS-9981-F).¹⁶ In these regulations, prefunding arrangements for College Health Programs (i.e., either designated health fees or general funding allocations from tuition, fees, or other funding sources) were defined as follows.

"Student administrative health fees are those that are charged to all students enrolled at a college or university, regardless of whether a student enrolls in student health coverage or utilizes any services offered by the clinic, which gives all students access to a student health clinic's services and supports a number of services and activities that foster a healthier campus community."

"(c) Student administrative health fees. (1) Definition. A student administrative health fee is a fee charged by the institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage."¹⁷

There was no explanation provided in the regulations for how the term SAHF was chosen. To our knowledge, the term had not been used prior to the March 2012 issuance of the regulation by HHS or any other federal or state regulatory agency. While the federal recognition of SAHF was important, because it concluded such prefunding arrangements for college health and counseling services do not constitute a form of health insurance, the definition is somewhat problematic as it does not fully recognize the broad spectrum of services that compose a College Health Program.

The definition of SAHF was recognized by the National Association of Insurance Commissioners (NAIC) in its model statute entitled "Individual Market Health Insurance Coverage Model Act,"¹⁸ The purpose of the model statute was noted as pertaining to "... guaranteed availability, guaranteed renewability and premium rating in the individual market and provide for the establishment of coverage and other benefit requirements in the individual market."¹⁹

Several state insurance departments have recognized SAHF in considering insurance billing for College Health Programs and other matters pertaining to the operation of College Health Programs (e.g., Pennsylvania).²⁰ The definition of SAHF is also recognized in formal SAHF plan documents that have been recently adopted by several major public universities and private colleges and universities (refer to "Eight Best Practices for Insurance Billing for College Health Programs").

MITIGATING THE IMPACT OF COST SHARING PROVISIONS ON STUDENT's ACCESS TO CARE

As explained in 2013 (refer to [Appendix A](#)), a secondary payor status for SAHF allows a health service to first bill a student's insurance, and SAHF funds may then cover some or all of the remaining charges, depending upon the benefits specified for SAHF, not paid by the student's personal insurance. This use of SAHF is further explained and updated in the section entitled "[State Regulation for Insurance Billing](#)." In states where it is permissible, designating SAHF funding as a secondary payor when College Health Programs bill students' insurance has resulted in cost savings for students via reduced tuition/fees without losing access to care because of cost sharing provisions (i.e., copayments, deductibles, and coinsurance) in students' personal insurance.

Unfortunately, there continues to be presentations and informal communications among college health administrators promoting insurance billing practices that would be impermissible in many state jurisdictions. In some presentations for insurance billing, there are appropriately accurate reviews for state jurisdictions obtaining a secondary payor status in COB for SAHF. An example of a balanced and cautionary presentation to this complex subject was provided by Diane Norris, Director of Health Services at Georgia Southern University, at ACHA's 2017 annual meeting "Is Third Party Billing the Answer?"²¹ Refer also to "[Permissibility of Separate Fee Schedules for Uninsured Students, Cash Discounts, and Other Mechanisms to Reduce Patient Cost Sharing](#)."

In some of the presentations referenced above, it was suggested there were ways to waive patient cost sharing responsibility that, in our view, were likely to be impermissible billing practices in most state jurisdictions and/or noncompliant with most participating provider agreements. Inappropriate waiving of patient cost sharing responsibility is not unique to College Health Programs. These practices continue to be the subject of litigation for community health care providers. In reviewing regulatory agency advisories/notices, journal articles, and other publications over the past few years, there are consistent and common points of advice for physician practices that can be broadly applied to many state jurisdictions (refer to recommendation for "[Have a consistently applied and formally written charity care/ability-to-pay-allowance determination](#)"). Since the previous publication in 2013, a review of the case law suggests commercial insurers and health plans will continue to litigate the effect of health care providers inappropriately waiving patients' financial responsibility for cost sharing provisions contractually specified in health insurance benefit schedules. Numerous courts have found such waivers of patient financial responsibility objectionable.²²

There is another major consideration for SAHF being used to fund charges, on a secondary payor basis, not covered by students' personal health insurance. Due to the long-term trend for employers to adopt high deductible health plans and/or have limited provider networks, equity concerns can be raised when students received significantly different financial benefits from SAHF (especially when there is a designated health fee). For example, a student with personal health insurance that only has a \$20 copayment for a primary care visit will receive a much lower benefit from SAHF than a student who is

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covered by insurance that has a \$1,000 deductible. In response to scenarios like this, some stakeholders have suggested that SAHF should only cover 50 percent of the charges incurred at the health service for students who are covered by high deductible health plans or for students who are covered by health plans that will not allow the health service to become a participating provider. Another option would be to require students under these situations to enroll in a bridge plan. Equity concerns for SAHF can present challenging questions that are inextricably related to the decision process for considering insurance billing.

STATE REGULATION FOR INSURANCE BILLING

It is important to reiterate from our 2013 publication that regulation of insurance billing often includes state specific statutes and/or regulations. For example, New Jersey passed legislation this year establishing clear penalties for health care providers who waive patient liabilities. The Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act specifies the following.

"Section 15 – WAIVER OF PATIENT RESPONSIBILITIES

- a. It shall be a violation of this act if an out-of-network health care provider, directly or indirectly related to a claim, knowingly waives, rebates, gives, pays, or offers to waive, rebate, give or pay all or part of the deductible, copayment, or coinsurance owed by a covered person pursuant to the terms of the covered person's health benefits plan as an inducement for the covered person to seek health care services from that provider. As the commissioner shall prescribe by regulation, a pattern of waiving, rebating, giving or paying all or part of the deductible, copayment or coinsurance by a provider shall be considered an inducement.
- b. This section shall not apply to any waiver, rebate, gift, payment, or offer that falls within a safe harbor under federal laws related to fraud and abuse concerning patient cost-sharing, including, but not limited to, anti-kickback, self-referral, false claims, and civil monetary penalties, including any advisory opinions issued by the Centers for Medicare and Medicaid Services or the Office of Inspector General pertaining to those laws."²³

As discussed below, there is widespread agreement that health care providers that are billing Medicare and Medicaid and/or are engaged as in-network participating providers with commercial insurers cannot simply waive charges for uninsured persons without completing a formally documented ability-to-pay allowance determination (an example charity care policy from the Mayo Clinic is provided in [Appendix B](#)). Again, the specificity of state regulation is important to emphasize. At least one state (Texas), includes this provision in its Insurance Code.

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“§ 552.001 – APPLICABILITY OF CHAPTER

- (a) This chapter does not apply to the provision of a health care services to a:
 - (1) Medicaid or Medicare patient who is covered by a federal, state, or local government-sponsored indigent health care program;
 - (2) financially or medically indigent person who qualifies for indigent care health services based on (A) a sliding fee scale; or (B) a written charity care policy established by a health care provider; or
 - (3) person who is not covered by a health insurance policy or other health benefits plan that provides benefits for the services and qualifies for services for the uninsured based on a written policy established by a health care provider.”²⁴

Finally, the number of state jurisdictions that are allowing SAHF for College Health Programs to take an always-secondary payor position has increased since 2013 (refer to [Appendix A](#)). Interestingly, this has occurred in some states that have adopted, verbatim, the National Association of Insurance Commissioners model statute for coordination of benefits (COB). In at least two instances, the federal definition of SAHF appears to have swayed state insurance regulatory agencies to view funding arrangements for College Health Programs as falling outside the definition of an insurance “Plan” for their respective COB statutes/regulations and, therefore, to allow SAHFs to take an always-secondary payor position (refer to, Definitions, pages 4–5, of [Appendix C](#)).

The importance of having legal counsel with expertise in insurance regulatory law for the state jurisdiction in which the College Health Program is located cannot be overstated, given the variability of regulation of insurance billing practices by state jurisdiction.

PERMISSIBILITY OF SEPARATE FEE SCHEDULES FOR UNINSURED STUDENTS, CASH DISCOUNTS, AND OTHER MECHANISMS TO REDUCE PATIENT COST SHARING

It is sometimes alleged informally by college health professionals and others that HHS has broadly ruled that any health care provider can choose to write-off some or all of the cost of a service or supply simply by determining that the patient does not have health insurance coverage. Such allegations are not supported by any of the articles, position papers, or regulatory guidance reviewed for this update ([note limited exception for the State of Texas](#)).

Guidance from the law firm, Holland & Hart, provides a succinct explanation for both impermissible and permissible gifts, rewards, and free or discounted services.

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"The federal Anti-Kickback Statute ('AKS') and Civil Monetary Penalties Law ('CMPL') generally prohibit offering anything of value to induce patients to order or receive services payable by federal healthcare programs unless the arrangement fits a regulatory safe harbor. Violations may result in criminal, civil and administrative penalties. Common marketing programs that may implicate the laws include but are not limited to:

- 'Patient appreciation' gifts or gift cards.
- Free supplies (e.g., free diapers, free formula, etc.).
- Free or discounted items or services as loss leaders to encourage other business.
- Free screening programs.
- Referral reward programs.
- Drawings for prizes.
- 'Insurance only' billing or waiving copays and deductibles.
- Free transportation programs.
- Rebates.

The AKS contains exceptions for certain discounts and transportation programs if regulatory conditions are satisfied. The CMPL also contains several potentially relevant exceptions, including:

- Providing an item of or service of low value, which the Office of Inspector General ('OIG') interprets as each item or service is less than \$15, and all such gifts total no more than \$75 per patient per year.
- Providing free or discounted items or waiving copays and deductibles after a good faith determination of financial need or unsuccessful collection efforts so long as the discount or waiver is not part of any advertisement or solicitation and is not routine.
- Incentives that promote certain types of preventative care, or that promote access to care and poses a low risk of harm to patients and government programs.

Providers should also check their state laws for similar prohibitions. Even if allowed under federal or state law, waiving copays or deductibles or offering inducements for services may violate commercial payer contracts."²⁵

A SAFETY AND WELFARE OF PATIENT EXCEPTION FOR COLLEGE HEALTH PROGRAMS

In addition to the common exceptions for providing services without charge that are noted above, it is our opinion that most state insurance departments and commercial insurers would be inclined to grant a special exception for SAHF to not bill insurance when there is concern for the safety or welfare of the student. This exception is warranted due to the communal living circumstances for residential colleges, the unique health care service role for College Health Programs and the common interplay of parental health insurance, and the widespread, highly publicized concerns for access to mental health care services and primary care services for college students. The following provision was adopted by a public university in its SAHF plan (SAHFP) document.

"The SAHFP Sponsor reserves the right to use Student Administrative Health Fee funds and/or other available funds to cover charges incurred at UHS [**University Health Service**] by a student when the SAHFP Administrator or their delegate determines that it is in the best interests of either the student or the University. Considerations for such a determination may include, but are not limited to, highly sensitive care situations where a student's wellbeing could be in jeopardy if charges were submitted to the student's personal health insurance and/or the student was required to pay for the service or supply. Such best-interest determinations will be made solely by the SAHFP Administrator or their delegate on a case-by-case basis."²⁶

We provide the foregoing text for illustrative purposes only. Any similar exception proposed for adoption by another university's College Health Program should be reviewed under applicable state law, and by commercial insurers for which a College Health Program is acting as an in-network participating provider.

CONFIDENTIALITY CONCERN FOR INSURANCE BILLING

The confidentiality of students' medical information and/or use of health and counseling services is often cited as a prominent concern for College Health Programs participating with commercial insurers and engaging in insurance billing. This matter is appropriate for including in a college's evaluation or formal insurance billing feasibility study for its College Health Program. The following section on "[Billing for Medical Visits and Not Psychological Counseling](#)" also addresses whether there should be special concerns for confidentiality relating to mental health care services. While there are noteworthy exceptions (we were recently informed that a president at a public university dismissed any discussion of insurance billing due to confidentiality concerns), most colleges considering insurance billing ultimately conclude that confidentiality concerns can be addressed or abated with appropriate information for students and parents/guardians, and with careful enactment of policy and administrative safeguards.

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For colleges that adopt insurance billing, the confidentiality concern will usually be addressed by reaching three conclusions. First, regulatory research confirms the permissibility of the “safety and welfare exception” that allows the College Health Program to not bill a student’s insurance plan whenever there is a concern for the welfare of the student (including a concern for confidentiality). Second, the college’s requirement for health insurance as a condition of enrollment includes a recommendation for remaining enrolled in the SHIBP to best assure access to care relative to concerns for confidentiality and independence of the student. A likely third conclusion to support insurance billing will be a finding that peer institutions have adopted it without experiencing significant harm to students.

Many college health professionals have emphasized the need to educate students and parents/guardians about the option to restrict access to explanation of benefit (EOB) information for students’ claims information. Federal law requires that EOB forms, providing information about adjudication of medical claims, must be provided to the primary insured person (usually a parent/guardian) for employer-sponsored health plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA).²⁷ An increasing number of states have passed laws due to recognized problems with the limits of federal protections, as explained in this excerpt from a 2016 article published by *National Public Radio*.

“Federal law does offer some protections, but they are incomplete, privacy advocates say. The Health Insurance Portability and Accountability Act of 1996 is a key federal privacy law that established rules for when insurers, doctors, hospitals and others may disclose individuals’ personal health information. HIPAA contains a privacy rule that allows people to request that their providers or health plan restrict the disclosure of information about their health or treatment. People can ask that their insurer not send to their parents the ubiquitous ‘explanation of benefits’ form describing care received or denied, for example. But an insurer isn’t obligated to honor that request.”²⁸

State laws, which are only applicable to commercial health insurance plans that are not governed by ERISA, allowing dependents to restrict parents/guardians access to health insurance claims information, are undoubtedly well intended. Such laws, however, may not provide meaningful confidentiality protections for students. A parent/guardian, who routinely manages medical billing, payments to health care providers, taxes, and other personal finances for all family members would readily see that online access to health insurance claims information is no longer available for the college student family member. It is not hard to imagine a student having difficulty declining a request from a parent/guardian to restore access to online insurance claims information.

BILLING FOR MEDICAL VISITS AND NOT PSYCHOLOGICAL COUNSELING

A 2015–16 survey of by the Association for University and College Counseling Center Directors (AUCCCD) showed that only about 4 percent (20 of 517 respondents) of college counseling centers billed third parties for services.²⁹ Thus, insurance billing for college counseling services is much less common than billing for medical services provided by College Health Programs. The factual basis for this disparity in billing is questionable, depending upon the specific circumstances of the college.

It is generally understandable that insurance billing for psychological counseling is low among community mental health care providers, given that participation by them as in-network for insurance remains a major problem in most parts of the country. National media reporting suggests 30 percent of clinical psychologists do not participate with insurance plans.³⁰ In California, a 2016 survey of family therapists found that half did not take insurance.³¹ Despite the passage of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA),³² a 2017 study by Milliman, a risk management and health care consulting company, found that behavioral health care was four to six times more likely to be provided out-of-network than medical or surgical care; and that insurers paid primary care providers 20 percent more for the same type of care than they paid mental health specialists. Simply put, the MHPAEA has failed to significantly improve access to mental health care benefits. Even though insurers and health plans have dropped annual limits for therapy visits, and higher copays and separate mental health deductibles have become less of a problem, there are more subtle access challenges, such as medical necessity reviews (whereby length and type of treatment must be reviewed and approved).³³

The low level of insurance billing for psychological counseling in College Health Programs may also be due to misunderstandings, and/or inaccurate assertions, about the confidentiality of medical information that is part of the claims administrative systems of commercial health insurers, health plans, and third-party claims administrators. These concerns are periodically expressed on list serve discussions and in previously referenced College Health Program meetings devoted to considering insurance billing. Unfortunately, there is a common inaccurate assertion that there is an insurance industry database of medical claims that employers, governmental agencies, and other organizations can use to access students' medical claims. This is usually based on a misunderstanding of the function and capability of the Medical Information Bureau.³⁴ Inaccurate or misleading information undoubtedly contributes to excluding psychological counseling from insurance billing for a College Health Program. There may be a rational basis for not billing psychological counseling, as explained above, but communicating to students and parents/guardians that caution is being taken to assure confidentiality of counseling records by not billing insurance may be a long-term disservice to students. For example, such communication could infer to students they should be concerned about use of an employee benefits plan for mental health care services after they graduate from college.

It is appropriate to consider confidentiality of students' use of College Health Program services and/or medical claims information as part of the overall decision process for considering insurance billing (refer to "[Confidentiality Concerns for Insurance Billing](#)"). Generally, there is not a rational basis for having any greater concerns for the confidentiality of psychological counseling records than the highly confidential and sensitive records for services that are routinely provided in primary care, psychiatry, pharmacy, and other components of College Health Programs.

BRIDGE PLANS AND OTHER PREPAID FUNDING ARRANGEMENTS

Among College Health Program administrators, the term “bridge plan” has become common to describe an additional prepaid benefit or discount program that students can purchase to augment SAHF benefits and services. They have also been referred to as optional health fees or complementary care plans.

Although bridge plans exist at both public and private colleges, they are primarily found at public universities (e.g., for 2018-19, University of California Los Angeles, Arizona State University, Colorado State University, and University of Louisville). As noted above, they are often viewed to best meet the needs for students who have health insurance that covers catastrophic illness or injury, but does not cover routine charges at the College Health Program because of a limited provider network, a high deductible, or other cost sharing feature. For example, a student with a high deductible health plan is allowed to waive enrollment in the SHIBP but is required to then complete a negative check-off to decline enrollment in the bridge plan to prefund care on-campus and provide benefits for urgent care and emergency room services at the hospital near campus.

A key question, particularly for private colleges, is how bridge plans can exist from a regulatory perspective. If a state were to conclude that bridge plans are a form of SAHF, then the programs might be required to be provided on a negative check-off basis (i.e., the fee is charged to all students and they must proactively waive the fee). This concern may be less important in state jurisdictions that have explicitly recognized College Health Programs in statute or regulation (e.g., Massachusetts)³⁵ or by general exemption for regulation of insurance under programs operated by the state or any of its political subdivisions (thereby exempting public colleges, e.g., North Carolina).³⁶ Colleges should consult with their state insurance departments for the operation of a bridge plan prior to implementation. For example, in one instance, a state insurance department informally asked that the name of the bridge plan not refer to “supplemental coverage,” as the state had reserved this terminology for Medicare supplemental policies. A second concern is whether SAHF can include benefits for services provided off campus, and at what point have the benefits become so significant they should be regulated as a form of insurance.

A final question for the operation of bridge plans is whether they should be viewed as being subject to ACHA insurance standards.³⁷ In our view, colleges should operate bridge plans under the same basis as SHIBPs relative to ACHA’s standards. For example, this would mean they should be operated in the best interest of covered students rather than being operated primarily to meet the revenue needs of a College Health Program. More specifically, a bridge plan should first and foremost be a good insurance value, reflecting a fair cost for the reasonable likelihood of incurring medical expenses covered by the plan. Having a consistent claims-to-premiums loss ratio of less than 80 percent might raise questions about whether the program is a good insurance value, and/or the cost of the program is simply excessive. Likewise, fear tactics or other marketing techniques that would otherwise be impermissible for insurance products in a given state jurisdiction should be carefully avoided (refer to your state’s insurance advertising code).³⁸

INSURANCE BILLING OFTEN REQUIRES CONSIDERATION OF OUTSOURCING/COMMUNITY PARTNERING

Because of the complexity of contracting with commercial insurance plans, compliance concerns, and ongoing administrative costs, outsourcing or some level of community partnering is often an integral part of the decision to evaluate insurance billing for a College Health Program. This is particularly true for colleges with enrollment of less than 15,000 students. In 2017 ACHA formed an Outsourcing Task Force with the following charges.

- “Explore the state of outsourced health and mental health services in higher education including reasons cited for outsourcing operations.”
- Examine the pros and cons of outsourcing in terms of service to the campus community, internal and external collaboration, and operational and fiscal efficiency.
- Identify best practices for outsourced health and mental health services using case examples.”³⁹

While it is beyond the scope of this paper, it is important to note there are numerous permutations for outsourcing, including partnering, joint ventures, and other collaborative arrangements with community and external resources. It is not surprising that outsourcing and community partnering would become a trend for College Health Programs, since it has become increasingly challenging for community health care physicians to maintain independent practices. A *US News & World Report* article summarizes several studies that confirm the widespread increase in the number of physicians opting to leave private practice. In summary, the article notes the following.

“ . . . a growing number of doctors are opting out of owning their own practices, especially in light of the fact that many will be able to make more money and have better support if they join a larger practice or hospital. This has led to health care experiencing a massive shift toward a ‘big-box’ approach – independent doctors joining larger group-, corporate- or hospital-owned practices.”⁴⁰

Low reimbursement rates from commercial insurers, administrative and technology burdens (many as a result of the ACA), burnout among providers, nonclinical paperwork, third party authorizations that detract from providing quality of care, and concerns for the future of the medical profession are all cited as key findings in a survey by The Physicians Foundation.⁴¹

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Outsourcing and community partnering has produced both highly positive and negative results for colleges. A recent positive example is Franklin & Marshall College, a private college located in Lancaster, Pennsylvania, that partnered with a local hospital to move to insurance billing for both health and counseling services, obtain funding for a state-of-the-art new facility, and significantly increase resources for wellness programs. This was accomplished through an employee leasing arrangement that allowed existing employees to maintain the college's benefits and compensation.

Concerns for outsourcing now include the potential instability of both large and small health care organizations. For example, two large health care organizations in Boston, which had historically provided outstanding services for the operation of College Health Programs, announced in 2017 they would no longer be able to continue these relationships with local colleges and universities. In other words, the continued trend toward mergers with large health care organizations can create uncertainty for the long-term stability of outsourcing arrangements for College Health Programs.⁴²

If the college is in a state where eligibility for Medicaid has been expanded, then the desire for a College Health Program to be a Medicaid participating provider can be a contributing factor for the need to assess outsourcing. For example, as of the date of this report, two College Health Programs operated by public universities in Kentucky, Western Kentucky University and Murray State University, have outsourced health services that participate with Medicaid. These two programs have been outsourced to community clinics that have the resources and capabilities to meet the administrative and care requirements for participating with Medicaid.

MEDICAID PREMIUM ASSISTANCE FOR SHIBPS

Medicaid funds have been used to pay for the cost of SHIBPs for many years in Minnesota and Montana. Based on this experience, ACHA developed a position paper in 2013,⁴³ following the expansion of Medicaid eligibility in numerous states under the ACA. Beginning in fall 2017, the Medicaid program in Massachusetts, MassHealth, began providing premium assistance to pay for the cost of SHIBPs at public colleges and universities. The program was subsequently expanded to private colleges. A flyer for the MassHealth program is included in [Appendix D](#) that explains the program to students. With technical assistance and support provided by UMass Medical School, in the 2017–18 plan year MassHealth enrolled just over 31,000 eligible college students into its student health plan premium assistance program, for a savings to the Commonwealth of approximately \$24 million.⁴⁴

A student health plan premium assistance pilot program adopted at Cornell University in 2014 is now in its fifth year of operation with over 400 students enrolled.⁴⁵ Efforts are underway to expand the program to other New York colleges and universities.

In addition to often providing much greater access to health care providers and reducing costs for the state, obtaining premium assistance for SHIBPs eliminates the need for College Health Programs to become Medicaid participating providers. This is important, as it has proven to be administratively impossible for most College Health Programs, which are not outsourced to large community health care providers that are already participating with Medicaid and Medicare, to meet the reporting and compliance requirements for Medicaid, including many commercial Medicaid programs.

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EIGHT BEST PRACTICES FOR INSURANCE BILLING FOR COLLEGE HEALTH PROGRAMS

With the possibility of a “safety and welfare of patient exception” that may be unique to College Health Programs, the general best practices for insurance billing for College Health Programs are the same as those that would apply to all health care providers. In our literature review, we found the following points of advice would apply to College Health Programs.

1. Carefully adhere to all requirements in commercial insurer participating provider agreements.

Retain internal staff and/or external consultants and billing services to assure all requirements for each of the participating provider agreements are fully understood and complied with by your College Health Program. Creating and following a voluntary compliance plan (refer to the “Office of Inspector General Compliance Program for Individual and Small Group Physician Practices”)⁴⁶ is also important if the College Health Program will be billing Medicare or Medicaid.

In entering into participating provider agreements, it is important to fully disclose any requirements that will be unique to your College Health Program. For example, it may be necessary to note that students’ medical records must be maintained by the College Health Program under the Family Education Rights and Privacy Act, yet all the technical requirements for the Health Insurance Portability and Accountability Act will still be fulfilled.

If the College Health Program is in a state jurisdiction where an always-secondary payor position is allowed for SAHF, it is our view that including notice of intent to use this arrangement should be documented in the negotiations for commercial participating provider agreements, and/or included as a notation in the agreements. As noted below, a formal plan document for SAHF is also required.

2. Retain billing consultants and legal counsel to assess and understand the regulatory environment.

Fully comprehending both federal and state regulatory environments for insurance billing is a best practice. Having access to billing consultants and legal counsel with expertise in insurance regulatory law, and the specific requirements for the state jurisdiction in which the College Health Program is located, is essential.

3. Have the same fee schedule for all patients.

An “OIG Advisory Opinion” from January 2008 fully shows the complexity for determining the permissibility of a prompt pay discount.⁴⁷ A cash discount or other form of “dual fee” schedule is probably not worth the trouble, since the amount of the discount probably cannot be greater than the fair market value of the administrative cost for billing and the time value of money for immediate payment. One billing consultant succinctly advises the following.

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“. . . strike the word ‘cash discount’ from your vocabulary. You do not have two fees – one for cash and one for insurance. You may, however, offer a TOS [time of service] discount for prompt payments for services rendered that day . . . the question of how much discount is too much is the subject of much rumor and fuzzy logic.”⁴⁸

If a College Health Program offers a service without any cost (e.g., flu shots), it should not also bill insurance for that service to other students (e.g., billing a service to students covered by a SHIBP for a service that is free to all other students, even though it might be covered by the plan).

As previously noted, we are only aware of one state ([Texas](#)) that specifically allows health care providers to offer a free or discounted service to uninsured individuals without having to complete an ability-to-pay or charity care documentation process.

4. Make sure charges from the College Health Program to the SHIBP for services, supplies, or administrative costs are not in excess of fair market value.

Since students covered by the SHIBP will often have either benefit incentives and/or referral requirements for seeking care at the College Health Program, it is arguable that SHIBP covered students should have the lowest cost of care (i.e., lowest cost fee schedule) compared to students covered by other commercial insurers with which the College Health Program is an in-network participating provider. In no event should the charges to the SHIBP be greater than the average reimbursement levels of major commercial insurers. This is likely to be what a regulatory agency or court would use to determine what constitutes fair market value in assessing the fee schedule for the SHIBP.⁴⁹

This standard for SHIBP charges not exceeding fair market value becomes particularly important when (1) funding for SHIBP claims at the College Health Program is based on a capitation that is solely determined by the college (i.e., the portion of the cost of the SHIBP is retained by the college and not remitted to the insurance carrier); (2) the college dictates a fee schedule to commercial insurers for reimbursement of claims for its College Health Program as part of a request for proposal process or other contract negotiation; or (3) the claims liability for the College Health Program is self-funded or directly contracted to a health care provider, and the college can solely determine the cost of the claims liability.

From the broadest perspective, it is a best practice for a College Health Program to comply with the standards for health insurance endorsed by the ACHA, which, regarding this specific recommendation, would focus on compliance with Standards III and IV respectively.

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"Standard III: The institution acknowledges it has a fiduciary responsibility to manage student health insurance programs in the best interest of students covered by the programs.

Standard IV: The student health insurance program is annually reviewed to assure it is in full compliance with all applicable federal and state statutes and regulations."⁵⁰

When a College Health Program adopts insurance billing, the fiduciary responsibility requirement in ACHA's insurance standards would also suggest that careful consideration be given to self-funding (assuming it is permissible in the state jurisdiction for the College Health Program) or capitation funding, along with other advanced plan management practices, to mitigate as much of the cost impact as possible for students covered by the SHIBP. More specifically, engaging in insurance billing for just health service medical visits could easily increase the cost of annual per student claims by \$125 to \$250 (assuming 100 percent coverage of health service charges), depending upon the level of utilization (e.g., two visits per year to the health service per student covered by the SHIBP) and the negotiated fee schedule for SHIBP charges.

If adopting insurance billing were to increase SHIBP claim charges by 25 percent under a fully insured program, it might be advisable to consider self-funding for the entire program. After appropriate capitalization for reserves and other costs, it would not be uncommon for self-funding to result in at least a 10 percent cost reduction for the SHIBP. Thus, reducing the cost impact of insurance billing to the SHIBP to a 15 percent cost increase. Another advanced management practice that could help mitigate the cost of insurance billing for the SHIBP includes direct contracting with local health care facilities and providers to eliminate provider network access fees and obtain optimum fee schedules.

5. Ensure accurate coding and maintain updated and proper documentation.

The following is advised from Hofstra University's Master's in Health Law and Policy "Best Practices for Health Care Providers to Avoid Fraud."

"Ensure Accurate Billing

Because insurers and patients place great trust in care providers, Congress mandates severe punishment for false claims. The government exercises broad power in auditing and investigating suspected fraud. To avoid inadvertent fraud, care providers must maintain accurate billing practices to avoid inaccuracies such as overcharges or claims for undocumented or undelivered services.

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Maintain Updated and Proper Documentation

Care providers should maintain accurate records to ensure that future treatments produce the best possible patient outcomes. Accurate records also assist care providers in defending themselves against malpractice suits.

Viewed from the Centers for Medicare and Medicaid Service's perspective, if a practitioner does not document rendered services, the treatment did not take place. Duly, care providers should maintain proper documentation for all delivered services.”⁵¹

Having accreditation through The Joint Commission or the Accreditation Association for Ambulatory Health Care can be an integral component of a compliance program. Commercial insurer participating provider agreements will also specify compliance with quality assurance measures, such as conformance with standards required under the health plan accreditation of the National Committee for Quality Assurance (NCQA).⁵² A College Health Program achieving recognition as a Patient-Centered Medical Home may also be advantageous for obtaining optimal reimbursement rates from payors and assure conformance with participating provider policies.⁵³

6. Have a consistently applied and formally written charity care/ability-to-pay-allowance determination.

For many reasons, a College Health Program may conclude that it is beyond its capabilities to administer an ability-to-pay-allowance determination to reduce charges not covered by students' personal health insurance. Absent the ability to have a secondary payor status for its SAHF, the complexity and burdens of this process may be reason enough for a College Health Program to not engage in insurance billing. This is a particularly important determination, since many students remain dependents of their parents/guardians for tax purposes, and the financial information required would probably necessitate obtaining complete data for income, assets, and expenses from parents/guardians.

An example charity care policy, used by the Mayo Clinic, is provided in [Appendix B](#) for those College Health Programs administrators that may want to implement a charity care/ability-to-pay-allowance policy. The policy should be included as an appendix to a formal plan document for SAHF.

Some medical societies, such as the Medical Association of the State of Alabama, have recently provided cautions for waiving cost sharing charges and have provided recommendations for documenting charity care, noting that the HHS “Roadmap for New Physicians” states the following.

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“The kickback prohibition [Anti-Kickback Statute, 42 U.S.C. § 1320a-7b (b)] applies to all sources of referrals, even patients. For example, where the Medicare and Medicaid programs require patients to pay copays for services, you are generally required to collect that money from your patients. Routinely waiving these copays could implicate the AKS and you may not advertise that you will forgive copayments. However, you are free to waive a copayment if you make an individual determination that the patient cannot afford to pay or if your reasonable collection efforts fail.”⁵⁴

7. Regardless of whether there is a designated health fee, develop and publish a formal plan document for SAHF.

Especially if a secondary payor position is being taken for SAHF, in our view, a formal plan document is required for coordination of benefits with students’ personal health insurance. As of the date of this report, several public universities and private colleges and universities have adopted formal SAHF plan documents (refer to the [document repository](#) for example SAHF plan documents). It is also important for SAHF to include a complete explanation of the circumstances when a patient may not be billed for a service or supply due to concern for the safety and welfare of the patient (refer to “[A Safety and Welfare of Patient Exception for College Health Programs](#)”).

Even when a secondary payor arrangement is not implemented, or when there is no insurance billing, a plan document for SAHF is recommended to establish the highly important nature of the service the college provides for its students. It is one thing to discontinue or change access to a program in a career center, recreation center, dining service, residence hall, or other student services program. It is far more serious to discontinue or change access to medical or psychological services that are highly regulated under state and federal licenses, and closely linked to the safety and well-being of students. In other words, a plan document for SAHF can be used to reinforce, for all stakeholders, the unique and special requirements that come with providing a College Health Program.

8. Use care in developing program descriptions and terminology.

It is important to not use terms such as “waiving charges,” “discounting charges,” or “free care,” when a College Health Program is engaged in insurance billing. Beyond the simple fact there is no such thing as “free care,” (i.e., there must be a funding source such as tuition and fees, grant funding, or other funding to provide a service), there could be either regulatory concerns and/or compliance concerns with commercial participating provider agreements, if correct and accurate billing language is not used. An example occurred when an insurance department informally asked a private college to not refer to its college health service bridge plan as a “supplemental coverage,” since that term was reserved, exclusively, for Medicare supplemental health insurance plans in that state jurisdiction.

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The above list is not intended to cover all circumstances and requirements for insurance billing. It is provided only to highlight major points that would apply in most state jurisdictions. For example, for audit purposes it may be important to document a fund transfer from a SHIBP under a capitation funding system to a College Health Program for on-campus services. Such detailed and specific requirements are beyond the scope of this paper.

SUMMARY

The following are highlights for this updated publication on insurance billing for College Health Programs.

- Colleges continue to receive information about insurance billing that likely constitute impermissible practices in most state jurisdictions. Adopting insurance billing without fully understanding the regulatory environment and compliance requirements can result in liability for possible violation of insurance fraud statutes, and/or for noncompliance with insurance participating provider agreements. Given the variability of insurance billing regulation by state jurisdiction, it is essential to consult with legal counsel with expertise in insurance regulatory law specific to the state in which the College Health Program is located.
- While many colleges have achieved long-term success funding a substantial portion of health services operations through insurance billing revenue, the overall results remain highly variable due to numerous and complex environmental factors. Challenges for insurance billing are also common for community health care providers and are a major driver in the trends for consolidation of physician practices and hospital-owned physician groups.
- Federal recognition for the existence of funding systems for College Health Programs as being student administrative health fees (SAHF) may be a contributing factor in more states permitting health fees and general tuition/fees to fund all or some of the charges not covered by students' personal health insurance. Designating SAHF funding as a secondary payor when College Health Program's bill students' insurance has resulted in cost savings for students via reduced tuition/fees without losing access to care because of cost sharing provisions (i.e., copayments, deductibles, and coinsurance) in students' personal insurance. Equity concerns for SAHF can present challenging questions (e.g., extent of coverage for students with high deductible health plans) that are inextricably related to the decision process for considering insurance billing.
- Eight best practices for insurance billing for College Health Programs are identified and explained.
 1. Carefully adhere to all requirements in commercial insurer participating provider agreements.
 2. Retain billing consultants and legal counsel to assess and understand the regulatory environment.
 3. Have the same fee schedule for all patients.

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4. Make sure charges from the College Health Program to the SHIBP for services, supplies, or administrative costs are not in excess of fair market value.
5. Ensure accurate coding and maintain updated and proper documentation.
6. Have a consistently applied and formally written charity care/ability-to-pay-allowance determination.
7. Regardless of whether there is a designated health fee, develop and publish a formal plan document for the student administrative health fee (SAHF).
8. Use care in developing program descriptions and terminology.

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**CONSIDERING INSURANCE BILLING
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By Stephen L. Beckley, Valerie A. Lyon, and Marc M. Tract

APPENDIX A

Excerpt from Considering Insurance Billing for
College Health and Counseling Services (2013)

CONSIDERING INSURANCE BILLING FOR COLLEGE HEALTH AND COUNSELING SERVICES



By Stephen L. Beckley, Doreen Hodgkins, and Marc M. Tract

UNDERSTANDING COORDINATION OF BENEFITS

Coordination of benefits (COB) refers to the process for determining the order in which payments will be made when a person is covered by two or more health plans. On its website, one prominent multi-state Blue Cross and Blue Shield plan provides this explanation of COB for employers providing group health insurance coverage:

"When a member of your group is covered by more than one health plan (for example, when one of your employees is covered under your group plan as well as a spouse's health plan), one plan is considered to be the primary carrier and the other is considered to be the secondary carrier. The primary carrier covers the major portion of the bill according to plan allowances, and the secondary carrier covers any remaining allowable expenses. The COB provisions of your policy or plan determine which plan is primary. That plan's benefits are applied to the claim first. The unpaid balance is usually paid by the secondary plan to the limit of its responsibility. Benefits are thus "coordinated" among all of the health plans, and payments do not exceed 100% of charges for the covered services."²²

A common example of COB occurs when both of a child's parents cover him or her through each of their respective employer-sponsored group health insurance plans. When the child incurs health care expenses, the parent's plan that is required to pay first is referred to as the primary plan, and the plan that covers the remaining balance is the secondary plan.

Most states have adopted some form of the model coordination of benefits statute endorsed by the **National Association of Insurance Commissioners (NAIC)**. The NAIC's model statute is available at its web site at <http://www.naic.org/store/free/MDL-120.pdf>. Finding a specific state's COB statute is relatively easy with a Google® search (statutory citations by state can also be obtained at: <http://www.askmariatodd.com/resources/articles/state/163-sbscob.html>).



SECONDARY PAYOR STATUS FOR HEALTH FEES AND INSTITUTIONAL FUNDING

Even though college health fees are not a form of health insurance, and do not constitute health insurance premiums, state insurance regulatory authorities often conclude that health fees and other institutional funding arrangements fall within the definition of a “plan” in their COB statutes (refer to Appendix B) and are precluded from automatically covering remaining balances for copayments, deductibles, and coinsurance under students’ personal health insurance plans. More specifically, some state insurance departments have found that health fees and other institutional student health care funding arrangements constitute “Group Type Contracts” (refer to Appendix B). Having found that health fees and other institutional funding arrangements are a form of “plan” under COB, they also find student health care funding arrangements are not listed in the plans/funds that are excluded from the COB statute (refer to Appendix B). It is noteworthy that student health insurance plans that provide accident-only coverage (e.g., plans that cover only intercollegiate sports injuries) are permitted to take secondary payor positions by being excluded from their state’s definition of “plan” under COB.

Several states (e.g., Minnesota, Massachusetts, and Florida) either directly or indirectly permit college health and counseling services to establish their funding systems as secondary payors in coordinating benefits with students’ personal health insurance. In these states, colleges can use a funding model in which medical expenses are submitted to students’ personal health insurance before their health fees or other institutional health funding arrangements provide coverage. In other words, health fees and other institutional funding are able to take a secondary payor position in coordinating benefits with students’ personal health insurance (see examples below for health fees covering copayments, deductibles, and coinsurance). In such states, college health services have developed new insurance revenue streams that often exceed one-third of operating budgets. This substantial revenue may increase significantly as ACA preventive care services are expanded and appropriately charged to students’ personal insurance.

Colleges and universities in Minnesota, Massachusetts, and Florida have successfully contracted with insurance companies and health plans and are obtaining insurance reimbursements for office visit charges, ancillary services, and preventive care services that would have otherwise been funded by the college or university and/or direct charges to students. This requires health services to become participating providers with the health insurance plans that cover their students, develop electronic billing systems/processes, insure accurate service coding, and engage in other practices that are common for community health care providers. As is the case with community health care providers, small college health services with limited administrative capability may choose to retain a third party to submit medical claims to students’ insurance plans.

In summary, having a definitive statutory or regulatory authorization that establishes that health service funding arrangements may take secondary payor positions is the only certain path to having health fees or other student health care funding arrangements cover the expenses not paid by students’ private health insurance.



COMMON COMPONENTS FOR A SECONDARY PAYOR SYSTEM

When allowed by state statute, regulation, or regulatory ruling, the following are common components for a secondary payor system college health service funding (the same components would apply if counseling is provided or if there is a separate counseling service).

- The health service enters into participating provider agreements with the major insurance carriers/health plans covering its students. It is often advantageous for a health service to join a local independent provider association (IPA) or a physician hospital organization (PHO) to obtain participating provider status through a single contracting entity. Various commercial billing services may also be available to assist with obtaining participating provider status. Many large college health services have sufficient resources to obtain participating provider status without having to use an IPA, PHO, or commercial billing service.
- The health service develops fee-for-service charges for all medical services, including office visits. Counseling services usually continue to be pre-funded for students, regardless of whether they have personal health insurance coverage. Visit costs and other fee-for-services are typically set at a level that is above the highest participating provider reimbursement rates (i.e., participating provider contractually allowed charges).*
- If not already in existence, the college health service enters into a direct participating provider agreement with the college- or university-provided SHIBP. The reimbursement system can be based on either capitation or fee-for-service charges, but the total reimbursement must reflect the fair market value of the services provided. While the allowed charges can be at the lowest level of reimbursement among all participating provider agreements, some state insurance regulatory authorities will require the SHIBP's reimbursement level be generally comparable to the aggregated reimbursement (as a percentage of charges) from other private insurance plans. For example, the average total reimbursement from insurance plans other than the SHIBP could be 45 percent of billed charges (net of copayments, coinsurance, deductibles, and exclusion of services not covered), and the SHIBP capitation or fee-for-service charge system could be set to result in 40 percent of charges being covered.

Conversely, fiduciary responsibility requirements for the operation of SHIBPs²³ compel that reimbursements to college health services reflect fair market value, and that there are appropriate monitoring and controls for both utilization and cost of services received at health services. Using the preceding example, having the reimbursement level result in 55 percent of billed charges being covered by the SHIBP would raise concerns. Questions might be raised even if the reimbursement level is set to be at the average of other private insurance plan reimbursements if the SHIBP is the single largest third party payor for the health service. As is suggested in this discussion, the potential conflict of interest for college administrators and management committees being responsible for both health services and SHIBPs is a long-standing concern.

- The health service defines the services for which it will use health fees or other institutional funding to cover (i.e., covered services) what students' primary health insurance plans do not reimburse. For example, covered services could include charges for office visits, procedures,



allergy injections, flu shots, radiology, and lab tests (including certain reference lab tests). The scope of covered services typically excludes travel medicine services/immunizations, employment physicals, and other services routinely excluded by health insurance/benefit plans.

- The health service bills students' health insurance plans using its electronic health record/practice management systems. These systems typically have billing capability through the use of an electronic billing clearing house. Alternately, the health service may bill insurance plans directly or contract with a commercial billing service.
- Health fees or other institutional funding continue to cover health education and promotion services which are generally excluded by health insurance plans (i.e., no charges rendered for these services). Most colleges also continue to cover counseling services to insure there are no confidentiality barriers for students to access care (e.g., concern that explanation of benefits statements will be sent to parents when students are covered under a parent's group health insurance plan or individual family policy).*

* A discussion of the validity of the concern for confidentiality for counseling services versus medical care services is provided in point D on page 15.

SECONDARY PAYOR SYSTEM EXAMPLE CHARGES AND OUT-OF-POCKET EXPENSES

Health fees or other institutional funding would cover any copayments, deductibles, coinsurance, or excluded charges for covered services not paid by students' primary insurance plans.

- **Example 1:** Health center office visit charge = \$125, participating provider allowed amount = \$125, health center is participating provider, insurance pays 80% in-network:
The student's insurance pays \$100 and the college health fee covers the remaining \$25.
Student out-of-pocket expense = \$0.00.
- **Example 2:** Health center office visit charge = \$125, usual and customary allowance (U&C) = \$100, health center is not a participating provider, insurance pays 60% of U&C:
The student's insurance pays \$60 and the college health fee covers the remaining \$65.
Student out-of-pocket expense = \$0.00.
- **Example 3:** Health center office and laboratory service charges = \$200, student covered by SHIBP, SHIBP pays 40% of eligible charges:
SHIBP pays \$80.00 (payment is consistent with net reimbursements from other private health insurance) and \$120 balance is covered by health fee. Student out-of-pocket expense = \$0.00.
- **Example 4:** Health center office visit charge = \$125, student has not met her annual deductible (or she has an HMO with no coverage in the local area):
The student's insurance pays nothing and the college health fee covers the entire \$125.
Student out-of-pocket expense = \$0.00.



- **Example 5:** Health center non-preventive immunization charge (excluded service from health fee funding, not a covered service) = \$50, student's personal health insurance excludes this service:
The student's insurance pays nothing and the balance is put on student's account. Student out-of-pocket expense = \$50.00.
-

SECONDARY PAYOR SYSTEM EXAMPLE COMMUNICATIONS

The following are example communications of the secondary payor system for colleges and universities in Massachusetts, Minnesota, and Florida.

Wentworth Institute of Technology

Student Health Services uses an insurance-based model. The SHS will bill students' insurance plans for all services rendered. Students must present their student identification cards and also their health insurance cards at every appointment, just as they do when accessing their physicians at home.

The college will pay for any co-payments, co-insurance or deductibles due for primary care services after the student's insurance plan has been billed. Students will not be responsible for co-payments, co-insurance or deductibles due for primary care services.

University of Minnesota

The Student Services Fee is not health insurance and does not apply to visits at University of Minnesota Medical Center, Fairview, Hennepin County Medical Center, or any other facility . . . Students who are assessed the Student Services Fee and have health plan coverage will receive most services at Boynton Health Service subsidized after their insurance has been billed and their insurance responds to the claims.

University of Florida

The per-credit-hour student health fee, paid as part of tuition, covers any patient responsibility associated with most SHCC office visits and with telephone or online services initiated by the patient . . . Charges are assessed for things like medical equipment, X-rays, laboratory work, procedures and visits with specialists, which are first sent to the insurance company if the patient has provided their insurance information and card for verification. Any applicable charges are then billed directly to the patient's UF account . . . Charges for patients without insurance coverage are billed directly to the patient's UF account.



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APPENDIX B

Mayo Clinic Charity Care Policy



Charity Care Policy -Administration of Financial Assistance

Policy

Mayo Clinic's mission is to provide the best care to every patient every day through integrated clinical practice, education and research. Mayo Clinic strives to benefit humanity through work in these three areas, while supporting the communities in which we live and work. As part of that commitment, Mayo Clinic appropriately serves patients in difficult financial circumstances and offers financial assistance to those who have an established need to receive medically necessary medical services. Above all, Mayo Clinic's guiding philosophy is that the needs of the patient come first.

Charity care is only one component of Mayo Clinic's charitable mission. Educating the next generation of health care professionals and supporting biomedical research to decrease the burden of human disease are vital to Mayo Clinic's charitable purpose.

Purpose

This policy serves to establish and ensure a fair and consistent method for the review and completion of requests for charitable medical care to our patients in need.

Scope

This policy is to be used by All Mayo Clinic tax-exempt sites including Mayo Clinic Health System tax-exempt sites. Throughout the remainder of the document, use of the term "Mayo Clinic" refers to all Mayo Clinic affiliated tax-exempt hospitals and locations

Policy statements

Revenue Cycle staff are responsible for the following actions:

It is the policy of Mayo Clinic to offer financial assistance to patients who are unable to pay their hospital and/or clinic bills due to difficult financial situations. A Mayo Clinic Financial Counselor, designated business office representative, or committee with authority to offer financial assistance will review individual cases and make a determination of financial assistance that may be offered.

Mayo Clinic determines the need for financial assistance by reviewing the particular services requested or received insurance coverage or other sources of payment, a person's historical financial profile and current financial situation. This method allows for a fair and accurate way to assist patients who are experiencing financial hardship. Partial and/or full charity care will be granted based on the individual's ability to pay the bill.

Eligible individuals include patients who do not have insurance and patients who have insurance but are underinsured. Patients must cooperate with any insurance claim submission and exhaust their insurance or potential insurance coverage before becoming eligible for financial assistance. Other factors affecting eligibility are as follows:

- **Income** – Assuming that other financial resources are not identified as viable funding sources, the Federal Poverty Income Guidelines will be used in determining the amount of write-off. The Poverty Guidelines are updated annually each January.
 - The minimum criteria for full (100 percent) charity write-off will be 200 percent of the most recent Federal Poverty Income Guidelines.
 - Minimum criteria for partial write-offs will be to grant patients earning between 201 and 400 percent of the Federal Poverty Income Guidelines some level of discount depending on the circumstances in each case, but averaging a 50 percent discount for all patients in this income level.
 - Individual Mayo Clinic site policy may allow write-offs to patients with income levels over 400 percent of the Federal Poverty Guidelines, depending on the market served and other charity care options available within the community.
- **Evaluation of Assets** – the patient's household savings, checking, investment assets, real property assets, and overall financial position will be considered.
- **Evaluation of the Patient's Monthly Expenses** – review of living expenses includes medical expenses, and other basic needs.
- **Nature of the Medical Condition or Care Required** – consideration of services unique to Mayo Clinic versus potential of local facilities providing care.
- **Considerations**
 - Any special circumstances that the patient would like Mayo Clinic to consider.
 - Eligibility is contingent upon patient cooperation with the application process, including Medicaid or Medical Assistance application completion where applicable, and submission of all information that Mayo Clinic deems necessary in order to determine the level of any financial assistance that may be considered, including written permission for Mayo Clinic to check consumer credit information.
 - Priority is given to requests for care of local and regional patients, and to care that is unique to Mayo Clinic.

Measures to Publicize Mayo Clinic's Financial Assistance Policy

Mayo Clinic is committed to offering financial assistance to eligible patients who do not have the ability to pay for their medical services in whole or in part. In order to accomplish this charitable goal, Mayo Clinic and Mayo Clinic Health System sites will widely publicize this Policy in the communities that the individual Mayo Clinic affiliated sites serve.

Mayo Clinic affiliated sites will make a copy of this Policy available by posting it on their webpage including the ability to download a copy of the Policy free of charge. Individuals in the community served will be able to obtain a copy of the Policy in locations throughout each Mayo Clinic affiliated site or upon request.

Definitions

Financial Assistance is the cost of providing free or discounted care to individuals who cannot afford to pay, and for which Mayo Clinic ultimately does not expect payment. Mayo clinic may determine inability to pay before or after medically necessary services are provided. This is also referred to as **Charity Care**.

Bad debt is the cost of providing care to persons who are able but unwilling to pay all or some portion of the medical bills for which they are responsible.

Limitations

Mayo Clinic financial assistance does not include all costs that may be associated with medical services. The following is a non-exhaustive list of items or services that are not included in our financial assistance program:

- Transportation and Lodging: The patient is responsible for transportation to and from Mayo Clinic.
- Food: Social Services may have vouchers to help cover costs of food during the Mayo Clinic visit.
- Durable Medical Equipment: Social Services may have limited vouchers available to help cover costs associated with durable medical equipment.
- Pharmacy Supplies: The Mayo Store has a charity program to provide supplies at reduced costs for patients requiring financial assistance. Contact the Mayo Store Supervisor for additional information.
- Prescriptions filled at a non-Mayo pharmacy.
- Home Health Care or services provided at a non-Mayo entity are not covered under this policy. Follow up care may be coordinated through Social Services, but approval for financial assistance is limited to services provided on-site and billed by a Mayo Clinic entity.

- Smoking Cessation (Rochester only): The Nicotine Dependence Center (NDC) Fund at Mayo Clinic Rochester provides financial assistance for those interested in smoking cessation with financial need.
- Note: Mayo Clinic Social Services can provide limited funds in certain situations. The funds are generally less than \$50, offered once, and for short-term situations.

Hospice Care (Rochester only)

Coverage for Mayo Rochester Hospice Program end of life services may be approved in special situations when provided in the patient's home or a facility where Mayo Hospice has an established contact (e.g. selected area nursing homes and/or Charter House).

- Patient meets hospice eligibility criteria – patient's doctor and the Hospice Program medical Director agree that the patient's condition is terminal and the goal of treatment is comfort rather than cure.
- Hospice care will avoid hospitalization in a Mayo Clinic Rochester hospital or will facilitate discharge from one of the Mayo Clinic Rochester hospitals.
- Medical evaluation suggests difficulty moving the patient to home and/or care is not available in the patient's home.
- Patient resides in the Mayo Hospice program service area or is unable to return home for end of life care.

Home Health and Post Service Care

Mayo Clinic may provide Home Health, Pharmaceutical, or other services related to discharge planning on a limited basis depending on the medical needs of the patient and services provided and billed by each location for such care. Should it be determined that follow up or out-patient care would better serve or hasten the recovery of the patient and reduce overall cost to provide patient care, Mayo Clinic will review out-patient care options. Services may include, but are not limited to, home health nursing care, wound care, physical therapy, and other palliative care services. Mayo Clinic reserves the right to limit the extent and duration of home health services. Services may be limited to only those provided by the site providing initial care or provided by an approved contracted home health provider.

Procedure for Financial Assistance

Identification of Patients Who May Be Eligible

Prior to receiving services, there are a number of ways a patient can be identified and evaluated for financial assistance prior to, during, or following care. Following is a non-exhaustive list of examples for identification prior to receiving services:

- Patients or their representatives may request financial assistance.
- Mayo Clinic employees may refer patients to a Financial Counselor or business office representative.
- The Business Services/Patient Financial Services Department may refer patients to a Business Office Representative.
- Referring physicians may refer patients.
- Mayo consulting physicians may refer patients. Associate Consultants (ACs) and Senior Associate Consultants (SACs) must have the approval of their Division Chair.
- Local government agencies may refer patients

Following services, patients can be referred for financial assistance in a number of ways. Following is a non-exhaustive list of examples:

- Patients or their representatives may request financial assistance.
- Mayo Clinic employees may refer patients to a Financial Counselor or business office representative.
- Collection agencies or attorneys may refer patients back to Mayo Clinic.
- The Business Services/Patient Financial Services Department may refer patients to a Business Office Representative.
- The Business Services/Patient Account Services area may identify financial need through conversations with patients regarding billing and payment options.
- Referring physicians may refer patients.
- Mayo consulting physicians may refer patients.
- Local government agencies may refer patients.

Method of Applying for Financial Assistance

Patients who want to apply for financial assistance or who have been identified as a potentially eligible for financial assistance will be informed of the application process either before

receiving services if the facts suggest potential eligibility or after the billing and collection process has begun. The application process may be waived or suspended due to medical necessity, including timing and urgency of care. Patients or their representative can obtain a financial assistance application by mail by contacting Patient Account Services at 507-266-5670, or downloading and printing the [financial application](#) at no charge from our website.

All patients/guarantors who receive a Financial Statement application must complete and return the application within ten (10) working days (unless the patient calls with a legitimate reason to extend the deadline), along with the following documents that serve as the minimum information necessary to process an application for financial assistance. Mayo Clinic reserves the right to request additional documentation before finalizing a request for assistance:

- Proof of completion of Medical Assistance application process, as applicable
- Proof of household income (pay stubs for the past ninety days)
- A copy of 3 most recent bank statements from all banking or credit union institutions of the household
- A copy of the 2 most recent tax returns, including all schedules of patient, spouse, or any person who claims the patient as a tax dependent
- Full disclosure of claims and/or income from personal injury and/or accident related claims

A Business Office Representative will review all returned Financial Statements for completeness. Individual Mayo Clinic sites may require additional information or identify a minimum financial assistance request amount before requiring a Financial Statement application. The Financial Counselor or business office representative will consult the Financial Assistance authorization guidelines and present the Financial Statement to the appropriate person/committee for consideration. Once a decision has been made for financial assistance, a letter is sent to each applicant advising them of the decision. Notification for pre-service financial assistance requests will be sent if time permits.

Mayo Clinic and the Mayo Clinic Health System locations may share patient Financial Assistance information across our locations for the benefit and ease of administering Financial Assistance to patients seen at multiple locations. No information will be shared outside of Mayo Clinic unless authorized or required by law.

Basis for Calculating the Amounts Charged to Patients

The amount that a patient is expected to pay and the amount of financial assistance offered depends on the patient's insurance coverage and income and assets as set forth in the eligibility section of this Policy. The Federal Income Poverty Guidelines will be used in determining the amount of the write off and the amount charged to patients, if any, after an adjustment.

Amounts charged for emergency and medically necessary medical services to patients eligible for Financial Assistance will not be more than the amount generally billed to individuals with insurance covering such care.

Eligibility Criteria Considered for Financial Assistance

The appropriate business office will review all circumstances surrounding the request. The Mayo entity will notify the patient about the decision within a reasonable time after submitting a completed financial assistance request. A patient's request will be deemed complete after Mayo receives a complete financial assistance application, and all required documentation, including current pay stubs, income tax statements, and bank statements, if applicable.

Mayo Clinic will consider requests for charity medical care with priority given to local and regional patients, and care that is unique to Mayo. Local and regional patients do not require physician referral before applying for financial assistance. Patients from beyond the site's service area (generally the state where services are provided) will require referral by a physician for unique Mayo services or an approved application from a recognized charitable organization known to Mayo Clinic. Appropriate physician and/or administrative medical staff may be consulted to determine uniqueness of care to Mayo Clinic. Senior Associate Consultant (SAC's) decisions may be reviewed by the Division Chair. The charity care request must be supported by the Mayo treating physician.

Delivery of charity care does not obligate Mayo Clinic to provide continuing care unless the services and support are unique to our organization. Patients may be required to re-apply for charity care at least every 180 days. Each local Mayo Clinic site reserves the right to require a patient to re-apply at any time.

Mayo Clinic requires compliance with the application process of appropriate service organizations that may provide coverage for care, such as Medicaid or Medical Assistance.

Mayo Clinic makes every reasonable attempt to collect from insurance companies and other third-party payers. Financial hardship and charity care adjustments may be considered for those patients whose income and assets will not allow full payment within a reasonable time. Mayo Clinic may also consider paying COBRA premiums for a limited period of time if a patient is approved to receive financial assistance. Factors that are considered include the patient's residency (local, region, national, international) and the availability of care outside the Mayo system. Assistance may consist of:

- Full adjustment of the self pay balance
- Partial adjustment of the self pay balance
- Alternate or extended payment options

Mayo Clinic and Mayo Clinic Health System locations reserve the right to reverse financial assistance adjustments and pursue appropriate reimbursement or collections. This may occur as a result of a variety of reasons, such as newly discovered information such as insurance coverage or pursuit of a personal injury claim related to the services in question.

Reasons for Denial

Mayo Clinic may deny a request for financial assistance for a variety of reasons including, but not limited to:

- Sufficient income
- Sufficient asset level
- Patient is uncooperative or unresponsive to reasonable efforts to work with the patient
- Requests for care when there is no identifiable means of obtaining long-term support (e.g. medication or implantable devices) needed to sustain the initial successful outcomes of care
- Incomplete Financial Assistance application despite reasonable efforts to work with the patient
- Pending insurance or liability claim
- Withholding insurance payment and/or insurance settlement funds, including insurance payments sent to the patient to cover services provided by Mayo Clinic, and personal injury and/or accident related claims

Emergency Services

Mayo Clinic and Mayo Clinic Health System's policy is to provide emergency care to stabilize patients, regardless of their ability to pay. Following medical evaluation, non-emergent patients requiring charity care consideration should be reviewed and approved before additional services are provided.

Equal Opportunity

Mayo Clinic is committed to upholding the multiple federal and state laws that preclude discrimination on the basis of race, sex, age, religion, national origin, marital status, sexual orientation, disabilities, military service, or any other classification protected by federal, state or local laws.

Mayo Clinic will not consider: Bad debt, contractual allowances, perceived underpayments for operations, public programs, cases paid through a charitable contribution, professional courtesy discounts, community service or outreach programs, or employment status as a means to determine financial assistance.

Indigent Care

Emergency room patients who cannot pay their bills may be classified as "charity" if they do not have a job, mailing address, residence, or insurance. Consideration is also given to classifying emergency room only patients as charity if they do not provide adequate information as to their

financial status. In many instances, these patients are homeless and have few resources to cover the cost of their care.

Government Assistance

In determining whether an individual qualifies for charity care, other county or governmental assistance programs will be considered. Many applicants are not aware that they may be eligible for public health insurance programs or have not pursued application.

Mayo Clinic staff will help the individual determine eligibility for governmental or other assistance, as appropriate. Persons who are eligible for programs (such as State-sponsored Medicaid) but who were not covered at the time that medical services were provided may be granted financial assistance, provided that the patient completes an application for government assistance. This may be prudent, especially if the patient requires ongoing services.

Collection Activity

Mayo Clinic will not engage in extraordinary collection actions before it makes a reasonable effort to determine whether a patient is eligible for financial assistance under this Policy.

Collection activity will proceed based on a separate Collection Policy.

If a collection agency identifies a patient as meeting Mayo Clinic's financial assistance eligibility criteria, the patient's account may be considered for financial assistance. Collection activity will be suspended on these accounts and Mayo Clinic will review the financial assistance application. If the entire account balance is adjusted, the account will be returned to Mayo Clinic. If a partial adjustment occurs, the patient fails to cooperate with the financial assistance process, or if the patient is not eligible for financial assistance, collection activity will resume.

Confidentiality

Mayo staff will uphold the confidentiality and individual dignity of each patient. Mayo Clinic and Mayo Clinic Health System will meet all HIPAA requirements for handling personal health information.

This policy will be reviewed annually by the Board of Trustees. Last Update: 06/2012

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APPENDIX C

National Association of Insurance Commissioners,
Model Statute for Coordination of Benefits

COORDINATION OF BENEFITS MODEL REGULATION

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Appendix B.	Consumer Explanatory Booklet

Section 1. Authority

This regulation is adopted and promulgated by the Commissioner of Insurance pursuant to Section [insert section] of the Insurance Code.

Section 2. Purpose

The purpose of this regulation is to:

- A. Establish a uniform order of benefit determination under which plans pay claims;
- B. Reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this regulation, do not have to pay their benefits first; and
- C. Provide greater efficiency in the processing of claims when a person is covered under more than one plan.

Section 3. Definitions

As used in this regulation, these words and terms have the following meanings, unless the context clearly indicates otherwise:

- A. (1) “Allowable expense,” except as set forth below or where a statute requires a different definition, means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.
 - (2) If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan’s deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.
 - (3) An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.
 - (4) Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.
 - (5) The following are examples of expenses that are not allowable expenses:

- (a) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
- (b) If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.
- (c) If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- (d) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

Drafting Note: Many plans negotiate rates with physicians, hospitals and other providers that are lower than the providers' usual and customary charges using other reimbursement methodology, such as relative value schedule reimbursement or other similar reimbursement methodology. Because the provider has agreed to accept the negotiated payment, less any required deductibles, coinsurance or copayments for the services, COB is not to be used to increase the provider payment. Conversely, because the provider has agreed to accept the negotiated payment, less any required deductibles, coinsurance or copayments for the services, COB is not to be used to decrease the amount the provider has negotiated to accept in payment for the services. This provision limits COB allowable expense to the negotiated rate. Plans should include provisions in their provider contracts to account for payments under coordination of benefits.

- (6) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expense in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense shall include similar expenses to which COB applies.

Drafting Note: The intent of this provision is to permit plans to limit the extent of coordination to plans with similar types of coverages or benefits, e.g., coordination of health plans with health plans or dental plans with dental plans, etc.

- (7) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.
- (8) The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:
 - (a) Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or
 - (b) Because the covered person has a lower benefit because the covered person did not use a preferred provider.

- B. "Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

- C. “Claim” means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:
 - (1) Services (including supplies);
 - (2) Payment for all or a portion of the expenses incurred;
 - (3) A combination of Paragraphs (1) and (2); or
 - (4) An indemnification.
- D. “Closed panel plan” means a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- E. “Consolidated Omnibus Budget Reconciliation Act of 1985” or “COBRA” means coverage provided under a right of continuation pursuant to federal law.
- F. “Coordination of benefits” or “COB” means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.
- G. “Custodial parent” means:
 - (1) The parent awarded custody of a child by a court decree; or
 - (2) In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
- H. (1) “Group-type contract” means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage.
(2) “Group-type contract” does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.
- I. “High-deductible health plan” has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.
- J. (1) “Hospital indemnity benefits” means benefits not related to expenses incurred.
(2) “Hospital indemnity benefits” does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.
- K. (1) “Plan” means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

Drafting Note: A state may choose to allow coordination only between group plans within its COB rules. In that case, a state would need to modify Section 3K(4) to exempt certain coverages from the definition of “plan.”

- (2) If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term “plan” or some other term such as “program,” the contractual definition may be no broader than the definition of “plan” in this subsection. The definition of “plan” in the model COB provision in Appendix A is an example.
 - (3) “Plan” includes:
 - (a) Group and nongroup insurance contracts and subscriber contracts;
 - (b) Uninsured arrangements of group or group-type coverage;
 - (c) Group and nongroup coverage through closed panel plans;
 - (d) Group-type contracts;
 - (e) The medical care components of long-term care contracts, such as skilled nursing care;
 - (f) The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts;
 - (g) Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (4)(h). That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; and
 - (h) Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.
 - (4) “Plan” does not include:
 - (a) Hospital indemnity coverage benefits or other fixed indemnity coverage;
 - (b) Accident only coverage;
 - (c) Specified disease or specified accident coverage;
 - (d) Limited benefit health coverage, as defined in [insert reference in state law equivalent to Section 7 of the NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act];
 - (e) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a “to and from school” basis;
 - (f) Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
 - (g) Medicare supplement policies;
 - (h) A state plan under Medicaid; or
 - (i) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.
- L. “Policyholder” means the primary insured named in a nongroup insurance policy.

- M. “Primary plan” means a plan whose benefits for a person’s health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:
 - (1) The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or
 - (2) All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.
- N. “Secondary plan” means a plan that is not a primary plan.

Section 4. Applicability and Scope

This regulation applies to all plans that are issued on or after the effective date of this regulation, which is [insert date].

Section 5. Use of Model COB Contract Provision

- A. Appendix A contains a model COB provision for use in contracts. The use of this model COB provision is subject to the provisions of Subsections B, C and D and to the provisions of Section 6 of this regulation.
- B. Appendix B is a plain language description of the COB process that explains to the covered person how health plans will implement coordination of benefits. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which the two (2) or more plans will pay for or provide benefits.
- C. The COB provision contained in Appendix A and the plain language explanation in Appendix B do not have to use the specific words and format shown in Appendix A or Appendix B. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted.
- D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:
 - (1) Another plan exists and the covered person did not enroll in that plan;
 - (2) A person is or could have been covered under another plan, except with respect to Part B of Medicare; or
 - (3) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.
- E. No plan may contain a provision that its benefits are “always excess” or “always secondary” except in accordance with the rules permitted by this regulation.
- F. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person is enrolled in two (2) or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the plan year when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use the provisions of Section 7 of this regulation to determine the amount it should pay for the benefit.
- G. No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan under Section 3K of this regulation.

Section 6. Rules for Coordination of Benefits

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

- A. (1) The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.
 - (2) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.
 - (3) When multiple contracts providing coordinated coverage are treated as a single plan under this regulation, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this regulation.
 - (4) If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this regulation, has its benefits determined before those of that secondary plan.
- B. (1) Except as provided in Paragraph (2), a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

Drafting Note: The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts (often referred to as "med pay"), which is included in the definition of "plan" under Section 3K(3) of this model regulation, does not normally contain order of benefit determinations provisions. As such, unless state law or regulation specifies otherwise, in accordance with paragraph (1), such coverage would be primary. Med pay coverage is not liability coverage and is not dependent upon fault.

- (2) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the 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 take into consideration the benefits paid or provided by another plan only when, under the rules of this regulation, it is secondary to that other plan.
- D. Order of Benefit Determination

Each plan determines its order of benefits using the first of the following rules that applies:

- (1) Non-Dependent or Dependent
 - (a) Subject to Subparagraph (b) of this paragraph, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.
 - (b) (i) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - (I) Secondary to the plan covering the person as a dependent; and

- (II) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),
- (ii) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

Drafting Note: The provisions of Subparagraph (b) address the situation where federal law requires Medicare to be secondary with respect to group health plans in certain situations despite state law order of benefit determination provisions to the contrary. One example of this type of situation arises when a person, who is a Medicare beneficiary, is also covered under his or her own group health plan as a retiree and under a group health plan as a dependent of an active employee. In this situation, each of the three plans is secondary to the other as the following illustrates: (1) Medicare is secondary to the group health plan covering the person as a dependent of an active employee as required pursuant to the Medicare secondary payer rules; (2) the group health plan covering the person as a dependent of an active employee is secondary to the group health plan covering the person as a retiree, as required under Subparagraph (a); and (3) the group health plan covering the claimant as retiree is secondary to Medicare because the plan is designed to supplement Medicare when Medicare is the primary plan. Subparagraph (b) resolves this problem by making the group health plan covering the person as a dependent of an active employee the primary plan. The dependent coverage pays before the non-dependent coverage even though under state law order of benefit determination provisions in the absence of Subparagraph (b), the non-dependent coverage (e.g. retiree coverage) would be expected to pay before the dependent coverage. Therefore, in cases that involve Medicare, generally, the dependent coverage pays first as the primary plan, Medicare pays second as the secondary plan, and the non-dependent coverage (e.g. retiree coverage) pays third.

The reason why Subparagraph (b) provides for this order of benefits making the plan covering the person as dependent of an active employee primary is because Medicare will not be primary in most situations to any coverage that a dependent has on the basis of active employment and, as such, Medicare will not provide any information as to what Medicare would have paid had it been primary. The plan covering the person as a retiree cannot determine its payment as a secondary plan unless it has information about what the primary plan paid. The plan covering the person as a dependent of an active employee could be subject to penalties under the Medicare secondary payer rules if it refuses to pay its benefits. The plan covering the person as a retiree is not subject to the same penalties because, in this particular situation, as described above, which does not involve a person eligible for Medicare based on end-stage renal disease (ESRD), the plan can never be primary to Medicare. As such, out of the three plans providing coverage to the person, the plan covering the person as a dependent of an active employee can determine its benefits most easily.

(2) Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

- (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - (ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
- (b) For a dependent child whose parents are divorced or separated or are 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 health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
 - (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) of this paragraph 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) of this paragraph shall determine the order of benefits; or

- (iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (I) The plan covering the custodial parent;
 - (II) The plan covering the custodial parent's spouse;
 - (III) The plan covering the non-custodial parent; and then
 - (IV) The plan covering the non-custodial parent's spouse.

- (c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

Drafting Note: Subparagraph (c) addresses the situation where individuals other than the parents of a child are responsible for the child's health care expenses or provide health care coverage for the child under each of their plans. In this situation, for the purpose of determining the order of benefits under this paragraph, Subparagraph (c) requires that these individuals be treated in the same manner as parents of the child.

- (d)
 - (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph (5) applies.
 - (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

Drafting Note: Subparagraph (d) is intended to address the situation created by the enactment of Section 2714 of the Public Health Service Act, as that section was added by the federal Patient Protection and Affordable Care Act (Public Law 111-148) (ACA), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Section 2714 of the PHSA extended coverage for dependents to age 26 regardless of any dependency factors, such as support, residency, student status or marital status.

- (3) Active Employee or Retired or Laid-Off Employee
 - (a) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
 - (b) 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.
 - (c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits.

Drafting Note: This rule applies only in the situation when the same person is covered under two plans, one of which is provided on the basis of active employment and the other of which is provided to retired or laid-off employees. The rule in Paragraph (1) does not apply because the person is covered either as a non-dependent under both plans (i.e. the person is covered under one plan as an active employee and at the same time is covered as a retired or laid-off employee under the other plan) or as a dependent under both plans (i.e. the person is covered under one plan as a dependent of an active employee and at the same time is covered under the other plan as a dependent of a retired or laid-off employee). This rule does not apply when a person is covered under his or her own plan as an active employee or retired or laid-off employee and a dependent under a spouse's plan provided to the spouse on the basis of active employment. In this situation, the rule in Paragraph (1) applies because the person is covered as a non-dependent under one plan (i.e. the person is covered as an active employee or retired or laid-off employee) and at the same time is covered as a dependent under the other plan (i.e. the person is covered as a dependent under a plan provided on the basis of active employment or a plan that is provided to retired or laid-off employees).

(4) COBRA or State Continuation Coverage

- (a) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to 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 plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
- (b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- (c) This rule does not apply if the rule in Paragraph (1) can determine the order of benefits

Drafting Note: COBRA originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), allows the COBRA coverage to continue if the newly acquired group health plan contains any preexisting condition exclusion or limitation. In this instance two group health plans will cover the person, and the rule above will be used to determine which of the plans determines its benefits first. In addition, some states have continuation provisions comparable to COBRA.

Drafting Note: This rule applies only in the situation when a person has coverage pursuant to COBRA or under a right of continuation pursuant to state or other federal law and has coverage under another plan on the basis of employment. The rule under Paragraph (1) does not apply because the person is covered either: (a) as a non-dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own plan as an employee, member, subscriber or retiree); or (b) as a dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a dependent of an employee, member, subscriber or retiree). The rule under Paragraph (1) applies when the person is covered pursuant to COBRA or under a right of continuation pursuant to state or other federal law as a non-dependent and covered under the other plan as a dependent of an employee, member, subscriber or retiree. The rule in this paragraph does not apply because the person is covered as a non-dependent under one of the plans and as a dependent under the other plan.

(5) Longer or Shorter Length of Coverage

- (a) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.
- (b) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.
- (c) The start of a new plan does not include:
 - (i) A change in the amount or scope of a plan's benefits;
 - (ii) A change in the entity that pays, provides or administers the plan's benefits; or
 - (iii) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.
- (d) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.
- (6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

Section 7. Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim

In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Section 8. Notice to Covered Persons

A plan shall, in its explanation of benefits provided to covered persons, include the following language: "If you are covered by more than one health benefit plan, you should file all your claims with each plan."

Section 9. Miscellaneous Provisions

- A. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.
- B. (1) A plan with order of benefit determination rules that comply with this regulation (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this regulation (non-complying plan) on the following basis:
 - (a) If the complying plan is the primary plan, it shall pay or provide its benefits first;
 - (b) If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and
 - (c) If the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as to the actual benefits of the non-complying plan, it shall adjust payments accordingly.
- (2) If the non-complying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the non-complying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to the covered person or on behalf of the covered person an amount equal to the difference.
- (3) In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the non-complying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against a non-complying plan in the absence of subrogation.

- C. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.
- D. If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

Section 10. Effective Date for Existing Contracts

- A. A contract that provides health care benefits and that was issued before the effective date of this regulation shall be brought into compliance with this regulation by:
 - (1) The later of:
 - (a) The next anniversary date or renewal date of the contract; or
 - (b) Twelve (12) months following [insert date that the amended regulation is adopted]; or
 - (2) The expiration of any applicable collectively bargained contract pursuant to which it was written.
- B. For the transition period between the adoption of this regulation and the timeframe for which plans are to be in compliance pursuant to Subsection A, a plan that is subject to the prior COB requirements shall not be considered a non-complying plan by a plan subject to the new COB requirements and if there is a conflict between the prior COB requirements under the prior regulation and the new COB requirements under the amended regulation, the prior COB requirements shall apply.

APPENDIX A
MODEL COB CONTRACT PROVISIONS

**COORDINATION OF THIS CONTRACT'S BENEFITS
 WITH OTHER BENEFITS**

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** does not exceed 100% of the total **Allowable expense**.

DEFINITIONS

- A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - (1) **Plan** includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - (2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

- B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan**'s benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

- D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses.
- (2) If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
- (3) If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
- (4) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
- (5) The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

- E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

- A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under 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 that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of 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 health care expenses or health care 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 health care 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**.

EFFECT ON THE BENEFITS OF THIS PLAN

- A. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. [Organization responsibility for **COB** administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. [Organization responsibility for **COB** administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give [Organization responsibility for **COB** administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, [Organization responsibility for **COB** administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. [Organization responsibility for **COB** administration] will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Organization responsibility for **COB** administration] is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

APPENDIX B
CONSUMER EXPLANATORY BOOKLET

COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called “coordination of benefits” to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the “primary” or “secondary” benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state’s COB rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse’s Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child’s Expenses

- The claim is for the health care expenses of your child who is covered by this plan and
- You are married and your birthday is earlier in the year than your spouse’s or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual’s birthday. This is known as the “birthday rule”;
or
- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child’s health care expenses;
or
- There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An “allowable expense” is a health care expense covered by one of the plans, including copayments, coinsurance and deductibles.

- If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.
- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

Questions About Coordination of Benefits? Contact Your State Insurance Department

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1971 Proc. I 54, 58, 208, 225, 226-230 (adopted).
1980 Proc. II 22, 26, 588, 592-593 (added section on divorced parents).
1983 Proc. I 6, 35, 644, 693, 699 (added section on laid-off and retired employees).
1984 Proc. II 9, 20, 536, 616, 625-636 (revised and added birthdate rule and reprinted).
1985 Proc. II 11, 23, 609, 615, 627-638 (adopted easy-to-read version).
1986 Proc. I 9-10, 23, 665, 673 (footnote added).
1988 Proc. I 9, 20-21, 630, 713, 715-728 (amended and reprinted).
1989 Proc. I 9, 24-25, 703-704, 839, 843-846 (amended).
1990 Proc. II 7, 16, 600, 676-677, 678-683 (amended).
1991 Proc. I 9, 17-18, 609, 648-652 (amended).
1995 Proc. 3rd Quarter 4, 18, 692, 696, 703-717 (amended and reprinted).
2004 Proc. 4th Quarter 683, 738, 739-761 (amended and reprinted, adopted by parent).
2005 Proc. 1st Quarter 48 (adopted by Plenary).
2013 Proc. 2nd Quarter 113, 127-130, 364-370 (amended).

COORDINATION OF BENEFITS MODEL REGULATION

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

COORDINATION OF BENEFITS MODEL REGULATION

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COORDINATION OF BENEFITS MODEL REGULATION

KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama		ALA. ADMIN. CODE R. 56 (1985/1986) (Birthday rule eff. 8/29/87). ALA. CODE § 27-1-17 (1981/2003) (includes payment of claims rules related to COB).
Alaska		ALASKA STAT. § 21.42.205 (1997) (authority to adopt regulations).
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. ADMIN. CODE § 20-6-217 (1982/1985) (birthday rule eff. 1-1-87); § 054-00-021.
Arkansas		054-00-21 ARK. CODE R. 4 (2010) (birthday rule eff. 1-13-86).
California		CAL. CODE REGS. tit. 10, §§ 2232.52 to 2232.59 (1975/1986) (birthday rule eff. 1-1-87).
Colorado	3 COLO. CODE REGS. § 702-4:4-6-2 (2014) (birthday rule eff. 1-1-87).	
Connecticut		CONN. AGENGIES REGS. 38A-480-1 to 38A-480-7 (1988) (birthday rule eff. 4-1-88); CONN. GEN. STAT. § 38a-546 (1958/2011); BULLETIN 6-20-2008 (2008).
Delaware		DEL. CODE ANN. tit. 18, § 1307 (1988/2007) (birthday rule eff. 10-26-88).
District of Columbia	NO CURRENT ACTIVITY	

COORDINATION OF BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Florida		FLA. STAT. § 627.4235 (1974/1992) (birthday rule eff. 10-1-85) (different coordination rule for Medicare beneficiaries).
Georgia		GA. COMP. R. & REGS. 120-2-48 (1991) (birthday rule eff. 1-1-91).
Guam	NO CURRENT ACTIVITY	
Hawaii	NO CURRENT ACTIVITY	
Idaho		IDAHO ADMIN. CODE R. 18.01.74 (1998/2006).
Illinois		ILL. ADMIN. CODE tit. 50, §§ 2009.10 to 2009.60 (1988/1991) (birthday rule eff. 3-22-88 by statute).
Indiana		760 IND. ADMIN. CODE 1-38.1 (2007) (Birthday rule eff. 7-1-88).
Iowa		IOWA ADMIN. CODE R. 191-38.1 to 191-38.11 (1987/2010) (birthday rule eff. 4-15-87).
Kansas		KAN. ADMIN. REGS. § 40-4-34 (1981/1999) (adopted previous version of model by reference) (birthday rule eff. 7-1-85).
Kentucky		806 KY. ADMIN. REGS. 18:030 (1987/2001) (birthday rule eff. 1-1-87).
Louisiana	LA. ADMIN. CODE tit. 37, §§ XIII.301 to XIII.323 (Regulation 32) (1971/1998) (birthday rule eff. 5-9-85).	LA. REV. STAT. ANN. § 250.11 (1997/2001) (allows coordination with individual policies).
Maine		ME. REV. STAT. ANN. tit. 24-A, § 2723-A (1999); tit. 24, § 2332-A; tit. 24-A, § 2844 (1991/1998); 790 ME CODE R. (2004).
Maryland		MD. CODE ANN., INS. § 15-104 (1983/1997).
Massachusetts	211 MASS. CODE REGS. §§ 38.01 to 38.11 (2017).	
Michigan		MICH. COMP. LAWS §§ 550.251 to 550.255 (1984/1996) (birthday rule eff. 4-1-85).

COORDINATION OF BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Minnesota		MINN. R. §§ 2742.0100 to 2742.0500 (1986) (birthday rule eff. 7-4-87); DEPT. OF HEALTH REGULATION 4685.0950(1989) (applies to HMOs; birthday rule eff. 10-9-89); MINN. STAT. § 62A.046 (1990/2010).
Mississippi		88 MISS CODE R. § 102 (1988).
Missouri		MO. CODE REGS. ANN. tit. 20, § 400-2.030 (1991) (birthday rule eff. 1-1-86).
Montana		MONT. ADMIN. R. 6.6.2401 to 6.6.2405 (1987/2013) (birthday rule eff. 10-16-87).
Nebraska	210 NEB ADMIN CODE § 39 (2016).	
Nevada		NEV. REV. STAT. §§ 689B.063 to 689B.064 (1987) (birthday rule eff. 7-1-87).
New Hampshire		N.H. ADMIN. R. ANN. INS. 1904 (1986/2005) (birthday rule eff. 2-22-87).
New Jersey		N.J. ADMIN. CODE §§ 11:4-28.1 to 11:4-28.12 (1988/2002) (birthday rule eff. 10-17-88); N.J. ADMIN. CODE §§ 11:3-37.1 to 11:3-37.14 (1991) (coordination with auto).
New Mexico		N.M. CODE R. § 13.10.13.24 (2009).
New York		N.Y. COMP. CODES R. & REGS. tit. 11, § 52.23 (REGULATION 62) (1987/2009) (birthday rule eff. 1-15-87); N.Y. INS. LAW § 3224-c (2009).
North Carolina		11 N.C. ADMIN. CODE § 12.0514 (1978/1992) (Birthday rule eff. 7-1-86).
North Dakota		N.D. ADMIN CODE §§ 45-08-01.2 to 45-08-08 (2006) (birthday rule eff. 7-1-85); N.D. CENT. CODE §§ 26-03-48 to 26-03-48.1 (1971/1983); § 26.1-36-10 (1985/1993) (allows coordination with individual policies).
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. CODE ANN. §§ 3902.11 to 3902.14 (1988/1991) (birthday rule eff. 6-29-88); OHIO ADMIN. CODE § 3901-8-01 (2008); BULLETIN 90-6 (1990) (explains total allowable expense and phantom plans).

COORDINATION OF BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-11-1 to 365:10-11-11 (1985/2015) (birthday rule eff. 1-1-87) (portions of model).	
Oregon	OR. ADMIN. R. §§ 836-020-0770 to 836-020-0806 (2006/2014).	
Pennsylvania	NO CURRENT ACTIVITY	
Puerto Rico	NO CURRENT ACTIVITY	
Rhode Island	11-5 R.I. CODE R. §§ 48:1 to 48:10 (2014).	
South Carolina		S.C. CODE ANN. REGS. 69-43 (1990) (birthday rule eff. 5-24-90); BULLETIN 74-8 (1974).
South Dakota	S.D. CODIFIED LAWS § 58-18A-53 to 58-18A-83 (2006/2015) (portions of model).	
Tennessee		TENN. COMP. R. & REGS. 0780-1-53 (1987) (birthday rule eff. 3-1-88); BULLETIN May 3, 1990 (regarding HMOs).
Texas	28 TEX. ADMIN. CODE §§ 3.3501 TO 3.3511 (1985/2014) (birthday rule eff. 1-1-87).	TEX. INS. CODE ANN. §§ 1203.002 to 1203.003 (2005) (may not coordinate with supplemental policies).
Utah		UTAH ADMIN. CODE 590-131 (2007/2008) (birthday rule eff. 1-1-87); UTAH CODE ANN. § 31A-22-619 (1989/2009); BULLETIN 89-4 (1989); BULLETIN 91-1 (1991).
Vermont	NO CURRENT ACTIVITY	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia		VA. CODE ANN. § 38.2-3405 (1986/1995) (allows coordination between two health insurance plans); § 38.2-3543.1 (1994) (authority to adopt regulation); § 38.2-3407.13:1 (2000) (requires notice in individual or group plan that intend to coordinate benefits).
Washington		WASH. ADMIN. CODE 284-51-190 to 284-51-260 (2007/2011).
West Virginia		W.VA. CODE R. §§ 114-28-1 to 114-28-8 (1991/2010) (birthday rule eff. 8-1-91).

COORDINATION OF BENEFITS MODEL REGULATION

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Wisconsin		WIS. ADMIN. CODE INS. 3.40 (1987/2014) (birthday rule eff. 7-1-86).
Wyoming		10 WYO. CODE R. (1985) (birthday rule eff. 7-1-85).

COORDINATION OF BENEFITS MODEL REGULATION

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COORDINATION OF BENEFITS MODEL REGULATION

Proceedings Citations Cited to the Proceedings of the NAIC

Section 1. Authority

The model was initially developed as a series of guidelines rather than a regulation to preserve the flexibility to modify them easily, and to suggest limits on insurer discretion in design of a coordination of benefits provision. **1970 Proc. II 1204.**

Section 2. Purpose

Evidence was presented by industry spokespersons in 1969 that payment of duplicated benefits actually increased the cost to the individual insured. They pointed out that coordination of benefits would pay all or most of the incurred expenses of a claimant but would not increase costs to the employer or employees. A survey conducted by the health insurance industry estimated potential overpayments of 7.4% of total benefits paid were avoided by the use of COB provisions. **1969 Proc. II 839-841.**

The basic concept of COB, according to the model drafters, was to provide an effective restraint on over-insurance arising from group health insurance contracts, and to provide the covered person with the means to pay all covered expenses in full without profit to the insured, mis-utilization of medical facilities or artificially increased costs of medical care. **1970 Proc. II 1203.**

The group charged with development of a model expressed an interest in learning about the administrative problems experienced with group coordination of benefits provisions. An industry memorandum pointed out problems and possible solutions. The most pressing problems enumerated included: (1) administrative expense involved in investigating the existence of other coverage; (2) the necessity of obtaining information about the other coverage from another carrier; (3) delays in claims payments due to the time involved in those investigations; (4) employee understanding and acceptance; and (5) the cooperation of providers. **1969 Proc. II 856.**

The original guidelines contained recommendations to insurers regarding claims administration procedures that could be used to expedite claim payments where coordination of benefits was involved. They suggested the use of the Duplicate Coverage Inquiry Form, use of the telephone by claims personnel to speed exchange of coordination of benefits information, data files on other group carriers in the area, and establishment of a time limit before which payment should be made. A clearinghouse was not recommended because of the great expense. **1970 Proc. II 1206.**

In order to promote some degree of uniformity in handling coordination of benefits problems, industry organizations such as the International Claims Association, the Health Insurance Association of America, the American Medical Association, and the American Hospital Association developed several uniform approaches. Exhibits presented to the NAIC included a duplicate coverage inquiry form, Statements of Policy by Associations, and informational brochures for the consumer. **1969 Proc. II 858-867.**

One department reported to the drafting group on its experience in getting the various types of accident and health coverage providers to agree on standards. Areas of disagreement included whether to include only group coverage, or whether to extend the COB provisions to individually purchased hospital policies and/or casualty forms providing coverage for medical expenses, and whether it was possible to coordinate benefits with a self-insured plan. This state recommended the development of provisions which, when accepted in all jurisdictions, would tend to develop uniformity in the treatment of these problems from coast to coast. **1969 Proc. II 867-868.**

Industry spokespersons emphasized that even though there were many problems relative to the concept of coordination of benefits, they were not insurmountable. They stated that the principles were in the public interest and should be kept uppermost in the minds of the NAIC group. They expressed the belief that most problems could be solved by cooperative efforts of the commissioners and the industry. They emphasized the importance of uniform application of regulation to insurance companies, nonprofit hospital and medical service plans and self-insurers. **1970 Proc. I 373-374.**

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Section 2 (cont.)

When adopting the original guidelines, the committee added a statement clarifying its intent that the guidelines not require the use of a coordination of benefits provisions, but that, if one was included, it must be no less favorable than the substance of the report prepared by the committee. **1971 Proc. I 225.**

Coordination of benefits was created as an effective tool to eliminate the potential for profit when a person was covered by more than one group medical plan. Its existence eliminated the incentive to abuse the use of medical and hospital care. **1984 Proc. II 645.** Coordination of benefits operated in two phases. First, the rules determined which of two plans would pay first. Next, they determined how much the secondary carrier would pay. **1984 Proc. II 638.**

Interested parties encouraged the adoption of the guidelines, saying action by all or a great majority of states would contribute significantly to a larger measure of uniformity of COB contract design and administration, improved understanding of the purpose of COB by those protected by group health insurance, and reduced complaints, which tended to flow largely from the lack of uniformity and from misunderstandings. **1971 Proc. I 230.**

In 1984, the NAIC recognized a need to redraft the guidelines into more simplified language. **1984 Proc. II 616.** The result was the “easy-to-read” version adopted in June 1985, **1985 Proc. II 627-638**, and another attempt to organize the guidelines to be more readable, adopted in December of 1987. **1988 Proc. I 715-728.**

It was the consensus of the task force in 1984 that the current model regulation covered HMOs. **1984 Proc. II 648.** The draft proposed for adoption in 1985 addressed several problems in connection with coordinating with HMOs. The guidelines were drafted so they would apply on the same basis to insurers, service plans, HMOs and uninsured plans. **1985 Proc. I 611, 617.**

When the model was being revisited in 2002, a regulator suggested that Section 2 be renamed from the title “Purpose and Applicability” because the language of the section only discussed the purpose of the model, not its applicability. The provisions were revised to more clearly state the purpose. **2002 Proc. 4th Quarter 282.**

The working group drafting revisions received a comment questioning whether the language in Section 2 was accurate. An interested party suggested that Subsection D be revised to reflect that the regulation served to promote greater efficiency in the processing of claims when a person was covered under more than one plan, not just to reduce claims payment delays. After discussion, the working group decided to incorporate the suggestions in the next COB model draft. Subsections B and E would be deleted and Subsection D would be revised as suggested. The chair also asked working group members and interested parties to consider whether a provision should be added to the COB model concerning information sharing between plans. **2003 Proc. 4th Quarter 529.**

Section 3. Definitions

A. When the drafters of the original model defined “allowable expense,” the majority felt that over-insurance should be measured on the “total expense” basis, that is, without compartmentalizing the type of expense. The minority favored the concept that compartmentalization of hospital expenses from all other expenses should be permissible and that allowable expenses might be limited solely to the covered expenses of one’s own plan. **1970 Proc. II 1208.**

The task force spent a considerable amount of time considering the definition of “allowable expense,” an item which determined the maximum benefit level beyond which over-insurance would be deemed to occur. The service organizations indicated that the definition adopted was not generally suitable to their policy, structure or operations. It was concluded that a rigid position on this subject by the NAIC would not be advised. **1971 Proc. I 233-234.**

A change to the guidelines in 1984 made clear that the cost of a private hospital room should be an allowable expense only when its use was deemed necessary in terms of generally accepted medical practice. **1984 Proc. II 624.**

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Section 3A (cont.)

When considering the HMO issue, regulators agreed that allowable expense meant not only the necessary, reasonable and customary item of expense, but also the reasonable cash value of the services when a plan, such as a HMO, provided services. The concept of providing services was included whenever the concept of paying benefits applied. **1985 Proc. I 619.**

For some time the NAIC wrestled with the problem of self-referral or self-directed care, which occurred when a HMO member, who was also covered by a traditional reimbursement plan that was secondary, elected to be treated outside the HMO. This action resulted in the shifting of the cost for health care from what should be the primary plan to what should have been the secondary plan. The apparent remedy within COB was to reduce the benefits payable by the secondary plan. There was a precedent for doing this in certain cost containment programs designed to discourage the use of unnecessary services. Cost containment programs discouraged the use of unnecessary services by increasing the cost of those services to the individual. However, self-referral often dealt with services that were necessary. COB should not be perceived as a vehicle to deprive a person of free choice in the selection of a health care provider. If future experience should indicate that self-referral was becoming a regular occurrence that adversely affected indemnity plans and the health care objectives of HMOs, other approaches would have to be given serious consideration. **1985 Proc. II 620-621.**

An industry proposal presented in 1988 provided some cost containment measures for instances when practices such as preadmission certification or second surgical opinion were part of the primary plan. The committee decided to review the proposal and determine whether it would apply to preferred provider organizations and health maintenance organizations. **1988 Proc. II 640.**

The industry said it had developed programs to control utilization while assuring that good medical care remains available. One of these areas was network provider programs. If the individual chose to go outside the network, a lower benefit was paid. The industry urged that coordination of benefits be allowed to accommodate the benefit differentials built into the programs as incentives. If the financial incentives were eliminated by the continued presence of a secondary carrier, the checks and balances of these cost containment programs rapidly disappeared. **1988 Proc. II 645-646.**

In December of 1988, the NAIC voted to adopt amendments providing that the secondary carrier was not responsible for the differential when benefits were reduced because the covered person did not comply with the cost containment measures of the primary plan. The amendment included differentials related to preferred provider organizations, but specifically excluded instances where an HMO member chose to have health care services provided by a non-HMO provider. **1989 Proc. I 840-841.**

In 1994 a committee was formed to look at revisions to the COB model. After reviewing a list of questions, the working group agreed on the answer to one question immediately. The question related to the practice of some physicians to bill the secondary carrier for an amount that had been negotiated as a discount with the primary carrier. The group agreed that clearly the provider should not bill the secondary carrier for the amount that had been discounted. Neither the covered person nor the secondary carrier was liable. This agreement was later summarized in a drafting note to Subsection A. **1994 Proc. 2nd Quarter 593.**

An interested party suggested an earlier version of the definition of allowable expense was not well written. At that time drafters had tried to use the private hospital room as an example of an item of expense that might not be allowed under either plan. He said it had been phrased in such a way that people got the impression it was the only exception so he suggested redrafting the definition of allowable expense to clarify the issue. **1994 Proc. 3rd Quarter 588.**

In 2002, a working group was charged to review the model. The chair began by asking for comments on issues that should be considered for revision. The NAIC staff support for the group said that she had received a number of questions regarding the model with respect to certain definitions, particularly the definition of "allowable expense." **2002 Proc. 2nd Quarter 202.**

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Section 3A (cont.)

One issue raised by interested parties concerned the situation where a provider had contracts with both the primary and secondary plans and the secondary plan has negotiated fees that applied regardless of whether it paid as primary or secondary. To address this situation, interested parties suggested revising the definition of “allowable expense” in Section 3A(5)(d) to permit the provider’s negotiated fee with a plan to be the allowable expense for the secondary plan regardless of the payment arrangement of the primary plan. A regulator expressed reservation about determining allowable expense solely by what was in the provider contract. The COB model should ensure that a claimant’s out-of-pocket expenses were covered. **2002 Proc. 3rd Quarter 218-219.**

Another regulator noted that this suggested revision raised two different issues. The first was to ensure that the secondary plan covered the claimant’s out-of-pocket expense. The second issue was whether the COB model should dictate what the allowable expense was, as currently in the COB model, or leave it up to provider and the plan through their contracting. A regulator from another state explained the approach his state had taken to address this problem in its recently adopted COB rule. The primary plan was responsible for paying the claim without regard to any other plan. The secondary plan was responsible for payment up to the limits it normally would have paid if it had been the primary plan, including any deductible, coinsurance or co-payment for which the covered person was liable. The fundamental rule was that the covered person should be made whole. **2002 Proc. 3rd Quarter 219.**

The working group discussed comments received on the definition of “allowable expense”; specifically, a provision that stated that, when a claimant was covered by one plan that calculated its benefits or services on the basis of usual and customary fees and another plan that provided its benefits and services on the basis of negotiated fees, the primary plan’s payment arrangement would be the allowable expense for all plans. The drafting note provided that if a provider has contracts with both the primary and secondary plan, the provider could bill the higher of the two rates, if permitted by the provider’s contract. The chair questioned whether the COB model should specify what the secondary plan must pay. On one hand, the secondary plan could save money if its payment was higher than that of the primary plan, but it could hurt small carriers that were trying to build a provider network.

The group decided to include in the text of Paragraph (5)(d) language from the drafting note stating that the provider’s contract with the carrier would control what would be considered the allowable expense regardless of whatever the primary plan’s payment arrangement. A carrier’s own negotiated fee should override any other payment arrangement. **2003 Proc. 2nd Quarter 290-291.**

Late in the drafting process, the task force heard from one regulator who suggested deleting the concept of “allowable expense” and replacing it with his “out-of-pocket” alternative proposal. This proposal would use a newly defined term “covered expense.” The secondary plan would pay whatever the covered person would have to pay out-of-pocket, unless there was an exception, such as a private hospital room. The secondary plan would pay the lesser of what it would have paid if it had been the primary plan or the amount the primary plan has told the covered person he or she owed (balance billed amount). The provisions in the COB model concerning allowable expense did not take into account what the provider actually billed. What the provider billed could be more than the “allowable expense.” In his opinion, if the covered person has enough insurance to pay more than the allowable expense, then that should be paid. The covered person should not have to pay that difference.

However, he noted that the provider could inflate his or her price. The problem was determining what was the “street price” or usual and customary reimbursement for the specific service provided in order to preclude provider fee inflation. **2004 Proc. 3rd Quarter 687.**

Near the end of the drafting process, Paragraph (2) was added to address the possible conflict of the COB model with a provision in the recently enacted Medicare Prescription Drug, Improvement and Modernization Act of 2003 that permitted individuals to establish health savings accounts in connection with high-deductible health plans. A conflict could arise because of provisions in the COB model that permitted coordinating plans to pay all of a covered person’s allowable expenses, including deductibles. An interested party suggested that the model be revised to state that all deductibles incurred

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by a person covered by a primary high deductible health plan shall not be considered an allowable expense. Another interested party suggested requiring the covered person to advise the plan if all plans covering the person were high deductible plans and state that the person intended to contribute to a health savings account. **2004 Proc. 4th Quarter 737.**

B. A definition of “birthday” was added for clarity because some questioned whether “birthday” included not only the month and day in a calendar year, but also the year in which the individual was born. **2002 Proc. 3rd Quarter 219.**

D. A definition of “closed panel plan” was drafted in 1994. One of the questions the drafters were trying to address was how to coordinate benefits between two managed care plans requiring different actions before reimbursement could be made. As new arrangements were created for delivery of health care, some interested parties suggested a new comprehensive term, “closed panel plan,” be used rather than health maintenance organization, preferred provider organization, etc. **1994 Proc. 3rd Quarter 588.**

The chair suggested that the reference to preferred provider organizations be deleted because PPOs were not closed panel plans. Another regulator suggested deleting all references to specific plans such as HMOs and exclusive provider organizations (EPOs), noting that HMOs were no longer exclusively closed panel plans. After discussion, the task force agreed to this suggestion. **2004 Proc. 3rd Quarter 687.**

E. The definition was added during the revisions adopted in March 2005. **2004 Proc. 4th Quarter 742.**

G. A definition of custodial parent was added in 1995 to address some concerns voiced that it was not always clear who was the custodial parent. **1995 Proc. 3rd Quarter 705.**

H. During the revisions begun in 2002, a definition for “group-type contract” was added to Section 3. Staff alerted the working group to the fact that it may need to re-examine this definition because language in the definition could conflict with provisions in the NAIC Small Employer Health Insurance Availability Model Act. Provisions in that model outlined conditions when a policy will be considered a small group policy even when the policy was marketed or otherwise treated as an individual policy. **2002 Proc. 3rd Quarter 219.**

I. This definition was added during the redraft completed in March 2005. **2004 Proc. 4th Quarter 742.**

K. The drafting committee appointed to create the original model guidelines recommended that individual or family policies not be included in the definition of plan because of the difficulties that arose in making prompt discovery and identification of such plans. **1970 Proc. II 1204.**

When drafting amendments in 1994, the working group requested input on the issue of coordination of benefits with individual policies. Interested parties recommended inclusion of individual policies. The chair asked why the NAIC had been reluctant to include individual policies in the past. One reason was that at that time lower amounts of coverage were available; group plans often provided only basic coverage, rather than the comprehensive coverage common later. Individual company writers had been against coordination, so at that time there had been a conflict within the insurance industry as to the appropriate position to take. A regulator asked if that conflict still existed, and the response was affirmative. **1994 Proc. 3rd Quarter 588.**

At a later working group meeting, several members stated their reservations about including individual policies within the COB model. An insurer representative said coordination of benefits rules had been developed to eliminate over-insurance so that people would not profit from an illness. He said most insurers were of the opinion that any duplication that encouraged abuse should be eliminated. A regulator said he was not in favor of coordination because an individual purchased coverage because he anticipated getting value for his premiums; he did not think the group policy should have an opportunity to reduce its payment because of that decision. **1994 Proc. 4th Quarter 696.**

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Section 3K (cont.)

Another insurer representative said most of the time coordination with individual policies was not an issue because premiums for individual coverage were so high there was not often duplication. **1994 Proc. 4th Quarter 696.**

Most of the members of the working group said they felt strongly that individual policies should not be coordinated with group policies. An interested party said he thought there was a strong public interest in including individuals and pointed out that 10–12 states did include individual policies in coordination rules, and he said that was the trend. Another interested party provided a paper for working group consideration. **1994 Proc. 4th Quarter 681.**

The interested party said the original NAIC model did not include individual policies because of opposition by large individual writers, although the only reason given in the industry report was that individual policies were difficult to discover, and that the attempt to do so could result in delays and complaints. The report indicated there was still a strong consensus that coordination ought not be allowed against a reasonable amount of truly supplemental coverage, which some policyholders choose to maintain. However with respect to major medical coverage, there had been a large shift in opinion. Full coordination was now thought by many to be appropriate. **1994 Proc. 4th Quarter 695-696.**

The working group voted not to include individual coverage within the model, but to insert a drafting note suggesting that states that wanted to include individual coverage could consider doing so. An interested party expressed concern that, if a state tried to add provisions for individual policies, all of the necessary changes might not be made. The chair of the working group noted that a draft of the model with all those changes had been included in the December 1994 *Proceedings*. **1995 Proc. 1st Quarter 511-512.**

When a working group was appointed in 2002 to consider revisions to the model, an interested party expressed a desire that the model be revised to coordinate with individual policies. He suggested that this could be achieved by permitting coordination only with individual policies that contained a coordination of benefits provision or limiting coordination with individual major medical policies. He stated that such a revision would also help to resolve the problem with self-insured ERISA plans where these plans were always declaring themselves secondary and not voluntarily following the order of determination rules established in the model. The chair noted that the issue of group-to-individual policy coordination had been debated during a previous revision of the model. One regulator said that his state had enacted legislation revising its coordination of benefits law to permit group-to-individual policy coordination by providing that the individual policy was always secondary. By doing this, the individual policy truly acted like a supplemental policy. This revision also resolved the problem his state had experienced with self-insured ERISA plans. **2002 Proc. 2nd Quarter 202.**

At another meeting, the issue of group to individual coordination was again raised. A regulator asked if the climate had changed since the model was last revised. A representative from an insurer said that, in his opinion, nothing had changed. His company discouraged individuals from retaining their individual policies after they obtained group coverage by using the variable deductible method to determine which policy was primary. In addition, if a person had a group policy and applied to his company for an individual policy, the company would not write the policy. A regulator responded that he would prefer to reject the variable deductible method as a way to determine which policy was primary. His preference would be to have the individual policy always primary. Another regulator expressed support for including coordination for individual to group, as long as the revisions expressly stated which was primary. He opined that such a move might bolster the individual market. **2002 Proc. 4th Quarter 283.**

Early in 2003, a regulator expressed concern about the working group's decision to permit individual-to-group coordination. He stated that when the COB model was being revised in 1995 the group working on the revisions decided not to permit this. He questioned the reasoning that led this working group to now want to permit this type of coordination. NAIC staff who had worked with the 1995 drafting group confirmed that the 1995 group had had extensive discussions on whether to permit individual-to-group coordination. That working group decided ultimately not to permit such coordination based on the reasons why consumers maintained their individual coverage even when they obtained group coverage. Consumers maintained individual coverage to ensure that they have health insurance coverage when they lost the job that provided the group coverage. Because they have paid the premium for this coverage, the group working on the revisions to the COB model

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in 1995 felt that they should reap the benefit. The chair expressed an understanding for why the group working on the 1995 revisions decided not to permit individual-to-group coordination, but he also questioned whether a consumer should be able to profit from filing claims under both the individual policy and the group policy, which could happen if there was no individual-to-group coordination. The chair also noted that, although the working group has preliminarily agreed to permit individual-to-group coordination, it had not decided which coverage would be primary and which would be secondary. After discussion, the working group decided to allow for additional discussion on the issue of group-to-individual coordination when it began discussion of language that would specify which policy should be primary and which policy should be secondary. **2003 Proc. 1st Quarter 197.**

At its next meeting, the working group again discussed individual-to-group coordination and which plan should be primary. One regulator noted that the individual paid the premium for the individual plan, whereas the employer paid most of the premium for a group plan. This was seen as a good reason to make the individual plan primary. Another regulator supported that logic, but expressed interest in knowing the effect of such a decision on the amount of premium charged. An interested party from a company selling individual coverage expressed support for making the individual plan secondary. He stated that individuals who chose to retain an individual plan despite having group coverage should not be rewarded for their anti-selective behavior. Another interested party urged the working group to consider treating an individual plan the same as a group plan. The same rules in the COB model would apply regardless of whether the plan was group or individual.

A regulator expressed concern with that approach because it would require a statutory change. She expressed some support for making the individual plan always secondary to give the fragile individual market some relief. The chair suggested that one strategy to obtain legislative approval of the suggested approach would be to assert the argument that the statutory change would prevent individuals from being enriched by receiving double payment for the same health care service expense. One regulator questioned how widespread the double payment problem was to justify revising the COB model to address it. **2003 Proc. 2nd Quarter 289-290.**

A consumer advocate stated that her experience had been that those who retained individual coverage even after obtaining group coverage did so because of the uncertainty of maintaining employment with an employer that offered group coverage. For the most part, these individuals did not file claims with the individual plan. She added that, if the working group decided to revise the model to permit individual-to-group coordination, such a revision could create additional coordination of benefit problems. An interested party acknowledged that the double payment problem was not widespread because few individuals retained their individual coverage after obtaining group coverage. He asserted that the working group should revise the COB model to permit individual-to-group coordination regardless of how widespread the double payment problem was as a means to control costs. Even though very few individuals obtained double payments, when they did, it cost carriers money. **2003 Proc. 2nd Quarter 290.**

At its next meeting, the working group again discussed individual-to-group coordination and whether the COB model should specify which plan was primary. A regulator suggested that the appropriate approach would be not to specify which plan was primary. Instead, the same rules outlined in the COB model would apply regardless of whether a plan was group or individual. Sometimes the individual plan would be primary and sometimes it would be secondary depending on which rule applied. After discussion, the working group agreed not to specify in the COB model which plan was primary. **2003 Proc. 3rd Quarter 272-273.**

Coordination has always been permitted with “group-type” contracts, which were defined as those not available to the general public and which could be obtained and maintained only because of membership in, or connection with, a group or organization. The sole fact that premiums were paid through payroll deduction did not make an individual policy into a group-type policy. **1985 Proc. I 617.**

In the model originally adopted, the definition of “plan” included hospital indemnity plans that exceeded \$30 a day. The plans provided a convenient means of protecting the insured against uninsured incidents of his illness, but that rationale should not be given unlimited impact, for to do so would conflict with the basic purpose of COB. **1971 Proc. I 233.**

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It appeared that there was some dollar limit below which the administration of COB was inefficient. That limit was set at \$30 per day in 1970, and that was changed in June 1985 to \$100 per day. The intent of the NAIC was not to open up a new exemption from COB, but rather to modernize the definition of what a “small” hospital indemnity plan was. **1986 Proc. I 677.**

An insurer representative suggested that indemnity policies for any amount should be added to the list of exclusions from “plan.” Another insurer pointed out that the hospital indemnity policy was not intended to pay hospital medical costs, and he did not think it was fair to coordinate with medical insurance to reduce hospital costs. Just because it was measured by the same event did not make it the same type of coverage, he opined. **1994 Proc. 4th Quarter 697.**

When the working group decided to exclude individual policies, it still retained the \$200 per day exclusion for hospital indemnity policies that had been added to the draft when the group was considering the inclusion of individual coverage. **1995 Proc. 3rd Quarter 706.**

When amendments were being discussed in 2003, the definition of plan was revised to specifically delineate the types of supplemental coverages that would not be considered a plan for the purpose of coordinating benefits under the COB model. An interested party requested that the working group remove hospital indemnity coverage or other fixed indemnity coverage from being defined as a plan regardless of the amount of benefits paid. After discussion, the working group agreed. **2003 Proc. 2nd Quarter 288.**

The inclusion of medical benefits provided in automobile insurance plans was supported by the major casualty insurance associations. It could be assumed that these health benefits would sometimes be substantial, making inclusion in the definition of “plan” important from the standpoint of cost and over-utilization. **1971 Proc. I 233.**

Amendments adopted in 1985 made coordination possible with the medical expense benefits coverage of all automobile contracts, even those written on an individual basis. There was no logical basis for the earlier rule, which allowed coordination with no-fault policies, but not with traditional fault policies unless they were written on a group basis. **1985 Proc. II 619.**

The working group discussed whether or not to continue the coordination with automobile medical coverage. An interested party said the provision had originally been added to the model at the suggestion of the auto insurance carriers. **1994 Proc. 4th Quarter 697.**

When discussing amendments in 2003, one regulator explained his concerns regarding the treatment of medical benefits coverage in group, group-type and individual automobile “no fault” and traditional automobile “fault” type contracts (Medpay). For a myriad of reasons, he recommended that medical benefits coverage in an automobile contract should not be considered a “plan,” under Section 3K(3). A consumer should be allowed to apply and coordinate Medpay and health care coverages that would best suit his or her needs. Medpay payments would then be available for the insured’s funeral and uncovered health care expenses. **2003 Proc. 2nd Quarter 290.**

An interested party said that no-fault auto policies make Medpay primary to any other health insurance coverage. Another interested party stated that the typical consumer did not know what options he might have with respect to coordinating Medpay coverage and health insurance coverage. In his experience, health care providers requested reimbursement from the Medpay coverage before any health insurance coverage because of the higher reimbursement. The consumer did not even know that this was occurring. Another interested party urged the working group to keep in mind why Medpay was primary to any health insurance coverage an individual might have. Medpay was primary because a health care provider in an emergency room setting did not have to determine whether the patient had health insurance coverage and, if there was health insurance coverage, whether that coverage provided benefits for the health care services being provided. Another not. As

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such, Medpay benefits should not be exhausted in reimbursing for health care services when these benefits were needed to pay for non-medical costs. A consumer advocate urged the working group to leave the definition of “plan” unchanged because Medpay provided some form of health care coverage for individuals who did not have health insurance. An interested party said that this method of coordination had been functioning effectively. Where it did not, states made their own individual decisions and altered the language. **2003 Proc. 3rd Quarter 272.**

The working group solicited comments from the property/casualty insurance industry. Their representatives spoke in support of retaining the Medpay provision in the COB model without change for the following major reasons: (1) Medpay provided first dollar coverage with a single source to look to for compensation, which would not occur if health insurer was the primary plan; (2) administrative costs would rise substantially if the health insurer was made primary and claims payments were delayed because of the need to investigate claims and verify health insurance coverage; and (3) if Medpay were not primary, there would be problems in determining the appropriate rates and premiums to charge for automobile insurance. In addition, the representatives questioned the need to change the COB model because the provisions have worked without any problems for years. A representative from a health insurance trade association expressed support for the comments made by the property and casualty insurer association representatives with respect to retaining the Medpay provision in the COB model without change. **2003 Proc. 4th Quarter 531-532.**

A regulator requested additional information from the property and casualty association representatives regarding their concern with increased administrative costs if Medpay was deleted from the definition of plan. One of the insurance industry representatives responded that, under the current COB model, with Medpay being primary, the automobile insurer paid on the claim immediately without having to verify the obligations of the health insurer or having to assess the medical necessity and reasonableness of the services provided. He also noted that, instead of prompt payment for losses, automobile accident victims would have their claims payments delayed because of duplicate investigations and verifications of coverage. Eliminating the primacy of automobile coverage would generate two sets of claims and result in extra administrative costs to coordinate the two systems for determining payment. A commissioner questioned whether there had been cases where the health insurer applied its deductible after the auto insurer paid. If this happened, the consumer would not get all of the benefits that he or she was entitled to receive.

The chair stated that, as currently written, the COB model did allow for the problem cited by the commissioner to occur and that it also occurred when only health insurers were involved. He said that was one issue—what amount the secondary plan should pay on a claim—the working group was looking at and hoped to resolve as part of the revisions to the COB model. The working group decided to leave the Medpay provision in the COB model unchanged. **2003 Proc. 4th Quarter 532.**

The model defined “plan” to include coverage provided through HMOs, although the drafters did identify several problems particular to coordination of benefits with and by an HMO. They identified three major problem areas: (1) HMOs did not fully understand how COB worked. Many traditional group plans also did not understand how HMOs and traditional plans could and should interrelate in a COB setting. (2) In some jurisdictions, HMOs were not subject to regulation by the insurance department. As a result, they were lawfully free to make up their own COB rules. (3) Self-referral was seen as a problem when a member of an HMO, who was also covered by a traditional plan that would be secondary, elected treatment outside the HMO. The apparent effect of that action would be a shift in responsibility from the primary plan (the HMO) to the secondary plan (the traditional plan). **1985 Proc. I 615.**

In discussing the application of COB to HMOs, the drafters pointed out that some HMOs did not fully appreciate the importance of uniformity of application of COB by all parties. On the other hand, some traditional plans did not fully understand that when they were primary, they should pay benefits to the HMO, which was the provider of services or supplies, just as they would pay benefits to any other provider. Also, some traditional plans did not fully understand that when they were secondary, they almost always had no liability, and they rarely knew how much they saved because there

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Section 3K (cont.)

rarely was a claim. Interested parties stated that it was important that HMOs understand how COB worked when the HMO was the secondary plan. One very important feature, not always understood, was that a secondary plan may have to pay for benefits it did not usually cover if the expense was an allowable expense that was covered, at least in part, by the other plan. Paying for an expense specifically excluded by the plan was the price paid to achieve the savings through COB. **1985 Proc. I 618-619.**

In order to expedite coordination with HMOs, the Health Maintenance Organization Model Act was amended to provide that, if HMOs wished to include a coordination of benefits provision, it should be consistent with the provisions in general use in the state by insurers. **1989 Proc. II 40-41, 79.**

The model, as originally adopted, did not include school accident coverage at the grammar and high school level in the definition of plan. The reason for this was because this type of coverage was generally purchased by the parent as a supplement to the parent's group coverage. **1971 Proc. I 233.**

In 1985, the exception for school accident-type policies was expanded to include similar plans covering college students and students in schools above high school level. The drafters recommended coordination with all accident policies initially, **1985 Proc. I 617**, but, as adopted, the regulation prohibited coordination with any of the plans paid for by parents that covered students against accidental injuries. **1985 Proc. II 620.**

A regulator suggested including an exclusion from the definition of plan for long term care insurance. The working group agreed to apply the exclusion only to expenses beyond medical expenses. **1994 Proc. 4th Quarter 697.**

The working group reviewed a report from the Health Care Financing Administration (HCFA) and made technical changes in response to it. In addition, the concerns of HCFA were addressed by noting in appropriate places that the COB rules did not apply where federal law provided otherwise. **1995 Proc. 3rd Quarter 696.**

One regulator asked the purpose of Paragraph (4)(i). An association representative said that, when a governmental plan said that it was secondary, coordination of benefit rules cannot be used to try and make a governmental plan primary. The language was generic, without reference to specific government plans, so that the model would not need to be changed as federal law changed. **1994 Proc. 4th Quarter 697.**

Early in the drafting of amendments that began in 2002, the working group spent a considerable amount of time discussing whether the model should permit coordination with supplemental plans. For many years the model had included a list of specified types of coverage that were not included in the definition of "plan." Interested parties suggested that the subsection should clearly state that the definition of plan did not include coverages such as accident-only, specified disease, hospital indemnity or other coverage designed to pay the insured a fixed daily indemnity amount without regard to expenses incurred or other coverage in force. **2002 Proc. 4th Quarter 282.**

A regulator spoke in support of the recommendation. He stated that coordination should be with respect to major medical policies, not supplemental plans. Supplemental coverage was designed to pay in addition to what any other coverage an insured might have had in force. He opined that requiring coordination would prevent the insured from getting his or her money's worth from that supplemental policy. Another regulator asked if there was some threshold that could be included in the model that, if the supplemental coverage satisfied, would permit the supplemental coverage to be coordinated with a major medical policy. **2002 Proc. 4th Quarter 282.**

An interested party pointed out that the model already had been prohibiting coordination with supplemental policies because most of those policies were sold on an individual basis. If the working group decided to permit individual to group coordination, the language would maintain that exception. **2002 Proc. 4th Quarter 282.**

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Section 3K (cont.)

Early in 2003, the working group discussed a proposal to Section 3K(4) by stating that the term “plan” did not include the following coverages that pay benefits regardless of other coverage in force: (1) accident-only coverage; (2) specified disease or specified accident coverage; (3) hospital indemnity or other fixed indemnity coverage; and (4) limited benefit plans. The chair expressed tentative support for the amendment, but was concerned that the listed coverages were not sufficiently comprehensive. The interested party that made the proposal stated that the list was compiled based on what was typically considered health insurance. Disability income insurance, for example, was not included. After discussion, the working group agreed, conceptually, to include the amendment, but directed NAIC staff to review the NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act to determine whether additional coverages should be added and to determine whether it would be appropriate to define some of the terms used in the proposed amendment. **2003 Proc. 1st Quarter 197.**

L. An industry trade association suggested that a definition of “policyholder” be added because the model would now apply to individual plans. As suggested, “policyholder” would be defined as the primary insured named in a non-group insurance policy. The drafting group decided to add the definition of “policyholder” and to be sure that, when the term was used substantively in the COB model, it was used appropriately. **2004 Proc. 2nd Quarter 468.**

N. An interested party suggested that most of the language in the existing model did not belong in a definition and more appropriately belonged in a substantive section of the COB model, such as Section 7. Without objection, the working group adopted the suggestion. **2003 Proc. 4th Quarter 530.**

Section 4. Applicability and Scope

The drafting group listened to comments as to whether to add language to the new Section 4 or whether to include information in Section 10 to clarify the date when the provisions of the COB model and any amendments would be applicable to existing plans. The task force decided to include language in Section 10. **2004 Proc. 2nd Quarter 468.**

Section 5. Use of Model COB Contract Provision

B. Subsection B was added to explain the new appendix added in 1995. **1995 Proc. 3rd Quarter 707.**

D. The language was adopted specifically for the purpose of prohibiting coordination with a “phantom plan”; that is, a plan under which a person was not covered, but for which he or she was eligible. **1984 Proc. II 619.**

The committee report said coordination against a phantom plan would be difficult to administer, and would lead to unfortunate results as people inadvertently fell prey to its provisions. **1984 Proc. II 623.**

The drafters called “always secondary” plans irresponsible and intolerable. Such an approach could never lawfully modify the provision of a plan that would be secondary following the standard order of benefit determination rules. As a result, people covered by two plans, one of which is always secondary, might find themselves with neither plan primary. **1984 Proc. II 623.**

F. Drafters revising the model in 1994 struggled with the issue of coordination of benefits between two HMOs. Interested parties suggested that no coordination of benefits take place between two closed panel plans. When the NAIC model was adopted, the only closed panel plans were HMOs, but now a much larger variety existed. Regulators were initially concerned about this suggestion, but were assured that it did not happen too often. When both spouses were covered, one was more likely to choose a closed panel plan and the other an indemnity plan. The situation would only arise if both employers offered only a closed panel plan option. **1994 Proc. 3rd Quarter 588.**

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Section 5 (cont.)

G. The working group drafting amendments in 2003 discussed a proposed amendment to Section 5 that would add a new Subsection G prohibiting a plan from using a COB provision, or any other provision that allowed it to reduce its benefits, with respect to any other coverage its insured had that does not meet the definition of “plan” in Section 3K(3). The interested party that made the proposal explained that this amendment was being offered in the context of the working group decision to permit group-to-individual coordination. The proposed amendment merely ensured that the status quo was maintained with respect to supplemental coverages in light of the working group’s decision to permit coordination with individual policies. After discussion, the working group agreed to accept the proposed amendment. **2003 Proc. 1st Quarter 197.**

Section 6. Rules for Coordination of Benefits

When the NAIC first considered uniform rules on coordination of benefits, it heard a report from one industry group that defined the rules in general usage at that time: (1) the benefits of a program that covered a person other than as a dependent shall be determined before benefits of a program that covered a person as a dependent; (2) the benefits of a program covering the dependent of a male person were determined before the benefits of a program that covered the person as a dependent of a female person; (3) if neither (1) or (2) established an order of benefit determination, the benefits of a program that covered the person on whose expenses the claim was based for the longer period shall be determined before the benefits of a program which covered the person the shorter period of time. **1970 Proc. I 376-377.**

The most difficult problem facing the drafters was the choice between proration and order of benefit determination as the method for handling the determination of benefits among carriers each of which has an anti-duplication provision. As far as the claimants were concerned, the aggregate amount of benefits produced by either method was essentially the same since the provision called for reimbursement up to 100% of allowable expense. As far as claims personnel were concerned, with adequate training either method could be used. However, more companies used the order of benefit determination at that time, so a greater number had been trained in those principles. The deciding factor was public understanding. The average person has difficulty in calculating a mathematical ratio and hence difficulty in understanding how the amount of his reduced benefit has been figured. The person could, however, generally understand the order of benefit determination system under which one carrier paid him its full benefit and the other generally paid him the difference between this benefit and his total allowable expense. **1970 Proc. II 1219-1220.**

A study of employee dissatisfaction revealed a principle cause of dissatisfaction with provisions already in use was the fact that the carriers preserved their deductible and coinsurance amounts in applying the anti-duplication provisions. This left the employee with out-of-pocket expenses. The employees felt that since two premiums were paid, they should get two benefits, or at least should get the total medical expenses paid. **1970 Proc. II 1219.**

In June 1985, after adoption of the revised easy-to-read version, interested parties were asked to consider a proposal for a new approach. The present system was sequential, that is, one plan paid first, and the other plan provided its benefits second. The proposal was for a proration plan under which each plan paid an equal share of the total allowable expenses. This was rejected because it would be costly and disruptive and would have no advantage to the claimant. It also created problems with a divorced parent who did not know where the other parent was, and disrupted coordination with HMOs. **1986 Proc. I 675-677.**

In changing the COB rules that determined the order of benefits, it was essential that certain principles be followed. First, the rule must be simple to administer. Everyone involved—employers, claimants and health care providers, as well as insurers—must be able to instantly know whose plan paid first. Second, the rule must be free from manipulation. It must turn on a factor similar to sex in that it must be difficult to disguise. Third, whenever the order of benefit determination rules changed, there must be an orderly and foolproof way to resolve a conflict when a plan following the new rule coordinated with a plan following the old rule. Such conflicts were inevitable over a fairly long period of time, and the rule must prevent double-primary or double-secondary results in all cases. Fourth, there must be adequate time to allow insurers to revise their claim forms and electronic claim payment systems to utilize the new rule. **1984 Proc. II 621.**

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Section 6 (cont.)

In 2002 a working group was assigned to revise the model. Early in 2003, the group heard a suggestion to specify how the model regulation would apply to multiple contracts providing coordinated coverage. The group agreed to include language suggested by one regulator. **2003 Proc. 1st Quarter 195.**

B. An interested party suggested that the phrase “coordination of benefits provision” in Subsection B(1) be deleted and replaced with the phrase “order of benefit determination.” This paragraph stated that a plan that did not contain a coordination of benefits provision that was consistent with this regulation was always primary. The chair explained that, if the working group accepted the proposed amendment, instead of requiring a plan to be in compliance with the entire COB model to avoid always being primary, a plan would be required to have provisions consistent with the order of benefit determination rules in Section 6 to avoid always being primary. **2003 Proc. 1st Quarter 195.**

A regulator suggested that there was a conflict between the provisions of Section 9B concerning the treatment of non-complying plans and Section 6B(1) concerning the treatment of plans that had order of benefit determinations that were inconsistent with the COB model. Section 6B(1) stated that a plan that did not contain order of benefit determination provisions consistent with the COB model was always primary. After discussion the task force decided to add language that would permit a plan that contained order of benefit determination provisions that were inconsistent with the COB model to be the secondary plan if the provisions of both plans stated that the complying plan was primary. **2004 Proc. 4th Quarter 737-738.**

D. A phrase was added to clarify that, when making the order of benefit determination, an insurer should use the first rule that applied. This phrase had been in Appendix A but was not included in the actual regulation. **1990 Proc. II 678.**

The Department of Health and Human Services communicated a desire to explore whether the COB guidelines might be an appropriate vehicle for effectuating some of the purposes of federal legislation that made Medicare secondary to coverage available to working aged. The Department of Labor was to promulgate regulations to prevent circumventing the law by offering employees inducements to reject coverage. **1985 Proc. I 633-634.**

After the rule on retiree coverage was adopted, the Medicare rules changed to make a working spouse’s coverage primary to Medicare. It became unclear at that point how to coordinate between a working spouse’s plan, a retiree’s plan and Medicare. Amendments adopted in 1990 clarified the order of benefit determination in this case. **1990 Proc. II 681.**

Because of concerns expressed by the Health Care Financing Administration, a technical amendment was made to the amendments adopted in June 1990. It only clarified the conditions that were necessary where Medicare was involved and contained no substantive revision. **1991 Proc. IB 655-656.**

In 2002, a working group was appointed to revise the coordination of benefits model. When reviewing comments on the first draft, one association suggested a revision for Section 6D(1), which set out the order of benefit determination between the plan that covered the claimant as an employee, member, subscriber, or retiree and the plan that covered the claimant as a dependent. This provision also included language outlining the order of benefit determination if the claimant was a Medicare beneficiary. The association suggested deleting all of the language in Section 6D(1) that referred to how plans would coordinate with Medicare and other governmental programs. In its place, they suggested adding language that would state that, if the claimant was a Medicare beneficiary, the order of benefit determination would be determined under federal law or regulation. A spokesperson for the association stated that she was recommending this approach so that the COB model would not have to be amended each time there was a change in the Medicare law or regulation that affected the order of benefit determination. The chair expressed concern about simply deleting the language about Medicare coordination because then the COB model would not provide any guidance to the states as to what the coordination would be in these situations. **2002 Proc. 3rd Quarter 218.**

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Section 6D (cont.)

At a later meeting, this proposal was discussed again. The chair noted that some comments had been received that suggested that the language be retained to avoid the “vicious circle” problem that this language was added to resolve at the time the COB model was last revised. The “vicious circle” problem occurred when a person was covered by: (1) Medicare; (2) an employer-sponsored retiree plan; and (c) a plan as a dependent of a spouse who is an active employee. In this situation, each plan was secondary to the others in a “vicious circle.” The language in Subsection D(1) was designed to break the “vicious circle” by making the plan covering the person as a dependent primary instead of the plan covering the person as a retiree. An interested party spoke in favor of retaining the language because federal law had not been revised to incorporate the vicious circle exception. A representative from the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)), agreed to discuss this issue with her colleagues at CMS, who were familiar with the Medicare secondary payer rules, to determine whether this language was accurate. **2003 Proc. 1st Quarter 195-196.**

The next draft included a drafting note accompanying Subsection D(1)(b). The drafting note explained the “vicious circle” problem and how the language in Subsection D(1)(b) addressed the problem. The working group also decided to add examples to further clarify Subsection D(1)(b). **2003 Proc. 2nd Quarter 288.**

The Centers for Medicare and Medicaid Services (CMS) submitted a comment suggesting that the drafting note to this provision be revised because it did not account for an individual who was a Medicare beneficiary due to end-stage renal disease. Staff suggested solving the problem by adding language to the drafting note indicating that the drafting note was not meant to address all Medicare secondary payer rules. The working group agreed to add that language. **2003 Proc. 4th Quarter 530.**

When this model was originally adopted, the order of benefit determination provided that the benefits of a plan that covered a person as a dependent of a male person should be determined before the benefits of a plan which covered a person as a dependent of a female person. **1971 Proc. I 234.** As early as 1979, commissioners began questioning whether the COB guidelines as they existed were sex biased in a manner no longer appropriate. A task force was established to examine the issue. **1979 Proc. II 333.**

In 1984, the NAIC adopted a change in the rule to determine the order of benefits when a claim for a dependent child was involved. Under the new “birthday rule,” the plan covering the parent whose birthday fell earlier in the year paid first, and the plan covering the parent whose birthday fell later in the year paid second. The rule solved any problems of sex discrimination that might arise under the male/female rule. The drafters also recommended a workable rule to deal with the situation where a plan that had placed the birthday rule in effect attempted to coordinate with a male/female plan. Otherwise, both plans could be secondary. The only workable, constitutional and practical solution would be to follow the male/female rule in those cases. **1984 Proc. II 617-618.**

When the task force considered how to avoid concern over questions of sex discrimination, they considered numerous plans. One state tried making the primary plan the policy in effect the longest, but this was found difficult to administer. Other suggestions were: Social Security numbers of the parents; father’s plan primary for daughters, mother’s plan primary for sons; father’s plan primary for children born in even months; mother’s plan primary for children born in odd months; employers self-insuring were excess to everything. One member of the task force questioned why state regulation was necessary, and asked why the industry couldn’t determine the benefit order without state regulation. An industry response was that the companies would be subject to antitrust violations if they developed COB rules without NAIC approval. **1984 Proc. II 647.**

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Section 6D (cont.)

An amendment to establish the order of benefit determination in the case of divorced parents was added in 1980. The rule provided that, if the parent with custody of the child has not remarried, the benefits of the plan of the parent with custody would be determined before the benefits of a plan that covered the child as a dependent of the parent without custody. If the parent with custody had remarried, the benefits of a plan that covered the child as a dependent of the parent with custody shall be determined before the benefits of a plan that covered the child as a dependent of the step-parent, and then the benefits of a plan that covered that child as a dependent of the parent without custody. The amendment also included a special provision for situations where a court decree established financial responsibility for a child's health care expenses. **1980 Proc. II 592-593.**

The provision regarding divorce decrees originally caused some unfortunate problems. In some cases, claim payments were delayed while carriers examined divorce decrees or argued about interpretation of ambiguous decrees. Insurance departments were often drawn into the disputes and put into the position of being asked to interpret unclear divorce decrees. A new paragraph was added to clarify the intent of the 1980 provisions, which stated that the plan of the parent with financial responsibility was primary when the decree has specific terms that the parent was responsible for the child's health care expenses, and the carrier has actual knowledge of that fact. Once benefits were paid by any carrier without actual knowledge of such a decree, the existence of the decree was no longer relevant to determine the order of benefits for that claim determination period. **1985 Proc. I 617.**

When amendments were being discussed in 1994, the chair questioned whether any of the model provisions were in violation of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). An interested party responded that there were few situations where there was coordination between two insured plans and Medicaid. He said the only part of OBRA '93 rules where there was even a potential for conflict was in the provision about the court decrees. **1994 Proc. 4th Quarter 698.**

By the mid-1980s, courts were more often awarding joint custody to divorced parents without specifying that either was responsible for medical care costs. In December of 1988, an amendment was adopted to use the birthday rule in this circumstance to determine which parent's coverage is primary. **1989 Proc. I 839.**

The provisions regarding dependent children were completely rewritten in 1995 to make them clearer and to address the order of benefit determination for family units that were not or had never been married. The requirements applicable to a child covered under more than one plan were expanded to specifically cover the children of unmarried parents. **1995 Proc. 3rd Quarter 698.**

When the NAIC began a review of the model in 2002, the chair of the drafting group asked for suggestions for issues to consider. NAIC staff reported that she often received questions about determining the order of benefits for dependent children in situations that the model did not seem to address and questions about the model's scope, whether it applies to group-to-individual policy coordination. **2002 Proc. 2nd Quarter 202.**

The working group discussed an interested party's recommendation that a drafting note be added to the model to explain how plans should determine the order of benefits with respect to a dependent child who was in the custody of a family member other than a parent. The existing model only referred to *parents* of the dependent child. The language of the drafting note would state that plans should determine the order of benefits for the dependent child as if these individuals were the parents of that child. The working group agreed to accept the suggested revision, but decided to add the language to the substantive provision of the section instead of placing it in a drafting note. This became Paragraph (2)(c) **2002 Proc. 3rd Quarter 218.**

Subsection D(2)(b) was drafted to provide exceptions to the birthday rule in two situations: (1) when there was a court order that stated which parent had responsibility for health care expenses or health insurance coverage of the child; and (2) when there was no court decree specifying which parent had responsibility for the health care expenses or health insurance coverage of the child and the order of benefits was determined based on which parent had custody of the child.

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Section 6D (cont.)

The working group heard a suggestion that Subsection D(2)(b) be deleted because it was unnecessary and burdensome. The interested party suggested that the “birthday rule” was the only rule needed to determine the order of benefits. The chair expressed support for this suggestion because of its ease of administration. **2003 Proc. 1st Quarter 196.**

A regulator said that he believed some exception for a court order would have to remain. Another regulator expressed support for the simplicity of always using the birthday rule, but he was concerned about situations where the birthday rule would make the non-custodial parent’s plan primary. After further discussion the working group decided to add language to require the use of the birthday rule except where there was a court decree specifying the order of benefits. **2003 Proc. 1st Quarter 196.**

The working group requested specific comments from interested parties on the feasibility of using the birthday rule to determine the order of benefits unless there was a court decree specifying the order of benefits. Only a few interested parties expressed support for that approach. Another option was to retain the existing language and modify it. An interested party suggested that the lead-in to the first sentence be revised to state “[u]nless there is a court decree stating otherwise” instead of “[u]nless there is a court decree specifying the order of benefits” because, court orders will specify which parent has responsibility for the health care expenses or health insurance coverage of a child, but not specify the order of benefits. Without objection, the working group adopted the suggestion. **2003 Proc. 2nd Quarter 288-289.**

An interested party stated that, although a rule requiring use of the birthday rule in all circumstances appeared attractive on its face because of its simplicity, it would not work for families with complicated custody arrangements. Therefore her organization supported retention of the existing language with amendments. **2003 Proc. 3rd Quarter 273.**

The provision regarding laid-off or retired workers was added to the model in 1982. Several large companies indicated a strong interest in achieving a change in the COB guidelines for the coordination of benefits between a laid-off or retired worker’s health insurance benefits accruing from a previous employment and benefits from his present employment. An industry spokesperson suggested that rather than change the rule, union agreements include a 25-hour break in coverage so the subsequent employer’s coverage would become primary. This would preserve the present uniformity of coordination procedures and prevent disruptive changes in the rules. Others pointed out potential problems with negotiating this arrangement and with preexisting condition rules. Industry also emphasized the importance of a change to the rules so that the coverage from a previous employer was always secondary. Retired/laid-off coverage must remain affordable or it would end. **1983 Proc. I 694.**

The change was designed to deal with the issue of coordination between a plan covering a person as a retired or laid-off worker and a plan covering a person as an “active” worker (that is, a worker who is not retired or laid-off—as distinguished from a worker who was not disabled).

In the 20 or so years since the COB rules were developed, major changes occurred in employment practices and employee benefit plans. Employees retired at relatively young ages. Guaranteed benefits for laid-off employees became more common. Many retired and laid-off employees began new careers. These developments should not be discouraged by inequitable or ineffective use of increasingly scarce benefit plan dollars. Since an employer of an “active” worker would have the direct and immediate benefit of that worker’s productivity, that employer should be in a better position to bear the cost of primary liability for benefit plans than an employer of a laid-off or retired worker. The drafting committee was also concerned that the insured individual should never be placed in a position where each plan was secondary. Therefore, the rule would not apply if the other plan didn’t have it. **1983 Proc. I 698-699.**

In June 1990 a drafting note was added after the laid-off/retiree rule to clarify its applicability to situations where the same individual was covered both as a retiree and as an active employee. **1990 Proc. II 680.**

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Section 6D (cont.)

When amendments were being drafted in 1994, an insurer representative suggested that the drafting note be made part of the language of the model because this was an issue that was often misunderstood. The working group agreed to add the second sentence as part of the language of Paragraph (3) and just leave the last two sentences as a drafting note because they were phrased as an explanation. **1994 Proc. 4th Quarter 698.**

The provision was again discussed in 2003 during a revision of the model. Staff said that a number of comments had been received on Paragraph (3) suggesting that the terms “active” and “inactive” should be deleted or, if retained, defined. She noted a suggestion from one interested party that would retain the terms, but would clarify their meaning in a drafting note. **2003 Proc. 1st Quarter 196.**

The working group also decided to retain the language found in both Subsection D(3) and (4) addressing the situation when one plan had this rule, but another plan did not. The working group decided to retain this language because there could be some states that had not adopted either rules part of their COB law or regulation and also to cover the situation when one plan was an insured plan and the other plan was a self-insured plan. **2003 Proc. 2nd Quarter 289.**

A new Paragraph (4) was added to the order of benefit determination rules as a result of the change in rules for continuation plans authorized under COBRA. It was broadly enough written to also provide for an order of benefit determination under any state plans allowing duplicate coverage. **1991 Proc. IB 656.**

The purpose of the revision was to make the rules consistent for continuation coverage provided as a laid off employee, a divorced spouse or a former dependent. In all cases, the continuation plan was secondary to one covering the individual as an employee, member or subscriber. However, the continuation rule did not change any other existing rules. The coverage of an individual provided as an employer, member or subscriber (other than as a dependent) was primary to one covering him as a dependent. This meant an individual’s continuation plan would be primary to one covering him as a dependent under his spouse’s employee plan. **1991 Proc. IB 652.**

The working group drafting amendments in 2003 discussed Subsection D(4) and its provisions for the order of benefits for a claimant whose coverage was provided under a right of continuation pursuant to federal or state law and who was also covered under another plan. Comments were received suggesting that this provision be amended to provide an exception for determining the order of benefits when the claimant was an employee, member, subscriber or retiree under continuation coverage. In this situation, the suggested amendment would specifically state that Subsection D(4) applied. An interested party stated that the proposed amendment would reflect what she believed was the original intent of the model regulation: that the continuation coverage always be secondary. The NAIC staff support at the time that amendment was drafted stated that the intent was that the covered person’s own coverage always be primary. A regulator expressed concern with the working group accepting an amendment that would make the continuation coverage always secondary. After discussion, the working group decided not to accept an amendment that would make the continuation coverage always secondary. The working group, however, suggested that language could be added that would clarify Subsection D(1)’s relationship with Subsection D(4), but maintain the principle that the person’s own coverage would be primary. **2003 Proc. 1st Quarter 196.**

An industry trade association suggested that the definition be revised to reflect that there are other federal continuation-of-coverage laws in addition to COBRA. Instead of revising the definition, the chair suggested revising Section 6D(4) to include the phrase “or other federal law.” That suggestion was adopted. **2004 Proc. 2nd Quarter 467.**

One insurance department submitted a comment suggesting that the word “successive” be added to Paragraph (5)(b) to clarify how to determine the length of time an individual has been covered under a plan for the purpose of determining the order of benefits. After discussion, the task force accepted the suggestion. **2004 Proc. 3rd Quarter 687.**

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Section 6D (cont.)

An insurer representative expressed a concern with a new Paragraph (6) being considered in 1995. He wanted the section to make clear that this was only applicable if both plans were subject to the regulation. He said that an ERISA plan not subject to insurance regulation often took an “always secondary” position, and he wanted the freedom to negotiate with it rather than automatically paying 50% of the cost. **1995 Proc. 2nd Quarter 556.**

A regulator suggested revising Paragraph (6) to include a method of calculating precisely the amount that each plan would pay instead of stating that the allowable expenses would be shared equally. After review and discussion of the proposed amendment, the working group decided to leave Subsection D(6) unchanged. **2003 Proc. 1st Quarter 197.**

Section 7. Procedure to Be Followed By Secondary Plan to Calculate Benefits and Pay a Claim

The benefits to be paid by the secondary carrier have undergone considerable revision over the years. The initial draft used two guiding principles. The first of these was the fact that an employer would accept an anti-duplication provision, provided it permitted his employees to recover their medical expenses. The second principle was that claims settlement should be simple. On the basis of these two principles a model provision was designed that would reimburse the claimant up to 100% of his allowable expenses, with “allowable expenses” defined in the broadest practical manner. **1970 Proc. II 1219.**

In 1984, the NAIC adopted options to be considered by the plan sponsor or policyholder to be used to contain health care costs. If a plan chose one of the alternative methods and allowed the secondary payer to pay less than 100% of the allowable expenses, the insurer was required to notify all covered persons, prior to providing coverage, that it might not be to their advantage to carry duplicate coverage. **1984 Proc. II 616.**

The amendments adopted in 1984 proposed two major changes in COB. One of these was permission for certain plans to preserve the deductibles and coinsurance features of the plan that was the most generous to the employee for the claim involved. Preservation of deductibles and coinsurance was urged by the industry as an important element in the battle to prevent the over-utilization of medical care. With perhaps half the families in the country having both spouses in full-time employment, the failure to address the problem could seriously impede effective cost care containment. The provision adopted contained provisions so that families that dropped duplicate coverage were guaranteed unrestricted reentry into a plan that had been dropped if the family subsequently lost the coverage on which it had relied. **1984 Proc. II 618.**

The alternative provisions provided for either preservation of the coinsurance amount, or a “carve-out” approach, where a secondary plan considered what it would have paid, subtracted what the other plan paid, and paid only the balance. The wording adopted provided that a plan could select one of two alternatives or a version that was more favorable to a covered person to determine the amount payable by the plan when it is secondary, that is, when it paid benefits after another plan. The first alternative provided that the benefits that would be payable under the plan in the absence of this provision, and the benefits that would be payable under all other plans in the absence of provisions of similar purpose to this provision, would be the greater of 80% of allowable expenses, or the amount of benefits that would be payable under the plan in the absence of this provision. **1984 Proc. II 646.**

The second alternative provided that the benefits that would be payable under the plan in the absence of this provision would be reduced by the benefits payable under all other plans for the expenses covered in whole or in part under this plan. **1984 Proc. II 627-628.**

An industry statement on the issue of cost containment urged the use of provisions to preserve the coinsurance and deductible. They said that, when insurance covered every penny of medical care cost, there was no incentive for anyone—not the patient, not the provider, not the government—to avoid unneeded services or to question excessive charges. **1984 Proc. II 646.**

One insurance commissioner reported on the reaction in his state when a hearing was held on the issue of the alternatives to 100% reimbursement. The general public attitude was outrage that the department would even consider such a change, even if there were a possible corresponding premium reduction. This was a very sensitive emotional issue. The general public’s

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Section 7 (cont.)

perception was that the guidelines would take away from them a health care benefit many of them considered to be vital. Other concerns raised in the hearing were the increased bad debts of hospitals, and the administrative burdens of administering varying benefit plans. The opinion was expressed that the financial savings possible were too small to justify the confusion, expense and unfavorable public image that would result. **1985 Proc. I 631-632.**

In 1987, a survey was taken of the state insurance departments asking about the alternatives providing less than 100% of allowable expenses. Only 10 states responded, but 8 of them did not believe the options should be retained. The working group was directed to prepare amendments consistent with the survey results. **1987 Proc. II 742-743.** After further request, 39 states responded. By a margin of 4 to 1 they were opposed to the alternatives. **1988 Proc. I 745.**

The working group revised the model to remove the alternatives allowing a secondary carrier to pay less than 100% of allowable expenses and reorganized the provisions of the regulation to make it more understandable. The alternatives were originally proposed by the industry as a cost containment feature, but a state survey concluded the commissioners did not find it in the best interests of their citizens to retain the two alternatives. The task force requested that the industry provide data on the cost containment impact realized from the alternatives, but no information was provided in support of their contention. **1988 Proc. I 713.**

In almost every case, the secondary plan would pay far less than it would have paid had it been the only plan providing coverage. The secondary plan was required to accumulate these “savings” during the claim determination period, which was usually the calendar year or plan year in which benefits were paid. The COB “bank” was available to reimburse the employee in full for future allowable expenses for health care services during the claim determination period. This “bank” was rarely used by medical plans that provide generous benefits. However, if there were recurrent claims, the secondary plan could have to use it when, for example, the maximum benefits available under the primary plan are used up during the period. The “bank” was never carried from one claim determination period to the next. **1984 Proc. II 621.**

When the secondary payer considered the benefits it should pay, it had to understand that an “allowable expense” was any expense for necessary health care services if at least a portion of the expense was covered by the primary plan. Thus, subject to its overall maximum liability, the secondary plan might have to pay benefits for a service it did not cover if that service was covered by the primary plan. For example, if the primary plan covered nursing home care and the secondary plan did not, the secondary plan would usually have to treat the nursing home expenses not paid by the primary plan as an allowable expense. That was the price to be paid that entitled one to enjoy the savings affordable by COB. In no event would the secondary plan ever pay more in the aggregate than it would have paid had it been primary. **1985 Proc. II 624.**

When the model was rewritten in 1995, significant changes were made to this subsection. The working group chair noted that the language describing the bank of benefits was not clear and asked technical resource advisors to give consideration to improving the description. **1995 Proc. 2nd Quarter 556, 563-564.**

An extensive discussion was held on how to help a consumer understand the bank of benefits. The group decided to use the term “benefit reserve” to make it clearer that this was a bookkeeping entry that would return to zero at the end of the claim determination period. Procedures for the insurer to follow were spelled out in the regulation. A report prepared by an interested party noted that the benefit reserve would be used by the secondary plan to pay for expenses or services that would not otherwise be covered by the contract, so long as the item, service or expense was covered by one of the plans as an allowable expense. If the covered person’s benefit reserve was exhausted, the secondary plan’s only obligation would be to make payments for services required by its contract. **1995 Proc. 3rd Quarter 699.**

When the model was being considered for revision in 2002, one regulator said he did not believe that the model needed major revisions, just tweaking in areas that could be clarified, such as the model’s benefit reserve requirements. **2002 Proc. 2nd Quarter 202.**

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Section 7 (cont.)

The chair asked for comments from working group members on whether the benefit resource should be retained. He noted that some states had chosen not to include it while others had. One regulator spoke in support of retaining it because without this requirement the consumer might not get the benefit from the secondary plan. The chair said that his state found it difficult to administer, and asked if it could be simplified. Another regulator suggested not changing the substantive language, but adding examples illustrating how to use it. The chair suggested that defining “benefit reserve,” coupled with adding a drafting note explaining the purpose of the benefit reserve could be one solution. An interested party suggested that, given that many states have taken different approaches with respect to the benefit reserve requirement, the working group should consider moving the benefit reserve requirement to a drafting note or making the provision an option that a state may choose to adopt or not. **2003 Proc. 2nd Quarter 289.**

At a later meeting, the question again was raised whether the benefit reserve provision should be retained or deleted and, if retained, how should this provision could be revised to make it easier for secondary plans to understand how much they should pay as the secondary plan and the amount of any savings that should be put in the benefit reserve as a result of being the secondary plan. One regulator expressed support for retaining the benefit reserve provision, because the benefit reserve helped ensure that consumers got the full value of both plans. She suggested adding some examples to the COB model to assist secondary plans in complying with the benefit reserve requirement. Another regulator offered a counter-argument for deleting the benefit reserve. If plans were coordinating properly, the consumer would not pay full value for both plans because the premiums would have been reduced due to the anticipated savings. **2004 Proc. 1st Quarter 538.**

An interested party said the philosophy behind having the benefit reserve requirement was to ensure that the covered person was covered 100% for all allowable expenses, including deductibles and co-payments. He noted, however, that the problem with the benefit reserve provision was that plans were not equipped to administer it properly, particularly with respect to small claims. An interested party restated her organization’s recommendation for deleting the provision. Many states did not require plans to establish a benefit reserve because it was too difficult and too costly to administer. Another interested party questioned the provision’s value in relation to the cost to plans in administering it and its benefit to consumers. He stated that few consumers are in the position to utilize the benefit reserve provision. **2004 Proc. 1st Quarter 539.**

The task force members again discussed the benefit reserve requirement in Section 7. The group reviewed three options: revise the existing model to make the requirement clearer, make the requirement optional or delete the benefit reserve. A regulator opined that the second option would not require the secondary plan to go back to review previous claims to determine the benefits to be paid. In his opinion, the procedures outlined in the second option were what plans were actually doing. Regulators again reviewed reasons for deleting the requirement entirely: the benefit reserve requirement had not been adopted by a significant number of states, self-insured plans did not use it and it was costly to administer. On the other side, one regulator said he would support retaining the requirement in order for the consumer to get the full benefit of both plans. Another regulator questioned whether the costs of administering the benefit reserve requirement were offset by the benefit reserve payout that consumers may receive in a small number of cases. Another member of the group suggested that the second option resolved part of the administrative cost problem by allowing plans to keep a running total instead of having to go back and review previous claims. If the second option were adopted, the greatest administrative costs that plans would incur would be start-up costs. The chair requested comments from interested parties on the administrative cost issue. One trade association representative indicated that the administrative costs were extremely high. Member plans reported that running and maintaining benefit reserve systems was labor intensive because, while some of the systems are automated, some still required substantial manual review of claims. The task force voted to delete the benefit reserve requirement. **2004 Proc. 2nd Quarter 468-469, 499, 502.**

At the next task force meeting, one regulator questioned whether language needed to be added to this section to ensure that any amounts paid by the primary plan on a claim were credited toward the deductible of the secondary plan. **2004 Proc. 3rd Quarter 688.**

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Section 7 (cont.)

The task force received a comment concerning language in this section that would require the secondary plan to credit any amounts that the primary plan paid on the claim toward the secondary plan's deductible. The comments stated that the secondary plan should be required to credit toward its deductible the amount it would have paid in the absence of other health care coverage. The task force adopted a revision to Section 7 to require the secondary plan to credit any amounts it would have paid in the absence of other health care coverage toward its deductible. Staff noted a technical change that needed to be made to this section for clarity. The intent of the section was to ensure that the total amounts paid by all plans on a claim did not exceed 100% of the total allowable expense. The task force agreed to the technical change. **2004 Proc. 4th Quarter 738.**

Section 8. Notice to Covered Persons

To address the concern that an individual might not understand the benefit reserve, an extensive discussion was held on how to make a consumer aware of the opportunity for payment of bills through the benefit reserve. It was agreed to add a new Section 8 to the model providing that a plan should, in its explanation of benefits, give notice that other benefits might be available, so all claims should be filed with each plan. **1995 Proc. 3rd Quarter 696.**

Section 9. Miscellaneous Provisions

A. When a traditional plan coordinated with an HMO and the traditional plan was primary, it paid its regular benefits to the HMO just as it would have done with respect to any other provider. The reasonable cost value of the services was considered an allowable expense. The primary plan's standards of what charges were reasonable and customary or usual and prevailing also apply. **1985 Proc. I 619.**

One of the issues considered in drafting amendments in 1994 was how to deal with a situation where an HMO was primary and the secondary plan does not know what value to use for coordination. Interested parties said that the closed panel plan should have a fee schedule to set a reasonable cost value for its services to use as an amount for coordination of benefits. **1994 Proc. 3rd Quarter 588.**

B. The NAIC recognized early the difficulties that arose when a regulated plan attempted to coordinate benefits with a self-insured plan or other plan not subject to insurance department regulation. Although some urged that no attempt be made to coordinate benefits with a self-insured plan, the drafters recommended that the NAIC recognize the danger to both state regulation and the insurance business in requiring insurers to pay full benefits in the presence of a self-insured plan. The NAIC should adopt a policy of encouraging self-insurers to follow the COB provision in administrating any over-insurance provision in their respective plans so as to minimize the necessity for regulated insurers having to pay primary benefits when they would otherwise be in a secondary position. Otherwise a further incentive was created for employers to self-insure, and for those who were presently self-insured to remain so. **1970 Proc. II 1204-1205.**

To address the problem of the unregulated plan that declared itself to always be secondary or excess, the task force recommended the following procedure: a group contact complying with the COB rules should determine its primary or secondary position according to these rules. If it was primary, it should pay as it would ordinarily in the primary position. If it would ordinarily be considered secondary under these rules, the carrier should make every effort to coordinate in the secondary position with benefits available through such excess plans. But if the other carrier was unwilling to provide the necessary information, the carrier might be required to assume the primary position because it has no legal authority to do otherwise. **1970 Proc. II 1205.**

Interested parties endorsed an approach that protected the insured person from the danger of a double secondary position created by the irresponsibility of an uninsured plan that declared itself always secondary. Nevertheless, they expressed concern that this protection would encourage uninsured plans to maintain their always secondary position because they knew the insurance department would force insurers to assume the responsibility of primary coverage. To avoid this, the guidelines were changed to provide that the secondary plan could reduce its benefits to the level it would pay in the secondary position.

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Section 9B (cont.)

If governing state law allowed subrogation in this instance, the complying plan could advance an amount equal to its primary benefits, less what it already paid. This subrogation right would be the rights the insured person had under the contract with the noncomplying plan, assumed only after the complying plan had advanced full benefits to the insured person. **1985 Proc. II 618.**

C. The task force recognized that the concept of coordination of benefits was separate entirely from the matter of subrogation since they were two different mechanisms. If subrogation was to be used, it should not be used as part of, or confused with, coordination of benefits. **1970 Proc. II 1205.** The right of subrogation varied quite widely from the so-called “classic” type that was recognized under the common law in some states to specific contractual provisions for personal injuries. **1971 Proc. I 235.**

The model originally adopted contained a small claims waiver. It urged carriers to waive the investigation of possible other coverage for COB purposes on claims less than \$50 to avoid payment delays. Furthermore, the cost of the additional administrative work might well exceed the share of the small claim attributable to over-insurance. **1971 Proc. I 235.** This provision did not appear in the “easy-to-read” version adopted in 1985 because it was not considered appropriate for a regulation, but rather was guidance for claims personnel. **1985 Proc. II 627-638.**

D. In 1995 an amendment was adopted that said that if the carriers could not agree which plan was primary, the two plans should split the cost and then determine the liability of the companies. **1994 Proc. 4th Quarter 698.**

Section 10. Effective Date for Existing Contracts

The drafters of the original regulation saw that no useful purpose would be served by disrupting contracts in force by retroactive imposition of the COB requirements. Therefore, they suggested the rule apply to a contract on the next anniversary or renewal date of the insurance contract or the expiration of the collectively bargained contract. **1970 Proc. II 1205.**

When amendments were being drafted that would allow individual to group coordination, the working group discussed a delayed effective date. After discussion, the group decided to permit a one-year delay to allow insurers to come into compliance. **2002 Proc. 4th Quarter 283.**

The drafting group listened to comments as to whether to add language to the new Section 4 or whether to include information in Section 10 to clarify the date when the provisions of the COB model and any amendments would be applicable to existing plans. The task force decided to include the language in Section 10. **2004 Proc. 2nd Quarter 468.**

An interested party suggested that Section 10 should include language to address what would happen during the period when one plan was subject to the old COB model requirements and the other plan was subject to the new COB model requirements. After some discussion, the task force agreed that transition language was needed. **2004 Proc. 4th Quarter 738.**

Appendix A.

An appendix containing information on coordination of benefits was included with the original model. It contained information to distribute to members of a group to explain the concept of COB and how the provisions worked, complete with examples. **1971 Proc. I 237-249.**

When the model was revised in 1987, the provisions to be included in an informational brochure to the policyholders were again made an appendix. The group considered attaching the explanatory brochure with examples but deleted it from the exposure draft, since it did not totally reflect current market practices. **1988 Proc. I 713.**

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Appendix A (cont.)

The text of a group contract's COB provision could be changed to fit the language and style of the rest of the contract, or to reflect the differences between plans that provided services and plans that indemnified or reimbursed expenses. However, substantive changes are not allowed, except as permitted by the regulation. **1985 Proc. I 617.**

When the model was considered for amendments beginning in 2002, staff noted that written comments had been submitted suggesting revisions to Appendix A of the model, which set out model COB contract provisions. The suggested revisions generally involved revising language in Appendix A for clarity so that the provisions could be understood by laypersons. **2002 Proc. 2nd Quarter 202.**

Appendix B

One of the regulators drafting amendments in 1994 suggested adding an Appendix B that contained a generic form with general information on coordination of benefits. He said this could be used by the states and the companies for a brochure to explain coordination of benefits. **1994 Proc. 4th Quarter 698.**

An interested party said that early NAIC models had contained such information, but at that time coordination of benefits was a new concept. He said that in the 1980s when the model was revised, that provision was deleted as not being necessary. A regulator responded that he worked with consumers every day and was aware that many of them did not understand coordination of benefits. He said examples and an explanation in simple language would be very helpful. **1994 Proc. 4th Quarter 682.**

He said examples and an explanation in simple language would be very helpful. **1994 Proc. 4th Quarter 682.**

Appendix B was amended along with the other changes that were adopted in March 2005. **2004 Proc. 4th Quarter 760-761.**

Chronological Summary of Action

December 1970: Original model adopted in the form of a series of guidelines for insurers and others.

June 1980: Added a section to deal with the issue of coordination between plans of divorced parents.

December 1982: Added a section to change the order of benefit determination when an individual was covered both as an employee and as a retired or laid-off person (or as a dependent under these policies).

June 1984: Rule for determining primary coverage for a dependent changed so that, rather than the father's policy being primary, the birthdays of the parents would determine which was primary. Provisions added to provide for less than 100% coverage by preservation of coinsurance and deductibles.

June 1985: Model extensively revised to make it easier to read.

December 1987: Again the model was rearranged in an attempt to make it easier to read. Provisions providing for less than 100% coverage options removed.

December 1988: An amendment was added to determine the primary carrier when divorced parents are given joint custody. A cost containment provision allowed preservation of cost containment incentives when the primary plan provided for second surgical opinions, precertification, preferred providers network, etc., and stated that these differentials need not be considered allowable expenses.

June 1990: Amended order of benefit determination with regard to Medicare recipients with working spouses.

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Chronological Summary of Action (cont.)

December 1990: Technical amendment to rule regarding Medicare recipients with working spouses. Adopted new order of benefit determination rule for continuation coverage.

December 1995: Entire model revised to clarify wording. Provisions added to require no coordination between two HMOs, to create a fall-back position when insurers could not agree on which was primary, and to address the issue of parents who had never married. Section 8 was added to the model, and a new Appendix B was created.

March 2005: Model revised to clarify and simplify wording. Coordination of benefits made applicable to individual, as well as group, plans. Provisions related to benefit reserve were deleted.

**CONSIDERING INSURANCE BILLING
FOR COLLEGE HEALTH PROGRAMS**

By Stephen L. Beckley, Valerie A. Lyon, and Marc M. Tract

APPENDIX D

Do You Have MassHealth Coverage? January 2017

Do you have MassHealth coverage?

If so, you will be required* to enroll in your school's Student Health Insurance Plan (SHIP) at no additional cost to you



If you currently have MassHealth coverage, you may be able to enroll in your school's health insurance plan, without paying any more than you currently do. If you qualify, you will be automatically enrolled into your school's SHIP, and MassHealth will pay for your SHIP premium.

You'll get more benefits, without paying more

Through this MassHealth Premium Assistance program, you'll pay the same amount that you do now, but you'll be able to:

- Have a greater choice of providers when you need health care services.
You can use any of the providers in your school's SHIP plan network, with no referral necessary.
- Pay the same MassHealth low or no co-pay when you see a SHIP in-network provider.
- Be covered when you're in other states or anywhere around the world if you are traveling.



How to get started

- Make sure you enter your 12-digit MassHealth ID number when you fill out information on your school's waiver form.
- You can find your MassHealth ID number on your MassHealth ID card.



What's next?

After you submit your information through your school's waiver process, you will be emailed updates about the status of your submission. If you are eligible, MassHealth will mail you a letter to verify that you have been enrolled in the MassHealth Premium Assistance program.

Questions?

If you have questions about your eligibility for the Premium Assistance program, call MassHealth Premium Assistance at 1-855-273-5903.

* some exceptions apply

Frequently Asked Questions

What are the benefits of this program?	Being covered by both a SHIP and MassHealth will give you access to a larger network of providers than just MassHealth providers. You will also have coverage for services out of state and out of country.
Will I lose my MassHealth coverage or access to other MassHealth covered services?	No, you will not lose your MassHealth coverage. You have to maintain your MassHealth in order to qualify for Premium Assistance. Premium Assistance is to pay for your SHIP plan premium. MassHealth covered services are not affected.
Will there be any changes to my MassHealth coverage when I enroll?	The same MassHealth covered services will continue, but <i>how</i> you get them will change. For example, if you were on a MassHealth managed care plan (Neighborhood Health Plan, BMC Health Net, Tufts Health Together, CeliCare, or Fallon), your school's SHIP plan will now be your primary plan. This means the SHIP plan pays your bills first and although still covered by MassHealth, you will no longer be in the MassHealth managed care plan. MassHealth will still pay for those covered services not covered by the SHIP plan and for the out-of-pocket costs you incur while on the SHIP plan up to what you would be responsible for under MassHealth.
What do I need to tell a provider when I get services?	Tell them you have both your SHIP plan and MassHealth. You need to show BOTH ID cards for providers to coordinate benefits and submit bills first to the SHIP plan and then to MassHealth.
What if I see a provider who is not covered through MassHealth?	If you see a doctor or other provider who is in the SHIP plan network but is NOT a MassHealth provider, as long as the service is a MassHealth covered service, MassHealth will reimburse you for your out-of-pocket costs up to what you would be responsible for under MassHealth. For example, if you see a mental health provider who participates in the SHIP plan but is not in the MassHealth network, you may have to pay your SHIP plan office visit co-pay up front, then submit documentation of the visit to MassHealth. MassHealth will either reimburse you if you already paid, or pay the provider directly.
Is this program going to cost me more money?	No, you'll pay no more than what you currently pay under MassHealth.
How long will Premium Assistance for the student health plan last?	MassHealth Premium Assistance will pay for your entire annual SHIP premium if you enroll in the fall, or for the entire spring semester premium if you are newly enrolled at your school in the spring. <i>At the beginning of each school year you will need to repeat the online waiver process to make sure you still qualify for both the MassHealth Premium Assistance and for your SHIP.</i>
What happens if I drop out of school or become a part-time student?	Once MassHealth pays for your SHIP premium and you are enrolled in the SHIP plan, you should be able to be covered through the end of the policy year even if you drop out of school or go part time (with some exceptions).
Will my MassHealth coverage change if I don't enroll in this program?	If you currently have MassHealth and qualify for Premium Assistance, you must enroll in the SHIP plan available to you. If you are required to but do not enroll in the SHIP plan, you will lose your MassHealth benefits. A check to determine whether you qualify for Premium Assistance will happen once you submit your waiver information.
Can I get a family health plan through this program?	No, at this time the Premium Assistance for the SHIP program is only available to students on individual (one person) plans. If you have other family members who also have MassHealth, your enrollment in the SHIP plan will not affect your family members' MassHealth coverage.
What if I have more questions?	Please contact MassHealth Premium Assistance at 1-855-273-5903 if you have more questions.

**CONSIDERING INSURANCE BILLING
FOR COLLEGE HEALTH PROGRAMS**

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APPENDIX E

Credentials for Authors

CONSIDERING INSURANCE BILLING FOR COLLEGE HEALTH PROGRAMS

CREDENTIALS FOR AUTHORS

MARC M. TRACT, JD



Marc Tract is a partner with Katten Muchin Rosenman LLP in New York City. He concentrates his practice in the areas of corporate and regulatory matters for the insurance and reinsurance industries, as well as the organization and licensing of health maintenance organizations.

In this role, Mr. Tract advises and counsels domestic and international insurers, reinsurers, agents, brokers, third-party administrators, private equity funds and hedge funds on public offerings, private placements, domestications, mergers, redomestications, demutualizations, corporate governance and regulatory issues, mergers, acquisitions, and divestitures.

He is a member of the boards of directors of several national and international insurance companies. Mr. Tract is experienced with state laws that impact insurance companies and businesses that do business with insurance companies. He regularly advises clients on regulatory matters, including investment limitations, holding company compliance, licensing, and the organization of subsidiaries and U.S. branches. Mr. Tract also advises companies and educational institutions on self-funding and captive insurance alternatives.

Mr. Tract has worked extensively with Hodgkins Beckley Consulting (HBC) clients through his membership in the Federation of Regulatory Counsel (FORC). He was retained by HBC on behalf of Cornell University, University of Rochester, and New York University to develop a regulatory path for the permissibility of self-funded student health benefit plans domiciled in New York. Mr. Tract periodically attends Lookout Mountain Group meetings and has spoken on topics pertaining to fiduciary duty, regulation of self-funded student health plans, and other matters regarding the operation of College Health Programs.

Education: JD, Pepperdine University School of Law.
Bachelor of Arts, Biology, Ithaca College.

STEPHEN L. BECKLEY, CEBS



Stephen Beckley has over 35 years of experience working with student health care financing and insurance programs, and he has 25 years of experience conducting program reviews for College Health Programs. He was employed as a consultant for a major employee benefits consulting firm prior to founding Stephen L. Beckley and Associates (SLBA) in 1991 and Hodgkins Beckley Consulting (HBC) in 2006. As a team leader for HBC's College Health Program consultations, Mr. Beckley specializes in conducting external and internal environmental assessment studies.

Mr. Beckley has served as a consultant to the American College Health Association's Task Force on Insurance, and he is the primary author of several ACHA publications relating to student health care financing and insurance. ACHA's "Standards for Student Health Insurance Coverage" were first adopted in 1997 and are periodically updated and reauthorized. He presently serves as a member of ACHA's Student Health Insurance/Benefits Plans Coalition. He has written articles and provided presentations at national meetings for compliance with ACHA standards and best practices for student health insurance/benefits plans. He is nationally recognized as one of the foremost authorities on student health insurance/benefit programs and health and counseling services funding.

Mr. Beckley is a founding member and a co-organizer for the Lookout Mountain Group, a nonpartisan organization devoted to considering health care reform for the college student population. He has conducted seminars and workshops at national and regional meetings on health care reform, College Health Program legal compliance, and student health care delivery and financing for ACHA, the National Association of Student Personnel Administrators (NASPA), the University Risk Managers and Insurance Association (URMIA), and other higher education associations.

Mr. Beckley has served as a member of the Idaho State University Alumni Association's Board of Directors. The Nursing Building at ISU is named for his mother, Helen Virginia Beckley.

Education: Bachelor of Arts degree in Rhetoric and Public Address, Idaho State University. Certified Employee Benefit Specialist (CEBS), Wharton School at the University of Pennsylvania and the International Foundation of Employee Benefit Plans.

CONSIDERING INSURANCE BILLING FOR COLLEGE HEALTH PROGRAMS

CREDENTIALS FOR AUTHORS

VALERIE A. LYON, MHA



Valerie Lyon has over 30 years of experience in health care administration including hospital, medical group practice management, and College Health Programs. Prior to joining HBC, she served for 20 years as the chief administrative and fiscal officer of

Cornell Health at Cornell University.

Ms. Lyon's operational expertise includes provider and vendor contracting, employee health, pharmacy oversight and management, physician and hospital community relations, strategic planning, human resource management, and student health insurance/benefit program management. Her fiscal expertise includes financial and business design analysis, budget planning and monitoring, capital planning, insurance billing, and cost allocation methodologies.

At Cornell, she was a leader in the creation of enabling legislation to allow for student health plans to be self-funded in New York State (NYS). Under Ms. Lyon's direction, Cornell became the first higher education institution in New York to self-fund its student health plan, resulting in annual administrative savings of 8 percent or about \$2.4 million per year. Concurrently to this initiative, she was the driving force behind a pilot program with the NYS Department of Health to offer annual premium assistance to approximately 400 Medicaid-eligible students. She also helped to implement a prepaid funding system that equalized access to care for students, regardless of income or insurance status, and helped achieve a \$55 million building expansion and renovation project, housing fully integrated health and counseling services.

Ms. Lyon is nationally recognized for her efforts to promote and advocate high quality student health plans and policy initiatives that improve access to care for college students. She is a founding member and co-organizer of the Lookout Mountain Group. She serves on the leadership team for ACHA's Student Health Insurance/Benefits Plans Coalition, and was chair of the ACHA Coalition during the implementation of the Affordable Care Act. She currently holds a faculty appointment at Cornell, serving as Executive-in-Residence for the Sloan Program in Health Administration.

Education: Masters in Health Administration, Sloan Program, Cornell University. Bachelor of Science in Health Care Administration, Ithaca College.