Coordination of benefits (COB) is applicable when a patient is covered by more than one dental benefit plan. COB was established to guarantee that providers are not overpaid for claims if the patient is covered under multiple insurance plans.

The primary purpose of federal and state COB laws is to establish a sequence in which payers reimburse claims for patients who are covered by more than one plan. One plan is designated as primary and that claim is sent to that payer first. That plan should pay its normal benefits without concern to any other insurance plan or additional coverage. If the primary payer does not pay the claim in full, the claim is then sent to the secondary payer(s) for consideration of the remaining balance for payment. In some cases, there may also be a 3rd (tertiary) and 4th (quaternary) benefit plan.

The National Association of Insurance Commissioners (NAIC) provides a forum for the creation of model COB insurance laws and regulations. The NAIC continually updates its regulations in response to evolving COB challenges. Each state has had the freedom to choose whether or not to adopt the NAIC’s recommendations. While many states have adopted at least one version of the NAIC’s COB model regulation over the years, many states have not updated their COB laws to the NAIC’s most current model. This has created a lack of uniformity in COB laws from state to state, resulting in confusion and frustration for patients, providers, and payers alike.

Dental professionals are often alarmed to learn that many dental plans are not regulated by state insurance and coordination of benefits laws. Self-funded plans are regulated by federal labor laws under the Employee Retirement and Income Security Act of 1974 (ERISA), which provide little to no guidance regarding coordination of benefits.

THE AFFORDABLE CARE ACT’S IMPACT ON COB

The Affordable Care Act (ACA) has created an interesting COB dilemma, which in turn has affected some dental insurance policies. Effective Sept. 23, 2010, health and medical policies are now required to insure children up to age 26, regardless of marital, financial dependency, or student status. Although dental plans are not required to cover dependents to age 26, some have voluntarily agreed to do so in order to keep uniformity between medical and dental benefits. The addition of this new class of dependents created a need for the NAIC to revisit its COB model regulation (2005) as previous NAIC COB models did not anticipate married adult children being covered by their parent’s plan(s) as well as their spouse’s plan.

Section 136 of the ACA, titled “Standardized Rules for Coordination and Subrogation of Benefits” states: “The Commissioner shall establish standards for the coordination and subrogation of benefits and reimbursement of payments in cases involving individuals and multiple plan coverage.” The primary purpose of Section 136 is to improve coordination of benefits for “dual eligibles,” who are the approximately nine million individuals who qualify for both Medicare and Medicaid. However, since Section 136 effectively requires all states to revisit and update their COB laws in order to be ACA compliant, it is expected that many states will consider adopting the current ACA compliant NAIC COB model regulation. If all or most states adopt the 2013 NAIC COB model regulation, this will be a major step toward standardizing coordination of benefits among states.

TYPES OF PLANS

Fully Insured Dental Plans

A fully insured dental plan is a traditional indemnity or PPO insurance plan for an individual or small business. Under this type of plan, the payer considers payment of all dental claims. Payment is dependent on the terms of the insurance contract and the plan document. The insured (or the insured’s small business employer) pays insurance premiums in exchange for coverage. These plans generally establish a maximum benefit and a deductible, and an option to purchase a variety of riders, such as an orthodontic rider, a periodontal rider, or an implant rider. The more services that are covered, the higher the premium. Fully insured plans are typically purchased by individuals or a small business that are too small to self fund.

Fully insured plans are typically regulated by insurance laws in the state where they were sold. Many states have laws regarding the time frame in which properly filed claims must be paid, and fully insured plans must comply with those prompt payment or any other applicable laws.

Self-Funded Dental Plans

Under a self-funded dental plan, the employer pays employee insurance claims out of its own pocket. Typically, the employer will hire a third-party, such as an Aetna or Delta Dental, to provide administrative services only (ASO) in exchange for a flat fee or a small percentage of each claim processed. The employer makes all decisions regarding the insurance coverage, including covered procedures, the UCR paid, the sequence of coordination of benefits, etc.

Self-funded plans are regulated by the U.S. Department of Labor under ERISA. There are no federal regulations dictating the time frame in which claims must be paid; ERISA only requires that an acknowledgement of the claim be provided within a reasonable period of time (90 days). In fact, if the plan is not adequately funded, dental practices may experience delays in payment.

In addition, processing policies may vary with self-funded plans. This is because self-funded plans may have separate processing policies that the third-party administrator (TPA) must follow.
HOW TO DETERMINE IF THE PLAN IS FULLY INSURED OR SELF-FUNDED

The easiest way to determine if the plan is fully insured or self-funded is to consider the size of the company and read the patient’s insurance card or patient benefit booklet (Summary Plan Description). For example, if the card indicates that the plan is “administered by” Guardian or “administrative services only” by Delta Dental, then it is a self-funded plan. Likewise, if the claim is sent to a company that has “administrator,” “management,” or “TPA” in its name, then the plan is probably a self-funded plan.

Generally speaking, large private employers, unions, hospitals, and trusts provide self-funded insurance plans for their employees. Examples of large employers include Walmart, Bank of America, Google, Amazon, etc.

Primary Plan

When two or more dental plans are involved, the dental team must first determine which plan is primary. It is important to research and understand the rules for coordinating benefits, as defined by your state’s laws and the patient’s dental contract. While there are slight variations from state to state, most plans use the following rules to determine which plan is considered the primary provider.

How Much Will the Secondary Plan Pay?

The following rules will apply if a dental plan is obligated to follow the 2013 NAIC COB model regulation in order to be ACA compliant, either because of state law or COB contract language.

As a general rule, the secondary plan must pay an amount that, when added to the primary plan’s payment, is not less than what the secondary plan would have paid had it been primary.

Examples:

1. The primary plan’s allowable expense is $300, and the secondary plan’s allowable expense is $200. The secondary plan would only coordinate its benefits up to the $200 allowable expense, because this is what it would have considered for reimbursement if it had been the primary plan.
2. The primary plan’s allowable expense is $200, and the secondary plan’s allowable expense is $300. The secondary plan is able to coordinate benefits up to $300, because that is what it would have coordinated to if it had been the primary plan.

Fee Charged to the Patient

The patient receives the benefit of the lowest contracted fee schedule. Thus, the “patient responsibility” is the lowest contracted fee.

According to the NAIC’s current COB model regulation:

- The primary plan must pay as if no other coverage exists. The COB rules of the secondary plan determine how much the secondary is required to pay. The COB rules of the secondary plan are established in the plan document and are part of the dental benefit contract that the employer purchased. The terms of the benefit contract are laid out in the plan document.
- The doctor may collect from the benefit plan up to his highest negotiated fee if contracted with two or more of the patient’s benefit plans.
- The patient is never responsible for more than the lowest contracted fee minus the total paid by all plans. If the claim is not paid in full between two or more dental plans, the most the doctor can balance bill the patient is the unpaid amount, up to the lowest contracted fee. This is the case regardless of whether the plan with the lowest contracted fee is primary or secondary. The patient cannot be penalized for having two plans simply because the negotiated fee for the primary plan is higher than the negotiated fee of the secondary plan. Likewise, the doctor should not be penalized because the primary plan’s contracted fee is lower than the secondary plan’s contracted fee. However, if the two plans pay the doctor more than the lowest contracted fee, the doctor may keep any excess up to the full practice fee.

General Rules of COB (Coordination of Benefits)

Generally speaking, the practice can keep up to the full practice fee submitted. However, a payer will typically never reimburse more than the charge reported on the claim. So, it is very important to always report the full practice fee on every claim form, never the contracted fee.

Patient responsibility is based on the lowest contracted fee. The patient will typically be required to pay the difference between the lowest contracted fee and the total paid by all insurance payers.

The following rules summarize the information contained in the previous COB sections:

- When treatment is performed by an in-network provider, the patient receives the benefit of the plan with the lowest contracted fee, whether primary or secondary. If the total paid by 2 or more dental plans is less than the lowest contracted fee, the patient may only be balance billed for the difference between the total paid and the lowest contracted fee.
- If the doctor is not contracted with the patient’s primary plan, but is contracted with the secondary plan, the doctor may collect more than the secondary plan’s negotiated fee if paid by the primary payer. However, the patient’s out-of-pocket responsibility is limited to the secondary plan’s negotiated fee minus the total paid by the primary and secondary dental plans.
- If a doctor is contracted with both the primary and secondary dental plan, the doctor may collect total payments up to the full practice fee submitted. However, the patient’s responsibility is limited to the lowest negotiated fee minus the total paid between the primary and secondary dental plans.
- If the secondary plan is a self-funded plan regulated by ERISA, the COB provision as defined by the secondary plan document applies (which may or may not conform to the plan’s state COB laws). Patients are often not aware of the highly restrictive coordination of benefits provisions that exist in some
ERISA benefit plans (e.g., non-duplication of benefits, integration of benefits, maintenance of benefits, etc.).

- If the patient’s secondary dental plan is a fully insured product, then the COB laws of the state where it was sold apply. COB laws vary widely from state to state. In some states, group plans do not coordinate with individual plans. In other states, the secondary payer is only required to coordinate up to the primary payer’s allowable fee, and some states have no COB laws.

- If the secondary plan is a federal plan, then federal COB rules apply.

**What Fee Should Be Reported on the Insurance Claim?**

The American Dental Association (ADA) encourages doctors to always bill their full practice fee (actual fee charged) on all dental claims, and take required write-offs after all claims have been paid. Do not report negotiated fees, such as PPO fees or any other reduced fee schedule fees on any claim form.

Some secondary plans coordinate up to their allowable fee if it is higher than the primary dental plan’s allowable fee. While other plans may coordinate up to the primary allowable fee, which may be lower than the secondary allowable fee. A secondary plan should never coordinate up to a fee that is higher than the fee reported on the claim form. By reporting your full fee, you may find that some secondary plans will coordinate up to the full fee submitted, if it falls within the secondary plan’s maximum allowable fee schedule.

**How Is the Write-Off Calculated?**

It is important that no write-offs be made on the patient’s account until all dental plans have paid. Do not rely on the Explanation of Benefits (EOB) forms to determine the amount to write off. You must calculate them. If write-offs are taken as indicated on both EOBs, the patient could have a negative or credit balance.

Begin by identifying the lowest contracted fee established by all the contracted plans. Then, total the payments made by (payment received from) all insurance payers. If the total of the insurance payments equals or is more than the lowest contracted fee, then the patient owes nothing. The difference between the full practice fee and the amount received is then written off. On the other hand, if the total of the insurance payments is less than the lowest contracted fee, the patient owes the difference between the total of the payments received and the lowest contracted fee. Any balance above the lowest contracted fee is written off. Note that this is only true if you are contracted with one or more of the payers. If you have no contract with a dental plan, you are not obligated to write off any part of your fee.

**Non-Duplication of Benefits**

Some patients are lucky enough to have dental insurance coverage from multiple plans. This is referred to as dual coverage. However, dual coverage does not translate into double benefits. Patients often think they will have no out-of-pocket expenses if they have dual coverage. However, this may or may not be the case.

Many payers’ contracts (particularly self-funded plans) contain a non-duplication of benefits clause. A non-duplication of benefits clause reduces or relieves the payer from reimbursing any benefits for services paid by another plan.

Non-duplication of benefits means that if the primary plan pays the same or a greater benefit than the secondary plan allows, no benefits will be paid by the secondary plan. If the primary plan pays less than the secondary plan allows, then secondary will pay the difference between the primary plan payment and the allowed amount of the secondary plan.

Unfortunately, patients are usually unaware of the non-duplication of benefits clause. Therefore, it is important for the dental team to confirm coordination of benefits rules prior to providing treatment to help eliminate misunderstandings regarding the financial expectations of the patient with dual coverage.

**SUMMARY**

Always submit the full fee on all claim forms. Never submit the PPO fee. A PPO negotiated fee does not change the actual fee charged for the service.

When a patient is covered by multiple plans, do not post any contracted write-offs until all plans have paid. Contracted write-offs may be reduced through coordination of benefits. If a patient credit exists following the coordination of benefits, perform an account analysis to determine if a claim was overpaid (the total amount collected was more than the full practice fee) or a contracted write-off was calculated incorrectly. Notify the secondary plan if it appears that the claim may have been overpaid (total amount received from all plans exceeds the fee reported on the claim form).

If the total paid by multiple plans equals or exceeds the lowest contracted fee, the patient’s out-of-pocket responsibility is zero.

If the total paid by multiple plans is less than the lowest contracted fee, the patient owes the difference between the lowest contracted fee and the total paid by the dental plans.

If the doctor is not contracted with any of the patient’s plans, the patient is responsible for the full practice fee as submitted on the claim form.

The 2013 NAIC COB model regulation allows contracted providers who are contracted with multiple third-party payers to receive an amount up to their highest contracted fee through coordination of benefits, whether paid by the primary or secondary payer. Contracted providers may receive more than the secondary payer’s contracted fee if paid by a non-contracted primary payer, thereby reducing the required provider write-off. Remember, the practice can collect up to its full submitted fee with multiple plans.

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