COORDINATION OF BENEFITS



APWU HEALTH PLAN

TOGETHER.
BETTER HEALTH.®

33rd Annual Open Season Seminar

Definition of COB

- **COB** (**Coordination of Benefits**): The process by which a **health insurance** company determines if it should be the primary or secondary payer of **medical** claims for a patient who has **coverage** from more than one **health insurance** policy.

Executing Coordination of Benefits

- Follow guidelines issued by the National Association of Insurance Commissioners (NAIC) to determine order of liability
- Primary Plan processes first
- Secondary Plan calculates liability based on primary Plan's handling
- Payment between the Plans should never exceed the total charge
- APWUHP will never pay more than it would in absence of other insurance coverage

COB Factors

- Who pays first? Who pays second?
  - Type of Plan
  - Subscriber of the Plan
  - Patient relationship (subscriber vs. dependent)
  - Date of birth of subscriber
  - Employment status of subscriber
  - Employment status of the patient

Types of Medical Plans

- Group Plans like APWU Health Plan
- Medicare
- Medicaid
- No Fault/Homeowner's
- Worker's Compensation
- TRICARE/CHAMPVA
- FEDVIP

Group Coverage

- Available through Employer
  - Retirement
  - Active
- Coverage is typically the primary payer for subscriber of Plan
- Other group coverage available as a dependent would be secondary

Group Coverage

Continued….

- Joe Schmoe works at Acme Produce and is the subscriber in a family Plan with ABC Health Plan, sponsored by his employer
- Lo Schmoe works at the USPS and is enrolled in a Self and Family Plan with the APWUHP
  - ABC Health Plan is primary for Joe and secondary for Lo
  - APWUHP is primary for Lo and secondary for Joe

Group Coverage

Continued….

- Children covered by both parents' policies
  - Birthday rule dictates which plan is primary for the children
- Children also covered as a subscriber based on their own employment
  - Coverage available through the dependent's employment would be primary

Plans Who Always Pay Primary

- Some Plans are designed to always pay primary for certain services
- With these plans, there is normally no patient responsibility after the plan's payment
  - Worker's Compensation
  - No Fault/Homeowner's
    - Subrogation
- If plan exhausts benefits available, APWUHP will assume primary liability

Plans Who Always Pay Secondary

- Some Plans are designed to pay secondary when there is other group coverage available
  - Medicaid
  - FEDVIP
  - TRICARE/CHAMPVA
    - Program for dependents of military personnel, military retirees or disabled Veterans
- APWUHP pays primary to benefits available under these plans

What is Medicare and who is eligible?

- Federal Health Insurance Program for aged and disabled
  - Over age 65
  - Disabled workers
  - Patients with End Stage Renal Disease (ESRD)
  - Patients with Lou Gehrig's disease (ALS)

Notification of Eligibility

- Mailing to those nearing age 65
  - 90 days prior to 65th birthday
  - Encourages visit to Social Security Administration
  - Explains options if still employed
  - Follow-up letter sent at 60 days if no response
- Those newly diagnosed with ESRD
  - APWUHP will be primary to Medicare for a period of 33 months beginning with patient's first dialysis treatment
  - We will reach out to secure a copy of patient's Medicare ID during this 33-month coordination period
  - Dialysis centers usually assist patients in completing their application for Medicare benefits

What if I'm still working?

- Working aged and disability
  - While you are still working, APWU Health Plan will remain your/your spouse's primary carrier
  - We encourage signing up for Medicare Part A since it requires no premium
    - Reduce out-of-pocket expenses if confined
  - Enrollment in Part B is not encouraged while you are still employed; requires monthly premium

What if my spouse is employed?

- If your spouse has health insurance through active employment, Medicare would be secondary to that coverage
  - If both you and your spouse are covered by any insurance available through active employment, Medicare will not be your primary carrier until retirement takes place

Types of Medicare

- Medicare Part A
- Medicare Part B

(Traditional Medicare)

- Medicare Part C (Medicare Advantage)
- Medicare Part D

Traditional Medicare

- Part A – Hospital Insurance
  - Inpatient facility costs including a qualifying stay in a Skilled Nursing Facility (SNF)
  - Some home health services
  - Hospice care
  - No premium

Traditional Medicare

- Part B – Medical Insurance
  - Physicians professional services, in and outpatient
  - Outpatient hospital services
  - Therapies
  - Some home health care
  - DME, supplies
  - Available for a monthly premium
    - Deducted from your monthly Social Security payment
    - A delay in applying for Part B when eligible, could result in an increased premium

Medicare Advantage

- Medicare C/Medicare Advantage
  - Private health carriers like regional HMO or PPO Networks who assume liability for paying on behalf of Medicare A and B
  - Beneficiary choice to forgo Traditional Medicare in lieu of enrollment with a Medicare Advantage Plan
  - Premiums vary by Plan based on many factors
  - Minimally, plans must provide comparable coverage to Medicare A and B

Medicare Advantage

Continued…

- Medicare C could cover items not covered under Traditional Medicare (Vision, Dental, etc.) for an additional premium
- Most Medicare C Plans include Rx coverage (Part D)
- APWU Health Plan will coordinate with Medicare C
- If patient uses a doctor who is not a part of the Medicare C Plan's network, APWU Health Plan will assume primary liability for those charges

Medicare Rx Coverage

- Medicare D
  - Run by Medicare-approved private insurance companies
  - Additional premium required
  - As a member of APWU Health Plan, we don't recommend the need for Medicare D coverage
  - APWU Health Plan's prescription coverage offers the same or more than one would receive with Medicare D

Coordination with Medicare A

- Inpatient Hospital Expenses
  - Medicare Benefit Period
    - Begins the first day you are admitted to a hospital
    - Ends when you have been out of a hospital or SNF for 60 consecutive days
    - Medicare pays 100% less a deductible for the first 60 confinement days of a Benefit Period
    - Medicare pays 100% less a per day coinsurance amount for confinement day 61-90 of a Benefit Period
      - For each new Benefit Period, the first 90 utilization days are renewable

Coordination with Medicare A

Continued…

- Optional, Medicare pays 100% less a per day Life-time Reserve amount for confinement day 91-150; These days are not renewable over Benefit Periods
  - If a patient opts to not use his/her LTR days, APWU Health Plan would assume primary liability for the remainder of the confinement and preauthorization requirements would apply
- Preauthorization requirements are waived when Medicare is paying primary

Coordination with Medicare A

Continued…

- Prior to confinement day 90, APWU Health Plan suggests that the hospital reach out to Cigna/CareAllies for preauthorization
  - This will ensure continued coverage should the patient choose not to use LTR days
- APWU Health Plan will coordinate payment of the inpatient deductible, coinsurance and LTR days

Coordination with Medicare A

Continued…

- Patient should not have any out-of-pocket expenses when Medicare A is paying primary

Coordination with Medicare A

Continued…

- Skilled Nursing Facility (SNF) Coverage
  - Medicare pays up to 100 days of care in an approved SNF after a qualifying in-patient stay
    - First 20 days of confinement are paid at 100% by Medicare A
    - Day 21 – 100 are paid at 100% less a per day coinsurance amount

Coordination with Medicare A

Continued…

- APWUHP SNF Coverage 2019
  - If APWU is secondary to Medicare, there is no need for preauthorization
  - APWU covers up to 30 days a year for care in a SNF
  - APWUHP will pay the Medicare co-insurance assessed for day 21 through day 30

Coordination with Medicare B

- Professional Services
  - Part B deductible applies before Medicare begins paying
  - Once satisfied, Medicare usually pays 80% of their approved amount
  - Some services are reimbursed by Medicare at 100% (most lab, covered preventive services)
  - Patient responsibility amounts could vary from the norm when there is coverage through Medicare C

Coordination with Medicare B

Continued…

- When Medicare Part B is paying primary:
  - Preauthorization requirements are waived
  - APWU Health Plan deductible, coinsurance and copays are waived
  - Little to no member out-of-pocket costs
  - Member could be responsible for the balance after Medicare where the service is one that is not covered by APWU Health Plan (i.e. chiropractic services in excess of our annual limit)

Coordination with Medicare C

- When Medicare C is paying primary
  - APWU Health Plan deductible, coinsurance and copays are waived
  - Little to no member out-of-pocket costs
  - Preauthorization requirements are waived
  - Member could be responsible for the balance after Medicare C where the service is one that is not covered by APWU Health Plan

NOTE: Because of the various Medicare C carriers, deductibles, copays and coinsurance will vary by Plan

Services Not Covered by Medicare

- When APWU Health Plan becomes primary:
  - Medicare (A, B, or C) denies services because they are not covered
  - If the service is covered by APWU Health Plan, we will apply our normal deductible, copay or coinsurance; the same as if the patient had no Medicare
  - Preauthorization requirements are enforced

Known Services Not Covered by Medicare

- Hearing Aids
- Shingles Vaccine (covered by Medicare D)
- Eye Exams/Refractions
- Some chiropractic services
- Skilled Nursing Visits
- Acupuncture
- Dental Services

Services Not Covered by Medicare

Continued…

- Often, when Medicare denies a service, the fee for the service has to be written off by the provider
  - Not all services denied by Medicare become a patient responsibility
  - Medicare may deny a service that the patient would not have known was excluded or did not have the opportunity to decline service
  - Exception: when patient signs a waiver to have the service rendered, knowing Medicare may not cover it

Medicare Assignment

- Most providers accept Medicare assignment
  - Difference in physician's fee and Medicare allowed amount must be written off by the provider
- When assignment is not accepted
  - Provider can only charge up to 115% of Medicare's normal allowance; any difference must be written off

Medicare Assignment *(Continued)*

Medicare Assignment Accepted

- Physician Fee $200
  - Medicare Allows $150
  - Medicare Pays $120
  - Medicare Coinsurance $30
  - Provider Write-off $50
  - APWU Pays $30
  - Patient Pays $0

Medicare Assignment Not Accepted

- Physician Fee $200
  - Medicare Allows $150
  - Medicare Pays $120
  - Medicare Coinsurance $30
  - Med B Limiting $22.50
    - 15% Additional Allowance
  - Provider Write-off $27.50
  - APWUHP Pays $52.50
  - Patient Pays $0

Filing Medicare Primary Claims

- Traditional Medicare (Parts A, B, D)
  - Provider will bill Medicare as the primary carrier
  - Medicare will then bill APWUHP as secondary carrier
    - Medicare billing to us is automatic and patient should not be required to submit paperwork to the Plan
- Medicare Advantage (Part C)
  - Provider will bill Medicare as the primary carrier
  - Member will be responsible to provide APWU Health Plan with a copy of the original claim for services along with the corresponding remittance/EOB from the Medicare C Plan.

When a Patient is Not Eligible for Medicare A

- When a patient does not work long enough under Social Security, they may not earn the quarters needed to qualify for cost-free Medicare A
  - If married, they could qualify through their spouse
  - If such a patient is confined as an inpatient, there is a limit to what the hospital can charge
  - Medicare DRG* Limiting fee

*Diagnosis Related Group (Medicare Equivalent Amount)

When a Patient is Not Eligible for Medicare A

- NOTES:
  - A patient who does not qualify for Part A based on their (or spouse's) earnings can purchase Part A coverage for a monthly premium
  - This option would be cost-prohibitive given coverage already available through APWU Health Plan

When a Patient Chooses Not to Enroll in Medicare Part B

- Even if a patient is not eligible for cost-free Medicare A, all who are 65 or over are eligible to enroll in Part B
- If a patient chooses not to enroll in Part B, some fees they can be charged by physicians are capped
  - Called Medicare B Limiting*
    - Physicians must write off any difference in their original fee and the Medicare B Limiting allowance

*Medicare Approved Amount

Medicare Costs

- **Cost Share - Patient Responsibility 2018**
  - Medicare A Deductible Day 1 – 60: $1,340
  - Medicare A Coinsurance Per Day 61-90: $335
  - Medicare A LTR Per Day 91-150: $670
  - Medicare A SNF Coinsurance Per Day 21-100: $167.50
  - Part B Deductible: $183
  - Part B Premium: $134
  - Part A Premium: $232 - $422

THANK YOU!

You will receive an email following our Seminar with a link to fill out your class evaluations online.

Please note any questions for the Roundtable discussion on the card provided and place in the drop box at the Registration Desk.

The Roundtable discussion will be during Closing Session:

Sunday, October 28, 2018

