

## **Information Regarding Coordination of Benefits With Medicare**

When you or your dependents have coverage under more than one health care benefit plan, policy or arrangement (“Benefit Plan”), an affiliate of UnitedHealthcare Services, Inc. (“United”) will determine the amount of benefits to which you are entitled under the Benefit Plan administered by United using a procedure called “Coordination of Benefits” or “COB.” This article does not provide an exhaustive explanation of how COB applies to all Benefit Plans. The Benefit Plan to which you are a member may vary from the practices contained in this article. The terms of the Employer Plan and applicable law will always govern in determining any entitlement to benefits. For example, some states mandate COB practices that may differ from the practices reflected in this article, and United will follow the laws or regulations that apply in those states. If you require information regarding your Employer Plan or to learn exactly how a particular claim was processed, you should consult your Employer Plan documents or contact United’s customer service department at the phone number listed on the back side of your insurance card.

In this article, United will discuss the COB procedure that it employs most frequently when you receive health services from an out-of-network provider or a provider who does not accept Medicare, and United must perform COB between Medicare and a Benefit Plan that it insures or administers. By “out-of-network” provider, we refer to a health care provider who has not entered into a participating provider agreement with United. When we say that United “administers” a Benefit Plan, we mean that United processes your claims for reimbursement under a Benefit Plan sponsored and funded by your or your spouse’s employer. When we say that United “insures” a Benefit Plan, we mean that a Benefit Plan is sponsored by your, your spouse’s, your parent’s or your domestic partner’s employer, and United both administers the plan and pays benefits from its own assets under a group insurance policy with the employer. In this article, we will refer to Benefit Plans insured or administered by United and sponsored by your, your spouse’s, your parent’s or your domestic partner’s employer as an “Employer Plan.”

When a member is covered by more than one Benefit Plan, United and other insurers, administrators or government agencies apply COB procedures under the Benefit Plans they administer to decide which Benefit Plan pays first and the amounts that must be paid by each Benefit Plan. Regardless of the type of Benefit Plan involved, an important objective of a Benefit Plan’s COB procedures is to prevent payment of more than 100-percent of the “Allowable Expenses” as provided by the Benefit Plan that is the Primary Plan. The “allowable” or “allowed” or “approved” expense refers to that portion of a health care provider’s billed charges that is subject to, or eligible for, a benefit payment from a Benefit Plan.

Set forth below is a general overview of how United determines the order in which two different Benefit Plans are responsible for claims payment and how United determines the “Allowable Expense” when United performs COB. We will then discuss how United performs COB with Medicare, when you receive health care services from an out-of-network provider or a provider who does not accept Medicare.

### **Determining Which Plan is Primary**

If you or your dependents are covered by more than one Benefit Plan, United will apply the

terms of your Employer Plan and applicable law to determine that one of those Benefit Plans will be the Primary Plan. The “Primary Plan” is the Benefit Plan that must pay first on a claim for payment of covered expenses. The Primary Plan is the plan that must determine its benefit amount as if no other Benefit Plan exists. Other Benefit Plans that cover you or your dependent are “Secondary Plans.” Any Secondary Plan may pay certain benefits in addition to those paid by the Primary Plan. For example, if your spouse covers you under her Employer Plan and you are also covered under a different Employer Plan, your Employer Plan is the Primary Plan for you, and your spouse’s Employer Plan is the Secondary Plan for you.

COB also applies when you or your dependents have health coverage under Medicare, worker’s compensation or motor vehicle or homeowner’s insurance. Your Employer Plan will often have a specific section entitled “Order of Benefit Determination Rules” which sets forth how your Employer Plan identifies the Primary Plan.

### **Medicare**

When you or any of your dependents are a member of an Employer Plan and you also are eligible for Medicare, United will apply the terms of the Employer Plan along with rules and regulations of Medicare in determining whether Medicare or your Employer Plan will be the Primary Plan. In general, under Medicare, working status and group size -- the number of employees covered under an Employer Plan -- determine when Medicare is primary. The Employer Plan is primary for people who are 65 or older, still working for an employer with 20 or more employees and eligible for Medicare. If the employer has fewer than 20 employees, Medicare is primary. If you retire, are eligible for Medicare and retain coverage under your Employer Plan, Medicare is primary. Other COB rules for Medicare apply if you are disabled and covered by a large Employer Benefit Plan or are covered under COBRA continuation benefits. If you are eligible for Medicare because you are disabled, or eligible for any reason other than age, please contact your plan administrator, the claims administrator or Medicare for information about the specific Medicare rules that apply to your circumstances.

### **Allowable Expenses**

As stated above, your Employer Plan describes the health care benefits that you or your dependents are entitled to receive. When United is a claims administrator for your Employer Plan as described above, you should refer to a document called a “summary plan description” (“SPD”) for a summary of the terms for your Employer Plan. Your employer is responsible for providing you with your SPD. When United is the insurer for your Employer Plan, you should refer to a document called a “certificate of coverage” (“COC”) for a summary of the terms of the group insurance contract for your Employer Plan. United is responsible for providing you with a copy of your COC. The SPD will inform you of whom you may contact for information about your coverage.

The Employer Plan will frequently provide a definition of the Allowable Expense that will be used in determining the amount of the benefit payable when coordinating benefits with another Benefit Plan. For example, an Employer Plan may define the Allowable Expense as “a health care service or expense. . . covered at least in part by any of the Coverage Plans covering the person.” The ‘Allowable Expense’ is a health care expense that is covered at least in part by one

of the health benefit plans covering the participant. In Coordination of Benefits between or among plans, there is always only one amount identified as the Allowable Expense.

The definition of Allowable Expense may also identify the sources which provide the amount that United will use as the Allowable Expense when coordinating benefits. Such sources may include the fee schedule for a provider who participates in a network of providers with whom United or some other managed care organization has a contractual relationship, or the “reasonable and customary amount” which United and other managed care companies determine by reference to various resources such as the applicable Fair Health database (*See* <http://www.fairhealth.org/>). When United coordinates benefits with Medicare and Medicare is the primary coverage plan, United will use the “explanation of Medicare benefits” issued by Medicare (the “EOMB”) to obtain Medicare’s Allowable Expense and will use the Medicare Allowable Expense to determine the amount payable, if any, by any secondary coverage such as your Employer Plan (referred to as a “secondary benefit”). But if an EOMB is not available because, for example, services were received from a provider who opted out of or did not accept Medicare, United may use other methods to determine the secondary benefit which will result in a secondary benefit that is equal to or greater than the secondary benefit that would have been payable if Medicare had paid your provider. This method for determining the secondary benefit when an EOMB is not available will be further described below.

The Employer Plan typically will provide a list of examples for determining the amount of the Allowable Expense. This list of examples is often based upon the examples used in Model Regulations published by the National Association of Insurance Commissioners (*See* <http://www.naic.org/store/free/MDL-120.pdf>).

### **Two COB Methodologies**

The Employer Plan will adopt one of two methodologies that United will use in performing COB for an Employer Plan. One method is known as the “non-duplication” (or “non-dup”) method. The other method is known as the “come out whole” method. There are two different types of “come out whole” structures as well – those with and without an excess benefit reserve or “bank.”

Under an Employer Plan that adopts the non-dup method, United compares: 1) the portion of the “Allowable Expense” it would pay, to 2) the amount of the “Allowed Expense” actually paid by the Primary Plan. After comparing these two amounts, United will pay secondary benefits for the Employer Plan only if the Plan would pay more than what the Primary Plan paid. Such a structure ensures that the member’s personal financial responsibility, if any, for a portion of the “Allowable Expense” under the Employer Plan is preserved.

For example, if the “Allowable Expense” under the Primary Plan was \$100 and the Primary Plan maintained coverage at 80% of the Allowable Expense, the Primary Plan would pay \$80 on the claim. If the Employer Plan also maintained coverage at 80% of the Allowable Expense, the Employer Plan would also pay \$80 if it were the Primary Plan (\$100 “Allowable Expense” x 80% coverage percentage). Because the \$80 United would pay under the Employer Plan is the same as what the Primary Plan actually paid, United would pay no additional secondary benefits

from the Employer Plan on the claim. The member would remain responsible for the \$20 portion of the “Allowable Expense” that is not covered by either plan.

Under an Employer Plan that adopts the come-out-whole method, United compares: 1) the amount of the “Allowable Expense” that the Employer Plan would pay, to 2) the member’s personal financial responsibility remaining after the Primary Plan (i.e., Medicare) has paid its benefit. The Employer Plan using the come-out-whole method will pay as a secondary benefit an amount sufficient to cover that remaining financial responsibility up to the amount of the Allowable Expense. Any amount left over is then credited to a benefit reserve or “bank,” if the Employer Plan has one.

For example, if the “Allowable Expense” under the Primary Plan was \$100 and the Primary Plan maintained coverage at 80% of the Allowable Expense, the Primary Plan would pay \$80 on the claim. If an Employer Plan using the come out whole method also had a coverage percentage of 80% of the Allowable Expense, such that it would pay \$80 on the same claim if it were the Primary Plan, there would be a maximum potential payment of \$80 from the Employer Plan as a secondary benefit. In this example, where the Employer Plan is the Secondary Plan, United would pay \$20 to cover the member’s remaining personal financial responsibility (which is calculated by subtracting the Primary Plan’s payment of \$80 from the “Allowable Expense” of \$100); and if the Employer Plan had an excess benefit reserve, United would deposit the remainder (\$60) in the “bank,” where it would be applied to cover any other member financial responsibility (co-pays, co-insurance, etc.) on other claims through the remainder of the year.

### **Medicare COB Under a “Non-Dup” Benefit Plan**

An Employer Plan frequently will describe the procedures United will follow when it coordinates benefits with Medicare. The following discussion is a more detailed description of the three steps United takes to determine the benefit under many Employer Plans which have adopted the “non-dup” methodology to coordinate benefits with Medicare when Medicare is the Primary Plan.

#### **Step 1: Determine the Medicare “Allowable Expense”**

United’s first step when coordinating benefits between an Employer Plan and Medicare is to determine Medicare’s “Allowable Expense.” When Medicare makes an actual payment to a provider for delivering health care services to a member, United uses the Medicare Allowable Expense as set forth on an EOMB following that provider’s delivery of health care services to the member.

#### **Step 2: Determine The Employer Plan’s “Would Pay Amount”**

United’s second step when coordinating benefits between the Employer Plan and Medicare is to determine the “Would Pay Amount”—i.e., “the benefit payments that the Employer Plan would have paid had it been the Primary Plan.” United uses the same Allowable Expense set forth on the EOMB to determine the Employer Plan’s “Would Pay Amount.” United coordinates benefits with Medicare in this manner because the Medicare Allowable Expense is the same amount that the Employer Plan “would pay” if it were Medicare. This procedure is also dictated by rules and regulations adopted by the government under Medicare.

United determines the Employer Plan's "Would Pay Amount" by multiplying the Medicare Allowable Expense by the Employer Plan's coverage percentage for the service. For example, if Medicare's Allowable Expense for a service was \$100 and the Employer Plan's coverage percentage for that service was 100%, then the Employer Plan's "Would Pay Amount" would be \$100 (i.e., \$100 x 100%).

### Step 3: Compare the Medicare Primary Benefit With the Employer Plan's "Would Pay Amount"

If the Employer Plan's "Would Pay Amount" determined under Step 2 exceeds the Medicare primary benefit based on the Allowable Expense determined based on Step 1, the Employer Plan will pay the difference as a secondary benefit under the Employer Plan.

### Medicare COB When Medicare Does Not Pay The Provider

In some circumstances, Medicare does not make an actual payment to the member's provider, either because a Medicare-eligible member is not enrolled in Medicare or the member visited a provider who does not accept, has "opted-out" of or for some other reason is not covered by the Medicare program. When a provider does not accept, has "opted-out" of or is not covered by the Medicare program, that means that the provider is not allowed to bill Medicare for the provider's services and that the member may be responsible for paying the provider's billed charge as agreed in a contract with the doctor that the member signs.

Medicare will not issue an EOMB when a member is eligible for but not enrolled in Medicare or when a member receives services from a provider who does not accept, has opted out or is not covered by Medicare. Accordingly, United cannot refer to an EOMB to obtain the Medicare Allowable Expense, and must determine the Medicare Allowable Expense using a different methodology. In such circumstances, United has adopted a methodology that mimics United's methodology for COB where a participant sees a Medicare provider. In these circumstances, United treats the provider's billed charge amount as the Medicare Allowable Expense. United sometimes refers to the use of the provider's billed charge in these circumstances as an "estimation." Employer Plans allow United to "estimate" in these circumstances either based upon express language or based upon United's reasonable interpretation of language in the Plan.

When United uses the provider's billed charge as the Allowable Expense both for Medicare and any Secondary Plans, the resulting secondary benefit payment is at least equal to and, in many cases, more generous to members than if the member visited a Medicare provider, or if United were to refer to the Medicare fee schedule to determine the Allowable Expense. This is because providers' billed charges are generally higher than Medicare fee schedule amounts, often significantly so. If Medicare's coverage percentage and the Employer Plan's coverage percentage match, then mathematically no secondary benefit will be payable in a non-duplication plan structure whether United uses billed charges or the Medicare fee schedule amount as the Allowable Expense. However, when the Employer Plan's coverage percentage is higher than Medicare's, the Employer Plan will make a secondary payment, and use of the billed charge as the Allowable Expense (rather than a lower amount such as the Medicare fee schedule amount) will result in a larger secondary benefit payment.

For example, if a provider's billed charge is \$200, the Medicare coverage percentage is 80%, and the Employer Plan's coverage percentage is 100%, United's methodology would result in a secondary benefit payment of \$40 ( $\$200 \times 100\%$ , minus  $\$200 \times 80\%$ ). By contrast, if the Medicare fee schedule were used to determine the Allowable Expense and it was \$100 for that same procedure, then the Employer Plan's secondary benefit payment would be \$20 ( $\$100 \times 100\%$ , minus  $\$100 \times 80\%$ ).