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COORDINATION OF BENEFITS BY HMO AS SECONDARY PAYOR

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It is often difficult to determine the obligations of a health maintenance organization as a secondary payor under coordination of benefits ("COB"). To illustrate the operation of COB rules in various scenarios, I will assume the following fact situations:

(1) The charge for the service received by the member is $125;

(2) A health maintenance organization, which we'll call "HMO," is the secondary payor and its benefit for the service is (a) $125 with a $5 copay under its 100% Plan, (b) $100 with a $5 copay under its 80% Plan, (c) $125 with a $5 copay for in-plan use and $100 with a $5 copay for out-of-plan use under its POS Plan and (d) zero (HMO has no benefit for the service); and

(3) The primary carrier (a) does not cover the service (*e.g.*, it is not a covered service or, if the primary carrier is a health maintenance organization, the member used providers outside of the primary's network); (b) provides $10 less in coverage than HMO; or (c) provides $10 more in coverage than HMO (in the scenario where HMO provides no coverage, we will assume that the primary carrier provides the same benefits as HMO's 100% Plan instead of $10 more).

Reduction of Benefits by Secondary Payor

Under the COB rules, a secondary carrier is entitled to reduce its benefits by the amount that its benefit (ignoring COB) plus the primary's benefit exceeds the total "allowable expense."[(1)] An allowable expense is an item that is covered at least in part by either plan,[(2)] which in these hypotheticals has a value of $125.

Under the first 100% Plan scenario, where the primary carrier does not cover the benefit, the total allowable expense is $120.[(3)]

Because the total allowable expense of $120 minus HMO's covered expense of $120 is zero, HMO may not reduce its benefit. Now assume that the primary carrier provides some coverage. Where that coverage is less than HMO's coverage, HMO will still pay part of the benefit. Thus, in the second 100% Plan scenario, the total allowable expense is $230[(4)]

and, therefore, HMO may reduce its $120 benefit by $110 (the total allowable expense of $230 minus HMO's covered expense of $120) to $10. Where the primary's coverage is more than HMO's coverage, HMO's benefit will be reduced to zero. Thus, in the third 100% Plan scenario, the total allowable expense is $250;[(5)]

therefore, HMO may reduce its $120 benefit by $130 (the total covered expense of $250 minus HMO's covered expense of $120) to zero.

The payment obligations of the various parties under HMO's 100% Plan could be summarized as follows:

Primary None Primary Less Primary More

	Primary None	Primary Less	Primary More
Primary's Benefit	$0	$110	$130
Member Copay	$5	$5	$0
Member Coinsurance	$0	$0	$0
HMO's Benefit	$120	$10	$0

Under HMO's 80% Plan, the parties' payment obligations would be as follows:

	Primary None	Primary Less	Primary More
Primary's Benefit	$0	$90	$110
Member Copay	$5	$5	$0
Member Coinsurance	$20	$20	$15
HMO's Benefit	$100	$10	$0

Under HMO's POS Plan, an in-plan claim would appear the same as the first table and an out-of-plan claim would appear the same as the second table. When HMO does not cover the service, the parties' payment obligations would be as follows:

	Primary None	Primary 100%
Primary's Benefit	$0	$120
Member Payment	$125	$0
Member Copay	$0	$5
HMO's Benefit	$0	$0

Application of "Savings" by Secondary

Reduction of benefits is not the end of the story because of COB "savings." Thus, the "secondary plan shall calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary," and these "savings shall be recorded as a benefit reserve ... to pay any allowable expenses, not otherwise paid, that are incurred ... during the claim determination period."[6]

In other words, HMO must use its $110 in "savings" under the second scenario in the 100% Plan[7]

and $120 in "savings" under the third scenario in the 100% Plan[8]

to pay future benefits that are "allowable expenses," even if HMO does not cover the benefit.

Accumulation of Savings

Of course, HMO would have no "savings" in the scenarios where HMO does not cover the service. HMO has not "saved" the benefit if it would not have had to provide it in the first place.[9]

Also, HMO would obviously have no savings in the scenarios where the primary carrier does not cover the service, since it would have had to provide any benefit in full.[10]

Therefore, none of these scenarios would generate savings or a future obligation on the part of HMO to pay for otherwise uncovered services.

When a health maintenance organization does have savings, calculation of the savings is complicated by the fact that health maintenance organizations generally provide services through their networks instead of reimbursing the member for services provided by others. Thus, the scenarios mentioned above are oversimplified because often it is not clear that HMO's benefit is $125 or any other dollar amount. For example, while the "billed charge" for a physical examination by a physician in HMO's network might be $125, the HMO payment for that exam would presumably be less.[11]

In that case, would HMO calculate savings based on the billed charge or the contracted payment amount?[12]

The COB rules indicate the answer to this question by stating that "[w]hen 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."[13]

While "the reasonable cash value" does not necessarily equal the billed charge,[14]

the billed charge is likely to be the most convenient measure of savings and should satisfy COB mandates. This answer avoids putting a health maintenance organization in the dilemma of attempting to calculate savings when its compensation arrangement with the provider makes it virtually impossible to determine the actual payment for any particular service, such as when capitation or performance-based adjustments are used.

Payment Based on Savings

A secondary plan is only required to use savings to pay for an otherwise uncovered service if that service is an "allowable expense." As noted above, an allowable expense is an item that is covered at least in part by either plan.[15]

Thus, HMO would have to pay a member's coinsurance or copayment for the member's stay at a hospital that is not in HMO's network[16]

if HMO is the member's secondary plan and if that member has accumulated savings. In this situation, the hospital stay is covered at least in part (the part other than the coinsurance or copayment) by one of the plans (the primary plan). However, even assuming that HMO is the member's secondary plan and that the member has accumulated savings, HMO would not have to pay for a member's kidney disease treatment by a provider that is not in HMO's network once the member had exhausted his or her coverage by the primary plan.[17]

In this situation, the treatment is not covered at least in part by one of the plans. The primary plan does not cover any part of it because coverage has been exhausted, and HMO does not cover any part of it because the treatment is not by an HMO provider.[18]

Unlike calculation of savings, calculation of the amount payable based on savings should not be complicated by the fact that health maintenance organizations generally provide services through their networks instead of by indemnification. Since the secondary carrier must calculate how much of its savings it owes under COB, and since that calculation will be keyed to the primary's benefits, a situation where a health maintenance organization is primary could theoretically present the same difficulty in calculating the value of the health maintenance organization's benefit.[19]

However, this difficulty should not arise. As noted in the previous paragraph, a payment based on savings is only required when the benefit is covered at least in part by one of the plans. Therefore:

when the benefit is covered at least in part by one of the plans. Therefore:

If the benefit is covered in part by the primary health maintenance organization, the part that is not covered should be easily determined.[(20)]

For example, when the part that is not covered by the primary health maintenance organization is a copayment or coinsurance, the amount owed by the member, and thus by the secondary carrier, will be easily determined. A problem does not arise because the secondary carrier does not need to calculate the value of the health maintenance organization's benefit; it need only determine the uncovered amount.

If the benefit is not covered in part by the primary health maintenance organization, there would be no need for the secondary carrier to pay any part of its savings. As noted above, this would include a situation where the primary health maintenance organization had exhausted its benefit.

Savings Example

To demonstrate the operation of savings, suppose the same member in the 100% Plan scenarios described above, during the same claim determination period as the claim in those scenarios, obtains outpatient services from a provider that is not part of HMO's network but that is covered at 90% by the primary carrier. Normally, HMO could deny the claim totally, but now it must apply its savings to that claim. This is illustrated in following chart:

Primary None Primary Less Primary More

First Claim $125 $125 $125

Primary Benefit $0 $110 $130

Member Copay $5 $5 $0

HMO Benefit $120 $10 $0

HMO Savings $0 $110 $120

Second Claim $1150 $1150 $1150

Primary Benefit $1035 $1035 $1035

Member Coinsurance $115 $5 $0

HMO Coverage $0 $0 $0

HMO Benefit $0 $110 $115

HMO Cumulative Savings $0 $0 $5

While the "savings" concept results in the secondary plan making payments for services that otherwise would not be covered, such as use of non-participating providers, the drafters of the model COB rules state that:

This is not as shocking a concept as it may first appear. It is simply the price to be paid which entitles one to enjoy the savings afforded by COB. ... In no event will a secondary plan ever pay more in the aggregate than it would have paid had it been primary. In practice, it almost never reaches this point. This is why every plan wants to use COB - whenever it uses COB, it will always come out ahead.[(21)]

COB, it will always come out ahead.[(21)]

One can certainly question the logic of this approach, especially in the health maintenance organization context. However, it is how COB currently works.

Endnotes

1. Section 6.B. of the NAIC Group Coordination of Benefits Model Regulation, ("NAIC COB Model Regulation"), NAIC Model Laws, Regulations and Guidelines at 120 (1996).

2. NAIC COB Model Regulation 3.A.

3. This represents only HMO's covered expense of $120, since there is no coverage by the primary. We will assume for now that this is the first claim of the coverage year because, as discussed further below, later claims must take "COB savings" into account.

4. This represents HMO's covered expense of $120 plus the primary's covered expense of $110. Again, we will assume for now that this is the first claim of the coverage year.

5. This represents HMO's covered expense of $120 plus the primary's covered expense of $130. Again, we will assume for now that this is the first claim of the coverage year.

6. NAIC COB Model Regulation 6.A.(1). A "claim determination period" is a period of not less than 12 months during which allowable expenses are compared to total benefits payable to determine whether there is overinsurance. NAIC COB Model Regulation 3.C.

7. This is the reduction of $110 represented by HMO's $120 benefit ignoring COB less the $10 benefit paid after applying COB.

8. This is the reduction of HMO's entire $120 benefit (ignoring COB), since HMO had no benefit to pay after applying COB.

9. Technically speaking, the secondary plan's benefits are not "reduced" under NAIC COB Model Regulation 6.B. if it did not cover the benefit in the first place, so it has no obligation under 6.A. "to pay any allowable expenses, not otherwise paid."

10. Again, technically speaking, HMO's benefits are not "reduced" under NAIC COB Model Regulation 6.B. if it provides them in full, so it has no obligation under 6.A. "to pay any allowable expenses, not otherwise paid."

11. Indeed, some compensation arrangements, such as capitation and performance-based adjustments, make it virtually impossible to determine the payment for any particular service.

12. The same problem should not arise in the reciprocal situation, that is, when the health maintenance organization is primary. *See* the discussion below under "Payment based on Savings."

13. NAIC COB Model Regulation 3.A.(3).

14. A "usual, customary and reasonable" charge may match "reasonable cash value" better than the billed charge.

15. NAIC COB Model Regulation 3.A.

16. This assumes that HMO would have covered the stay at a hospital in its own network.

17. Of course, HMO would still have to cover such treatment by an HMO provider assuming coverage had not been exhausted.

18. Likewise, HMO would not have to pay for treatment by providers not in its network once the member had exceeded his or her lifetime or other benefit maximum. Also, HMO would not have to pay for treatment by providers not in its network if the treatment was excluded from coverage by the primary plan.

19. Of course, when an indemnity carrier is primary, the calculation of the payment based on savings is generally the same billed charge (or, more likely, a part of the billed charge) that the primary carrier would pay.

20. Of course, if the benefit is covered in full by the primary health maintenance organization, there would be no need for the secondary carrier to pay any part of its savings.

21. Report of the Advisory Committee to the NAIC COB Task Force at 15 (June 1985).