

Duplicate Health Coverage By Jacques Chambers

Should you get all the insurance coverage you qualify for? What if you are eligible for two or even three different insurance plans? As far fetched as that sounds, when everyone is talking about the problem of people without any health insurance, opportunities for multiple coverage do happen and trying to get medical care paid for under multiple policies can be a challenge, to put it mildly.

It is surprisingly easy to end up covered under more than one health plan:

- You may be covered as an employee where you work and covered as a dependent under your spouse's employee health plan.
- You may have individual health insurance and kept it active after you enrolled in your employer's plan.
- You may be on Medicare and/or Medicaid and your employer's plan is continuing to cover you because you are 65 or older and still working or because they continue health insurance for disabled employees.
- You may be covered under a guild or union plan as well as under an employer's plan or Medicare or Medicaid.

Back in the 1950s, duplicate coverage started creating a problem for insurance companies, and it was increasing in significance as more and more families had both spouses in the workforce. While they realized that two premiums were being paid for coverage, the insurance companies did not want to nor did they believe it was right to pay full benefits under both – which would permit the insured person to actually make a profit from medical charges and insurance reimbursement. They worked with the National Association of Insurance Commissioners to resolve the problem in a manner they hoped would be fair to all, and the result was the industry-wide Coordination of Benefits Provision.

Coordination of Benefits. The insurance industry adopted a uniform provision that was added to virtually all group health policies, and health policies purchased by employers and unions for their employees and members. This provision determines how duplicate coverage is handled in all instances except when Medicare or Medicaid is involved; these are addressed later in this article.

The general concept was simple: One plan will pay its full, normal benefits. The other plan will pay what is remaining of the total medical bill, up to the maximum amount it would have paid if it were the only insurance company involved. By this method, the insured can have his medical bills paid 100% by the two companies, but will not receive more.

The provision says that the Primary Plan will pay its full benefits, and the Secondary Plan will pay the remainder of the entire bill. Clean, simple; the insurance company doesn't pay double, and the insured person gets the claim paid at 100% of the total bill, leaving him/her to pay nothing out of pocket.

The difficulty lay in determining which plan would pay its full benefit, or be Primary. A complete chart of determining the order of payment is at the end of this article, but here is a summary of the rules to determine which plan pays first:

- Group plans which do not bother to add the Coordination of Benefits provision to their policy will always pay first or be Primary.
- The group plan covering the insured as an employee pays first.
- To determine who pays first on dependent children's claims, the endorsement originally had the male "breadwinner's" plan pay first, but times change. Now the plan covering the parent whose birthday is earlier in the calendar year is Primary.

Note that these rules only apply to GROUP policies. Individual health insurance policies as well as Medicare and Medi-Cal don't come under these rules.

Health Maintenance Organization (HMO)

The rational order of payment gets more complicated when one of the plans is an HMO. For example, HMOs pay nothing if the insured goes outside their network, so there is nothing to coordinate. Inside the network, usually the only expense is the copay which is paid directly to the treating provider, and it is usually low enough that neither patient nor the doctor's office is willing to invest the time and paperwork necessary to get reimbursed for that by the Secondary payer.

Medicaid

Medicaid plans for the medically needy do not often become involved in duplicate coverage issues, however when they do, Medicaid, by law, is always the payer of last resort so would always be "Secondary" to any other insurance plan including Medicare. Reimbursement rates by Medicaid plans are frequently so low that anything paid by the insurance company will usually exceed what Medicaid would have paid anyway.

Medicare

Medicare has its own set of rules about which plan becomes Primary. For a complete explanation of the rules, they publish a booklet, *"Medicare and Other Health Benefits: Your Guide to Who Pays First"* (Publication No. CMS-02179). It covers types of insurance more than just group health policies. It also covers Workers' Compensation, Veterans' benefits, special government programs like Black Lung, coverage under no-fault or liability insurance, and End Stage Renal Disease. A table below shows how Medicare works with group health plans.

Individual Health Insurance

The Coordination of Benefits endorsement on group health policies does not apply to individual health insurance policies so they generally pay their full benefits regardless of other group health policies in force.

It is important that you review the provisions of an individual health insurance policy because they will sometimes include their own provisions about other insurance.

Medicare's Coordination of Benefits does not apply to individual health insurance policies either. Many individual health plans do include a coordination provision in their contracts regarding Medicare, however.

Below are two tables that show the order of payment for group health policies with Medicare, Table 1, and with other group and individual health insurance policies, Table 2.

Table 1: Medicare and Group Health Plans

If you...	Condition	Pays first	Pays second
Are age 65 or older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age	The employer has 20 or more employees	Group Health Plan	Medicare
	The employer has less than 20 employees or is part of a multi-employer plan	Medicare	Group Health Plan
Have an employer group health plan after you retire and are age 65 or older	Entitled to Medicare	Medicare	Retiree Coverage
Are disabled and covered by a large group health plan from your work, or from a family member who is working	The employer has 100 or more employees	Large Group Health Plan	Medicare
	The employer has less than 100 employees and isn't part of a multi-employer trust	Medicare	Group Health Plan

Table 2: Coordination of Benefits Endorsement

<p>Read Across for Plan 1 to the column that, describes how you are covered under one plan.</p> <p>Read Down for Plan 2 to the row that describes how you are covered under the other plan.</p> <p>Where the column and the row meet shows how Coordination of Benefits affects the payments.</p>		P L A N 1							
		Individual Policy	Group Health Plans						
			No Coordination of Benefits Endorsement	With Coordination of Benefits Endorsement					
				Covered as Employee	Covered as Spouse	Covered as Dependent Child			
P	Individual Policy		Both Plans Pay Full Benefits	Both Plans Pay Full Benefits	Both Plans Pay Full Benefits	Both Plans Pay Full Benefits	Both Plans Pay Full Benefits		
	L	No Coordination of Benefits Endorsement		Both Plans Pay Full Benefits	Both Plans Pay Full Benefits	Plan 2 is Primary	Plan 2 is Primary	Plan 2 is Primary	
		A	WB	Covered as Employee	Both Plans Pay Full Benefits	Plan 1 is Primary	X	Plan 2 is Primary	X
			THE	Covered as Spouse	Both Plans Pay Full Benefits	Plan 1 is Primary	Plan 1 is Primary	X	X
N	HEALTH INSURANCE	Covered as Dependent Child	Both Plans Pay Full Benefits	Plan 1 is Primary	X	X	Plan of parent with the birthday that comes earlier in the calendar year is Primary		