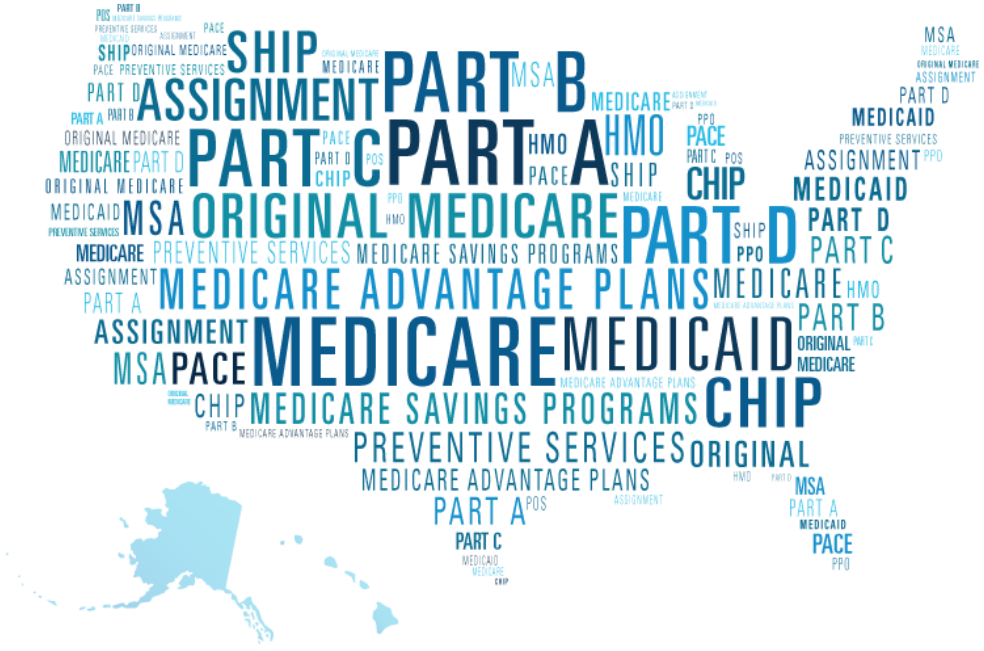
2014 National Training Program

Workbook

Module: 5
Coordination of Benefits



Centers for Medicare & Medicaid Services
National Training Program
Instructor Information Sheet

Module 5 - Coordination of Benefits

Module Description

The lessons in this module, "Coordination of Benefits," explain the coordination of health insurance benefits for people with Medicare who have multiple sources of health insurance. This module explains health and drug insurance coordination, how to determine which pays first, and where to get additional information.

The materials—up-to-date and ready-to-use—are designed for information givers/trainers who are familiar with the Medicare program, and would like to have prepared information for their presentations.

Objectives

- Explain health and drug insurance coverage coordination
- Determine who pays first
- Learn where to get additional information

Target Audience

This module is designed for presentation to trainers and other information givers.

Time Considerations

The module consists of 44 PowerPoint slides with corresponding speaker's notes and knowledge check activities. It can be presented in 50 minutes. Allow approximately 30 more minutes for discussion, questions, and answers. Additional time may be added for add-on activities.

Course Materials

Most materials are self-contained within the module.

Module 5: Coordination of Benefits

Contents

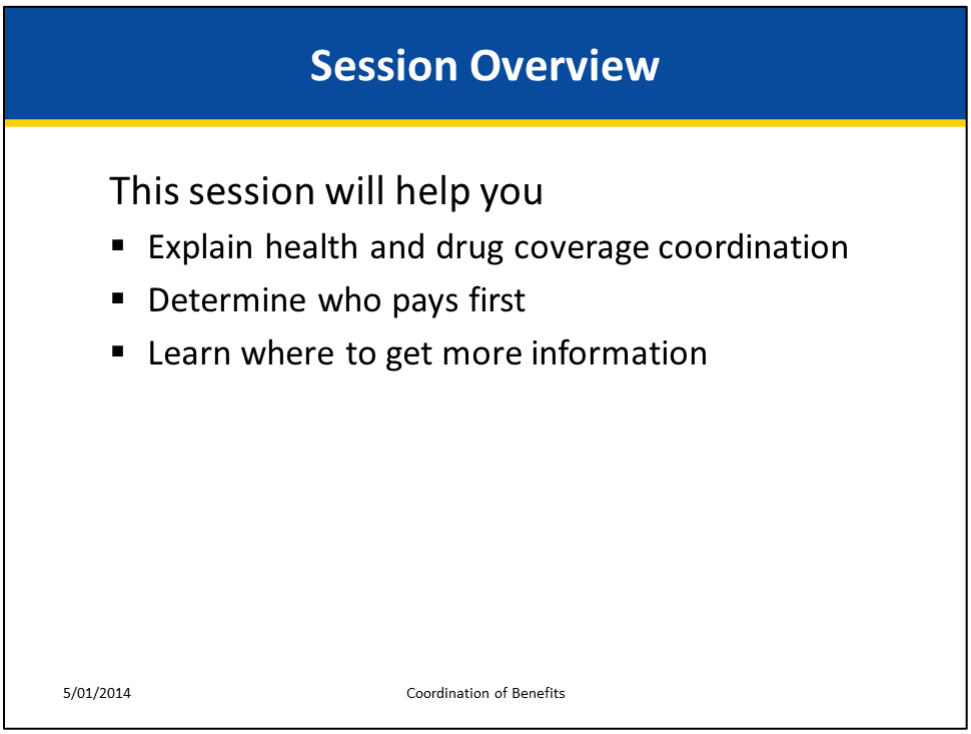
Contents (continued)

Module 5 explains the Coordination of Benefits when people have Medicare and certain other types of health coverage.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace. The information in this module was correct as of May 2014.

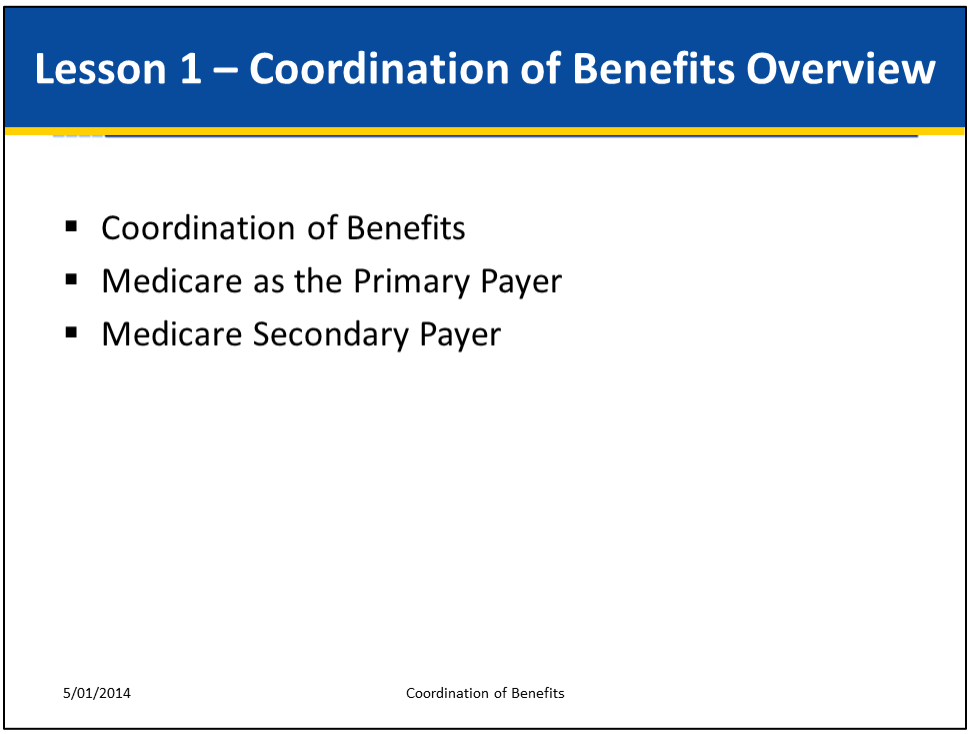
To check for an updated version of this training module, visit cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html.

This set of CMS National Training Program materials isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.



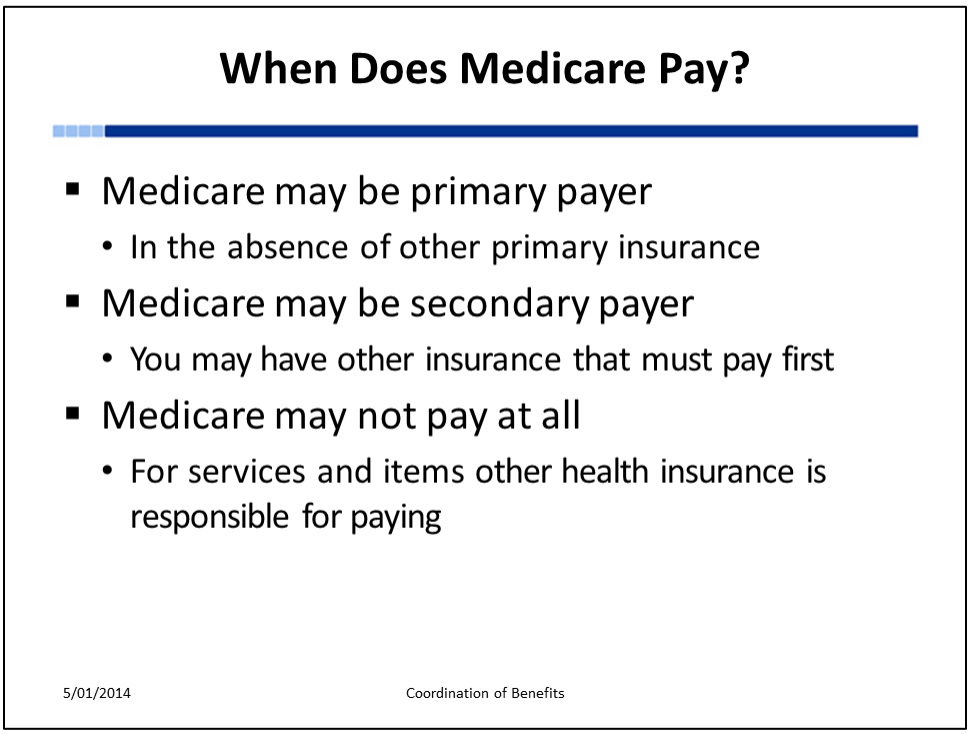
This session will help you

- Explain health and drug coverage coordination
- Determine who pays first
- Learn where to get more information



Lesson 1, “Coordination of Benefits Overview,” covers the following

- Coordination of Benefits
- Medicare as the Primary Payer
- Medicare Secondary Payer

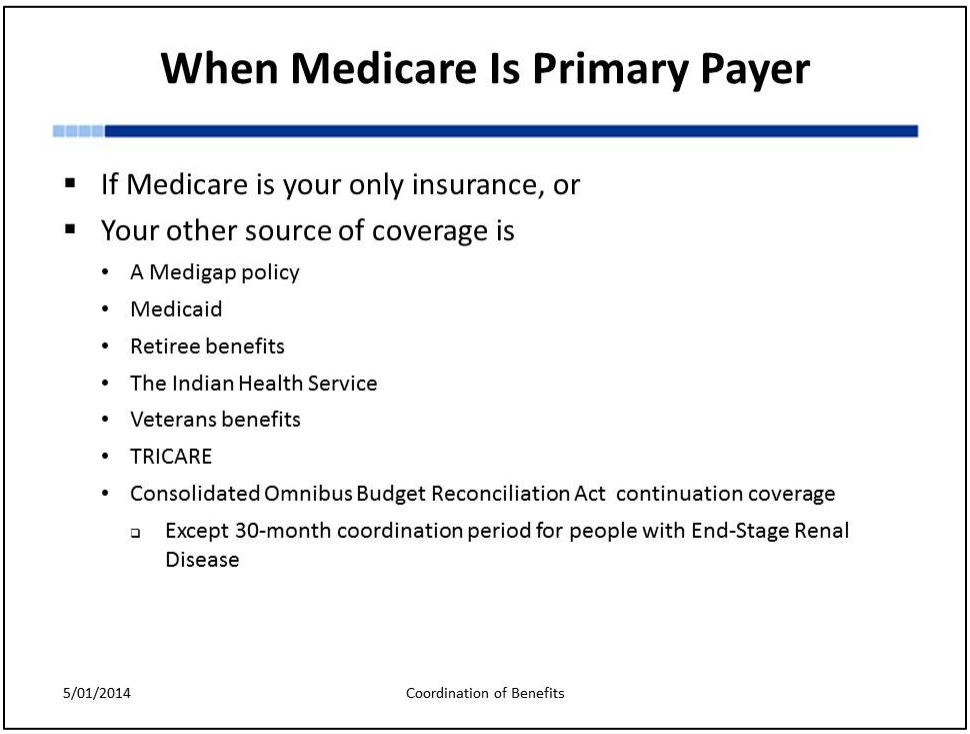


Medicare can be the primary payer, the secondary payer, or sometimes, other insurance plans should pay and Medicare shouldn't pay at all.

Medicare may be the primary payer if you don't have other insurance, or if Medicare is primary to your other insurance. Medicare may be the secondary payer if the other insurance pays first.

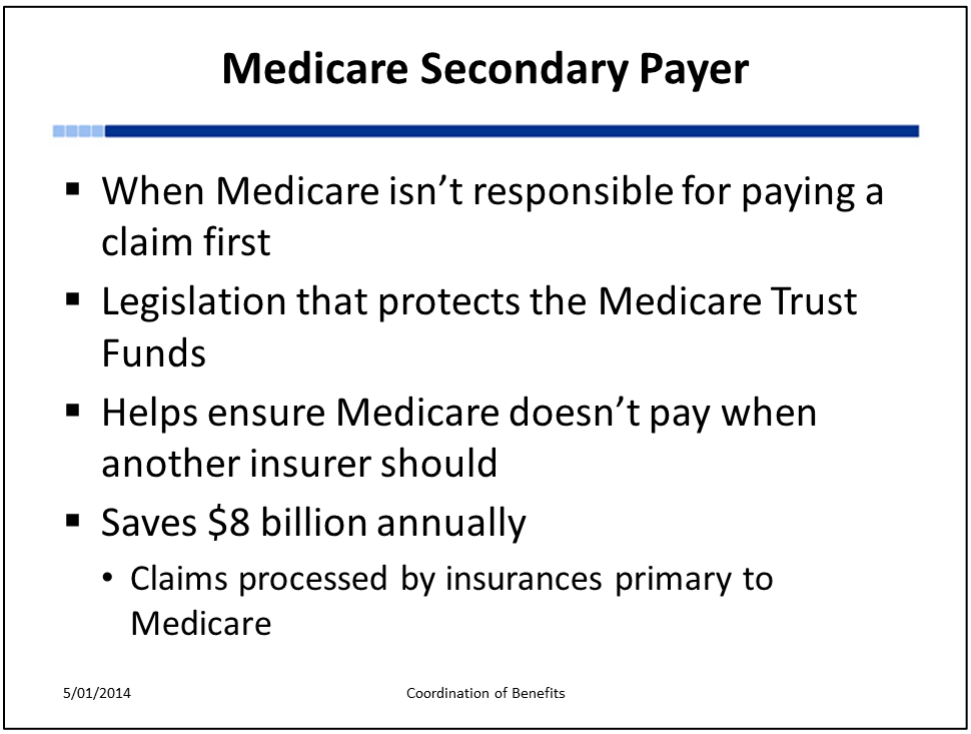
Medicare may be the secondary insurance payer in situations where Medicare doesn't provide your primary health insurance coverage, or when another insurer is primarily responsible for paying.

Medicare may not pay at all for services and items that other health insurers are responsible for paying.



For most people with Medicare, Medicare is their primary payer, meaning Medicare pays first on their health care claims. Situations where Medicare is the primary payer include the following

- Medicare is your only source of medical, hospital, or drug coverage.
- You have a Medigap policy or other privately purchased insurance policy that isn't related to current employment. This type of policy covers amounts not covered by Medicare.
- Coverage through Medicaid and Medicare (dual eligible beneficiaries), with no other coverage that could be primary to Medicare.
- Retiree coverage, in most cases. To know how a plan works with Medicare, check the plan's benefits booklet or plan description provided by the employer or union, or call the benefits administrator.
- Health care services provided by the Indian Health Service.
- Veterans benefits.
- TRICARE (Note: TRICARE is the U.S. Department of Defense health program for active-duty service members and their families. TRICARE for Life is the program for military retirees and their families.).
- Coverage under the Consolidated Omnibus Budget Reconciliation Act, with one exception: End-Stage Renal Disease. We'll talk about this coverage shortly.



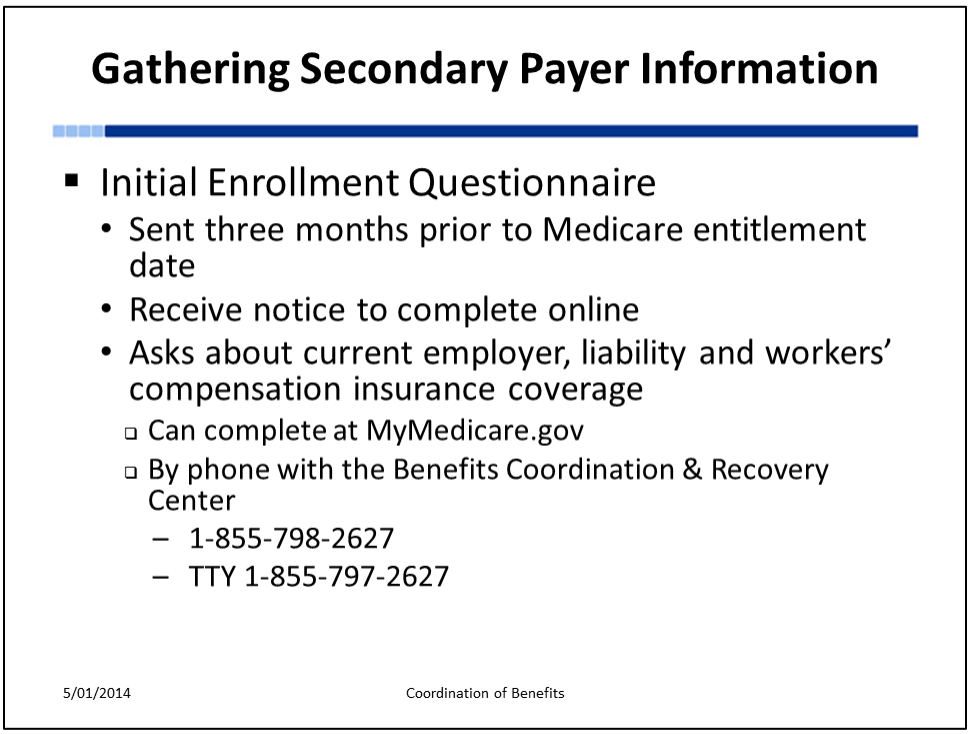
Medicare Secondary Payer (MSP) is the term generally used when Medicare isn't responsible for paying a claim first.

When Medicare began in 1966, it was the primary payer for all claims except for those covered by workers' compensation, Federal Black Lung Program benefits, and U.S Department of Veteran's Affairs benefits.

In 1980, Congress passed legislation that made Medicare the secondary payer to certain primary plans in an effort to shift costs from Medicare to the appropriate private sources of payment.

The MSP provisions have protected Medicare Trust Funds by ensuring that Medicare doesn't pay for services and items that certain health insurance or coverage is primarily responsible for paying. The MSP provisions apply to situations when Medicare isn't the beneficiary's primary health insurance coverage.

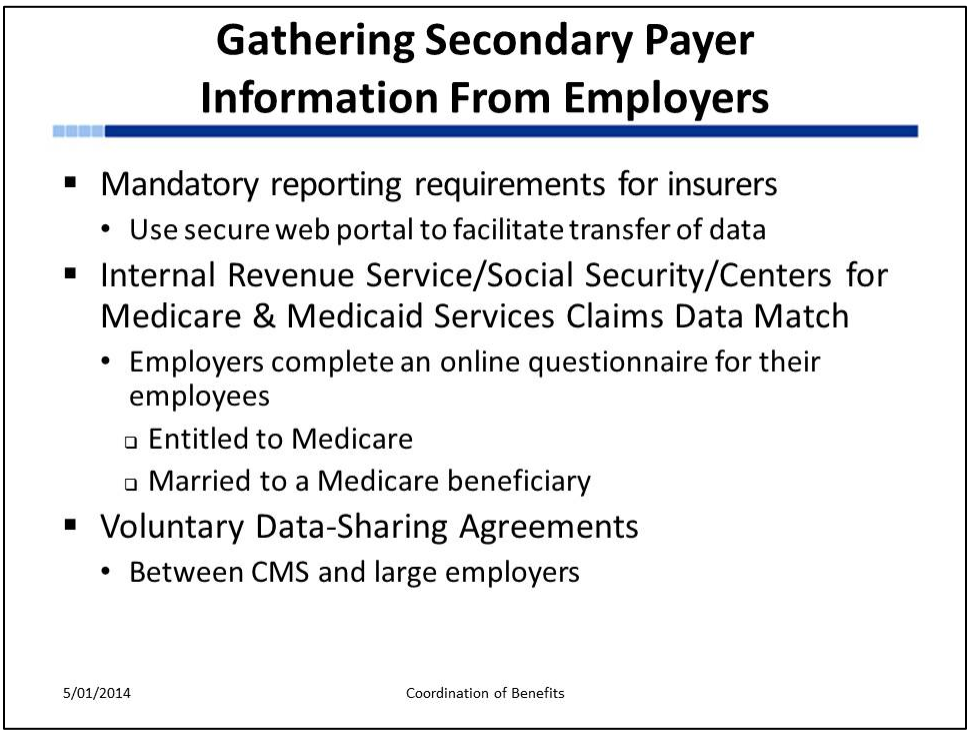
Medicare saves more than $8 billion annually on claims processed by insurances that pay primary to Medicare.



Three months before Medicare coverage begins, you are sent a notice asking you to complete the Initial Enrollment Questionnaire online. It asks these questions about other health insurance you have, like group health coverage from your or a family member's employer, liability insurance, or workers' compensation

- Do you have any group health plan coverage through your current employer?
- How many employees, including yourself, work for your employer?
- Does your employer group health plan cover prescription drugs?
- Will you be receiving any group health plan coverage through the current employment of your husband/wife on your Medicare eligibility date?
- How many employees work for your husband's or wife's employer?
- Are you receiving Federal Black Lung Program benefits or workers' compensation benefits?
- Are you receiving treatment for an injury or illness that another party could be held responsible or could be covered under no-fault, automobile, or liability insurance?

As a new Medicare enrollee, you are automatically registered to use the mymedicare.gov website, which is Medicare's secure online service that allows you, or your designee, to access your personal Medicare information, health care claims, preventive services information, Medicare Summary Notices, and more. You may complete the questionnaire online at mymedicare.gov, or over the phone by calling the Benefits Coordination & Recovery Center at 1-855-798-2627. TTY users should call 1-855-797-2627.

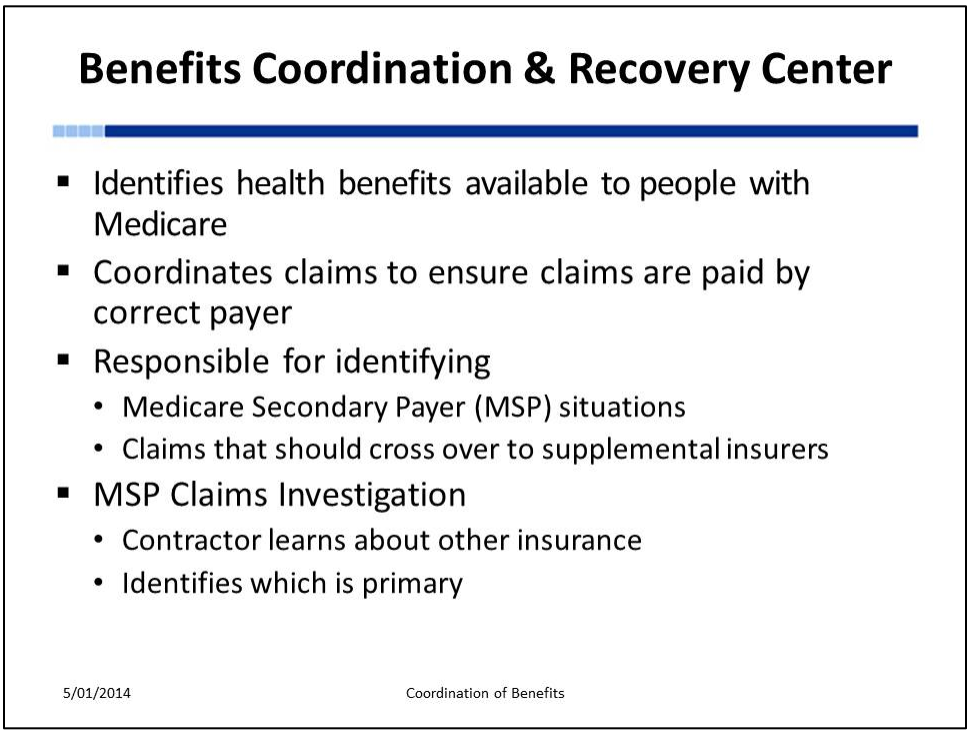


Coordination of benefits relies on multiple databases maintained by multiple stakeholders, including federal and state programs, plans that offer health insurance and/or prescription coverage, pharmacy networks, and a variety of assistance programs available for special situations and/or conditions. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 added mandatory reporting requirements for group health plan (GHP) arrangements and for liability insurance, including self-insurance, no-fault insurance, and workers' compensation. Insurers are legally required to provide information.

Penalties up to $1,000 per day/per beneficiary may be incurred for failure to report data. Stakeholders must use a secure web portal to facilitate the transfer of data.

Internal Revenue Service (IRS)/Social Security (SSA)/Centers for Medicare & Medicaid Services (CMS) Claims Data Match - The law requires the IRS, SSA, and CMS to share information about Medicare beneficiaries and their spouses. A key data source is the IRS/SSA/CMS Claims Data Match. By law, employers are required to complete a questionnaire on the group health plan that Medicare-eligible workers and their spouses choose. The Claims Data Match identifies situations where another payer is primary to Medicare.

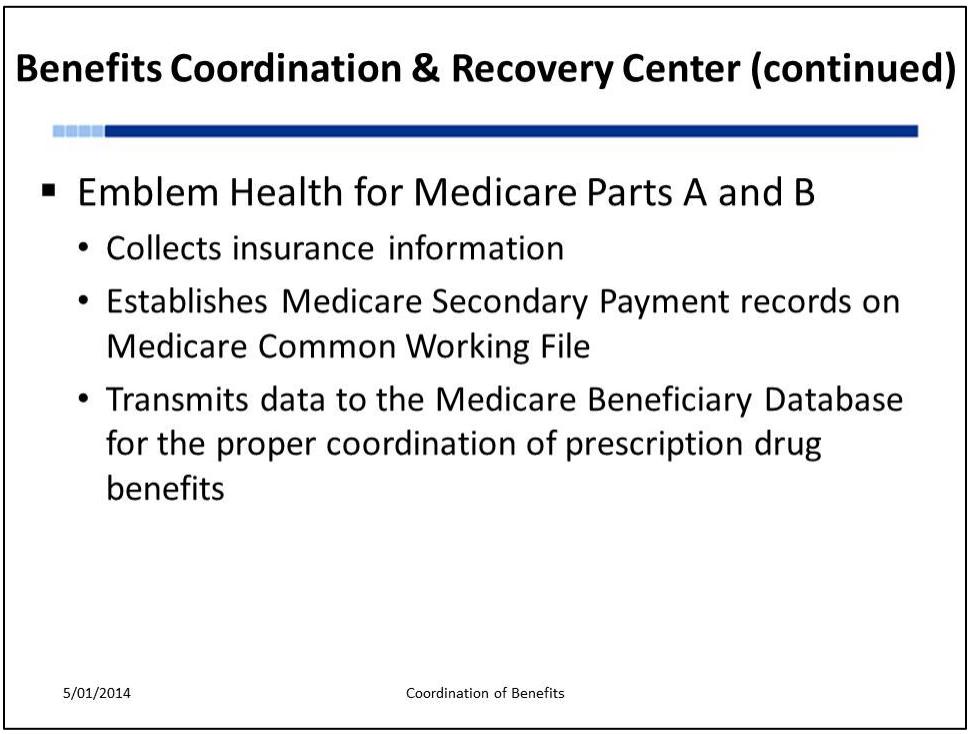
Voluntary Data-Sharing Agreements (VDSAs) - CMS has entered into VDSAs with numerous large employers. These agreements allow employers and CMS to send and receive GHP enrollment information electronically. Where discrepancies occur in the VDSAs, employers can provide enrollment/disenrollment documentation. The VDSA program includes Part D information, enabling VDSA partners to submit records with prescription drug coverage, be it primary or secondary to Medicare prescription drug coverage (Part D).



The purposes of the coordination of benefits program are to identify the health benefits available to a Medicare beneficiary, and to coordinate the payment process to prevent mistaken payment of Medicare benefits. It also enables Part D sponsors to correctly determine which payments are eligible for true out-of-pocket costs.

Medicare eligibility data are shared with other payers and Medicare-paid claims are transmitted to supplemental insurers for secondary payment. An agreement must be in place between the Centers for Medicare & Medicaid Services Benefits Coordination & Recovery Center (BCRC) and private insurance companies for the contractor to automatically cross over medical claims. In the absence of an agreement, the person with Medicare is required to coordinate secondary or supplemental payment of benefits with any other insurers he or she may have in addition to Medicare. Plans are ensured that the amount paid in dual coverage situations doesn't exceed 100 percent of the total claim, avoiding duplicate payments.

The BCRC initiates an investigation when it learns that a person has other insurance. The investigation determines whether Medicare or the other insurance has primary responsibility for meeting the beneficiary's health care costs. The goal of these Medicare Secondary Payer (MSP) information-gathering activities is to identify MSP situations quickly, ensuring correct payments by the responsible parties.



Emblem Health is the coordination of benefits contractor for Medicare Parts A and B. This contractor collects information on Employer Group Health Plans and non-group health plans, liability insurance, including self-insurance, no-fault insurance, and workers' compensation.

Emblem Health establishes Medicare Secondary Payer records at the Common Working File (CWF) to keep Medicare from paying when another party should pay first. The CWF is a single data source for fiscal intermediaries and carriers to verify beneficiary eligibility and conduct prepayment review and approval of claims from a national perspective. It's the only place in the fee-for-service claims processing system where full individual beneficiary information is housed.

They transmit other health insurance data to the Medicare Beneficiary Database for the proper coordination of prescription drug benefits.

Check Your Knowledge–Question 1

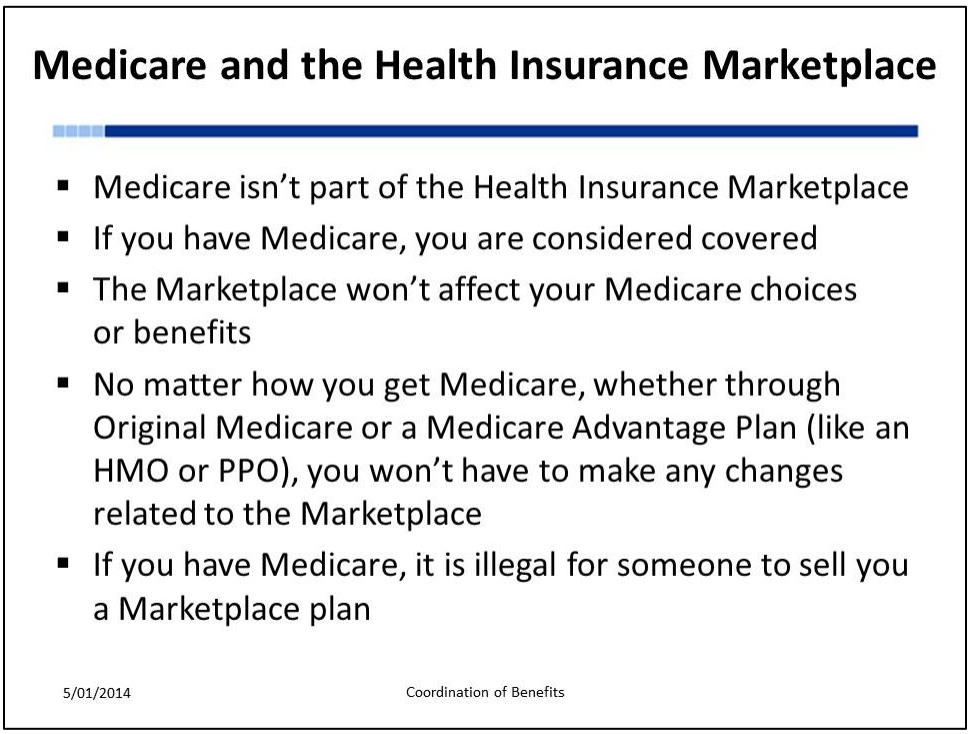
Which of the following isn't true about Medicare Secondary Payer?

a. It's legally mandated
b. It saves $8 billion annually on claims processed by insurances that are primary to Medicare
c. Applies to situations where Medicare is the primary payer
d. Protects the Medicare Trust Funds

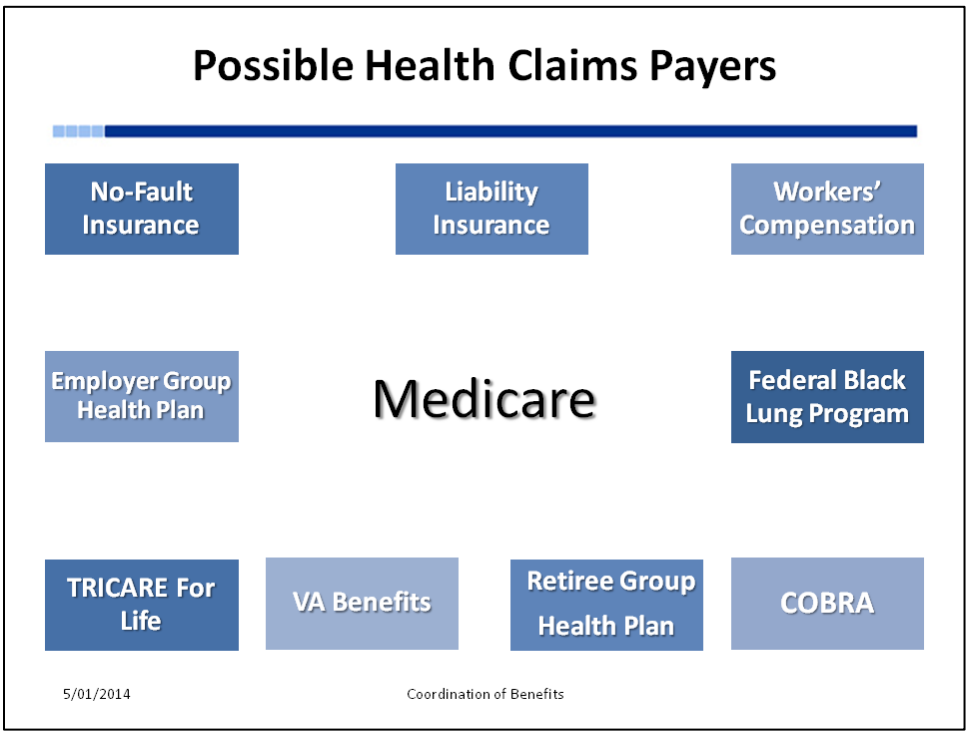
Refer to page 45 to check your answers.

Lesson 2, “Health Coverage Coordination,” explains the following

- Medicare and the Marketplace
- Identifying Appropriate Payers
- Medicare Secondary Payer
- Determining Who Pays First



Medicare isn't part of the Health Insurance Marketplace, so if you have Medicare you don't need to do anything related to the Marketplace; you are considered covered. No matter how you get Medicare, whether through Original Medicare or a Medicare Advantage Plan (like a Health Maintenance Organization or a Preferred Provider Organization), you won't have to make any changes related to the Marketplace. If you have Medicare, it is illegal for someone to sell you a Marketplace plan.

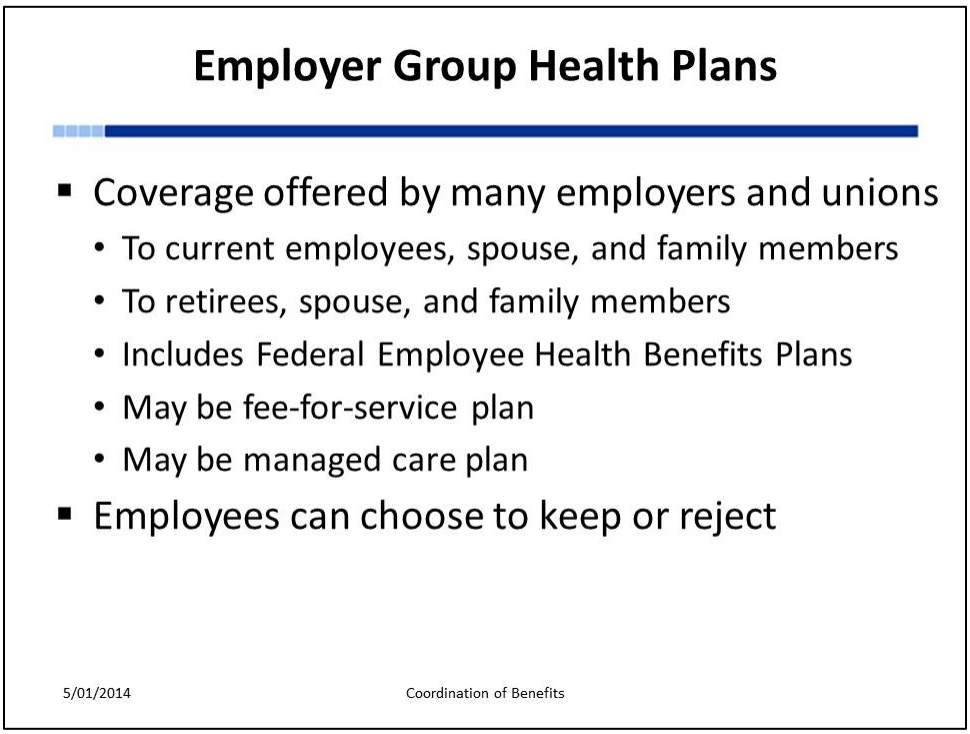


It's important to identify whether a person's medical costs are payable by other insurance before, or in addition to, Medicare. This information helps health care providers determine whom to bill and how to file claims with Medicare.

There are many insurance benefits a person could have and many combinations of insurance coverage to consider before determining who pays and when:

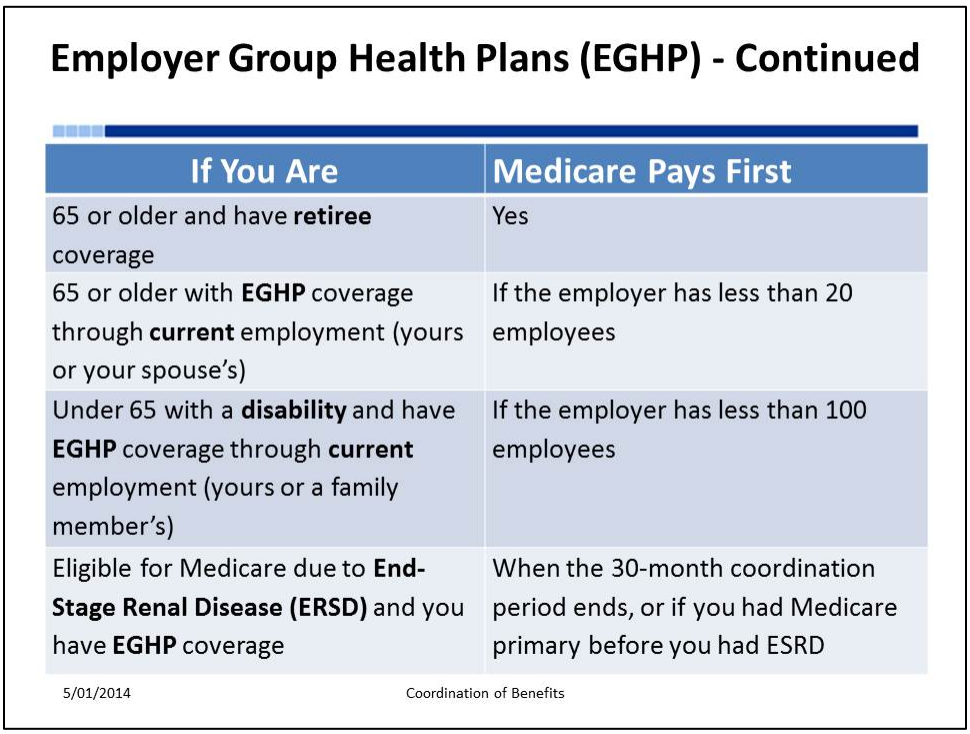
- Medicare
- No-Fault Insurance
- Liability Insurance
- Workers' compensation insurance
- Federal Black Lung Program
- Consolidated Omnibus Budget Reconciliation Act of 1985
- Retiree Group Health Plan
- Veterans Affairs Benefits
- TRICARE for Life
- Employer Group Health Plan

Depending on the type of additional insurance coverage a person may have, Medicare may be the primary payer or secondary payer for a person's claim, or may not pay at all.



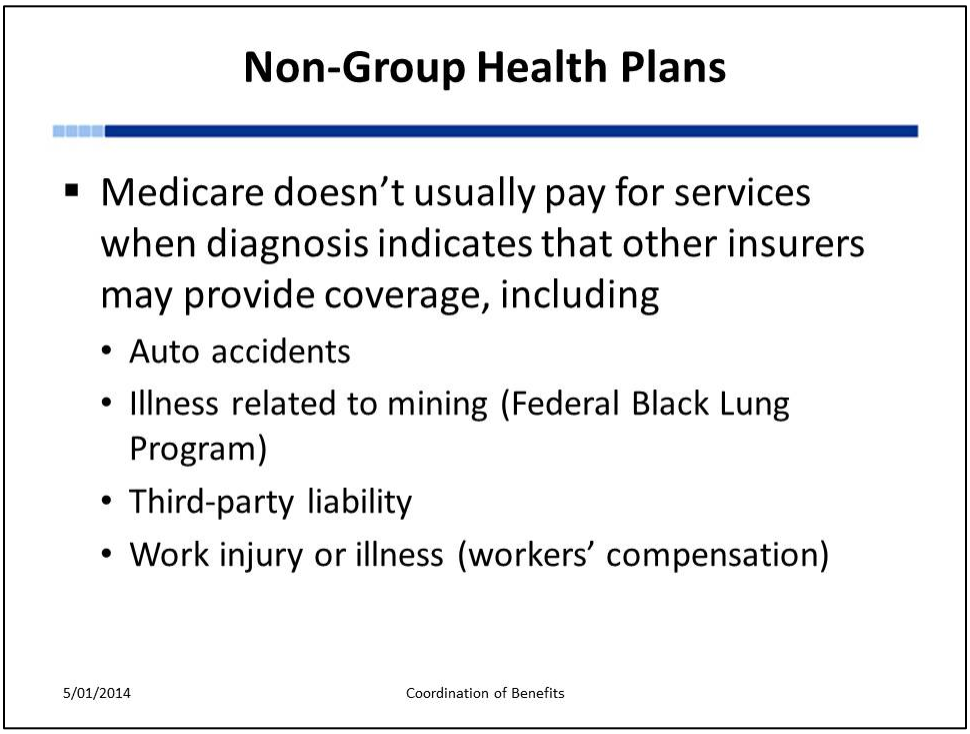
Coordination of benefits is dependent on whether the person, or his/her spouse or family member, is currently working or retired, and on the number of employees of that company. The Federal Employee Health Benefits program is a type of Employer Group Health Plan (EGHP).

EGHP coverage is coverage offered by many employers and unions for current employees and/or retirees. A person may also get group health coverage through a spouse's or other family member's employer. If someone has Medicare and is offered coverage under an EGHP, he or she can choose to accept or reject the plan. The EGHP may be a fee-for-service plan or a managed care plan, like a Health Maintenance Organization.



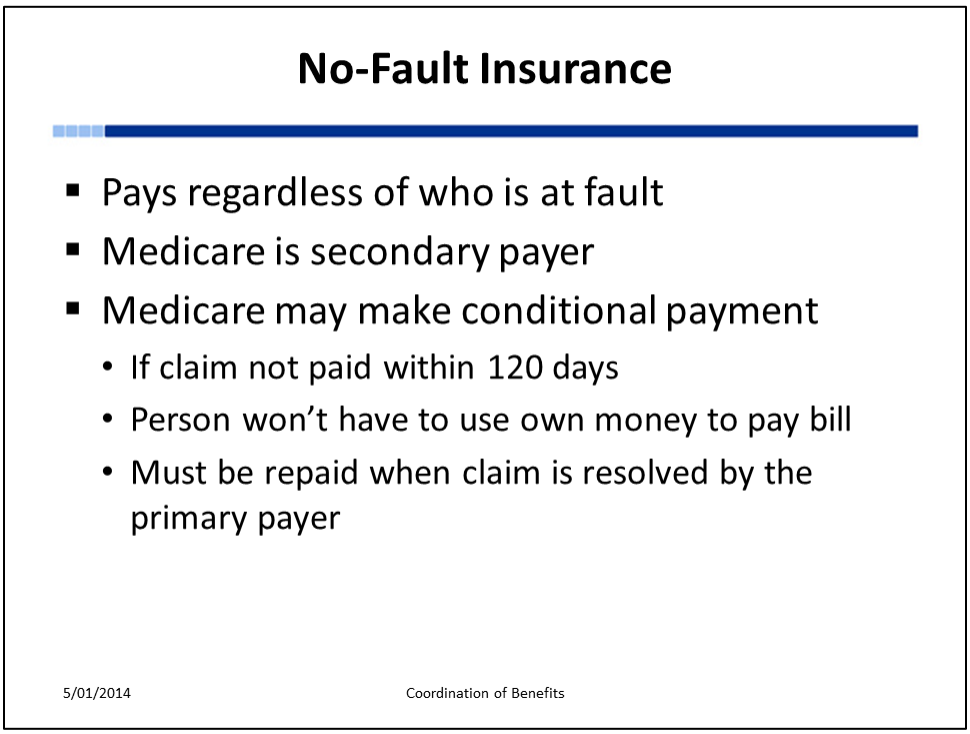
When does Medicare pay first for people with employer group health plans (EGHPs)?

- If you are 65 or older and have retiree coverage
- If you are 65 or older with EGHP coverage through current employment, either yours or your spouse's, and the employer has less than 20 employees
- If you are under age 65, have a disability and are covered by an EGHP through current employment (either yours or a family member's), and your employer has less than 100 employees
- If you are eligible for Medicare due to End-Stage Renal Disease (ESRD) and you have EGHP coverage, either yours or your spouse's, and the 30-month coordination period has ended, or if you had Medicare as your primary coverage before you had ESRD



Medicare doesn't usually pay for services when the diagnosis indicates that other insurers may provide coverage, including the following:

- Auto accidents
- Illness related to mining (Federal Black Lung Program)
- Third-party liability
- Work-related injury or illness (workers' compensation)



No-fault insurance is insurance that pays for health care services resulting from personal injury or damage to someone's property regardless of who is at fault for causing it. Types of no-fault insurance include the following:

- Automobile insurance
- Homeowners' insurance
- Commercial insurance plans

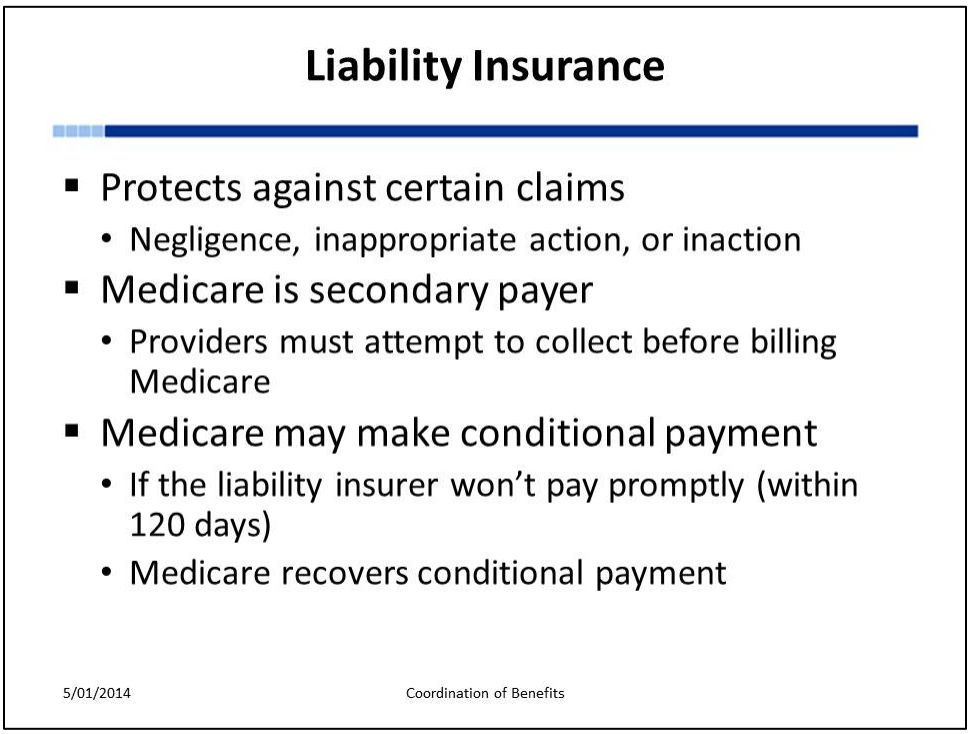
Medicare is the secondary payer where no-fault insurance is available.

Medicare generally won't pay for medical expenses covered by no-fault insurance. However, Medicare may pay for medical expenses if the claim is denied for reasons other than not being a proper claim. Medicare will make payment only to the extent that the services are covered under Medicare. Also, if the no-fault insurance doesn't pay promptly (within 120 days), Medicare may make a conditional payment. A conditional payment is a payment for which Medicare has the right to seek recovery.

The money that Medicare used for the conditional payment must be repaid to Medicare when the no-fault insurance settlement is reached. If Medicare makes a conditional payment and the person with Medicare later resolves the insurance claim, Medicare will seek to recover the conditional payment from the person. He or she is responsible for ensuring that Medicare gets repaid for the conditional payment.

Need more information?

The Medicare Modernization Act of 2003 (P.L. 108-173, Title III, Sec. 301) further clarifies language protecting Medicare's ability to seek recovery of conditional payments.

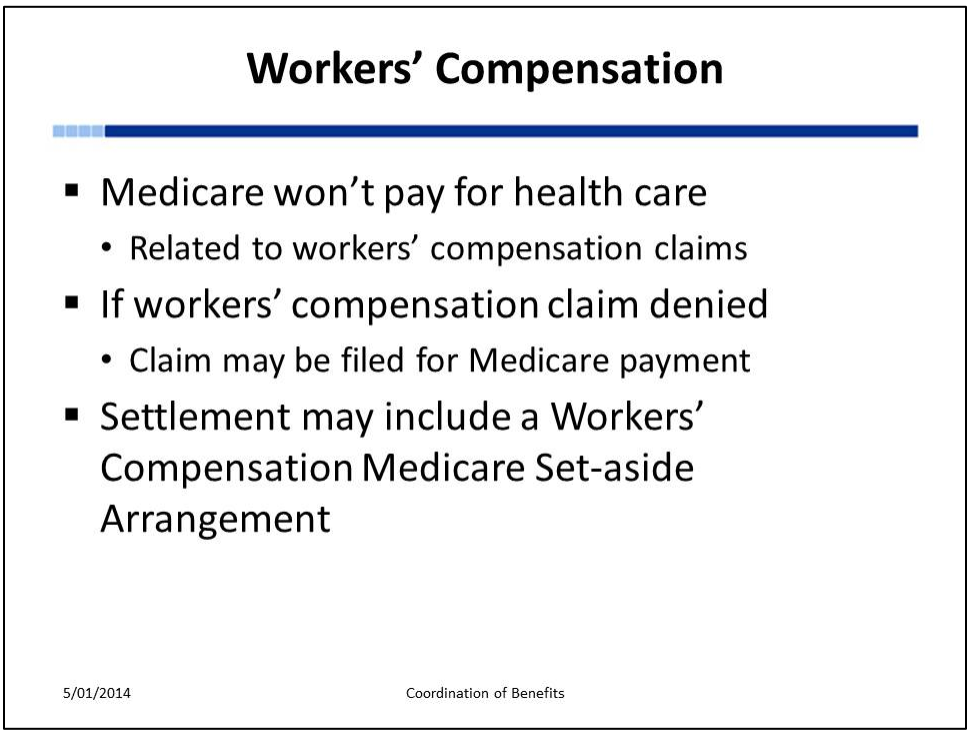


Liability insurance is coverage that protects you against claims based on negligence, inappropriate action, or inaction that results in injury to someone or damage to property. Liability insurance includes, but isn't limited to, the following:

- Homeowners' liability insurance
- Automobile liability insurance
- Product liability insurance
- Malpractice liability insurance
- Uninsured motorist liability insurance
- Underinsured motorist liability insurance

Medicare is the secondary payer in cases where liability insurance is available. If health care professionals find that the services they gave a person can be paid by a liability insurer, they must attempt to collect from that insurer before billing Medicare. Providers are required to bill the liability insurer first, even though the liability insurer may not make a prompt payment.

Sometimes this can take a long time. If the insurance company doesn't pay the claim promptly (usually within 120 days), your doctor or other provider may bill Medicare. Medicare may make a conditional payment to pay the bill. A conditional payment is a payment Medicare makes for services another payer is responsible for. Medicare makes this conditional payment so you won't have to use your own money to pay the bill. The payment is conditional because it must be repaid to Medicare when a settlement judgment, award, or other payment is made.



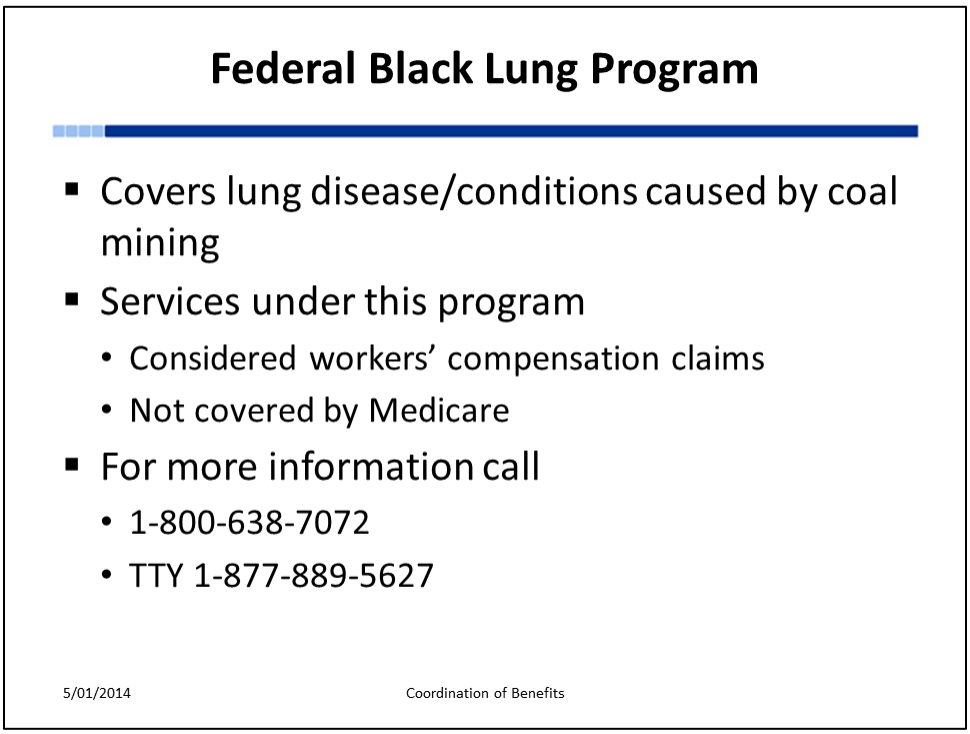
Medicare generally won't pay for an injury or illness/disease covered by workers' compensation. If all or part of a claim is denied by workers' compensation on the grounds that it isn't covered by workers' compensation, a claim may be filed with Medicare. Medicare may pay a claim that relates to a medical service or product covered by Medicare if the claim isn't covered by workers' compensation.

Prior to settling a workers' compensation case, parties to the settlement should consider Medicare's interest related to future medical services and whether the settlement is to include a Workers' Compensation Medicare Set-aside Arrangement (WCMSA).

Need more information?

WCMSAs are discussed in detail at go.cms.gov/wcmsa.

See Section 1862(b)(2) of the Social Security Act of 1954 (42 USC 1395y(b)(2)).



Some people with Medicare can get Federal Black Lung Program medical benefits for services related to lung disease and other conditions caused by coal mining. Medicare doesn't pay for health services covered under this program. Black lung claims are considered workers' compensation claims. All claims for services that relate to a diagnosis of black lung disease are referred to the Division of Coal Mine Workers' Compensation in the U.S. Department of Labor.

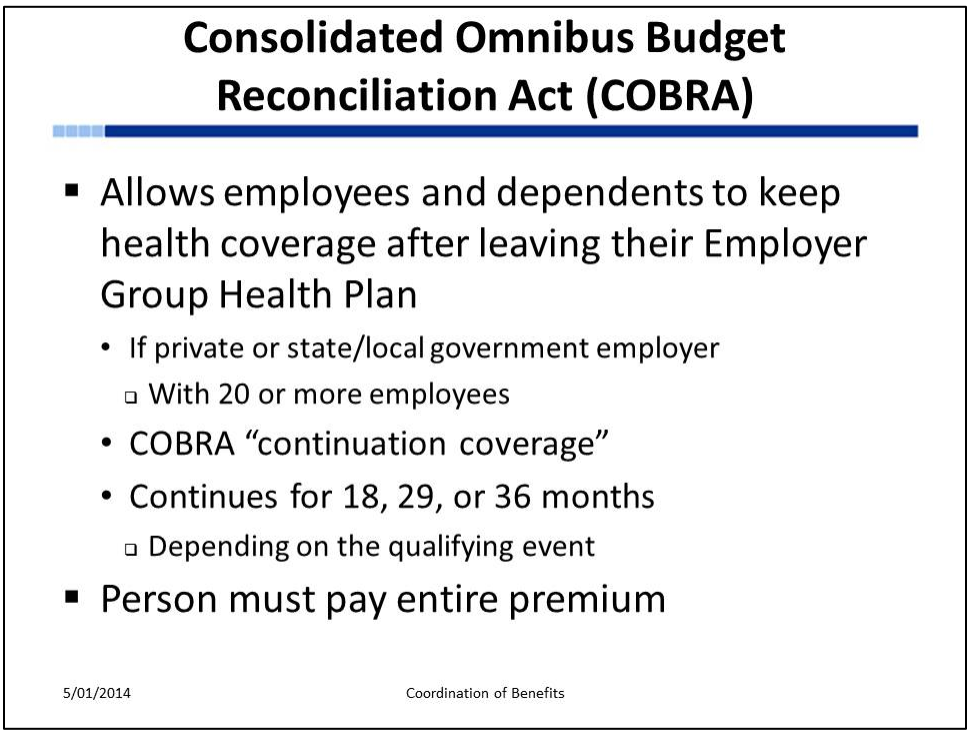
However, if the services aren't related to black lung, Medicare will serve as the primary payer if all the following are true:

- There is no other primary insurance
- The individual is eligible for Medicare, and
- The services are covered by the Medicare program

Federal Black Lung Program beneficiaries are eligible for prescription drugs, in-patient and out-patient services, and doctors' visits. In addition, home oxygen and other medical equipment, home nursing services, and pulmonary rehabilitation may be covered with a doctor's prescription.

Need more information?

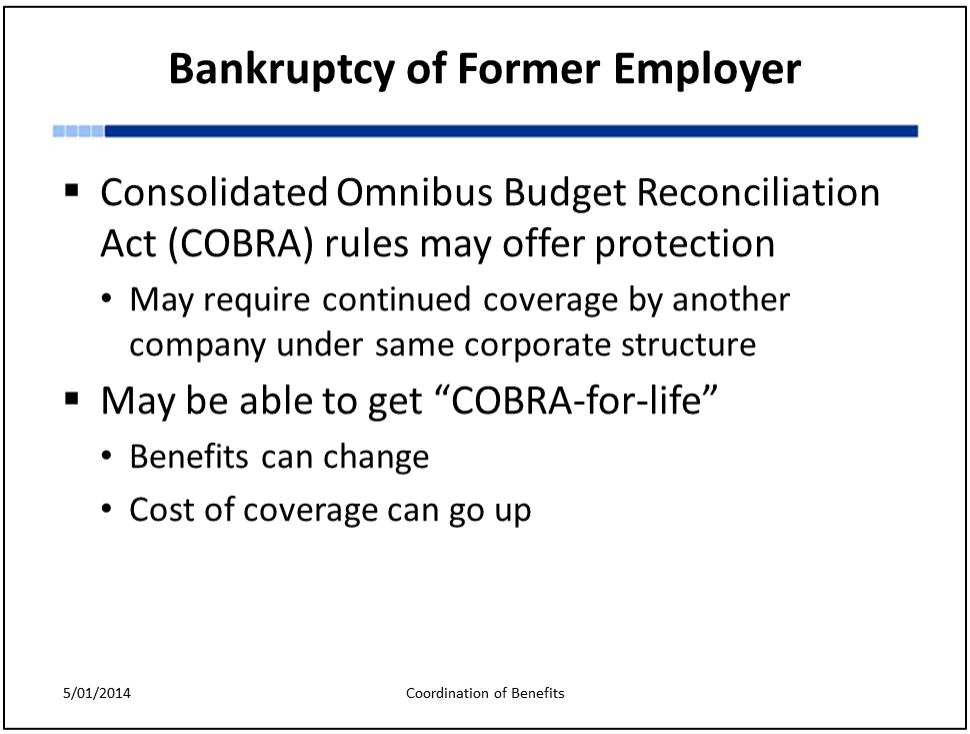
A toll-free number, 1-800-638-7072, has been designated for the office that's responsible for the Black Lung Program's medical diagnostic and treatment services. TTY users should call 1-877-889-5627.



The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers with 20 or more employees to let employees and their dependents keep their health coverage for a time after they leave their Employer Group Health Plan, under certain conditions. This is called COBRA "continuation coverage." The law applies to private sector and state and local government–sponsored plans, but not to federal government–sponsored plans, the governments of the District of Columbia, any territory or possession of the United States, or to certain church-related organizations. (The Federal Employee Health Benefits Program is subject to similar temporary continuation of coverage provisions under the Federal Employees Health Benefits Amendments Act of 1988.)

COBRA coverage can begin due to certain events, such as loss of employment or reduced working hours, divorce, death of an employee, or a child ceasing to be a dependent under the terms of the plan. For loss of employment or reduced working hours, COBRA coverage generally continues for 18 months. Certain disabled individuals and their non-disabled family members may qualify for an 11-month extension of coverage from 18 to 29 months. Other qualifying events call for continued coverage up to 36 months.

Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since the participant pays both his/her part and the part of the premium his/her employer paid while he/she still worked. However, it usually costs less than individual health coverage.



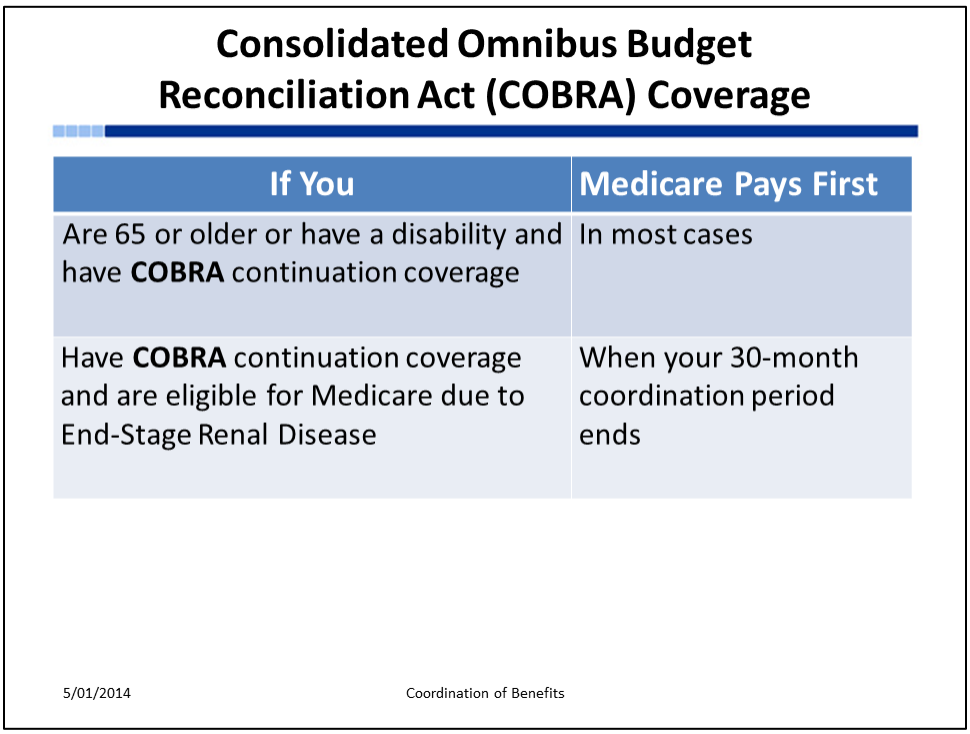
If you have retiree health coverage after you retire and your former employer goes bankrupt or out of business, federal Consolidated Omnibus Budget Reconciliation Act (COBRA) rules may offer protection. These rules require any other company within the same corporate organization that still offers Employer Group Health Plan coverage to its employees to offer COBRA continuation coverage through that plan.

If someone loses group health coverage after retirement because a former employer goes bankrupt, it may be possible to get "COBRA-for-life." This means that the person can keep COBRA for the rest of his or her life or until the company ceases to exist. Like any other employer plan, benefits can change and the cost of coverage can go up.

Need more information?

See "Medicare and Other Health Benefits: Your Guide to Who Pays First", CMS Product No. 02179.

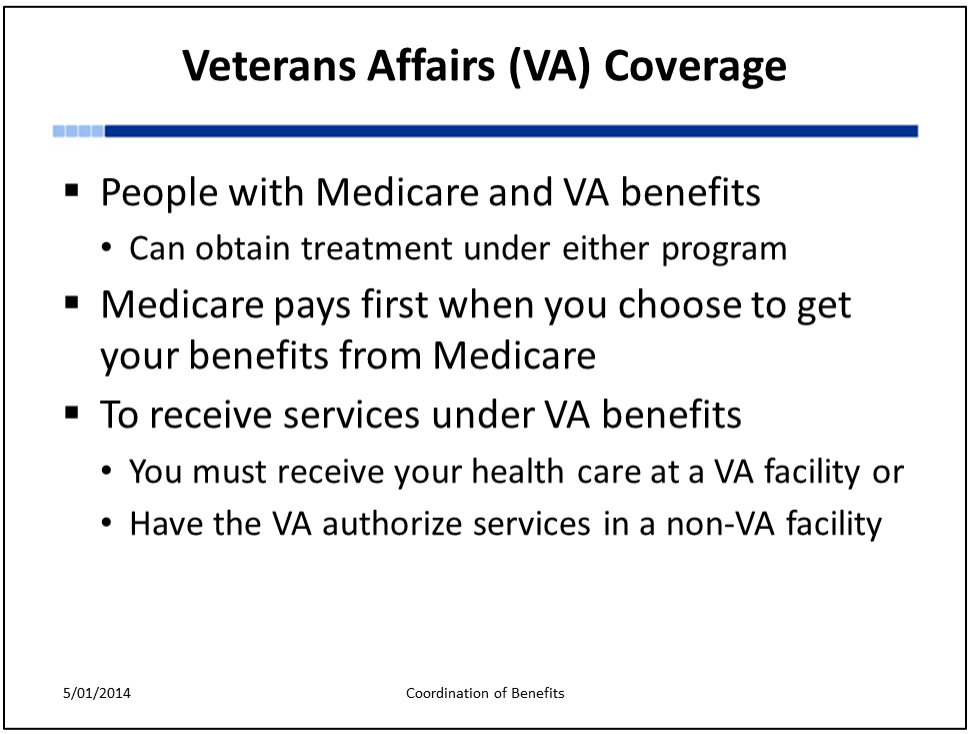
medicare.gov/publications/pubs/pdf/02179.pdf



Medicare usually pays primary to Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage for aged and disabled individuals. Medicare pays secondary to COBRA for individuals with End-Stage Renal Disease during the 30-month coordination period.

Before electing COBRA coverage, people may find it helpful to talk with a State Health Insurance Assistance Program (SHIP) counselor to understand their options better. For example, if a person who already has Medicare Part A (Hospital Insurance) chooses COBRA, but waits to sign up for Medicare Part B (Medical Insurance) until the last part of the 8-month special enrollment period following termination of employment, the employer can make the person pay for services that Medicare would have covered if he or she had signed up for Part B earlier.

In some states, SHIP counselors can also provide information about time frames on COBRA and Medigap guaranteed issue rights in a given state. Time frames may differ depending on state law.

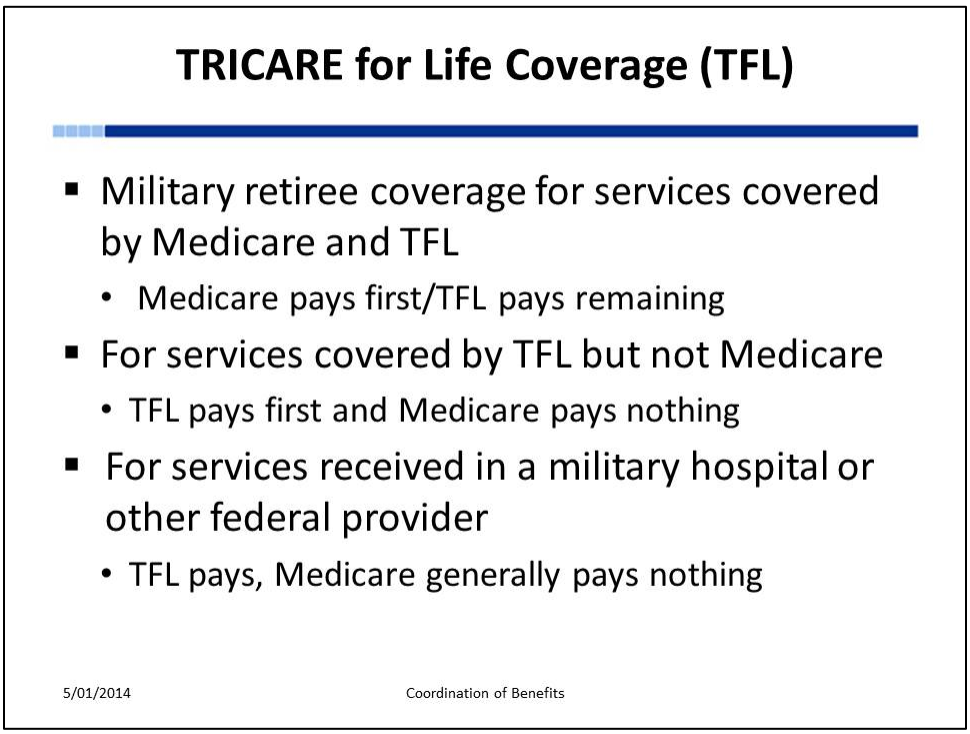


People with both Medicare and Veterans' benefits can access health care treatment under either program. However, **they must choose which benefit they'll use each time the person sees a doctor or receives health care** (e.g., in a hospital). Medicare won't pay for the same service that was authorized by Veterans Affairs (VA); similarly, Veterans' benefits won't make primary payment for the same service that was covered by Medicare.

To receive VA services, a person must receive his/her health care at a VA facility **or** have the VA authorize services in a non-VA facility. Veterans could be subject to a penalty for enrolling late for Medicare Part B, even if they're enrolled in VA health care.

VA benefits are provided to people who served in the active military, naval, or air service **and** were honorably discharged or released, or were/are a Reservist or National Guard member and were called to active duty by a federal order (for other than training purposes) **and** completed the full call-up period.

Veterans of the United States Armed Forces may be eligible for a broad range of programs and services provided by VA. Eligibility for most VA benefits is based on the service member's discharge from active military service under other than dishonorable conditions. Active service means full-time service, other than active duty for training, as a member of the Army, Navy, Air Force, Marine Corps, Coast Guard, or as a commissioned officer of the Public Health Service, Environmental Science Services Administration or National Oceanic and Atmospheric Administration.



If you have TRICARE for Life (TFL), while Medicare is your primary insurance, TFL acts as your secondary payer, minimizing your out-of-pocket expenses. TFL benefits include covering Medicare's coinsurance and deductibles.

If you use a Medicare provider, he or she will file your claims with Medicare. Medicare pays its portion and electronically forwards the claim to the TFL claims processor. TFL pays the provider directly for TFL-covered services.

For services covered by both Medicare and TFL, Medicare pays first and TFL pays the remaining coinsurance for TRICARE-covered services.

For services covered by TFL but not by Medicare, TFL pays first and Medicare pays nothing. You must pay the TFL fiscal year deductible and cost shares.

For services covered by Medicare but not by TFL, Medicare pays first and TFL pays nothing. You must pay the Medicare deductible and coinsurance.

For services not covered by Medicare or TFL, Medicare and TFL pay nothing and you must pay the entire bill.

When a TFL beneficiary receives services from a military hospital or any other federal provider, TFL will pay the bills. Medicare doesn't usually pay for services received from a federal provider or other federal agency.

NOTE: TFL is coverage for all TRICARE beneficiaries who have both Medicare Parts A and B. Active-duty personnel are covered by TRICARE insurance. Coordination of benefits situations concerning TRICARE should be handled like other employer group health plans.

Check Your Knowledge—Question 2

People with Medicare and Veterans Affairs benefits

a. Can get medical treatment under either program
b. Must choose which benefits to use each time they get health care
c. Can't have a Part D plan
d. Both a and b

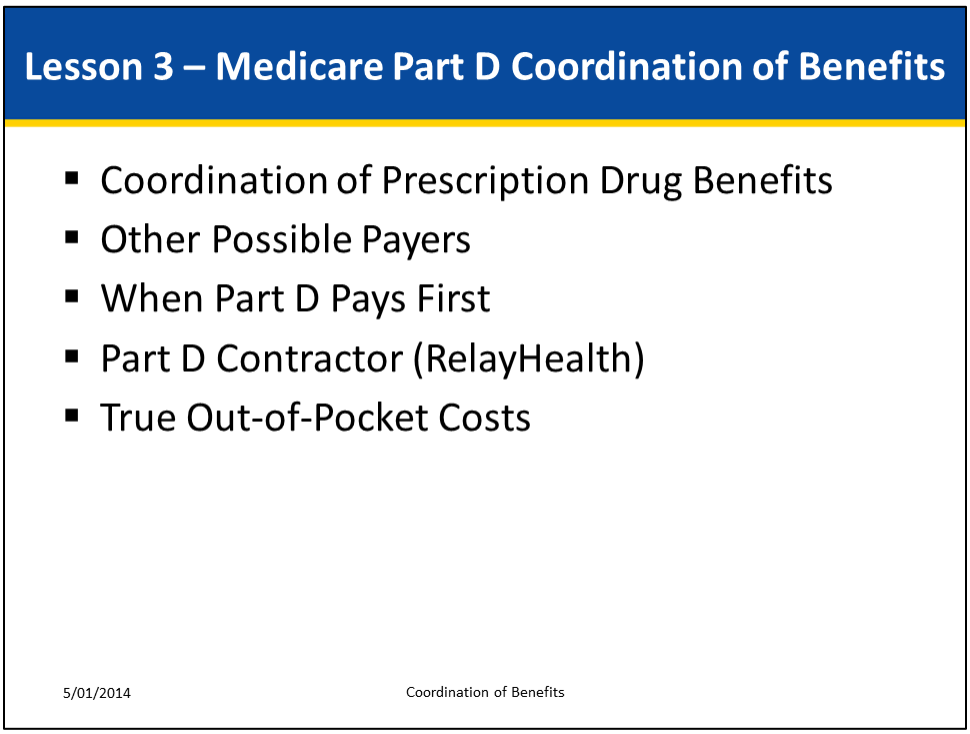
Refer to page 45 to check your answers.

Check Your Knowledge—Question 3

Who pays John's bill first? He is 34 years old. He has End-Stage Renal Disease, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, and has been enrolled in Medicare for 8 months?

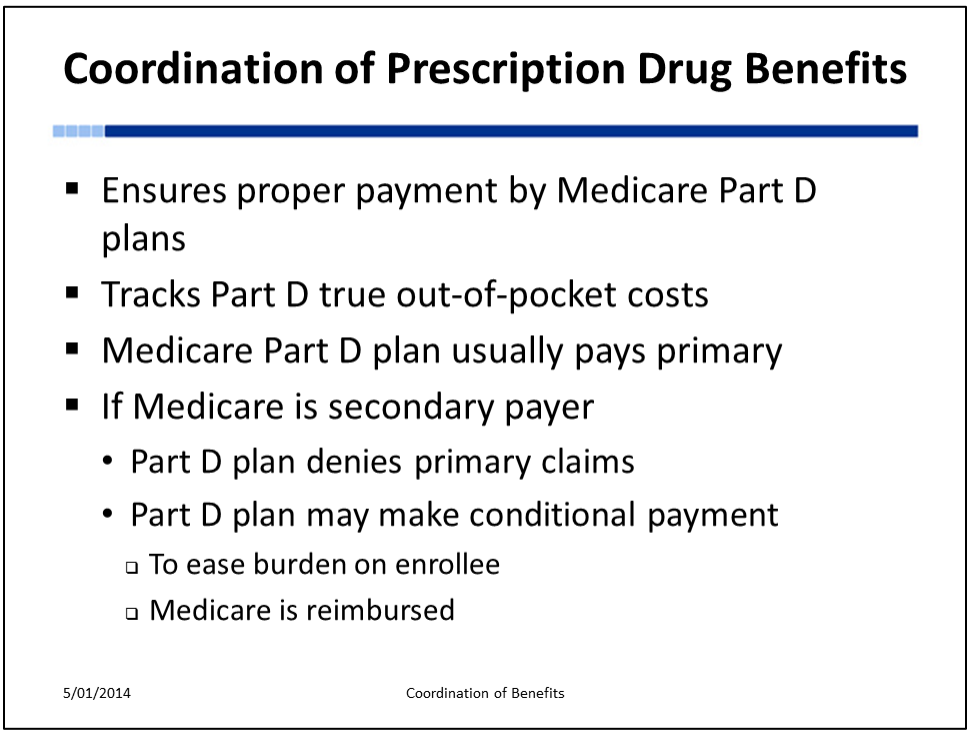
a. Medicare
b. COBRA

Refer to page 45 to check your answers.



Lesson 3, "Medicare Part D Coordination of Benefits," explains the following:

- Coordination of Prescription Drug Benefits
- Other Possible Payers
- When Part D Pays First
- Contractor (RelayHealth)
- True Out-of-Pocket Costs



Coordination of benefits provides the mechanism for support of the tracking and calculating of beneficiaries' true out-of-pocket (TrOOP) prescription drug expenditures. TrOOP costs are the expenses that count toward a person's Medicare drug plan out-of-pocket threshold of $4,550 (for 2014). TrOOP costs determine when a person's catastrophic coverage will begin. The drug plan keeps track of each member's TrOOP costs.

Generally, Medicare Part D provides primary coverage for prescription drugs. Whenever Medicare is primary, the Part D (Medicare prescription drug coverage) plan is billed and will pay first. When Medicare is the secondary payer, Part D plans will generally deny primary claims.

When Medicare is the secondary payer to a non-group health plan, or when a plan doesn't know whether a covered drug is related to an injury, Part D plans will always make a conditional primary payment to ease the burden on the policyholder, unless certain situations apply. The Part D plan won't pay if it's aware that the enrollee has workers' compensation, Federal Black Lung Program benefits, or no-fault/liability coverage and has previously established that a certain drug is being used exclusively to treat a related illness or injury. For example, when an enrollee refills a prescription previously paid for by workers' compensation, the Part D plan may deny primary payment and default to Medicare Secondary Payer. The payment is conditional because it must be repaid to Medicare once a settlement, judgment, or award is reached. The proposed settlement or update should be reported to Medicare by calling 1-800-MEDICARE and asking for the Benefits Coordination & Recovery Center (BCRC), or by mailing relevant documents to the BCRC. TTY users should call 1-877-486-2048.

Employer Group Health Plans

- Retiree
- Active employment
- Consolidated Omnibus Budget Reconciliation Act

State

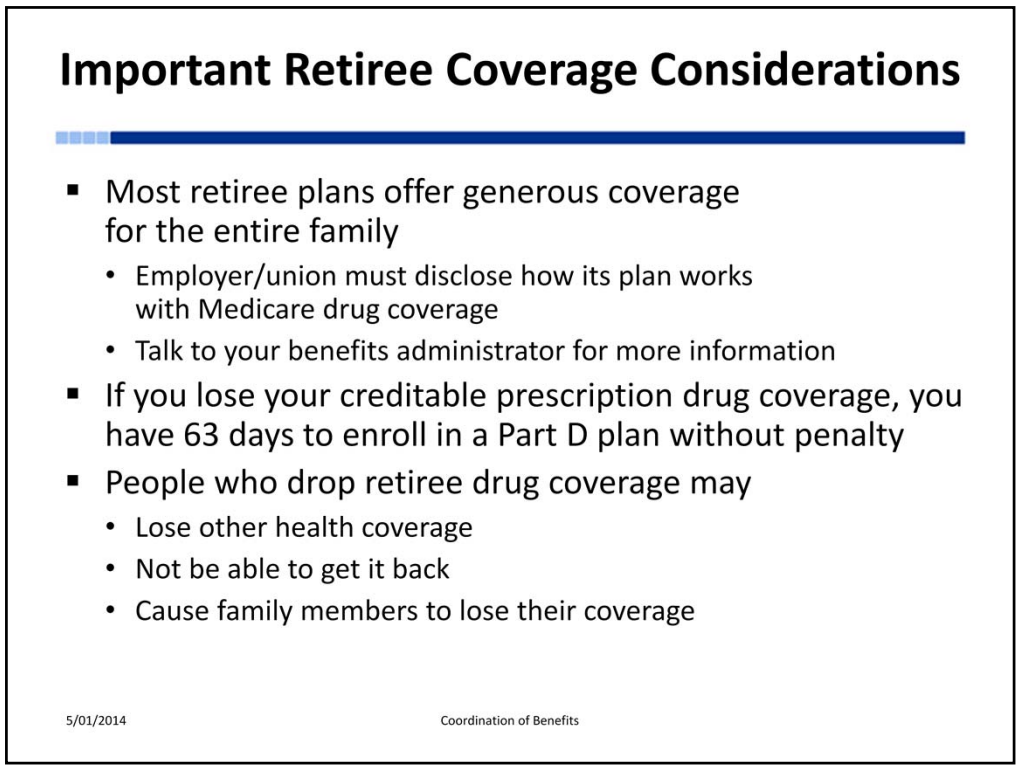
- Medicaid programs
- State Pharmaceutical Assistance Programs
- Workers' compensation

Federal

- Medicare Parts A or Part B (limited)
- Federal Black Lung Program
- Indian Health Service
- Veterans Affairs
- TRICARE for Life
- AIDS Drug Assistance Programs

Other

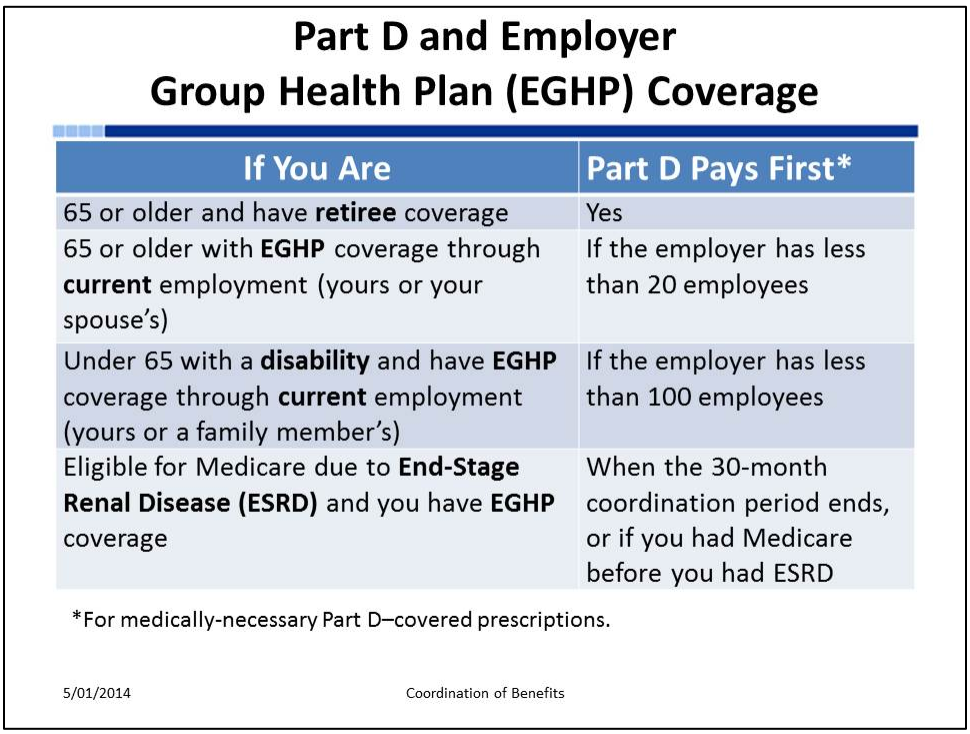
- No-Fault\Liability
- Patient Assistance Programs
- Charities



As discussed previously when discussing health coverage, people with Medicare who have employer or union retirement plans that cover prescription drugs must carefully consider their options. A person's needs may vary from year to year based on factors like health status and financial considerations. Options provided by employer or union retirement plans can also vary each year. Each plan is required by law to annually disclose to its members how it works with Medicare prescription drug coverage. If a person with Medicare loses "creditable' drug coverage, he/she has 63 days to enroll in a Part D plan without incurring a late enrollment penalty. Contact the Employer Group Health Plans benefits administrator for information, including how it works with Medicare drug coverage. Creditable coverage is coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

When making a decision on whether to keep or drop coverage through an employer or union retirement plan, there are some important points to consider:

- Most employer/union retirement plans offer prescription coverage comparable to Medicare drug coverage, and often generous hospitalization and medical insurance for the entire family, which is particularly important for those who are chronically ill or have frequent hospitalizations.
- If you drop retiree group health coverage, you may not be able to get it back.
- If you drop drug coverage, you may also lose doctor and hospital coverage.
- Family members covered by the same policy may also be affected, so any decision about drug coverage should consider the entire family's health status and coverage

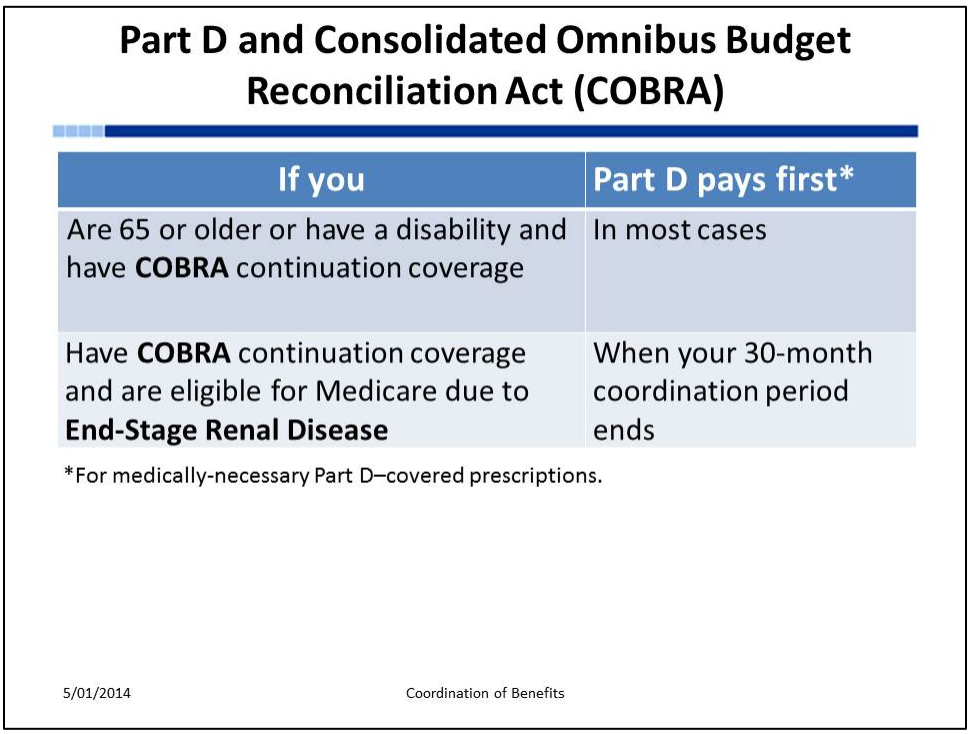


Part D (Medicare prescription drug coverage) usually pays first if you have retiree coverage.

Medicare Part D pays first also for:

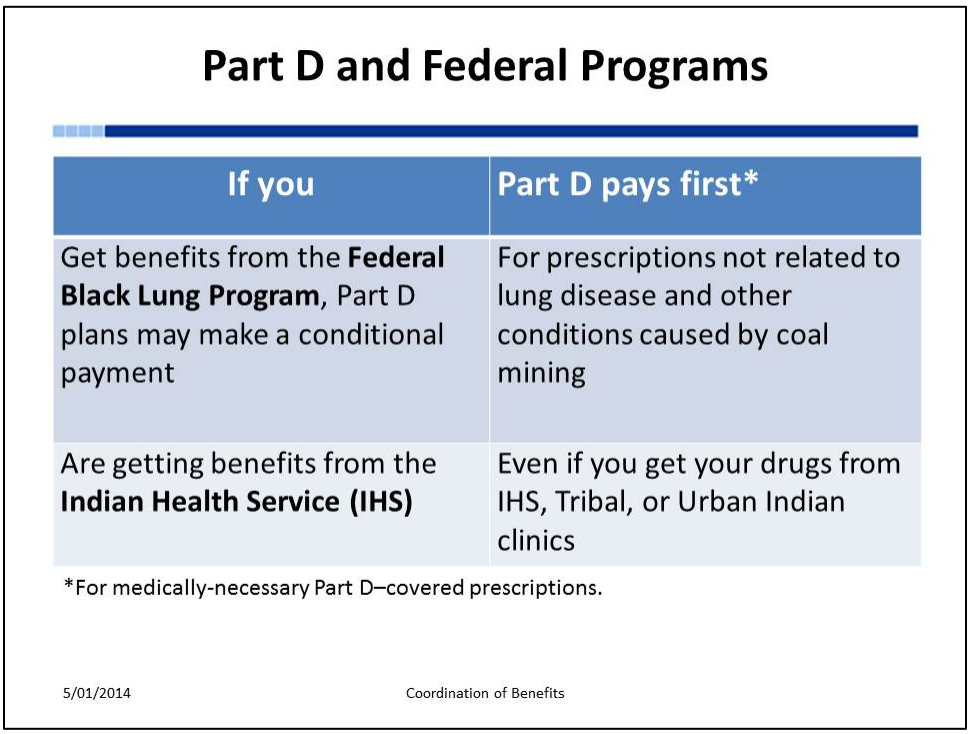
- Working-aged individuals 65 and older (they or their covered spouse is still working) with Medicare **and** an Employer Group Health Plan (EGHP) with **fewer than 20** employees
- A person with a disability with an EGHP with **100 or less** employees
- End-Stage Renal Disease with an EGHP of any size **after** a 30-month coordination period

NOTE: The Federal Employee Health Benefits (FEHB) program is a type of EGHP. It covers participating current and retired federal employees. There is usually not much benefit to having Part D and FEHB coverage, unless you qualify for Extra Help. If you have both, and are retired, Part D would pay first.



Part D (Medicare prescription drug coverage) generally pays first before Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage for people 65 and older and those who have a disability.

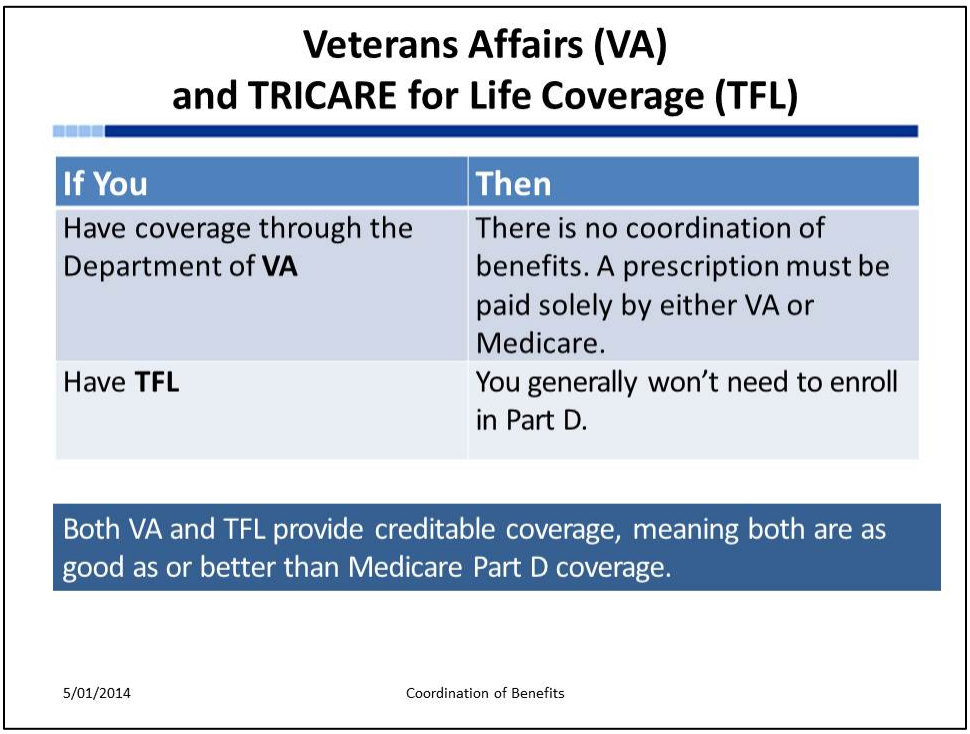
Medicare Part D pays first, if you have COBRA and have End-Stage Renal Disease, once you are out of your 30-month coordination period.



The **Federal Black Lung Program** covers people with lung disease from coal mining. If you get Federal Black Lung Program benefits, Part D (Medicare prescription drug coverage) won't cover prescriptions related to lung disease and other conditions caused by coal mining. It will pay first for all other covered prescriptions.

The **Indian Health Service** (IHS) is primary provider for the American Indian/Alaska Native (AI/AN) Medicare population. AI/AN people with Medicare can't be charged any cost-sharing. IHS, Tribal, and Urban Indian (I/T/U) (a pharmacy operated by IHS, an Indian tribe or tribal organization, or an Urban Indian organization, all of which are defined in Section 4 of the Indian Health Care Improvement Act of 1976, 25 USC 1603) facilities must waive any copayments or deductibles that would have been applied by a Part D plan.

Many Indian health facilities participate in the Medicare prescription drug program. If you get prescription drugs through an Indian health facility, you pay nothing, and your coverage won't be interrupted. Coordination of benefits with IHS and Tribes is tied to pharmacy network contracting. Regulations require all Part D sponsors to offer network contracts to all I/T/U pharmacies operating in their service area. Plans also must demonstrate to the Centers for Medicare & Medicaid Services that they provide convenient access to I/T/U pharmacies for AI/AN enrollees.

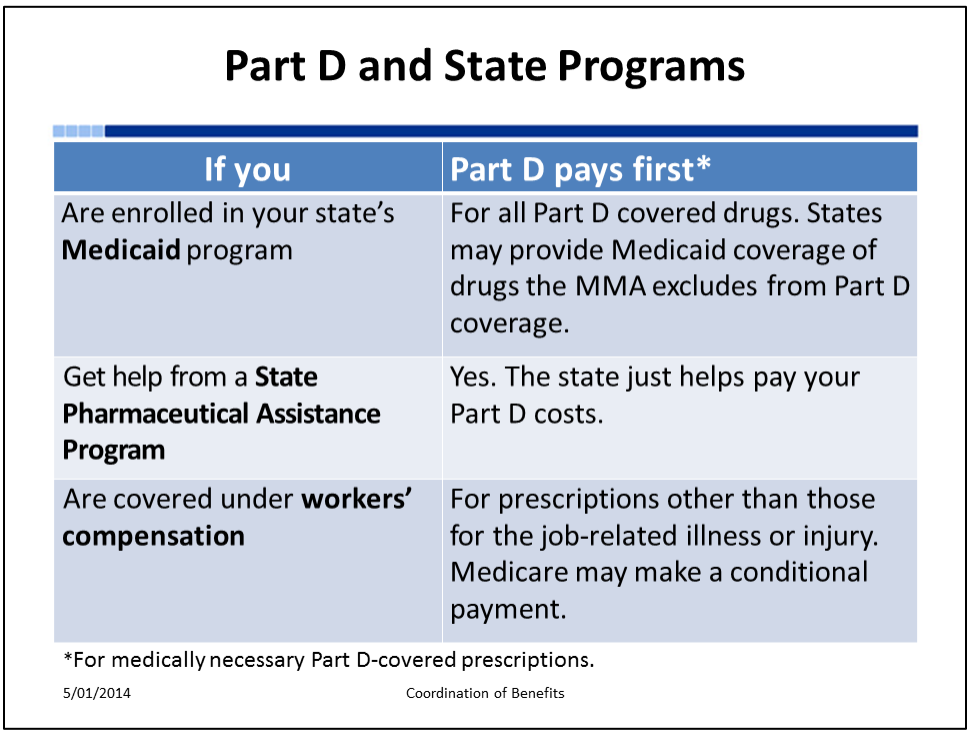


Veterans Affairs (VA) benefits, including prescription drug coverage, are separate and distinct from benefits provided under Part D (Medicare prescription drug coverage). Legally, VA can't bill Medicare. Although a person with Medicare may be eligible to receive VA prescription drug benefits and enroll in a Part D plan, he or she can't use both benefits for a single prescription.

VA prescriptions generally must be written by a VA physician and can only be filled in a VA facility or through VA's Consolidated Mail Outpatient Pharmacy operations. The VA doesn't fill prescriptions for Part D sponsors. Since VA and Part D benefits are separate and distinct, a veteran's payment of a VA medication copayment doesn't count toward his or her gross covered drug costs, or true out-of-pocket costs, under his or her Part D benefit.

Since VA prescription drug coverage is creditable coverage, beneficiaries won't face a penalty if they delay enrollment in a Part D plan. However, some beneficiaries who receive less than full VA prescription drug benefits may benefit from enrollment in a Part D plan—particularly if they're eligible for Extra Help.

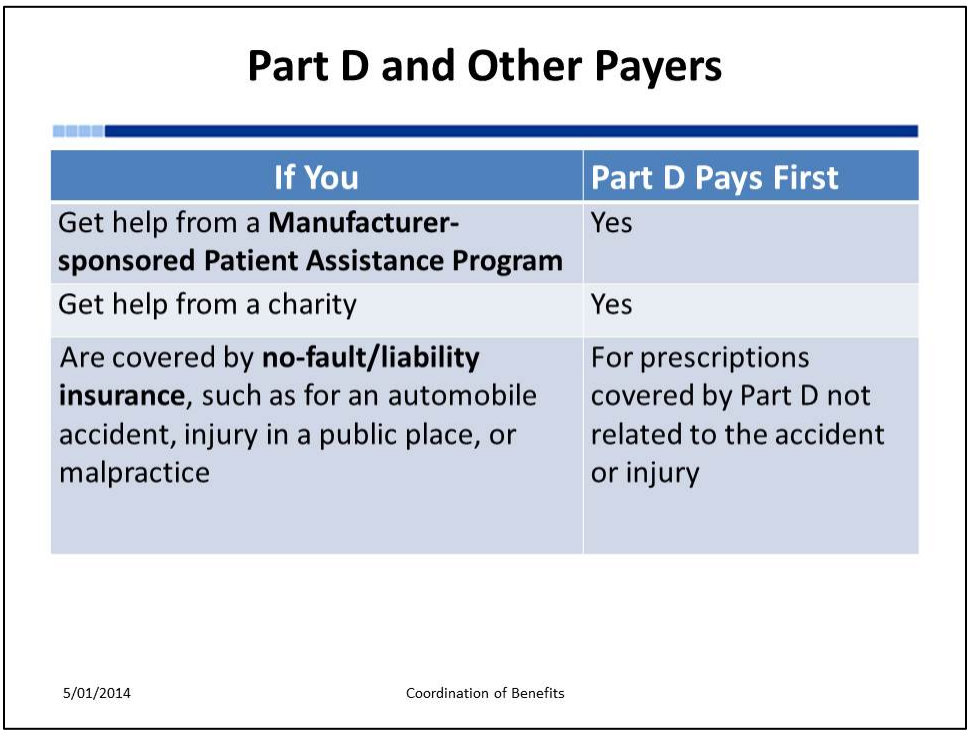
TRICARE for Life (TFL) coverage includes prescription drug benefits. These benefits qualify as creditable coverage, meaning they're as good as or better than the Medicare Part D benefit. People with TFL don't need to enroll in a Medicare Part D plan when they have the TFL pharmacy benefit. If they choose to enroll in a Medicare Part D plan at a later date, they won't be charged a late enrollment penalty.



Under the Medicare Modernization Act (MMA), people with both Medicare and full Medicaid benefits (called "full-benefit dual eligibles") now receive drug coverage from Medicare instead of Medicaid. States may choose to provide Medicaid coverage of drugs the MMA excludes from Part D coverage. Some Medicare Special Needs Plans coordinate Medicare-covered services, including prescription drug coverage, for people with both Medicare and Medicaid.

If you get help from a State Pharmaceutical Assistance Program, Medicare Part D pays first.

If you are covered under workers' compensation, Part D will pay first for covered prescriptions that aren't related to the job-related illness or injury. Part D plans will always make a "conditional" primary payment to ease the burden on the policyholder, unless certain situations apply. The Part D plan won't pay if it's aware that the enrollee has workers' compensation, Federal Black Lung Program benefits, or no-fault/liability coverage and has previously established that a certain drug is being used exclusively to treat a related illness or injury. For example, when an enrollee refills a prescription previously paid for by workers' compensation, the Part D plan may deny primary payment and default to Medicare secondary payer. The payment is "conditional" because it must be repaid to Medicare once a settlement, judgment, or award is reached.

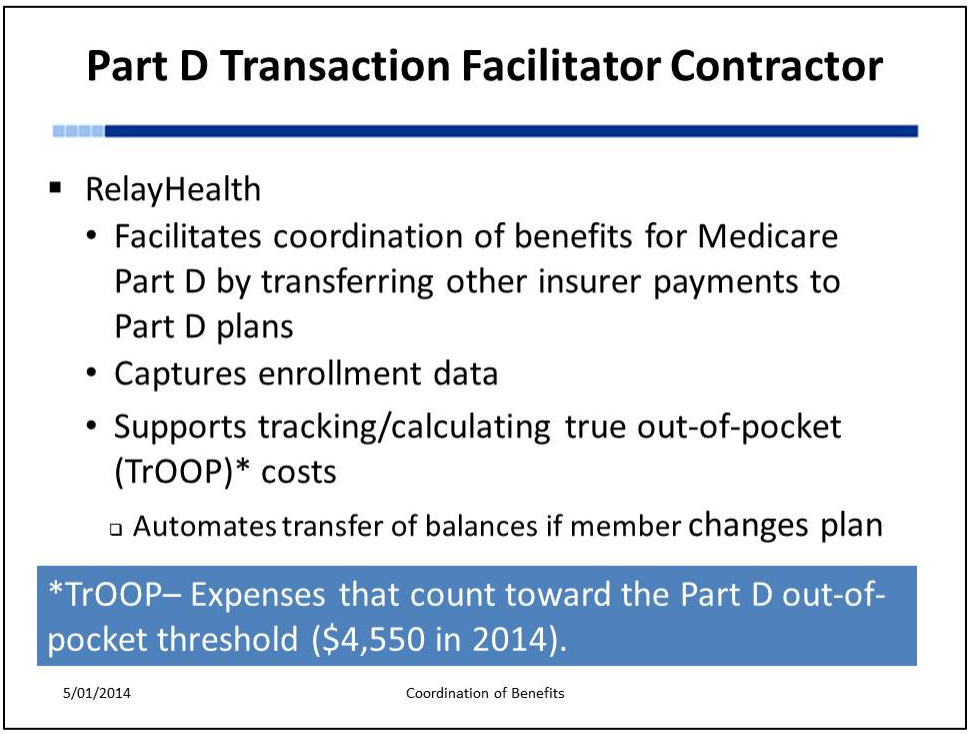


Manufacturer-sponsored Patient Assistance Programs (PAPs) may choose to structure themselves in order to continue providing in-kind assistance to Part D enrollees, but outside the Part D (Medicare prescription drug coverage) benefit. In other words, the value of the in-kind assistance won't count toward a Part D enrollee's true out-of-pocket (TrOOP) costs, and will be completely separate from the Part D benefit. The Centers for Medicare & Medicaid Services (CMS) encourages PAPs to exchange eligibility files with CMS so that Part D plans are aware of their enrollee's eligibility for PAP assistance and can set their computer systems edits to reflect when the drugs are provided free under the PAP. PAPs may charge a small copayment when providing this in-kind assistance, and this amount may count toward TrOOP. The person with Medicare will need to submit a paper claim to the drug plan, along with copayment documentation.

Charitable program members may present a retail ID card at the point of sale to get financial assistance. Charities that choose to participate in electronic data exchange can expedite adjudication of claims at the point of sale. Some charities require enrollees to submit a paper claim and then send claims to the TrOOP contractor in batch form for accurate TrOOP recalculation.

Any financial assistance a charity provides on behalf of a Part D enrollee will count toward the TrOOP catastrophic threshold, unless it's a group health plan, insurance, government-funded health program, or other third-party payment arrangement.

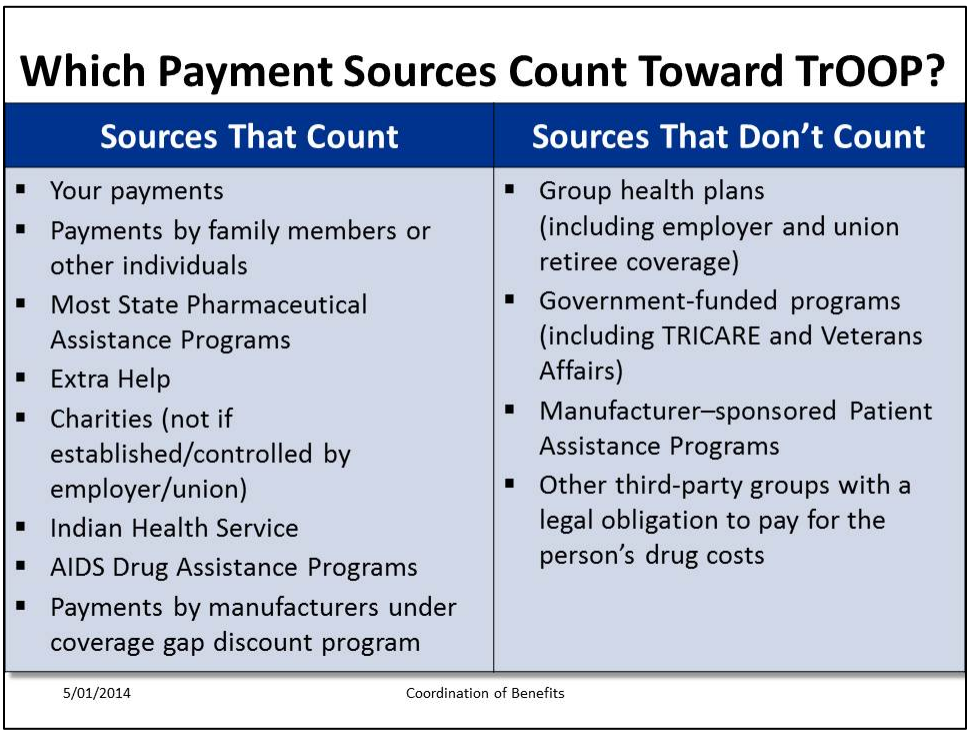
If you are covered by **no-fault/liability insurance**, such as for an automobile accident, injury in a public place, or malpractice, Part D pays first for prescriptions covered by Part D that aren't related to the accident or injury.



The Centers for Medicare & Medicaid Services awarded a single contract to RelayHealth as the Part D (Medicare prescription drug coverage) Transaction Facilitator Contractor, to facilitate the true out-of-pocket (TrOOP) costs tracking process and eligibility transactions for Medicare Part D. TrOOP costs are the expenses that count toward a person's Medicare drug plan out-of-pocket threshold of $4,550 (for 2014). TrOOP costs determine when a person's catastrophic coverage will begin. The drug plan keeps track of each member's TrOOP costs.

This service enables Part D plans to properly calculate TrOOP balances through electronic processing of claims at the pharmacy point of sale. When a Medicare Part D enrollee has other prescription drug coverage, coordination of benefits allows plans that provide coverage for this same beneficiary to determine each of their payment responsibilities. This process helps avoid duplication of payment and prevents Medicare from paying primary when it's the secondary payer.

The contractor will make sure accurate information is available to the Part D plans for proper calculation of how much a patient has paid toward the Medicare Part D program. It also automates the transfer of patient balances from one Part D plan to another if a member changes plans during the coverage year.



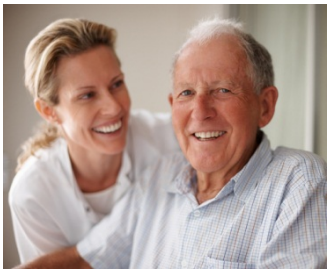
Payments that count toward true out-of-pocket (TrOOP) costs include payments for drugs on the plan's formulary made by the following:

- You, your family members, or other individuals
- Most State Pharmaceutical Assistance Programs
- Extra Help
- Charities, unless established, run, or controlled by a current or former employer or union
- Indian Health Services
- AIDS Drug Assistance Programs
- Pharmaceutical manufacturers under the coverage gap manufacturer discount programs

Payments that don't count as TrOOP costs include the following:

- Group health plans, including employer or union retiree coverage (and personal Health Savings Accounts when structured as a group health plan).
- Government-funded programs, including TRICARE or Veterans Affairs.
- Manufacturer-sponsored Patient Assistance Programs (PAPs) that provide free or significantly reduced-priced products (You can still take advantage of these programs, but the amount of this in-kind assistance won't count toward TrOOP). PAPs may charge a small copayment when providing this in-kind assistance, and this amount may count toward TrOOP. You'll need to submit a paper claim to your Medicare drug plan, along with documentation of the copayment.
- Other third-party groups with a legal obligation to pay for the person's drug costs.

Check Your Knowledge—Question 4



The Part D coordination of benefits contractor (COB), RelayHealth

a. Centralizes COB for Medicare Part D
b. Captures enrollment data
c. Supports tracking/calculating true out-of-pocket costs
d. All the above

Refer to page 46 to check your answers.

Check Your Knowledge—Question 5

For people covered by Medicare **and** full Medicaid benefits that have a medical issue that's covered by workers' compensation insurance

a. Medicaid pays for all prescriptions
b. Medicare pays for prescriptions other than those for the job-related injury or illness
c. Medicare pays for all prescriptions
d. Medicaid pays for prescriptions other than those for the job-related injury or illness

Refer to page 46 to check your answers.

Coordination of Benefits Resource Guide

Resources

Centers for Medicare & Medicaid Services (CMS)
1-800-MEDICARE
(1-800-633-4227)
TTY 1-877-486-2048
www.medicare.gov
www.cms.gov

Benefits Coordination & Recovery Center
1-855-798-2627
TTY 1-855-797-2627

U.S. Department of Labor
1-866-4-USA-DOL
(1-866-487-2365)
http://www.dol.gov/dol/topic/health-plans/cobra.htm

Office of Personnel Management (Federal Employees Health Benefit Program)
http://www.opm.gov/healthcare-insurance/healthcare/

Patient Assistance Program Center
www.rxassist.org

Medicare/TRICARE Benefit Overview
http://www.tricare.mil/welcome/eligibility.aspx

TRICARE
http://www.tricare.mil/

Department of Veterans Affairs
1-800-827-1000
TTY 1-800-829-4833
http://www.va.gov/opa/publications/benefits_book.asp

Veterans Affairs
http://benefits.va.gov/benefits/

Black Lung Program
http://www.dol.gov/compliance/topics/benefits-comp-blacklung.htm
1-800-638-7072
TTY 1-877-889-5627

Medicare Products

"Medicare & You Handbook"
CMS Product No. 10050

"Your Medicare Benefits"
CMS Product No. 10116

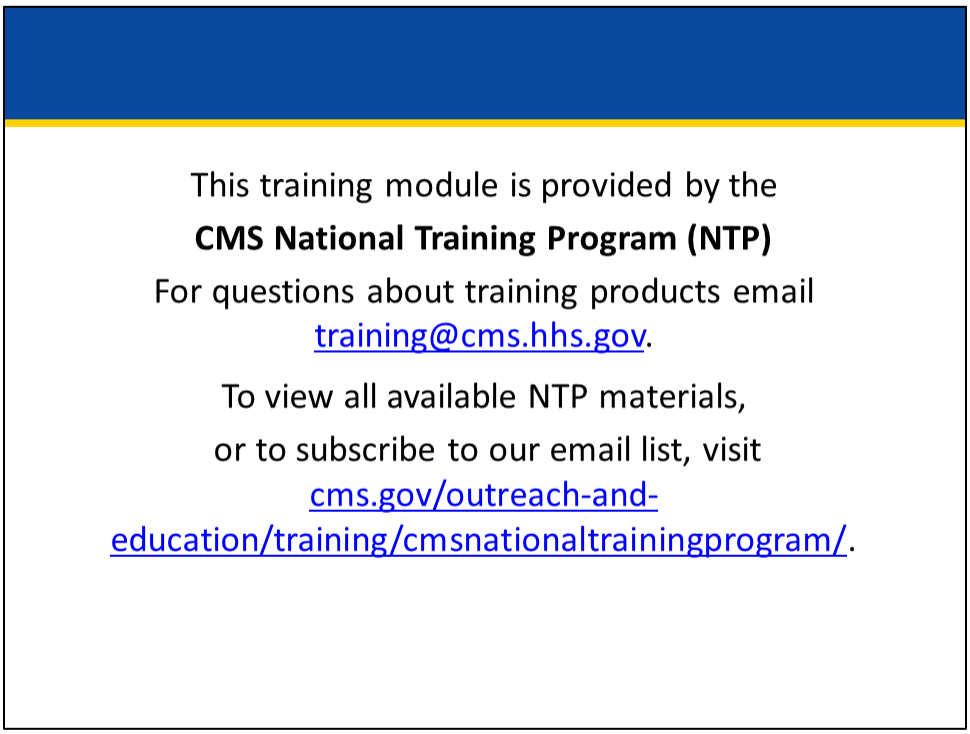
"Medicare and Other Health Benefits: Your Guide to Who Pays First"
CMS Product No. 02179

"Understanding True Out-of-Pocket (TrOOP) Costs"
CMS Product No. 11223-P

To access these products
View and order single copies at
www.medicare.gov

Order multiple copies (partners only) at
http://productordering.cms.hhs.gov
You must register your organization.

5/01/2014 Coordination of Benefits



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Check Your Knowledge Answer Key

Question 1 (page 11)

Which of the following isn't true about Medicare Secondary Payer?

Answer: c

c. Applies to situations where Medicare is the primary payer. Medicare Secondary Payer (MSP) is the term generally used when Medicare isn't responsible for paying a claim first. The MSP provisions protect the Medicare Trust Fund by ensuring that Medicare doesn't pay for services and items that certain other health insurance or coverage is primarily responsible for paying. The MSP provisions apply to situations when Medicare isn't the beneficiary's primary health insurance coverage.

Question 2 (page 27)

People with Medicare and Veterans Affairs (VA) benefits

a. Can get medical treatment under either program
b. Must choose which benefits to use each time they get health care
c. Can't have a Part D plan
d. Both a and b

Answer: d

d. Both a and b. People with both Medicare and VA benefits can access health care treatment under either program; however, they must choose which benefit they'll use each time the person sees a doctor or receives health care.

Question 3 (page 28)

Who pays John's bill first? He is 34 years old. He has End-Stage Renal Disease (ESRD), Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, and has been enrolled in Medicare for 8 months.

Answer: b

b. COBRA. Medicare is secondary to COBRA for individuals with ESRD during the 30-month coordination period. COBRA coverage generally continues for 18 months – Medicare will become primary upon termination of COBRA even if such termination occurs before the 30 month period.

Question 4 (page 41)

The Part D coordination of benefits contractor (COB), RelayHealth

Answer: d

a. Centralizes COB for Medicare Part D
b. Captures enrollment data
c. Supports tracking/calculating true out-of-pocket costs
d. All the above

d. All of the above. RelayHealth facilitates the true out-of-pocket (TrOOP) tracking process and eligibility transactions for Medicare Part D. This service enables Part D plans to properly calculate TrOOP balances through electronic processing of claims at the pharmacy point of sale.

Question 5 (page 42)

For people covered by Medicare and full Medicaid benefits that have a medical issue that's covered by workers' compensation insurance.

Answer: b

b. Medicare pays for prescriptions other than those for the job-related illness or injury. The Medicare Modernization Act established that people with both Medicare and full Medicaid benefits will receive drug coverage from Medicare rather than Medicaid.

Acronyms

AI/AN	American Indian/Alaska Native
BCRC	Benefits Coordination & Recovery Center
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CWF	Common Working File
EGHP	Employer Group Health Plan
ESRD	End-Stage Renal Disease
FEHB	Federal Employee Health Benefits
GHP	Group Health Plan
IHS	Indian Health Services
IRS	Internal Revenue Service
I/T/U	Indian Health Service, Tribal, and Urban Indian
MMA	Medicare Modernization Act
MSP	Medicare Secondary Payer
NTP	National Training Program
PAP	Patient Assistance Program
SHIP	State Health Insurance Assistance Program
SSA	Social Security
TFL	TRICARE for Life
TrOOP	True Out-of-Pocket
VA	Veterans Affairs
VDSA	Voluntary Data-Sharing Agreement
WCMSA	Workers' Compensation Medicare Set-aside Arrangement

Index

Website: cms.gov/outreach-and-education/training/cmsnationaltrainingprogram

Email: training@cms.hhs.gov

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244