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Finding sweet spot in benefits co-ordination

Rich, company-paid plans may be footing more than fair share for dependants

BY MICHELE BOSSI

In families with two working adults, it's common for each of them to have coverage under more than one medical or dental plan. However, it can be confusing to figure out which plan to use and how to co-ordinate benefits between plans. Some employees aren't even aware they can claim under more than one plan and, in most cases, receive 100-per-cent reimbursement of eligible expenses.

The Canadian Life and Health Insurance Association (CLHIA) guidelines determine which plan pays first and how benefits are calculated when a claim is made to more than one benefit plan.

Who pays first?

Employees and spouses: A plan is always "first payer" to its own employees and "second payer" to dependent spouses with coverage under their own employer plan.

For example, Luis and Sophie both work and are raising a family. Luis is covered under his own plan as an employee and under Sophie's plan as a dependant. Even though Sophie's plan covers 100 per cent of drugs and Luis' plan only covers 80 per cent, Luis must first submit his claim to his own plan and then submit his claim for the unpaid balance (20 per cent) to Sophie's plan.

Children: When children are covered under more than one parent's plan, the rules are a little more complicated. When both parents have custody, the first payer is the plan of the parent whose birth date falls earliest in the calendar year. If both parents have the same birth date, the first payer is the plan of the parent whose given name occurs first in the alphabet.

Luis, whose birthday is in February, and Sophie, whose birthday is in October, have a child, Jennifer. Medical and dental claims for Jennifer must be made under Luis' plan first.

When only one parent has custody, the first payer is the plan of the parent with custody. If that parent has a new spouse and the child or children are eligible, the new spouse's plan is the second payer. The plan of the parent without custody would be the third payer.

This is Luis' second marriage. He has a son, David, from his first marriage. Luis' first wife, Barbara, has sole custody of David so she would make any medical claims for David under her plan first. Since Barbara has remarried, any unpaid balance would be claimed under her new husband's plan and, if there is still an unpaid balance, under Luis' plan.

When students are covered either through their school or through a part-time job, these plans pay before any plans where they are covered as dependants.

Employers need to communicate these guidelines to employees in simple terms so they can submit their claims to the right plan and avoid the frustration of declined claims.

How benefits are calculated

The plan that pays first pays benefits according to the plan provisions, as it would with any other claim. The plan that pays second calculates payment for each covered item and pays the lower of:

- the amount that would have been paid had the plan been first payer
- 100 per cent of the eligible expenses minus the amount paid by the first plan.

In most cases, co-ordination of benefits between two plans or insurance carriers results in 100-per-cent reimbursement of eligible expenses. In no case does a claimant receive more than 100 per cent of eligible expenses. When submitting claims to the second payer, a copy of the statement of payment or explanation of benefits from the first carrier must be included to process the claim.

Offering more choices to employees

As benefit programs offer increasing choice to employees, it's becoming more important for employees to understand how those benefits are co-ordinated between plans so they can minimize their costs and receive the greatest value from the benefits available to their families.

When employees contribute to the cost of a plan through premiums, they should evaluate the premiums they pay against the cost of unpaid benefits under their spouse's plan. If those premiums exceed the cost of unpaid benefits under the spouse's plan, they may be better off opting out of their own plan and having coverage under the spouse's plan only.

Since Luis is in a contributory plan where he pays premiums, he may be better off opting out of his own plan and being covered as a dependant under Sophie's non-contributory plan that covers 100 per cent.

When evaluating these costs, it's important for employees to read their booklets carefully and compare each of the covered items within the plans. Certain items, such as vision care or paramedical practitioners, may not be covered under both plans. It's also important to take notice of limitations on certain items, such as paramedical practitioners and dental recall exams.

Plans that allow an employee to opt out and receive flex credits or health-spending account credits can be advantageous if a spouse has a comprehensive plan. If credits are more than sufficient to cover unpaid balances from the spouse's plan, the employee can receive 100-per-cent payment and have leftover credits to spend.

Costs should be carefully evaluated

For employers, plan design plays an important role in determining whether or not a plan will be the plan of choice for employees with spousal coverage. A company-paid plan with rich coverage will likely be the plan of choice. While it's attractive to provide the better plan, it means employers with better plans are likely paying more than their fair share of dependants' claims.

But if an employer offers employees a chance to opt out in exchange for spending credits, it will effectively be pushing the claims to the other plans and reducing costs. Employees are generally happy with this arrangement because it gives them a chance to get more out of their combined benefits.

Understanding how benefits are co-ordinated can help both employers and employees manage benefit costs effectively.

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