



BENEFIT *Advisor*

In This Issue

In this eighth issue of the McGraw Wentworth Benefit Advisor for 2007, we will discuss common coordination of benefit provisions that are found in many health plans. Coordination of benefit provisions dictate the payment order when more than one entity may be responsible for a health expense.

This Advisor will review standard coordination provisions between group health plans, coordination with Medicare and Tri-Care programs, and with auto carriers if the expense is a result of an auto accident. Employers should review their coordination provisions every few years to make sure they adequately reserve the most beneficial coordination order allowed by law.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGraw Wentworth web site at www.mcgrawwentworth.com.

“Coordination of Benefits Primer”

Sometimes more than one entity may be responsible for paying a health care expense. For example, a plan participant may be covered by two different employer group health plans. Or a person is involved in a car accident and the health plan and the auto insurance carrier may share responsibility to pay for any necessary treatment. When more than one organization is responsible for paying an expense, disputes often arise over how much of the expense each organization should pay. Unfortunately in these disputes, the participant is stuck in the middle.



Since these dual payment responsibilities occur far more frequently than you would think, health plans have established rules to determine which plan will pay primary and which plan will pay secondary. These rules are typically outlined in the “coordination of benefit” provisions in your summary plan description.

This Advisor summarizes various health plan coordination of benefit (COB) situations including:

- Standard coordination rules between group health plans.
- Standard coordination rules between group health plans and Medicare and TriCare.

- Standard coordination between group health plans and auto insurance carriers.

To ensure your plan pays only for covered expenses, you need to understand your coordination of benefit provisions. In some cases, your plan may be able to shift primary liability for claim expenses to another plan. Review your plan to make sure it coordinates benefits effectively. You also need to ensure your coordination provisions comply with federal and state regulations.

Standard Coordination Rules Between Group Health Plans

Coordination of benefit rules are important to participants covered by two group health plans. If a group health plan is fully insured, state law may govern the coordination of benefits payment order. Self-funded plans can be more flexible in determining payment order.

Coordination of benefit situations could get sticky: for example, if both plans reserved a secondary payer stance, the claim would never get paid. Recognizing the need for a glo-

bal set of rules most plans would recognize, the National Association of Insurance Commissioners (NAIC) released its first set of model COB guidelines in 1971. This model was to serve as an example for employers and state legislatures to adopt as a consistent set of rules for coordinating benefits. The NAIC model rules are amended from time to time, and many plans use the model coordination provisions.

Most COB provisions include the following:

- General rules for employees and spouses covered by two group health plans. The plan that covers the individual as an employee will generally pay primary and the plan that covers the individual as a dependent will generally be the secondary payer.
- The "birthday rule" is common for children covered by two employer group health plans. In this situation, the plan covering the parent whose birthday falls first in the year will pay primary on the children, the other parent's plan becomes the secondary payer. The plans consider only the parent's birth date, not the parent's birth year.
- If the parents are divorced, payment order may be affected. If the divorce decree does not specify health insurance responsibility and the parents have joint custody, the birthday rule applies. If a court order specifies the parent responsible for providing health care coverage, that group health plan is primary.

In a divorce, the coordination of benefit provisions can get complicated. Parents that

remarry can add even more group health plans into the mix. The general guidelines for determining payment are as follows:

- The plan of the custodial parent is primary.
 - Next, the plan of the spouse of the custodial parent pays.
 - Next, the plan of the non-custodial parent pays.
 - And finally, the plan of non-custodial parent's spouse pays.
- If a person has COBRA continuation coverage or any state mandated continuation coverage, the continuation coverage is secondary.
 - If a plan does not spell out coordination of benefit rules, the plan that covered the person for the longer period of time is primary.

Some plans have implemented very creative COB provisions over the years to shift primary responsibility for payment to other plans whenever possible. Several years ago, some plans would limit benefits for any employee covered under another employer's group health plan to \$5,000 a year. Once the employee used up the \$5,000, the secondary plan would take over primary responsibility. These types of provisions generated several lawsuits, which are still being decided, because the secondary plan ended up with the majority of the bills. While it may seem like a clever provision, it creates many questions about determining the primary payer and ul-

timately, if both plans refuse to pay, the employee ends up paying the bill.

Once the plan determines the payment order, it must calculate the payment amount. Coordination of benefit provisions do not allow the claimant to receive more than 100% of the eligible charges between both health plan payments. Plans take different approaches when they calculate coordination of benefit payments:

- **Full COB:** If your plan includes a full COB method, the primary plan calculates the claim payment as if there is no other insurance involved. The secondary carrier also calculates what benefit amount would have been paid for the claim if there were no primary carrier involved. The primary plan pays the benefit as calculated. The secondary

carrier pays the balance if its calculation shows at least that amount would have been payable if no other coverage had been in

place. For example, let's say a participant is covered by two plans, both with a \$250 deductible. The participant incurs a \$100 expense subject to the deductible. The primary payer applies \$100 to the deductible and pays none of the expense. The secondary carrier would also apply the \$100 to the deductible (calculating payment as if no



other coverage is in place), no benefit would be payable. The participant will need to meet the deductible before either the primary or secondary plan starts paying.

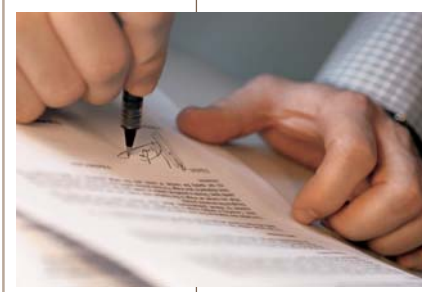
- Non-Duplication:** Under a non-duplication method, the secondary plan does not reimburse any more on the claim than it would have paid, if it were the primary payer. The secondary carrier reviews the primary paid amount. If the primary carrier's paid amount is equal to or more than what the secondary payer would have paid on its own, no benefit is payable. This approach is also referred to as a "maintenance of benefits" approach. This provision is commonly found in self-funded plans. For example, if both health plans had the exact same benefit structure, there would be no benefit to having dual coverage if the non-duplication approach to COB was used. Both plans calculate benefits payable as if no other carrier was in force. The secondary carrier looks at the benefits paid by the primary carrier. In this situation, since the benefits would be exactly the same (remember both plans have identical benefit designs), the secondary plan would never make an additional payment.
- Supplemental COB:** Under a supplemental method, the primary plan determines the amount it will pay, and the secondary plan pays the balance of allowable expenses after the primary plan payment. The secondary plan will apply its deductible and coinsurance when calculating

the secondary payment. This COB provision is not as common as full COB or a non-duplication of benefits approach.

These methods discuss how the payment is calculated when two group health plans coordinate to pay benefits for a covered expense. How the benefits are paid should also be discussed with your vendor. This information is critical if your plan is administered by Blue Cross Blue Shield of Michigan (BCBSM). The Blues have several options available for managing COB and you want to make sure your plan is paying claims responsibly.

The Blues options for administering COB are as follows:

- Pay and Pursue:** This approach is the least favorable to employers. BCBS pays the claim, regardless of the payer status (primary or secondary). If it is determined that another carrier should have paid primary, the Blues pursue a reimbursement.
- Passive Pursue and Pay:** The passive approach involves BCBSM sending letters of inquiry (LOI) on any claim submitted that could involve coordination of benefits (dependent claims, accident claims, and so on). If an employee fails to respond to the letter of inquiry within 45 days, BCBSM will pay the claim primary and then pursue a recovery if the primary responsibility belongs to another party.



- Aggressive Pursue and Pay:** The aggressive approach also involves BCBSM sending letters of inquiry on any claim that could involve coordination of benefits. However, under this approach, if an employee fails to respond to the letter of inquiry within 45 days, then the claim is denied until BCBSM receives a response.

If your plan is with BCBS, you should be using the aggressive pursue and pay strategy. You may assume this is how your plan is set up, but you should verify this with BCBS.

Most other claims payers are also very aggressive in managing COB provisions. If there is any indication the claim may be payable by another party, it is typically flagged and investigated. Most payers will not release payment until they are confident they are responsible for the claim.

To learn how your plan calculates coordinated benefits or how your claims payer administers COB situations, take the time to ask your payer about the process and your organization's potential options.

Standard Coordination Rules with Medicare and TriCare

It is likely at least one of your plan's covered participants is also covered by Medicare or Tri-Care, the plan that covers active and retired members of the military services.

Medicare used to pay primary for any Medicare beneficiary. The payment order changed in the nineties. The government was looking to control the cost of the Medicare program and decided to take a secondary stance to coverage available by virtue of current employment status. This shifted primary payment responsibility, in many cases, back to employer-sponsored benefit plans.

Recently, the federal government decided to make the Tri-Care program secondary as well using Medicare secondary payer rules. For that reason, the Medicare rules discussed in this section also apply to any employee covered by Tri-Care.

Medicare is the secondary payer to all of the following types of coverage:

- All forms of liability insurance (general business liability, workers' compensation, and so on).
- Automobile insurance and no-fault automobile insurance.
- Group health plans that cover end-stage renal disease patients (ESRD).
- Group health plans of employers with 20 or more employees that cover current employees and/or their spouses after age 65.
- Large group health plans, sponsored by employers with more than 100 employees that cover currently employed Medicare eligible individuals.

For patients with ESRD, if they are covered by a group health plan,

Medicare is the secondary payer for the first 30 months. After 30 months, Medicare becomes the primary payer. If the patient becomes eligible for Medicare because of end stage renal disease and turns 65 during the 30-month time period, Medicare remains the secondary payer until 30 months have elapsed. Even though the patient is now old enough to qualify for Medicare by virtue of age, the fact the individual first became eligible only because of ESRD keeps the health plan paying primary for the full 30 months.

Also, employers with 20 – 100 employees have special rules. The group health plan must offer coverage to individuals 65 or older, if the individual meets the eligibility requirements of the plan. However, if the employer falls in this size range, individuals have a choice to elect Medicare coverage or the group health plan coverage. There are specific rules that apply to employers of this size that make it illegal for the employer to provide any incentive to the employee to choose Medicare primary over the employer's plan. The government has stated

that if a company offers an "opt-out" bonus to any employee that waives coverage under the plan because of other group health coverage; this will not violate the Medicare Secondary Payer rules.

However, if you structure any incentive to encourage a Medicare eligible individual to elect Medicare coverage instead of your group health plan, it will be an issue. In fact, the government really does not want employees to elect Medicare primary so they do not allow an employer's plan to pay secondary to Medicare.

If an employee selects Medicare primary, Medicare is the only coverage that will be provided. When Medicare coverage is compared with most group health plan benefits, clearly the group health plan should be the plan of choice.

Finally, Medicare considers employers with over 100 employees to be large group health plans, and it always pays secondary to these plans for Medicare beneficiaries with coverage by virtue of current employment status.

These coordination rules apply specifically to currently employed Medicare eligible plan participants. They also apply to any of their covered dependents. To ensure health plans are not paying secondary to Medicare, the government monitors payments very closely. Your organization has likely received a data match request from CMS (Centers for Medicare and Medicaid Services). Be sure to reply to these requests promptly.

The rules for retiree health plans are different. In general, at this point, Medicare becomes primary and your retiree health plan will be secondary.

Standard Coordination with Auto Insurance Carriers

Coordination of benefits becomes important in auto accidents as well because an employee may be covered under both the group health plan and the auto carrier's plan.

Since Michigan is a no-fault auto insurance state, coordinating health and auto coverage can be tricky. The state regulates payment order for medical services required because of an automobile accident.



The payment order depends on how your plan is funded. If your plan is fully insured under state law, it must be the primary payer for auto accident injuries. This law applies to any carrier fully insuring plans in Michigan.

If your plan is self-funded, your plan is exempt by ERISA from complying with state law. Therefore, your plan can reserve a secondary payer status for auto accident expenses. Your plan could choose not to cover auto accident related expenses at all. It is very important your summary plan description states your health plan's payment stance related to auto coverage. Some plans pay secondary, other plans do not cover these expenses at all.

If your plan covers employees in other states, state law may dictate payment order. There are not that many states that have no fault auto provisions, so it is very typical that states won't have mandates specifying payment order with auto accident claims. In this situation, it is up to your plan to dictate the payment status. If not obligated by law, your plan wants to reserve a secondary payment stance for auto accidents.

It is important to note, it is *not* common for auto carriers to cover medical expenses as a result of an auto accident in full in states other than Michigan. Typically, the individual buys a certain level of medical benefit coverage with an auto insurance carrier. It may limit medical benefits payable to \$10,000 or \$25,000 per incident. In this case, when the secondary stance is reserved and if medical expenses are sizable; your health plan will bear some of the responsibility for paying certain medical expenses as well.

This is not the case in Michigan where the no-fault auto insurance law requires the majority of medical expenses related to the accident be payable by the auto carrier. This is substantial as the auto carrier may pick up the majority of the cost. That, of course, is if your plan is self-funded and you can reserve a secondary payment stance.

This also explains why auto insurance carriers in Michigan typically inquire about your medical benefits periodically. At the same time you purchase auto coverage, you are asked if you need to purchase coordinated or uncoordinated medical benefits. This speaks to the type of health insurance that covers you and your family.

It is important to understand how your plan coordinates with auto coverage. In Michigan, if your health plan is fully insured, your plan must pay primary on auto accident medical claims. It is required by state law. If your plan is self-funded, your plan is exempt from complying with state law by ERISA. This means you can reserve a secondary payment stance or exclude coverage for injuries incurred in an auto accident all together.

If you have employees in other states, you may have more flexibility in coordinating with auto coverage. It is important to understand any state law restraints but whenever possible it makes sense to reserve a secondary stance to auto insurance.

Concluding Thoughts

Coordination of benefits provisions have not been around since the beginning of time, it just seems that way. They were introduced in the seventies by the National Association of Insurance Commissioners. They are a critical provision in your health plan because they clarify the primary and the secondary payer when one or more entities may be responsible for paying a claim.



State and federal law may dictate how your plan is required to pay when more than one party is liable. If the law does not apply, the health plan can determine

payment order. The best stance to take, if it is possible, is a secondary stance for payment. Most plans follow the NAIC model COB provisions.

In general, organizations do not tend to review the COB portion of the medical plan regularly. Employers seem to reexamine the provisions only when they have a claim that may be another party's responsibility. It is good practice to check your COB provisions every few years to make sure they reflect your plan's intentions accurately. In addition, ask your health plan vendor how coordinated benefits are calculated and how the vendor manages the COB process.

If you have any questions, please contact your McGraw Wentworth Account Manager. **MW**

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