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Dual Coverage: Who Picks Up the Tab?

By Constance Gilchrest

Consider a common blind date scenario. The couple meets for a dinner date, and everything is going great until the bill comes. Who will pay?

Health plans face a similar situation when an individual has dual coverage, especially when COBRA is involved. Coordination-of-benefits (COB) rules and other regulations come into play. The COB rules provide a standard order-of-benefit determination (OBD), a priority list, if you will. The challenge for employers is that the COB rules are in accordance with state law, and states have adopted different versions of the Model COB Regulation, issued by the National Association of Insurance Commissioners. Because the COB rules are based on state law, they do not apply to self-funded health plans because of ERISA preemption (although most plans follow the OBD in the COB rules). In addition, Medicare Secondary Payer (MSP) rules also come into play.

Ultimately, who pays first is the key inquiry. The “primary payer” pays what it owes on the bill first, and the remainder is left for the “secondary payer” to pay. A much more extensive review of COB issues can be found in ¶1243 of the *Guide* and Thompson’s *Coordination of Benefits Handbook*.

The OBD, in its simplest form, presents the following priority list:

- **Priority Rule 1:** Spouse/dependent coverage is secondary to coverage where the individual is the employee or subscriber.
- **Priority Rule 2:** Also known as the “birthday rule,” if the individual is a child and the dual coverage belongs to parents, the parent with the earliest birthday has the primary coverage. An exception exists if a court decree (for example, divorce) assigns responsibility to a parent.
- **Priority Rule 3:** Active employee coverage is primary to coverage not based on being an active employee.

- **Priority Rule 4:** Active employee coverage is primary to COBRA and state continuation coverage.
- **Priority Rule 5:** The plan covering the individual longest is primary.

Following are some examples of COB situations that arise in the COBRA context.

1. Ex-employee’s COBRA Coverage and Spousal Coverage

An employee, covered under his employer’s plan, loses coverage due to a termination of employment. The employee is also covered under a spouse’s group health plan. Since this employee was covered under the spouse’s plan before electing COBRA, dual coverage is allowed.

Who is the primary payer? COBRA coverage is primary for the former employee, and the spouse’s plan is secondary. For the spouse, the result is the reverse: The spouse’s plan is primary and the COBRA coverage is secondary. For the dependent children, the birthday rule is in effect.

2. Ex-employee’s COBRA Coverage and Coverage Through a New Employer

Typically, the new employer coverage would cause the COBRA coverage to terminate early. However, if the new employer coverage has a pre-existing condition exclusion (PCE) that applies to the individual, dual coverage is possible.

Who is the primary payer? COBRA coverage is secondary. This applies for a covered spouse and any dependent children on COBRA and the new employer’s plan.

3. Divorce Scenarios

First, let’s look at children. In the event of divorce or separation where both parents have coverage (COBRA or otherwise), you typically look to the divorce documents first to see if there is a court order on whose coverage is primary. Very often, this will take the form of a Qualified Medical Child Support Order (QMCSO). Absent a QMCSO or

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similar document, you would apply the birthday rule to determine which plan is primary.

Second, let's look at the ex-spouse. In the event of divorce, an ex-spouse elects COBRA. Later, the ex-spouse gets remarried and is added to the new spouse's plan, which has a PCE that applies to the new enrollee.

Who is the primary payer? Priority Rules 1-3 don't apply. Therefore, COBRA coverage is secondary to the new spouse's plan, even though a PCE applies.

4. Conflicting COB Provisions

What if the two plans in question have different COB rules? For example, there may be policies underwritten in two different states or one plan may be self-insured and not subject to state COB insurance rules. Typically, in those cases you apply Priority Rule 5, and the coverage that has been in effect the longest is primary.

5. COBRA and Medicare

The MSP rules have been in effect for more than three decades, but the MSP reporting rules, which took effect in 2009, have put the spotlight on this "new" requirement. The MSP rules clarify when a group health plan is primary to Medicare. The rules also clarify that employers cannot offer Medicare beneficiaries a financial or other incentive to opt out of employer-provided coverage.

If an individual has Medicare and COBRA coverage, the following rules apply:

- Between COBRA coverage and age-based Medicare coverage, Medicare pays first.
- Between COBRA coverage and disability-based Medicare coverage, Medicare pays first.
- Between COBRA coverage and Medicare based on end-stage renal disease (ERSD), COBRA coverage is primary during the first 30 months of Medicare. Depending on when Medicare started and the maximum COBRA coverage period, you could see COBRA start as primary and finish as secondary.

The Centers for Medicare and Medicaid Services (CMS) takes violations seriously:

- Violating the complex MSP rules could result in the group health plan having to repay all claims that Medicare reimbursed incorrectly.
- A violation of the MSP rules would make the group health plan a non-conforming plan, subject to the 25-percent excise tax imposed by the IRS.
- Group health plans may not offer financial incentives to entice the employee to enroll in Medicare; this could be subject to a civil money penalty of up to \$5,000 per violation.

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ERISA Claims Resulting From COBRA Error Dismissed Due to Exhaustion Requirement

A conversation between a soon-to-be former employee and a representative of the employer does not constitute a formal request or claim for COBRA coverage, nor does it, without further affirmative action by the employee, allow the employee to get around the requirement to exhaust administrative remedies before filing a lawsuit.

An employer's and its insurer's failure to recognize that the employer became subject to COBRA when it began employing 20 or more employees, and thereafter failing to offer COBRA to its qualified beneficiaries, caused an employee to sue alleging ERISA violations against the employer and insurer. However, those claims were dismissed because the aggrieved employee failed to exhaust the plan's administrative remedies before filing her lawsuit. The case is *Dickerson v. Physicians Pain Specialists of Alabama, P.C.*, 2011 WL 4591191 (S.D. Ala., Oct. 4, 2011).

Facts of the Case

Amanda Christine Dickerson, as an employee of Physicians Pain Specialists of Alabama, P.C. (PPSA), participated in the company's group health plan. PPSA contracted with Blue Cross-Blue Shield of Alabama (BCBS) to insure the plan and administer claims.

When PPSA applied for a group health plan in December 2000, it employed fewer than 20 people, and therefore qualified as a small employer, which BCBS calls a "Category A" employer. In November 2007, PPSA received a letter from BCBS, which stated that PPSA was still classified as a Category A employer and requested that PPSA update its information if this classification was incorrect. On Nov. 14, 2007, PPSA's office administrator returned an updated form to BCBS,

indicating that PPSA was a "Category B" employer, meaning that it had more than 20 employees. As a "Category B" employer, PPSA was required to offer COBRA coverage. (See ¶1021 of the *Guide*.) Approximately one year later, in November 2008, the office administrator sent a second form to BCBS indicating that PPSA was a Category B employer. Nevertheless, COBRA coverage was not offered in connection with PPSA's plan.

On June 27, 2008, Dickerson resigned her position, effective as of July 11, 2008. At the time of her resignation, Dickerson approached PPSA's office administrator and "asked him about" COBRA coverage. He told Dickerson that PPSA did not offer COBRA coverage, and the two did not discuss the matter further. Accordingly, PPSA neither sent Dickerson a COBRA election notice nor provided her with COBRA coverage.

Subsequently, Dickerson broke her foot and suffered a mild stroke, both of which required medical care. In December 2008, approximately five months after resigning from her job and after recovering from the broken foot and mild stroke, Dickerson was rehired by PPSA and became covered on the plan effective Dec. 1.

In December 2009, Dickerson and her husband filed for bankruptcy; part of which involved dissolving her debts from medical expenses incurred while she was uninsured.

In March 2010, legal counsel for Janice Bishop, a former PPSA employee, contacted PPSA and asked why Bishop had not been offered COBRA coverage when her employment terminated. PPSA's office administrator researched the issue and determined that due to the company's size, it was required to offer COBRA coverage, which was confirmed by PPSA's BCBS representative. That representative later acknowledged that BCBS had a copy of PPSA's November 2008 notice that PPSA was a Category B employer.


On April 20, 2010, PPSA sent a letter to BCBS requesting that it commence COBRA coverage for its employees, effective retroactively to Jan. 1, 2010. Just a few days earlier, Dickerson's debts had been officially discharged and her bankruptcy case closed.

In June 2010, Dickerson and Bishop sued PPSA and BCBS (subsequently, Bishop's claims were voluntarily

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- Violating the MSP reporting rules could be subject to a civil money penalty of \$1,000 per day, per violation.

The COB rules are extensive and challenging. Keep the OBD priority list in mind. It is a useful tool, akin to finding out what a blind date is like before the date begins. After all, there is nothing worse than flying blind, going into a blind date. Unless it is trying to coordinate benefits without sufficient knowledge of the COB rules. 

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