

The following are brief descriptions of each mandate:

**Coordination of Benefits (COB)** – We are changing the way we process claims for members who have coverage under more than one plan. The change will occur for dates of service beginning Jan. 1, 2008.

We are making these changes to comply with a new rule issued by the Office of the Insurance Commissioner (OIC). There are two significant changes to current practice when Regence is the secondary plan:

**Highest Allowable Expense.** Under the new rule, all health plans processing COB claims will reimburse in the secondary-payer position using the "highest allowable expense" among the paying plans. In other words, we must make a payment that, when combined with the amount paid by the primary plan, will equal 100% of the total allowable expense under the total benefits paid or provided by all plans. However, plans in the secondary position are not required to pay more than their maximum benefit plus any accrued COB savings.

**Example:**

A provider charges \$150 for a service; one health plan may allow \$120 while another allows only \$100. The goal is to pick up the patient balance and ensure that the provider is reimbursed up to the highest allowable--in this case, \$120.

Under current COB rules, when Regence is the secondary plan, we use the amount paid by the primary plan in order to determine our secondary payment. We determine the secondary payment by subtracting the amount the primary plan paid from the amount we would have paid had we been primary. Therefore, payment will not exceed our allowable.

**Estimated Secondary Plan Payment.** If the primary plan's payment amount is unknown, plans in the secondary position now must make a reasonable estimate of the primary plan payment and base their secondary payment on that estimated amount. Once the primary plan payment information is available, secondary plans can recover any excess amount paid after the primary plan pays under the plan's "right of recovery" provision. If the carrier underestimates its secondary payment, an adjustment will be done to pay the additional amount.

**Medically Necessary** – We have revised the definition of this term effective for dates of service beginning Jan. 1, 2008. The definition is modified slightly due to settlement of disputed litigation. The change in definition will not impact administration of medical necessity.

**Dental Necessary Service** – We have revised the definition of this term effective for dates of service beginning Jan. 1, 2008. (Applies to groups with Traditional Dental plans.) The definition is modified slightly due to settlement of disputed

litigation. The change in definition will not impact administration of medical necessity.

**Dental Necessary Service** – We have revised the definition of this term effective for dates of service beginning Jan. 1, 2008. (Applies to groups of 100 or more with Columbia Dental coverage.) The definition is modified slightly due to settlement of disputed litigation. The change in definition will not impact administration of medical necessity.