Workbook

2013 National Training Program

Module: 5
Coordination of Benefits

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Inside front cover

Module 5: Coordination of Benefits

Contents

Contents

This module can be presented in 1.5 hours. Allow approximately 30 more minutes for discussion, questions and answers, and the learning activities.

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, and the Health Insurance Marketplace. The information in this module was correct as of May 2013.

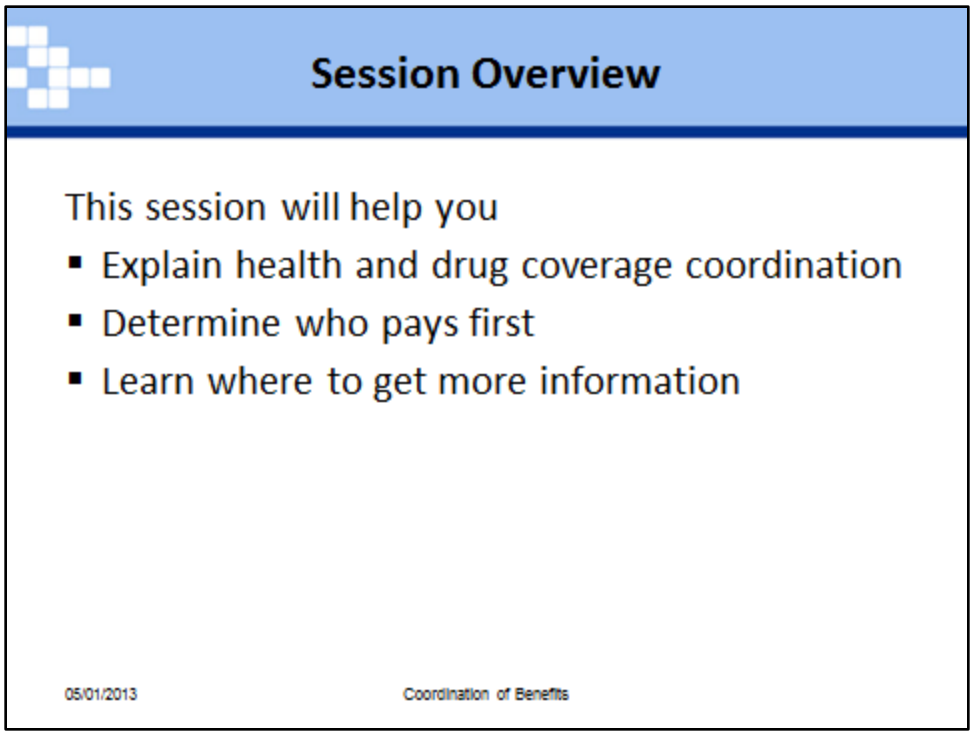
This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

Need More Information?

To check for updates on health care reform, visit www.HealthCare.gov

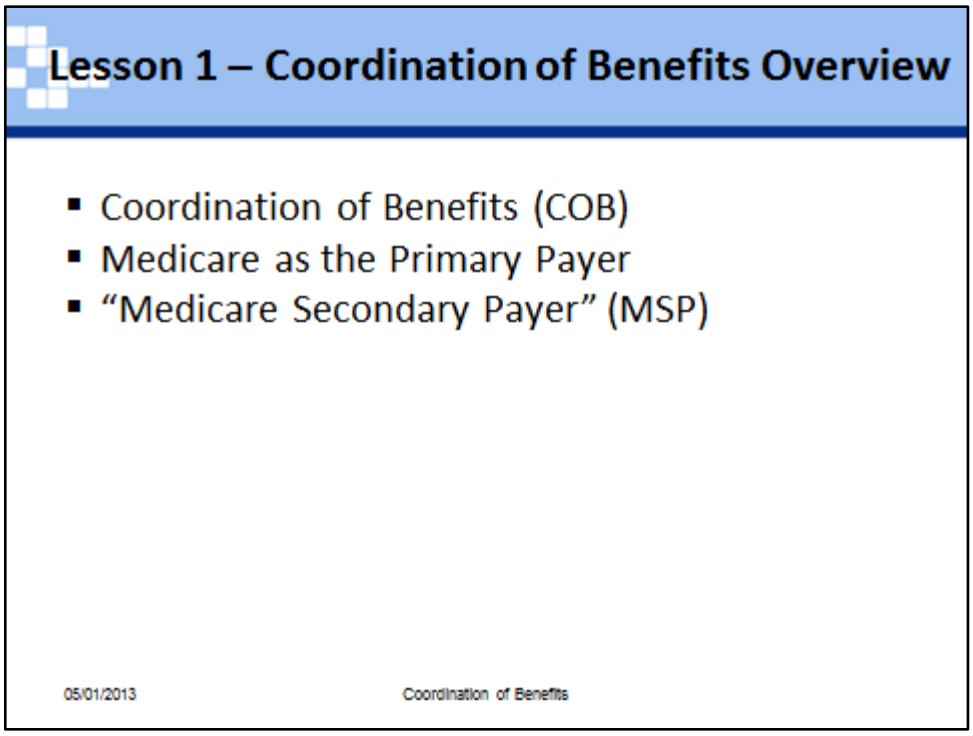
To view the Affordable Care Act, visit www.hhs.gov/healthcare/rights/law/index.html

To check for an updated version of this training module, visit http://cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html



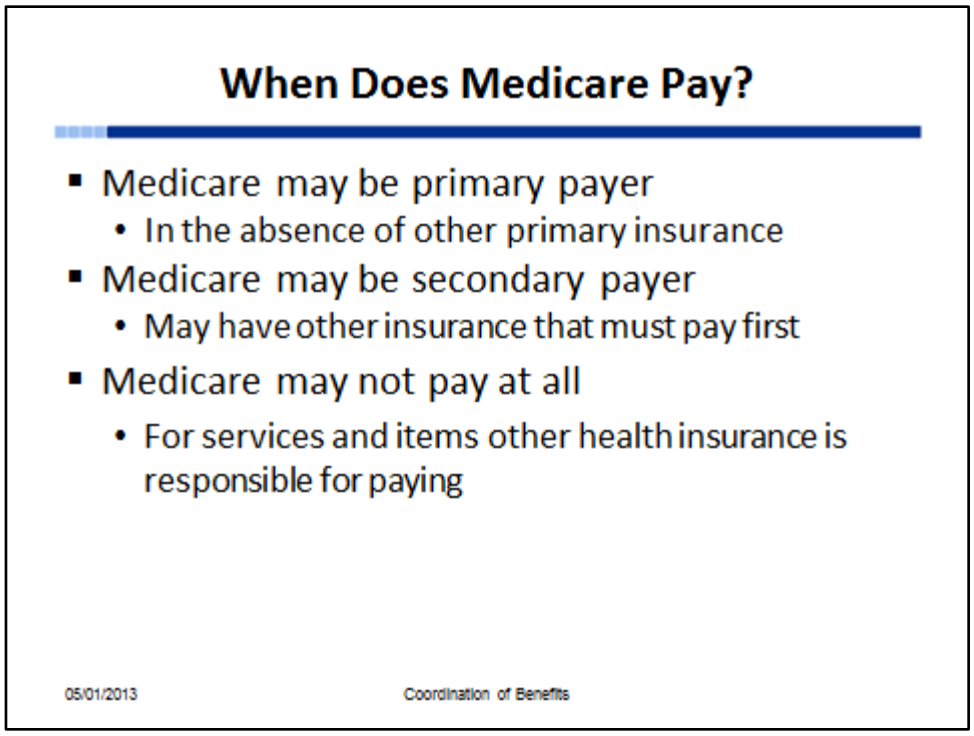
This session will help you to

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



This lesson provides an overview of

- Coordination of Benefits (COB)
- Medicare as the Primary Payer, and
- Medicare Secondary Payer (MSP)

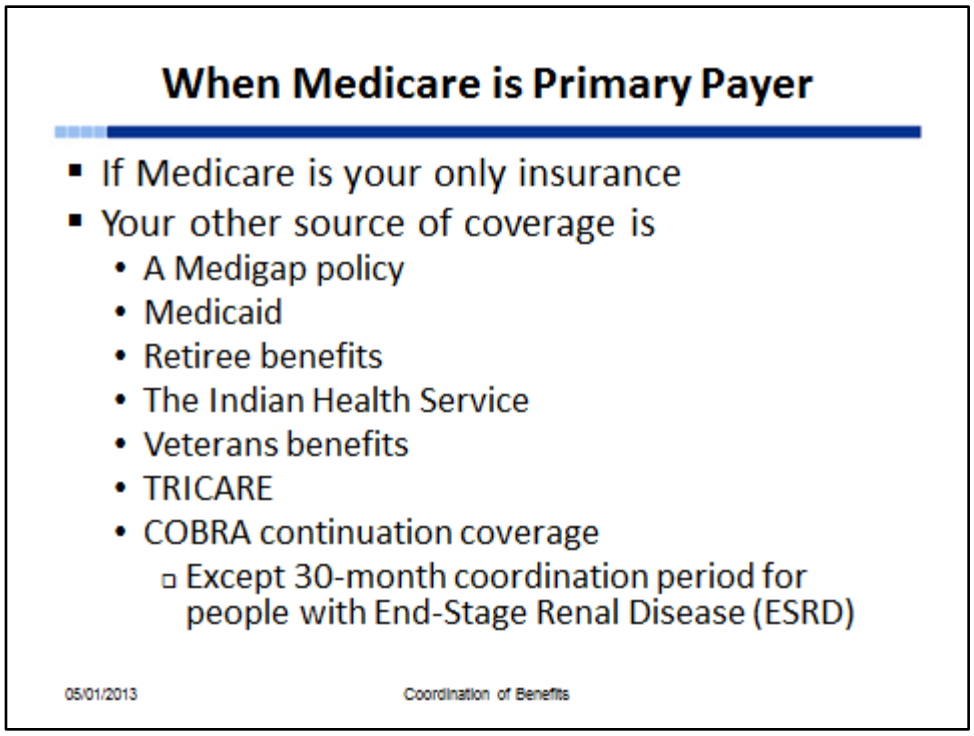


Medicare can be the primary payer, the secondary payer, or sometimes, other insurance plans should pay and Medicare should not pay at all.

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.

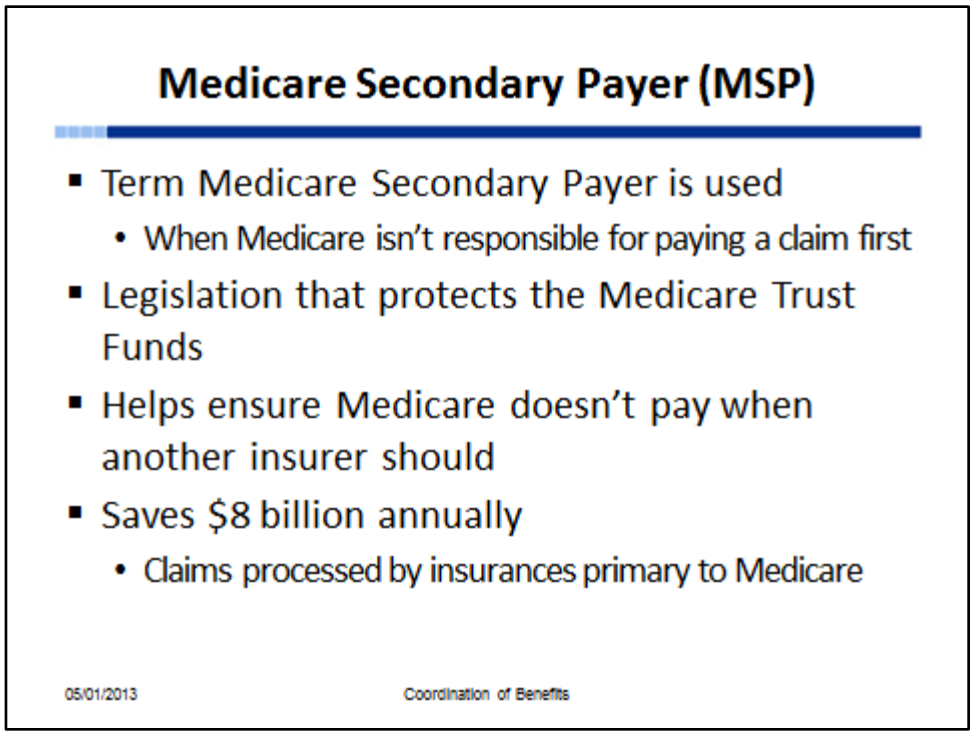
Medicare may be the secondary insurance payer in situations where Medicare does not provide your primary health insurance coverage, or when another insurer is primarily responsible for paying.

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 is not 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 Indian Health Service (IHS).
- Veteran's benefits.
- Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), with one exception, End-Stage Renal Disease (ESRD). We'll talk about this coverage shortly.



Medicare Secondary Payer (MSP) is the term generally used when Medicare is not 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 benefits, and Veterans Affairs (VA) 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.

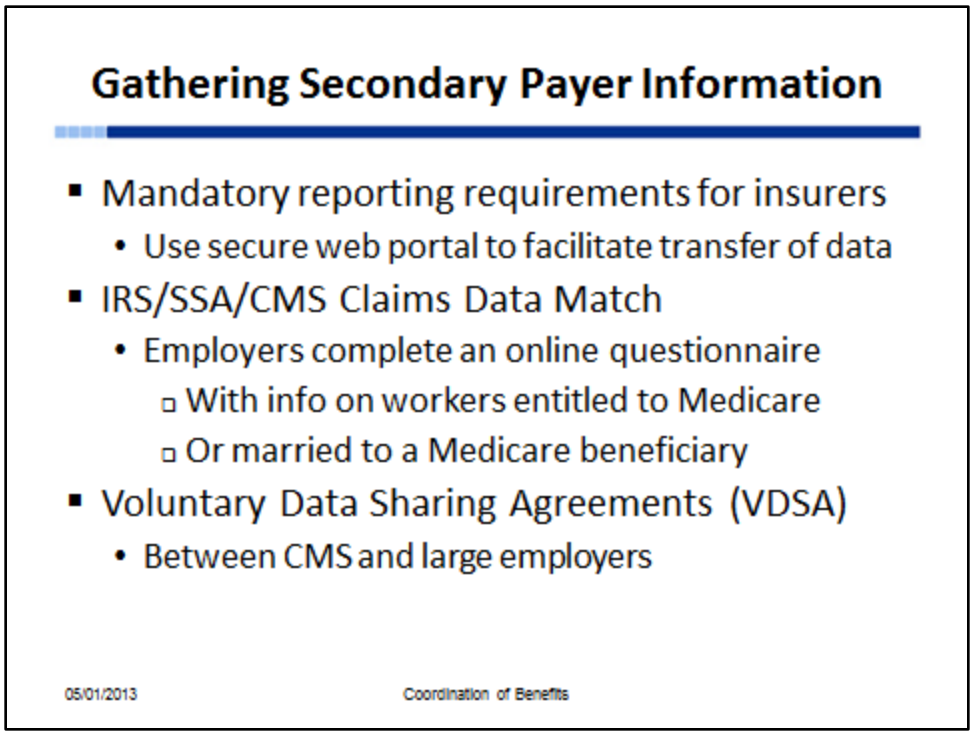
The MSP provisions have protected Medicare Trust Funds by ensuring that Medicare does not pay for services and items that certain health insurance or coverage is primarily responsible for paying. The MSP provisions apply to situations when Medicare is not the beneficiary's primary health insurance coverage.

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

The Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 added new mandatory reporting requirements for group health plan (GHP) arrangements and for liability insurance (including self-insurance), no-fault insurance, and workers' compensation.

Need More Information?

See Section 111 of the Medicare, Medicaid, and SCHIP Extension Act (MMSEA (P.L.110-173) and 42 U.S.C. 1395y(b)(7) & (8) for more information on mandatory reporting requirements.



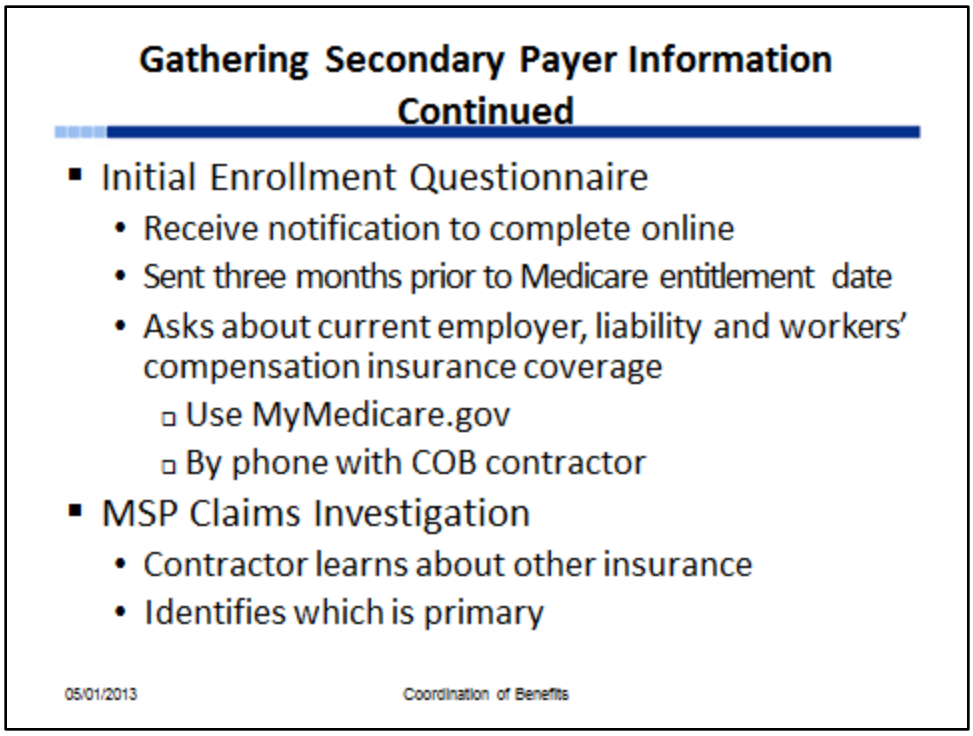
Coordination of benefits relies on multiple databases maintained by multiple stakeholders, including Federal and state programs, plans that offer health insurance and/or prescription coverage, pharmacy networks, and a variety of assistance programs available for special situations and/or conditions. Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)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 transfer of data.

IRS/SSA/CMS Claims Data Match - A key data source is the IRS/SSA/CMS Claims Data Match. The law requires the Internal Revenue Service (IRS), the Social Security Administration (SSA), and CMS to share information about Medicare beneficiaries and their spouses. By law, employers are required to complete a questionnaire on the group health plan that Medicare-eligible workers and their spouses choose. The 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 group health plan enrollment information electronically.

Where discrepancies occur in the Voluntary Data Sharing Agreement, 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 Part D.

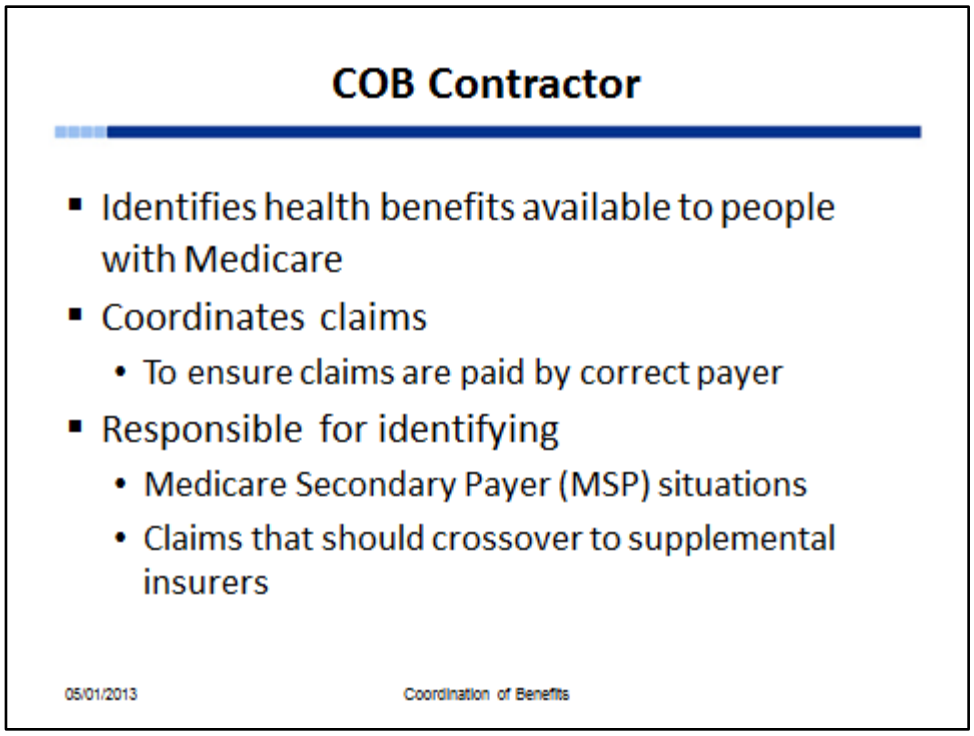


Three months before Medicare coverage begins, people are sent a notice sent asking them to complete the Initial Enrollment Questionnaire online. It asks questions about other health insurance you have, like group health coverage from your or a family member's employer, liability insurance, or workers'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

- 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?
- (On your Medicare eligibility date) Will you be receiving any group health plan coverage through the current employment of your husband/wife?
- How many employees work for your husband/wife's employer? (Please include your husband/wife.)
- Does your husband/wife's employer group health plan cover prescription drugs?
- Are you receiving Black Lung Benefits or workers' compensation benefits?
- Are you receiving treatment for an injury or illness which 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(MSNs), and more. You may complete the Initial Enrollment Questionnaire online at MyMedicare.gov, or over the phone by calling the Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782.

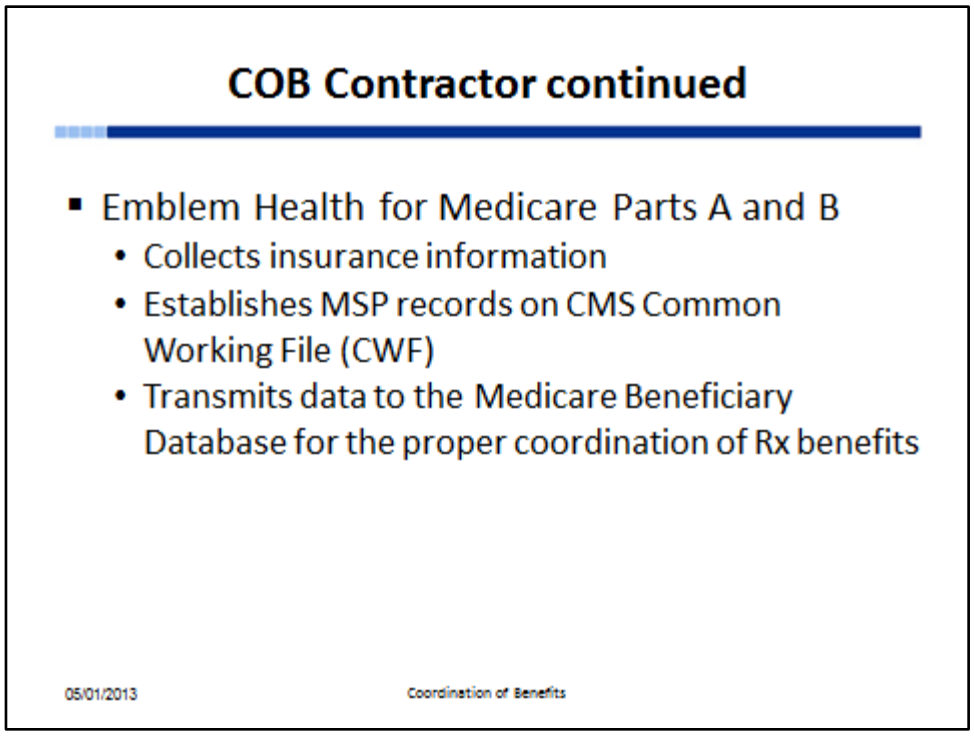
The COB Contractor initiates an investigation when it learns that a person has other insurance. The investigation determines whether Medicare or the other insurance has primary responsibility for meeting the beneficiary's health care costs. The goal of these MSP information-gathering activities is to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



The purposes of the Coordination of Benefits (COB) 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 True Out-of-Pocket (TrOOP) payments.

Medicare eligibility data is shared with other payers and Medicare-paid claims are transmitted to supplemental insurers for secondary payment. An agreement must be in place between CMS' Coordination of Benefits Contractor 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 does not exceed 100% of the total claim, avoiding duplicate payments.



Emblem Health 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.
- They establish 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 is 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 (MBD) for the proper coordination of Rx benefits.

Check Your Knowledge
Lesson 1 – Coordination of Benefits Overview

Answer the following questions:

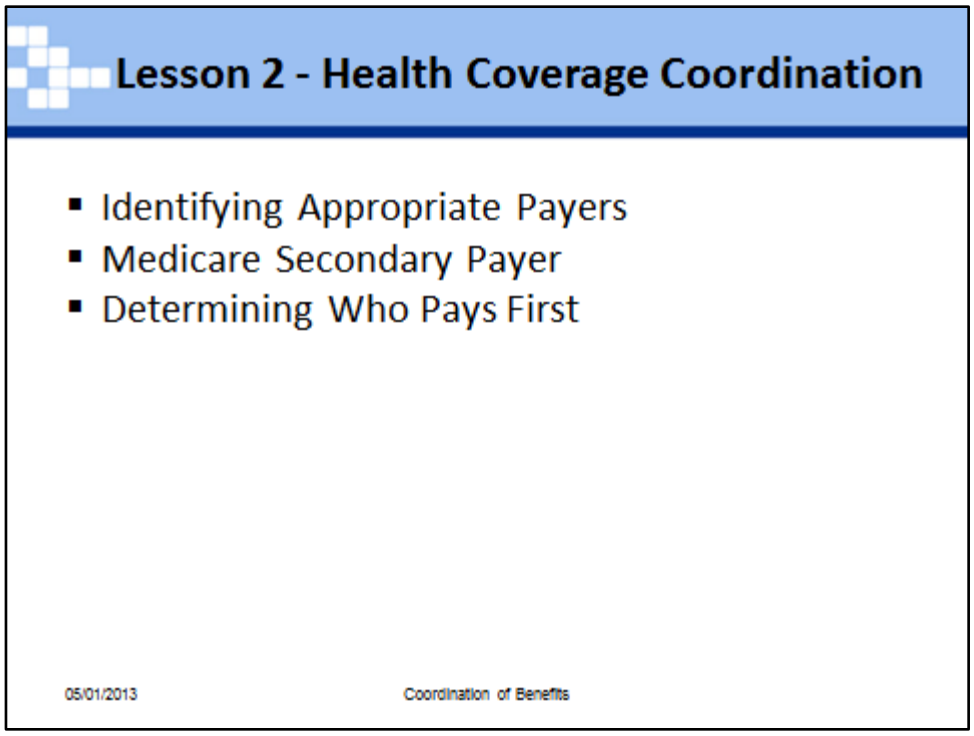
1. When does Medicare pay claims?

    a. Medicare may be the primary or secondary payer
    b. Medicare may not pay at all
    c. Both answers a and b

2. Janice's Medicare coverage will begin in 3 months. She received a notice asking her to complete the Initial Enrollment Questionnaire. She may complete this questionnaire:

    a. Online
    b. By phone
    c. In person
    d. Either online or by phone

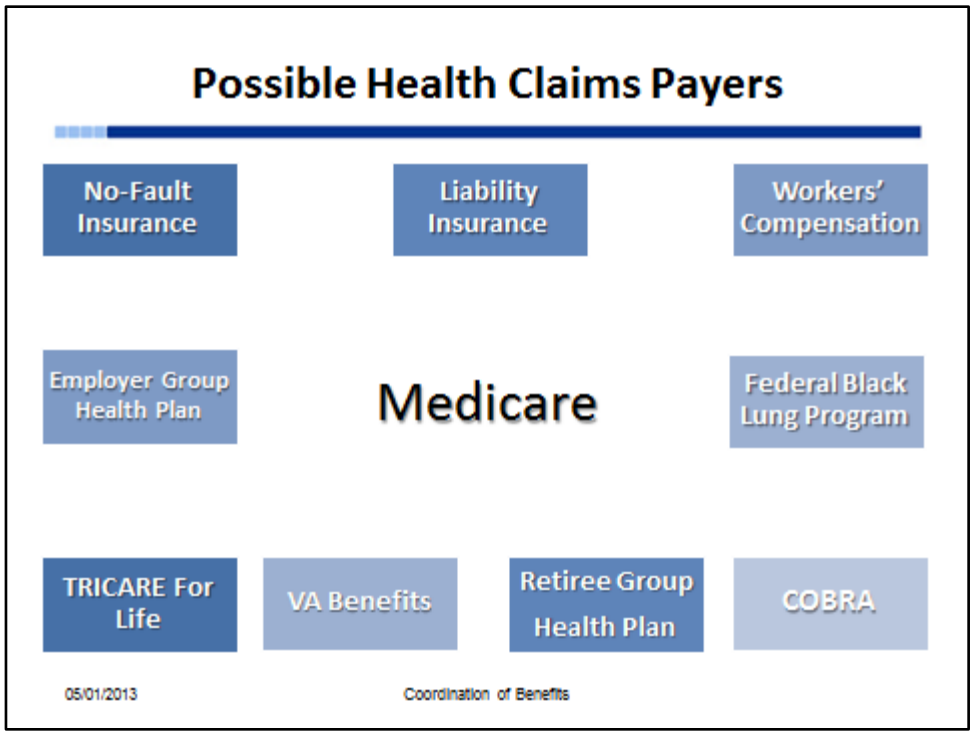
Refer to page 43 to check your answers.



The topics for the next lesson on Health Coverage Coordination includes

- Identifying Appropriate Payers
- Medicare Secondary Payer
- Determining Who Pays First

NOTE: Visit http://www.medicare.gov/Pubs/pdf/02179.pdf to download *Medicare and Other Health Benefits: Your Guide to Who Pays First* to see the chart of situations where you may have other coverage that shows who would pay first, and who would pay second.

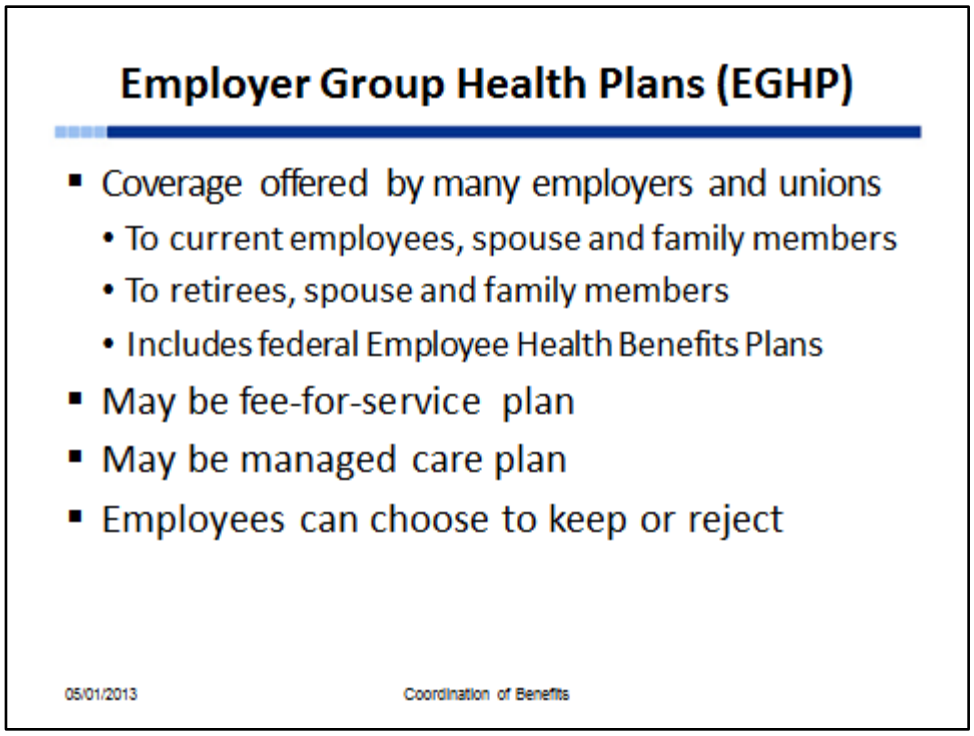


It is important to identify whether a person's medical costs are payable by other insurance before, or in addition to, Medicare. This information helps health care providers determine whom to bill and how to file claims with Medicare.

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

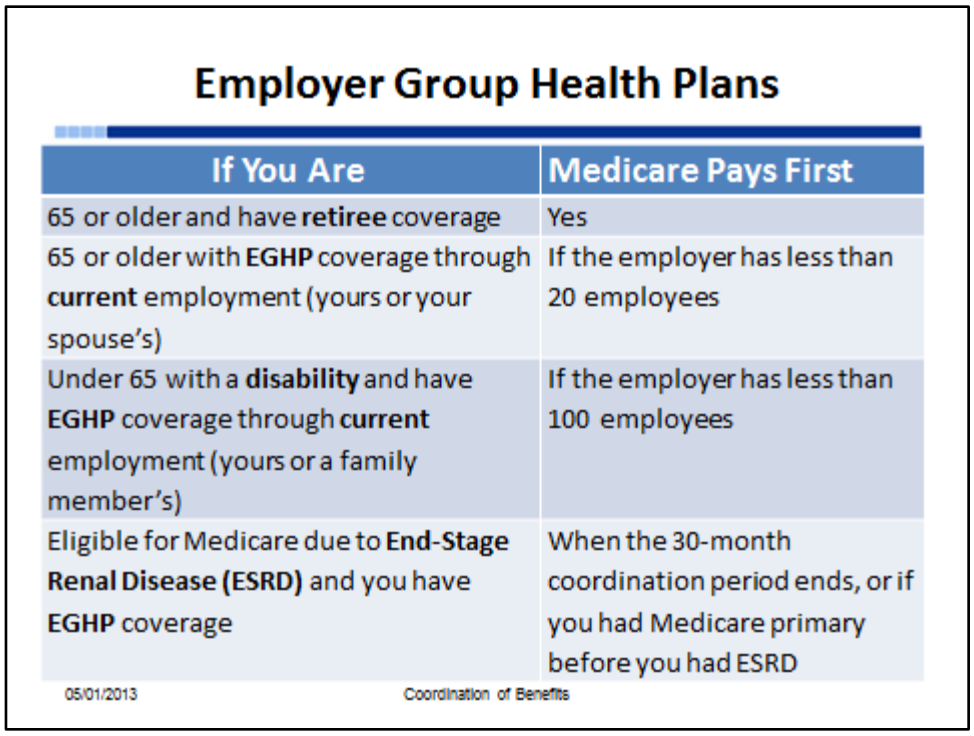
- Medicare;
- No-Fault Insurance;
- Liability Insurance;
- Workers' compensation insurance;
- Federal Black Lung Program;
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA);
- Retiree Group Health Plan;
- Veterans Affairs (VA) Benefits;
- TRICARE For Life
- Employer Group Health Plan.

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 (FEHB) program is a type of Employer Group Health Plan (EGHP).

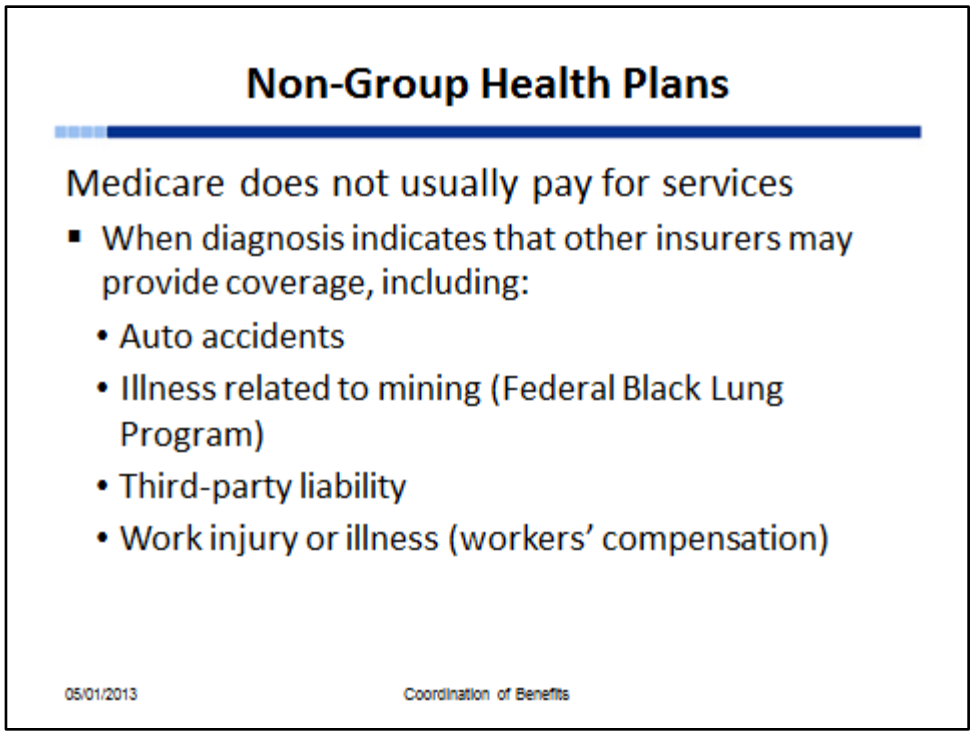
Employer group health coverage is coverage offered by many employers and unions for current employees and/or retirees. A person may also get group health coverage through a spouse's or other family member's employer. If someone has Medicare and is offered coverage under an EGHP, he or she can choose 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 (HMO).



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

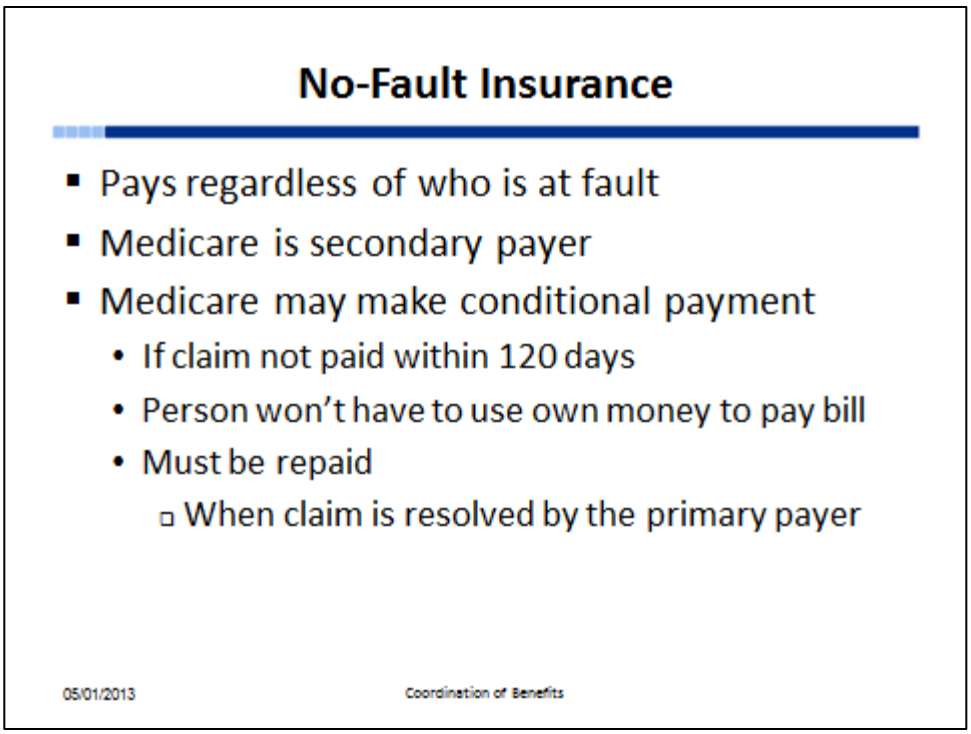
Medicare pays first if

- If you are 65 or older and have retiree coverage
- If you are 65 or older with employer group health plan 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 employer group health plan 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 employee group health 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 does not usually pay for services when the diagnosis indicates that other insurers may provide coverage, including

- Auto accidents;
- Illness related to mining (Federal Black Lung Program);
- Third-party liability; or
- 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; and
- Commercial insurance plans.

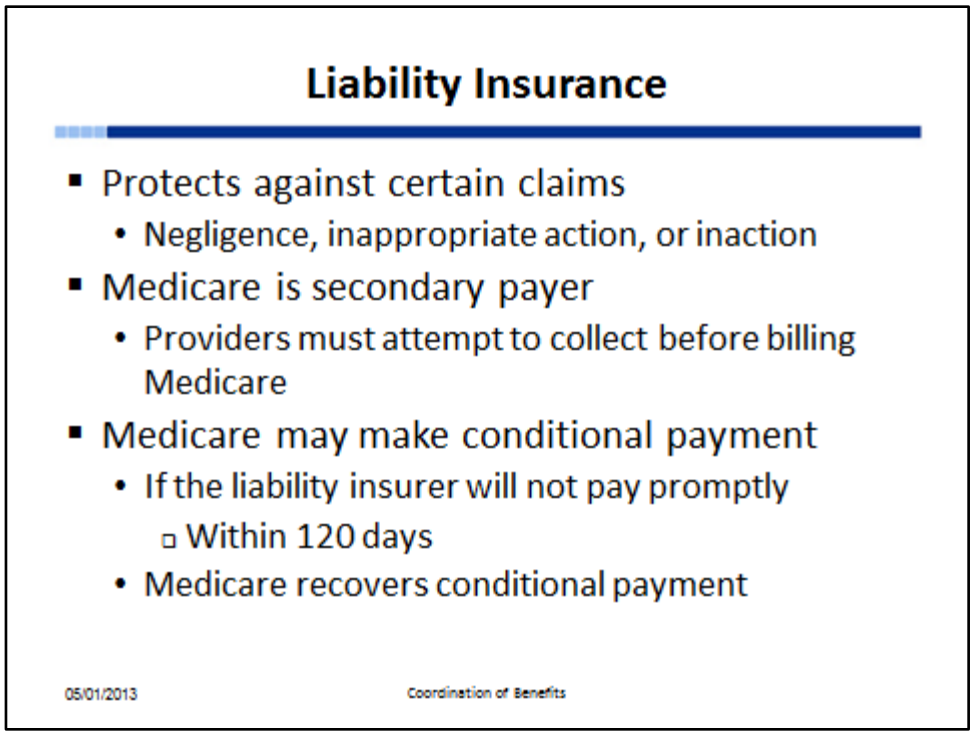
Medicare is the secondary payer where no-fault insurance is available.

Medicare generally will not 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 does not 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 making sure that Medicare gets repaid for the conditional payment.

Need More Information?

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

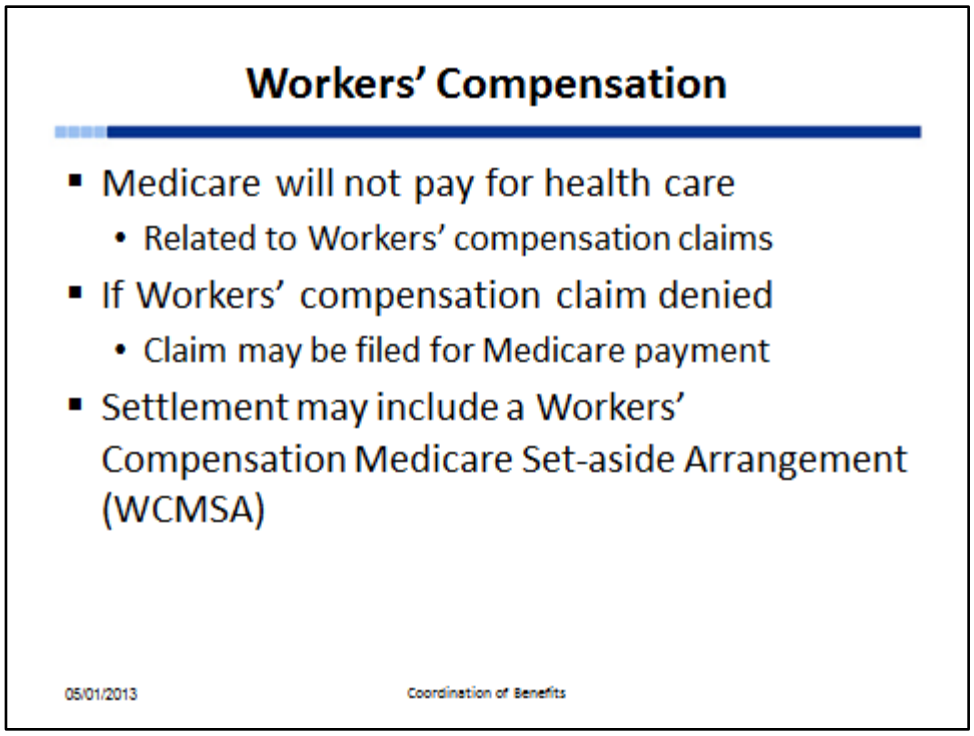


Liability insurance is coverage that protects a party against claims based on negligence, inappropriate action, or inaction that results in injury to someone or damage to property. Liability insurance includes, but is not limited to

- Homeowner's liability insurance;
- Automobile liability insurance;
- Product liability insurance;
- Malpractice liability insurance;
- Uninsured motorist liability insurance; and/or
- 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 an individual 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. The liability insurer must tell the provider on its remittance advice that it will not make a prompt payment. The Medicare contractor must receive the no payment, the associated reason, and information from the provider. The liability information is then identified by the provider on the claim to Medicare so Medicare can make a timely, correct conditional payment to the provider. When the liability insurer pays, Medicare recovers its conditional primary payment.

Medicare will only pay to the extent services are covered under Medicare.



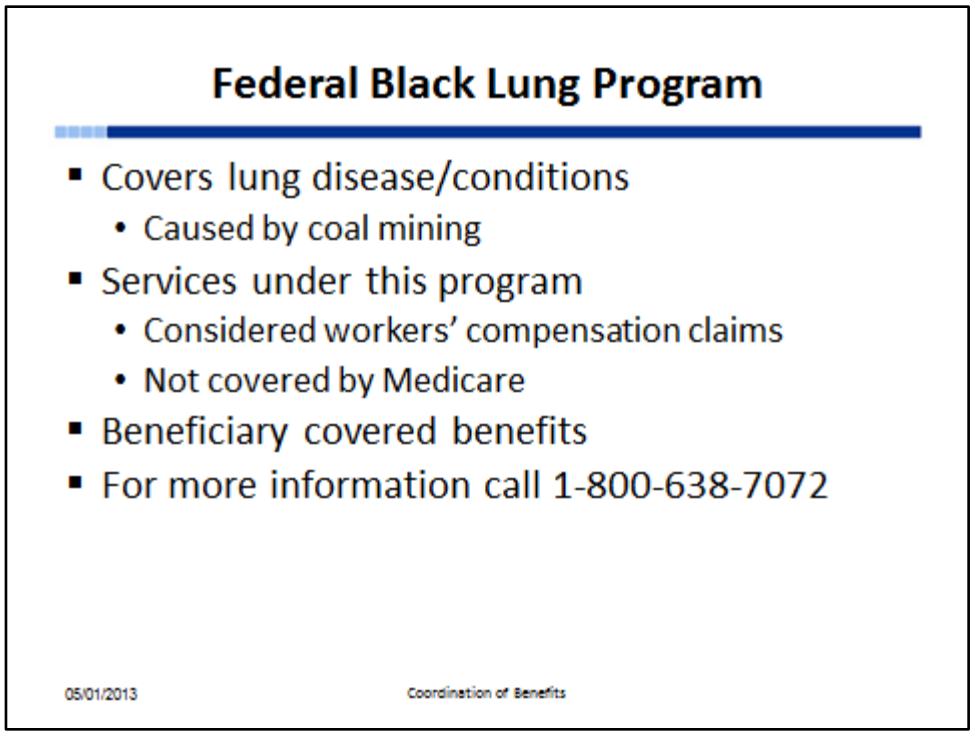
Medicare generally will not pay for an injury or illness/disease covered by workers' compensation. If all or part of a claim is denied by workers' compensation on the grounds that it is not covered by workers' compensation, a claim may be filed with Medicare. Medicare may pay a claim that relates to a medical service or product covered by Medicare if the claim is not 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 http://www.cms.gov/Medicare/Coordination-of-Benefits/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSAP-Overview.html

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 are not 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.

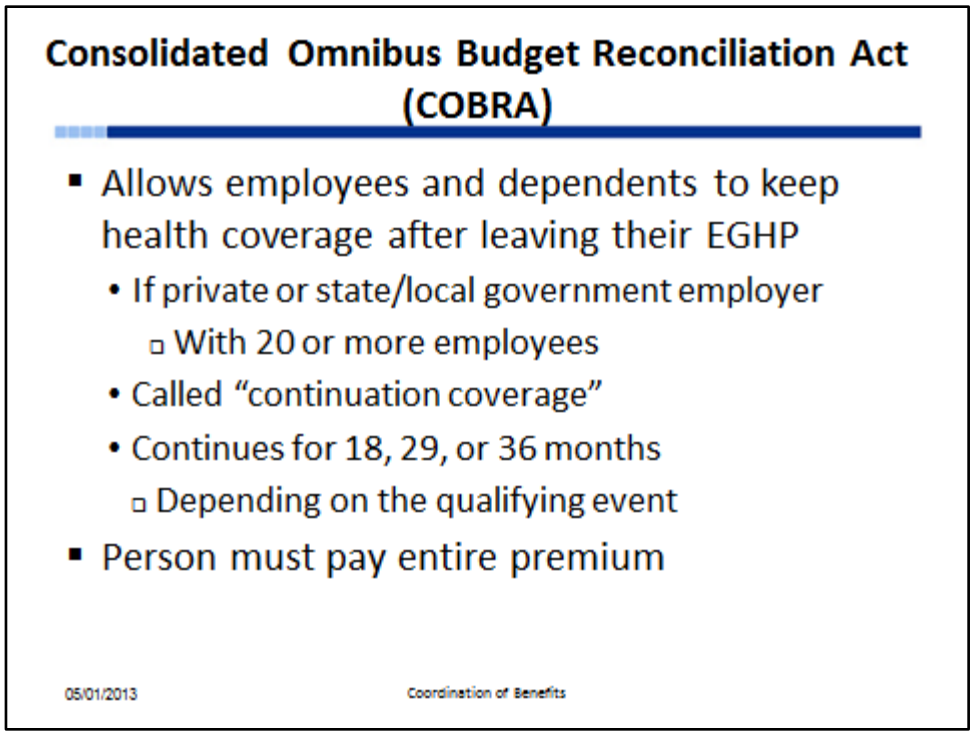
Federal Black Lung Program beneficiaries are eligible for prescription drugs, in-patient and out-patient services, and doctors' visits. In addition, home oxygen and other medical equipment, home nursing services, and pulmonary rehabilitation may be covered with a doctor's prescription.

Need More Information?

A toll-free number has been designated for each of nine Division of Coal Mine Workers' Compensation district offices located in PA, WV, KY, OH, and CO.

A toll-free number, 1-800-638-7072, has been designated for the office that is responsible for the Black Lung Program's medical diagnostic and treatment services.

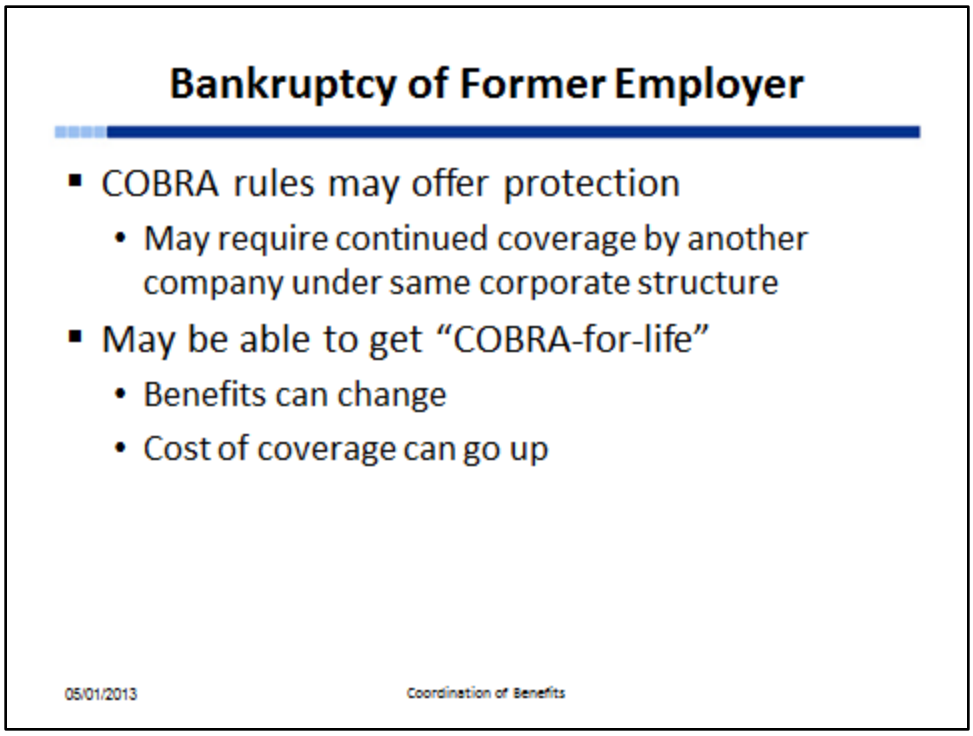
For more information about the Federal Black Lung Program, visit, http://www.dol.gov/compliance/laws/comp-blba.htm



The Consolidated Omnibus Budget Reconciliation Act of 1985 (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 (EGHP), under certain conditions. This is called "continuation coverage." The law applies to private sector and state and local government–sponsored plans, but not to federal government–sponsored plans or the governments of the District of Columbia or any territory or possession of the U.S. 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 their part and the part of the premium their employer paid while they still worked. However, it usually costs less than individual health coverage.



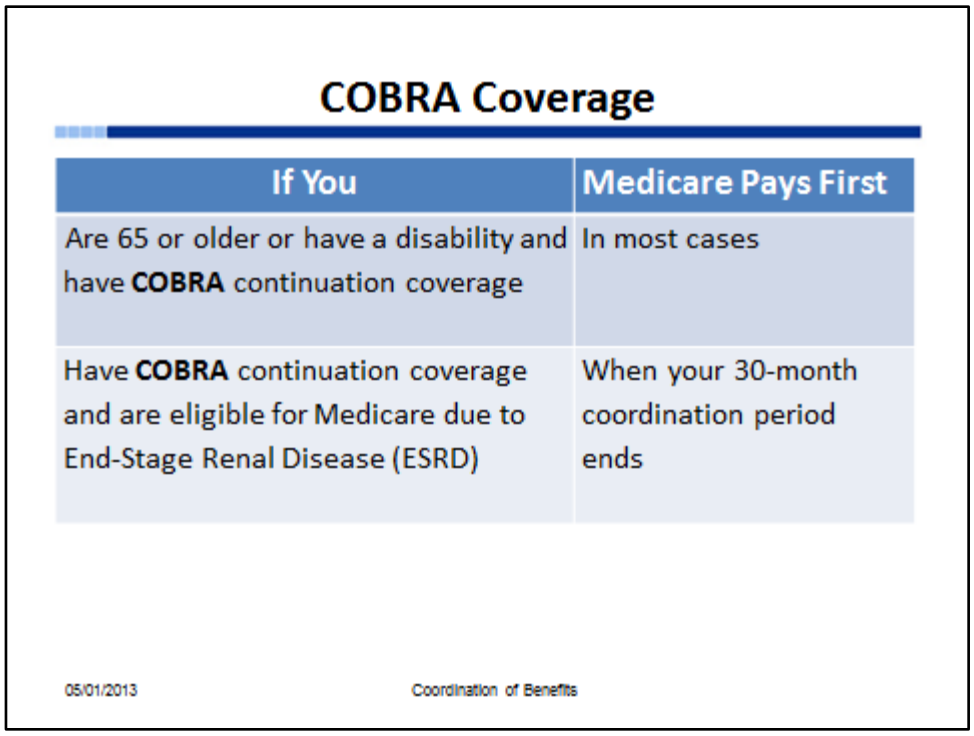
If you have retiree health coverage after you retire and your former employer goes bankrupt or out of business, federal COBRA rules may offer protection. These rules require any other company within the same corporate organization that still offers an EGHP to its employees to offer COBRA continuation 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.

You can view this publication at www.medicare.gov/Publications/Pubs/pdf/02179.pdf



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

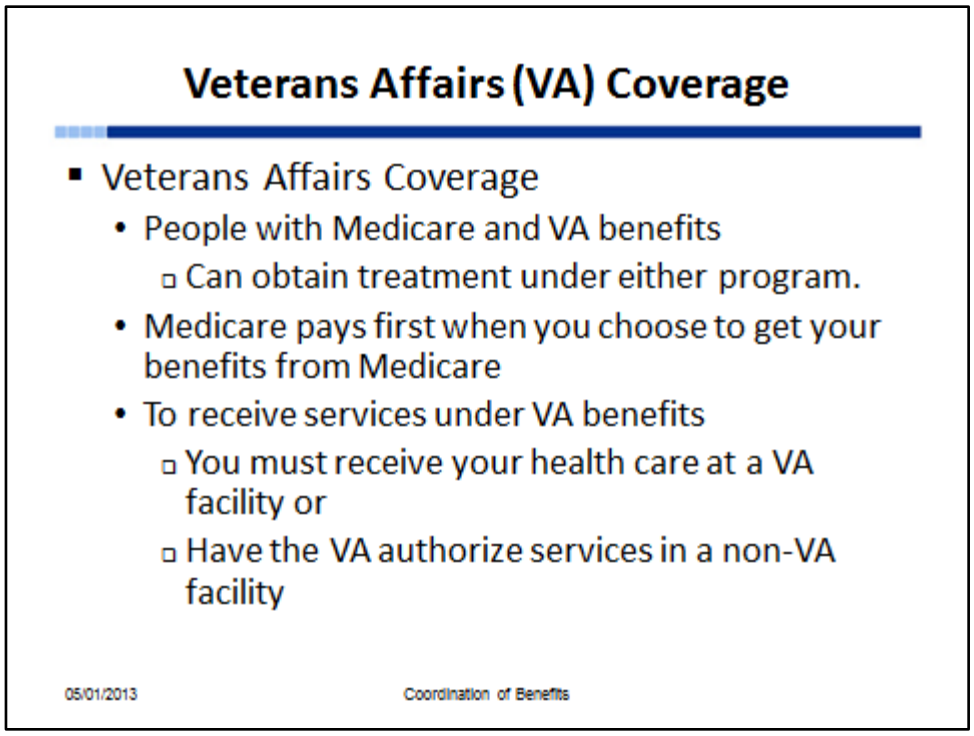
Before electing COBRA coverage, people may find it helpful to talk with a State Health Insurance Assistance Program (SHIP) counselor to better understand their options. For example, if a person who already has Medicare Part A chooses COBRA but waits to sign up for Medicare Part B until the last part 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 timeframes on COBRA and Medigap guaranteed issue rights in a given state. Timeframes may differ depending on state law.

Need More Information?

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

You can view this publication at www.medicare.gov/Publications/Pubs/pdf/02179.pdf



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

To receive services under Veterans Affairs (VA) benefits, a person must receive their health care at a VA facility OR have the VA authorize services in a non-VA facility.

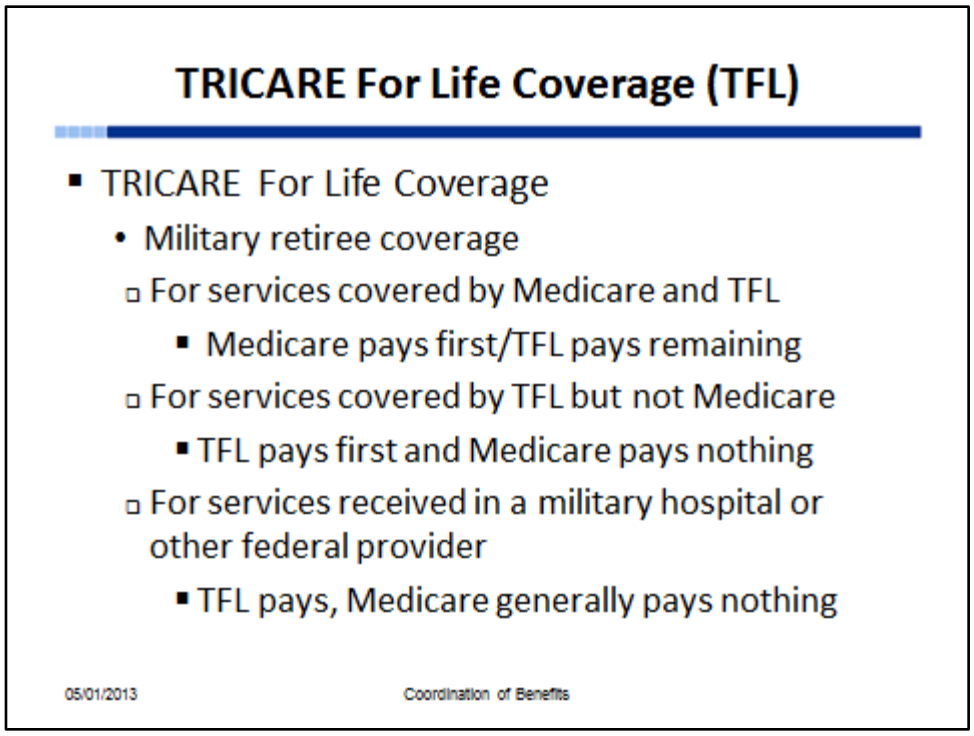
Veterans could be subject to a penalty for enrolling "late" for Medicare Part B, even if they are enrolled in VA health care.

Need More Information?

For more information on VA coverage, visit: http://www.va.gov/health/default.asp

NOTE: 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.

For more information, please contact the Veterans Affairs at 1-877-222-VETS (8387).



While Medicare is your primary insurance, TRICARE For Life (TFL) acts as your secondary payer, minimizing your out-of-pocket expenses. TFL benefits include covering Medicare's coinsurance and deductible.

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 your 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 does not usually pay for services received from a federal provider or other federal agency.

NOTE: TRICARE for Life 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 (COB) situations concerning TRICARE should be handled like other employer group health plans.

Check Your Knowledge
Lesson 2 – Health Coverage Coordination

Answer the following questions:

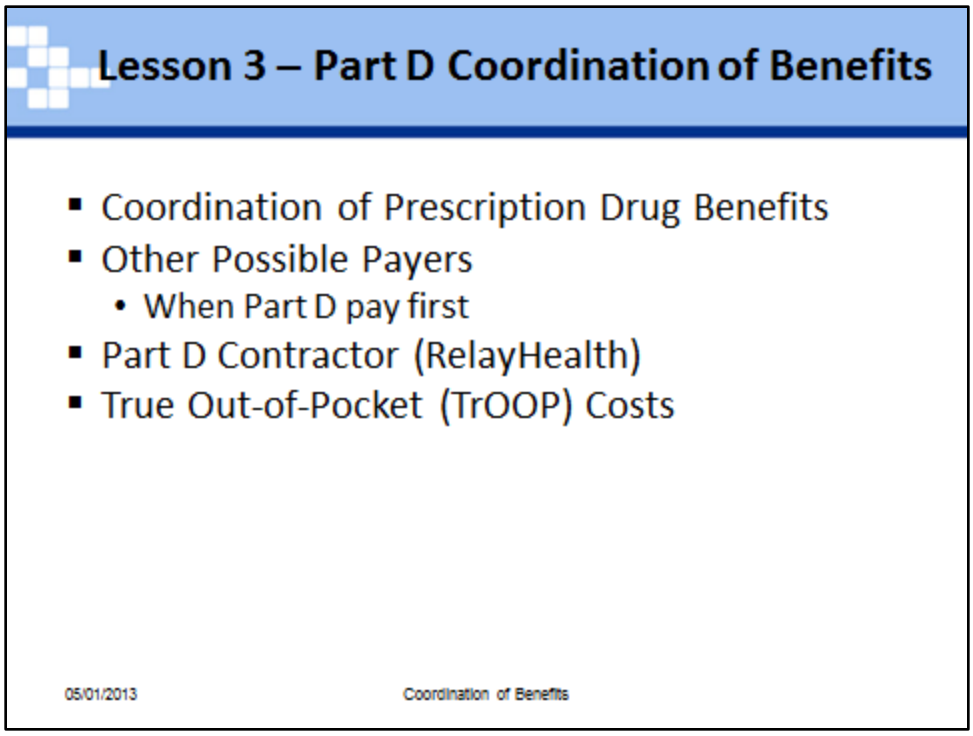
1. Cecilia was injured in an automobile accident. She has Medicare as well as a no-fault automobile insurance policy. Who pays first for her injuries?

    a. Medicare
    b. No-fault/Liability Insurance
    c. Medigap

2. If you are 65 or older and have Employer Group Health Plan (EGHP) coverage through your current employer, when will Medicare pay first?

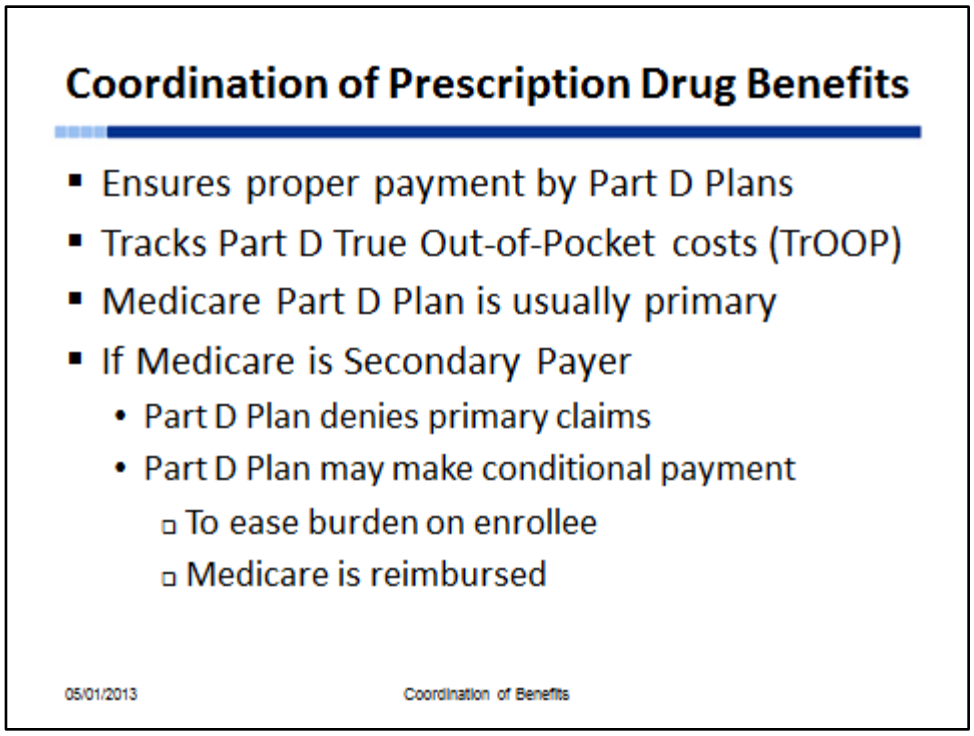
    a. When your employer has less than 10 employees
    b. When your employer has less than 20 employees
    c. When your employer has less than 50 employees
    d. When your employer has less than 100 employees

Refer to page 44 to check your answers.



This lesson provides an overview of Coordination of Prescription Drug Benefits.

- Coordination of Prescription Drug Benefits
- Other Possible Payers
  - When does Part D pay first?
- Contractor (RelayHealth)
- True Out-of-Pocket (TrOOP) Costs

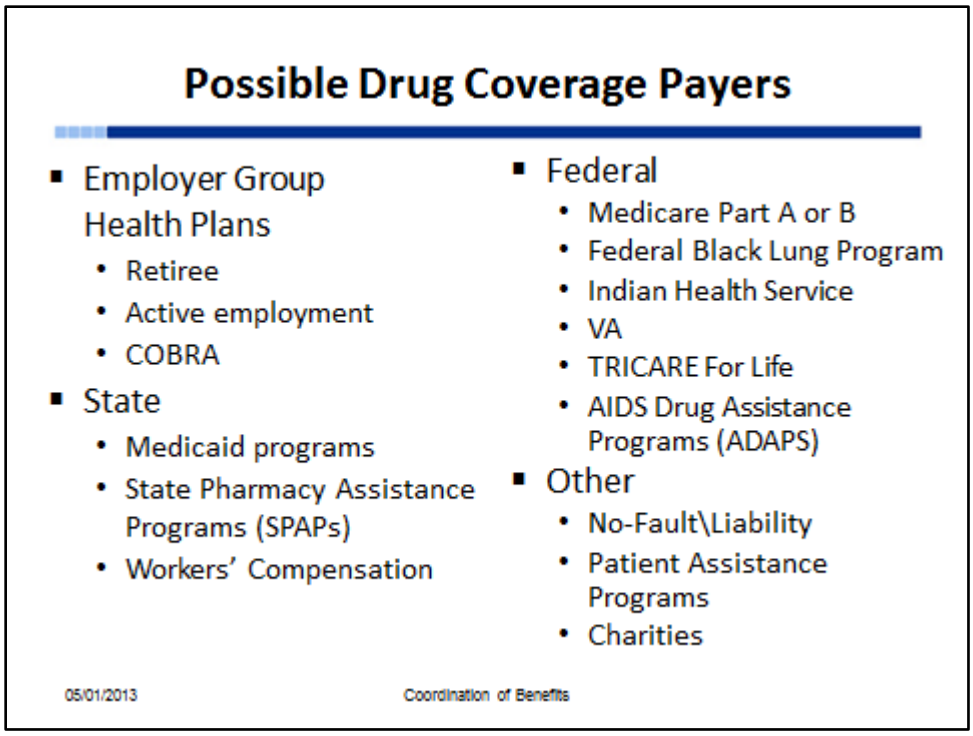


The Coordination of Benefits program (COB) identifies all of the benefits available to a person with Medicare, coordinates the payment process, and ensures that claims are paid correctly. The ultimate goal is to maintain the viability and integrity of the Medicare Trust Funds. COB provides the mechanism for support of the tracking and calculating of beneficiaries' "true out-of-pocket" (TrOOP) expenditures.

Generally, Medicare provides primary coverage for prescription drugs. Whenever Medicare is primary, the Part D 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 does not 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 will **not** pay if it is aware that the enrollee has workers' compensation, Black Lung Program, 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 worker's compensation, the Part D plan may deny primary payment and default to MSP. 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 Medicare Coordination of Benefits Contractor, or by mailing relevant documents to COB contractor.



Employer Group Health Plans

- Retiree
- Active employment
- COBRA

Federal

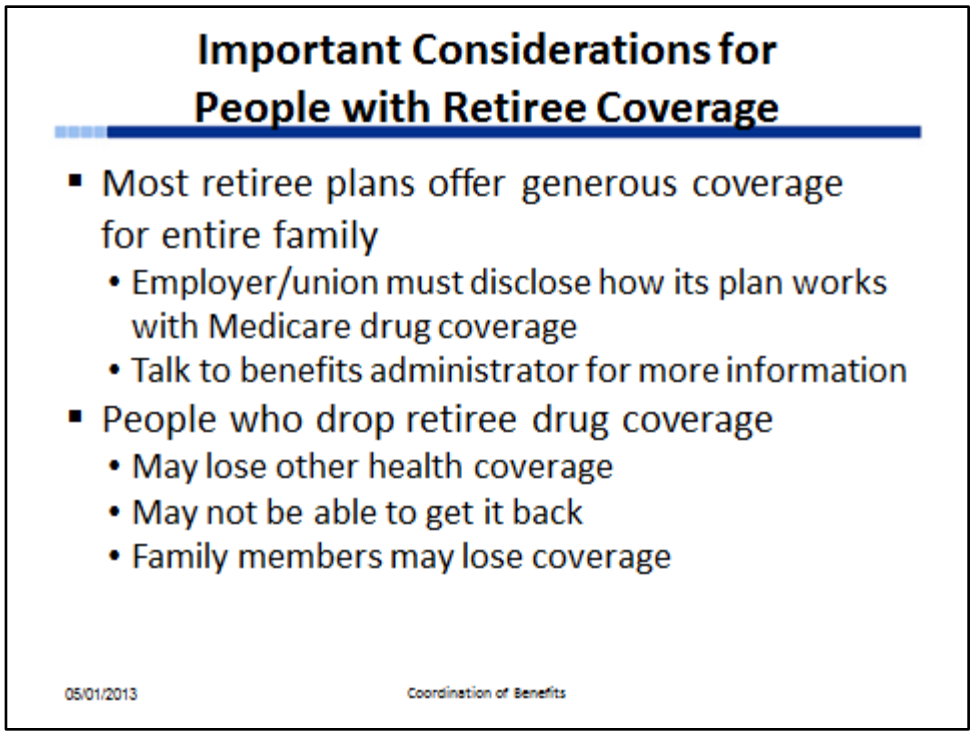
- Medicare Part A or Part B (limited)
- Federal Black Lung Program
- Indian Health Service (HIS)
- Veterans Affairs (VA)
- TRICARE For Life (TFL)
- AIDS Drug Assistance Programs (ADAPS)

State

- Medicaid programs
- State Pharmacy Assistance Programs (SPAPs)
- Workers' Compensation

Other

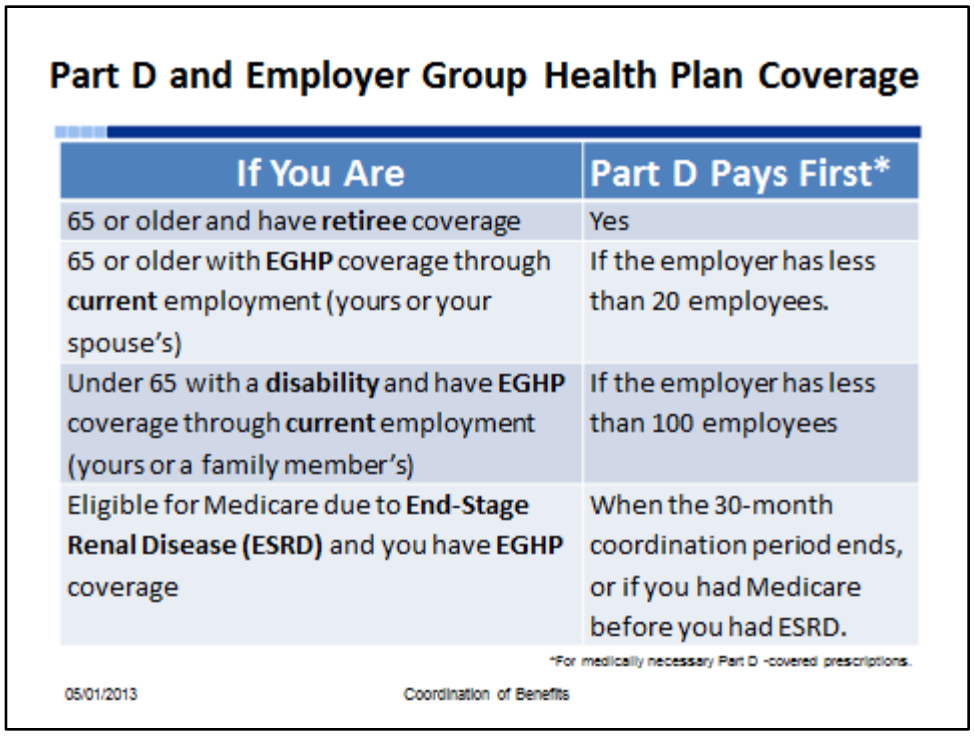
- No-Fault\Liability
- Patient Assistance Programs
- Charities



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" coverage, he/she has 63 days to find comparable coverage without incurring a late enrollment penalty. Contact the Employer Group Health Plan's (EGHP's) 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 needs.



Part D and Employer Group Health Plan Coverage

If You Are	Part D Pays First*
65 or older and have **retiree** coverage	Yes
65 or older with **EGHP** coverage through **current** employment (yours or your spouse's)	If the employer has less than 20 employees.
Under 65 with a **disability** and have **EGHP** coverage through **current** employment (yours or a family member's)	If the employer has less than 100 employees
Eligible for Medicare due to **End-Stage Renal Disease (ESRD)** and you have **EGHP** coverage	When the 30-month coordination period ends, or if you had Medicare before you had ESRD.

*For medically necessary Part D -covered prescriptions.

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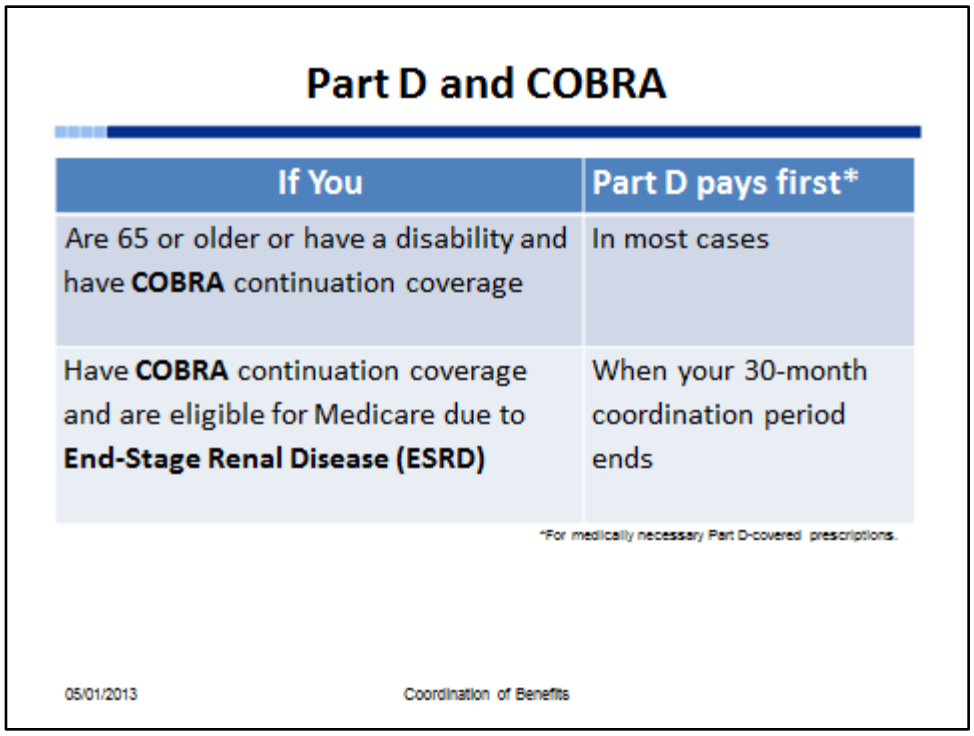
Medicare Part D usually pays first if you have retiree coverage.

Medicare Part D pays first also for

- Working-aged (individuals 65+ and they or their covered spouse is still working) with Medicare **and** Employer Group Health Plan (EGHP) with **fewer than 20** employees;
- A person with a disability with a Group Health Plan (GHP) with **100 or less** employees; and
- End-Stage Renal Disease (ESRD) with 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 have Part D and FEHB coverage, unless you qualify for Extra Help. If you have both and are retired, Part D would pay first.

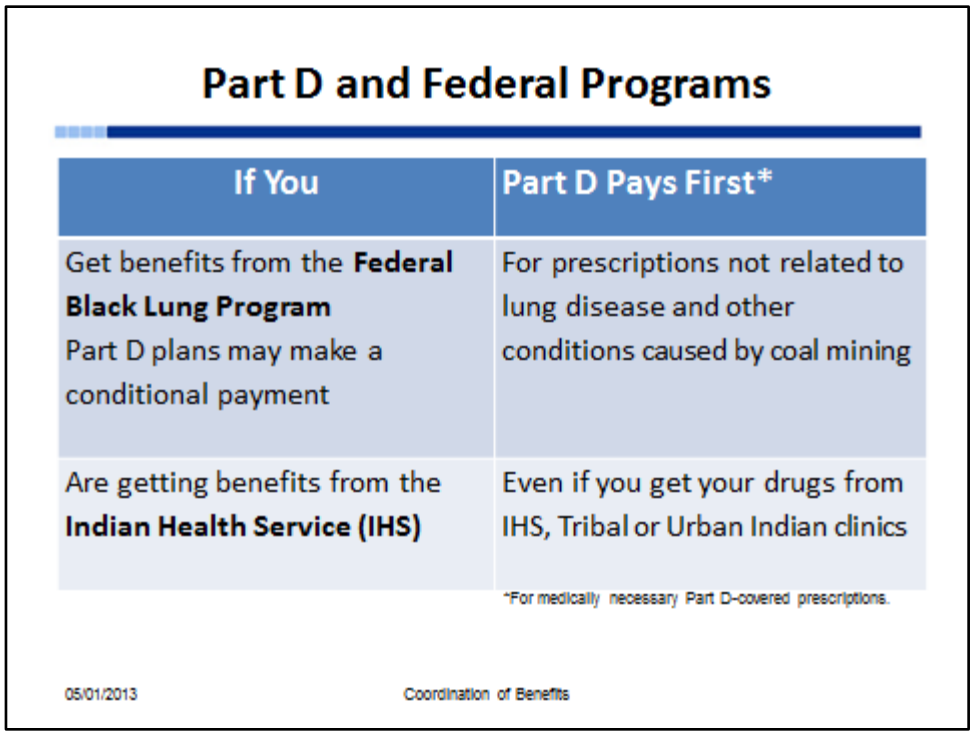


The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to let employees and their dependents keep their health coverage for a time after they leave their Employer Group Health Plan (EGHP), under certain conditions. This is called "continuation coverage." The law applies to private sector and state and local government–sponsored plans, but not to federal government–sponsored plans or the governments of the District of Columbia or any territory or possession of the U.S. 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.

Medicare Part D generally pays first before COBRA coverage for people 65 and older and those who have a disability.

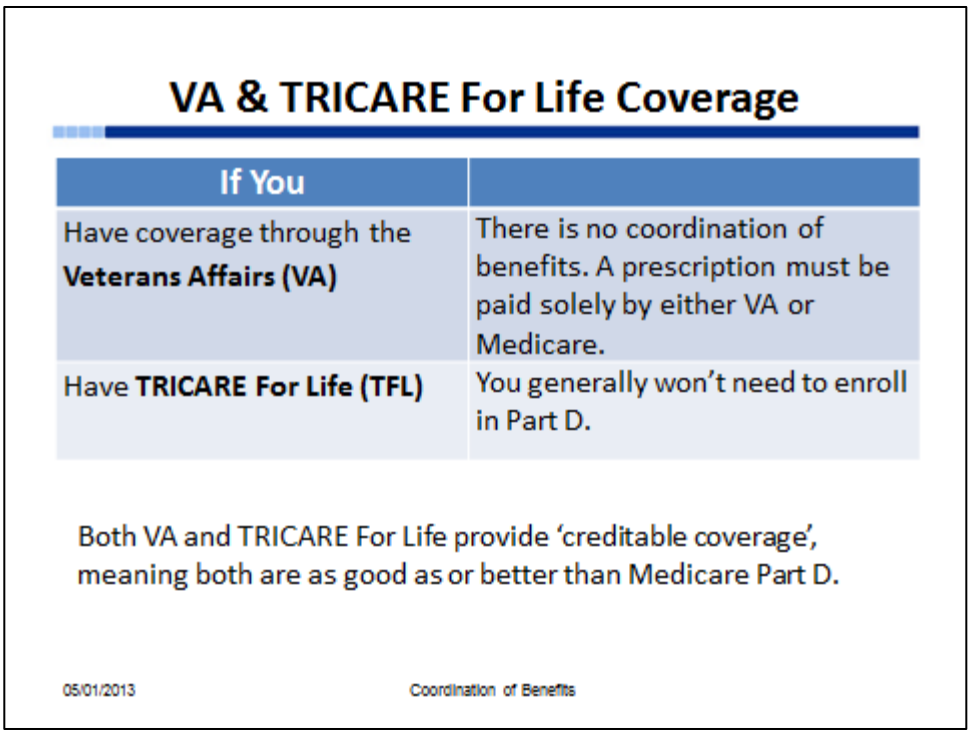
Medicare Part D pays first if you have COBRA and have End-Stage Renal Disease (ESRD) once you are out of your 30-month coordination period.



Black Lung – The Federal Black Lung Program covers people with lung disease from coal mining. Part D will not cover prescriptions related to this 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 American Indian/Alaska Native Medicare population. American Indian/Alaska Native (AI/AN) people with Medicare cannot be charged any cost-sharing. Indian Health Service, Tribal, and Urban Indian (I/T/U) (a pharmacy operated by the Indian Health Service, 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. COB 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 CMS that they provide convenient access to I/T/U pharmacies for AI/AN enrollees.

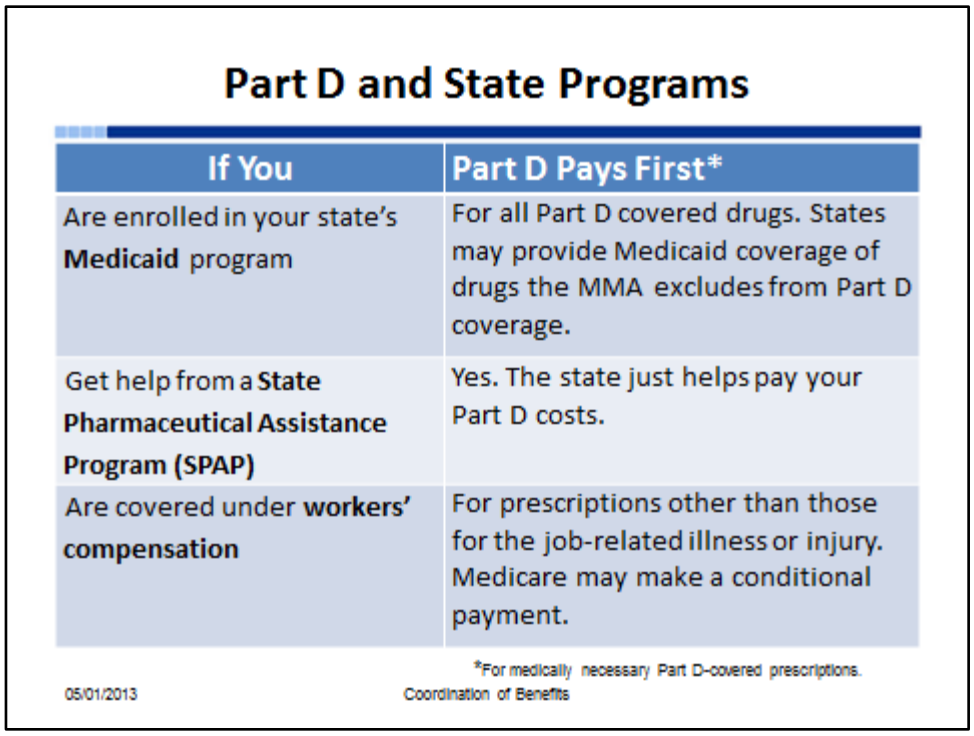


Veterans Affairs (VA) benefits, including prescription drug coverage, are separate and distinct from benefits provided under Medicare Part D. Legally, VA cannot bill Medicare. Although a person with Medicare may be eligible to receive VA prescription drug benefits and enroll in a Part D plan, he or she cannot 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 (CMOP) operations. The VA does not 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 does not count toward his or her gross covered drug costs or True Out-of-Pocket (TrOOP) expenditures under his or her Part D benefit.

Given the fact that VA prescription drug coverage is creditable coverage, beneficiaries will not 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 are eligible for the low-income subsidy.

TRICARE For Life Coverage (TFL) includes prescription drug benefits. These benefits qualify as "creditable coverage", meaning they are 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 will not be charged a late enrollment penalty.



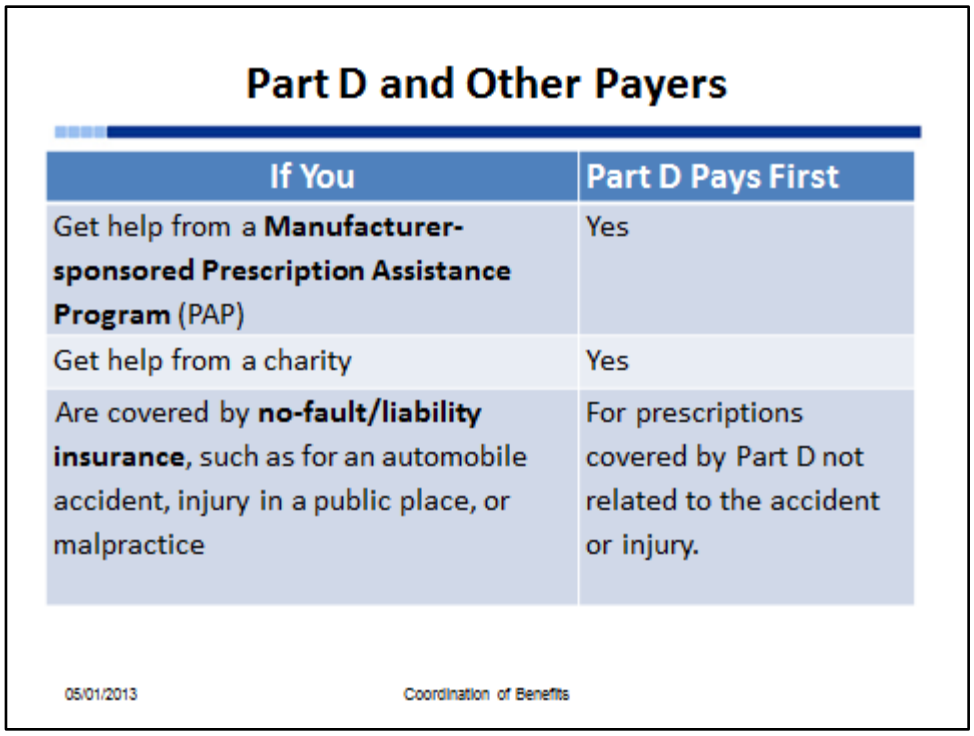
Under the Medicare Modernization Act (MMA), people with both Medicare and full Medicaid benefits (called "full-benefit dual eligibles") now receive drug coverage from Medicare instead of Medicaid. States may choose to provide Medicaid coverage of drugs the MMA excludes from Part D coverage. Some Medicare 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 (SPAP), Medicare Part D pays first.

If you are covered under workers' compensation, Part D will pay first for covered prescriptions that are not 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 will **not** pay if it is aware that the enrollee has workers' compensation, Black Lung Program, 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 MSP. The payment is "conditional" because it must be repaid to Medicare once a settlement, judgment, or award is reached.

Need More Information?

For more information about Coordination of Benefits and Medicaid, please visit http://www.medicaid.gov



Part D and Other Payers

If You	Part D Pays First
Get help from a **Manufacturer-sponsored Prescription Assistance Program** (PAP)	Yes
Get help from a charity	Yes
Are covered by **no-fault/liability insurance**, such as for an automobile accident, injury in a public place, or malpractice	For prescriptions covered by Part D not related to the accident or injury.

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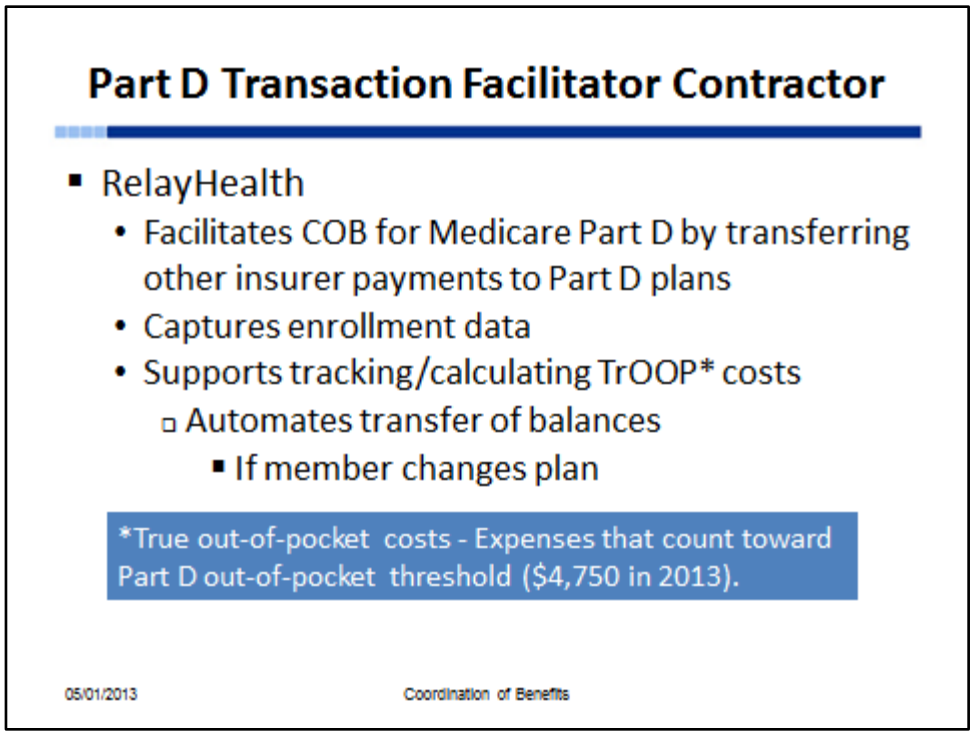
Prescription Assistance Programs (PAP) may choose to structure themselves in order to continue providing in-kind assistance to Part D enrollees, but outside the Part D benefit. In other words, the value of the in-kind assistance will not count toward a Part D enrollee's TrOOP ("true out-of-pocket costs") and will be completely separate from the Part D benefit. 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 is a group health plan, insurance, government-funded health program, or other third-party payment arrangement.

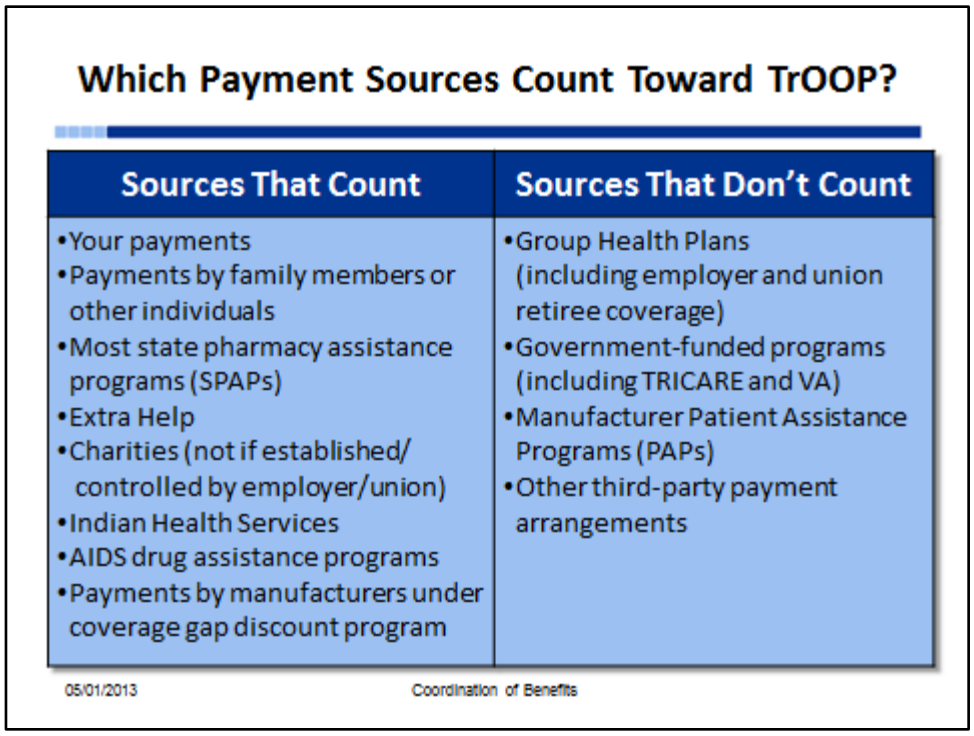
If you are covered by **no-fault/liability insurance**, such as for an automobile accident, injury in a public place, or malpractice, Part D pays first for prescriptions covered by Part D that are not related to the accident or injury.



CMS awarded a single contract to RelayHealth as the Part D Transaction Facilitator Contractor to facilitate the 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. When a Medicare Part D enrollee has other prescription drug coverage, COB 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 is the secondary payer.

The contractor will ensure 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.

True out-of-pocket (TrOOP) costs are the expenses that count toward a person's Medicare drug plan out-of-pocket threshold of $4,700 (for 2012). TrOOP costs determine when a person's catastrophic coverage will begin. The drug plan keeps track of each member's TrOOP costs.



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

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

The following payments don't count as true out-of-pocket costs:

- Group health plans, including employer or union retiree coverage (and personal Health Savings Accounts (HSAs) 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 will not count toward TrOOP. PAPs may charge a small copayment when providing this in-kind assistance and this amount may count toward TrOOP. You will need to submit a paper claim to your Medicare drug plan, along with documentation of the copayment; and
- Other third-party payment arrangements.

Need More Information?

A list of PAPs is available at www.rxassist.org

Check Your Knowledge
Lesson 3 – Part D Coordination of Benefits

Answer the following questions:

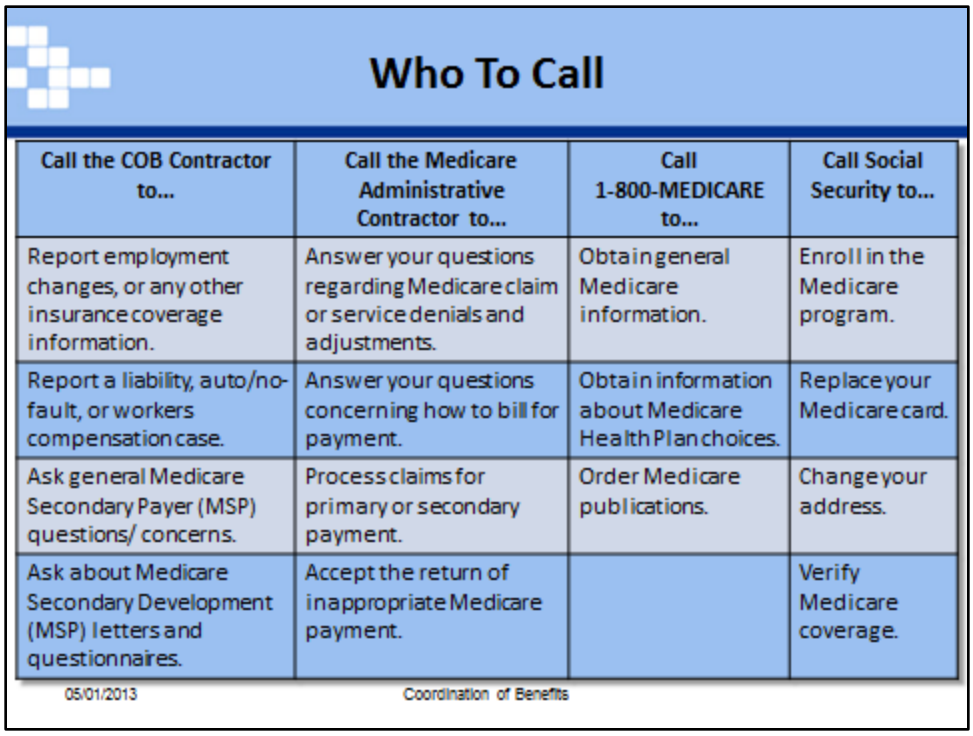
1. True or False: Retiree coverage always pays primary to Medicare Part D.

    a. True
    b. False

2. The Part D Transaction Facilitation contractor, RelayHealth

    a. Facilitates Coordination of Benefits (COB) for Medicare Part D by reporting other insurer payments to Part D plans
    b. Captures enrollment data
    c. Supports tracking/calculating TrOOP ("true out-of-pocket") costs
    d. All the above

Refer to page 45 to check your answers.



The Coordination of Benefits (COB) contractor does not process claims, nor does it handle any mistaken payment recoveries or claim specific inquiries.

Contact the COB contractor to

- Report employment changes, or any other insurance coverage information;
- Report a liability, auto/no-fault, or workers' compensation case;
- Ask general Medicare Secondary Payer (MSP) questions/concerns; or
- Ask questions regarding Medicare Secondary Development letters and questionnaires.

Resources		Medicare Products
Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) http://www.medicare.gov/ http://www.cms.gov/ **Coordination of Benefits Contractor** 1-800-999-1118 (TTY 1-800-318-8782) http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html **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** 1-888-767-6738 (TTY 1-800-878-5707)	**Medicare/TRICARE Benefit Overview** http://www.tricare.mil/Welcome/Eligibility.aspx **Department of Defense (To get information about TRICARE)** 1-877-363-1303 (TTY 1-877-540-6261) **Department of Veterans Affairs** 1-800-827-1000 (TTY 1-800-829-4833) http://www.va.gov/opa/publications/benefits_book.asp **Medicare Secondary Payer Recovery Contractor** 1-866-677-7220 (TTY 1-866-677-7294) **Affordable Care Act** http://www.hhs.gov/healthcare/rights/law/index.html	***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 **To access these products** View and order single copies at http://www.medicare.gov/ Order multiple copies (partners only) at http://productordering.cms.hhs.gov/ You must register your organization.

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Check Your Knowledge
Lesson 1 – Coordination of Benefits Overview
(from p. 11)

Answer the following questions:

1. When does Medicare pay claims?

    a. Medicare may be the primary or secondary payer
    b. Medicare may not pay at all
    c. Both answers a and b

    ANSWER: c. Medicare can be the primary payer, the secondary payer, or sometimes, other insurance plans should pay and Medicare should not pay at all. (p. 4)

2. Janice's Medicare coverage will begin in 3 months. She received a notice asking her to complete the Initial Enrollment Questionnaire. She may complete this questionnaire:

    a. Online
    b. By phone
    c. In person
    d. Either online or by phone

    ANSWER: d. You may complete the questionnaire online at MyMedicare.gov or over the phone. (p. 8)

Check Your Knowledge
Lesson 2 – Health Coverage Coordination
(from p. 26)

Answer the following questions:

1. Cecilia was injured in an automobile accident. She has Medicare as well as a no-fault automobile insurance policy. Who pays first for her injuries?

   a. Medicare
   b. No-Fault / Liability insurance
   c. Medigap

   ANSWER: b. No-fault/liability insurance. The no-fault/liability insurance is the primary payer when the diagnosis is related to the injury sustained in an automobile accident. (p. 17)

2. If you are 65 or older and have Employer Group Health Plan (EGHP) coverage through your current employer, when will Medicare pay first?

   a. When your employer has less than 10 employees
   b. When your employer has less than 20 employees
   c. When your employer has less than 50 employees
   d. When your employer has less than 100 employees

ANSWER: b. When your employer has less than 20 employees. Medicare pays first if you are 65 or older and have employer group health plan coverage through current employment, either yours or your spouse's, and the employer has less than 20 employees. (p. 15)

Check Your Knowledge
Lesson 3 – Part D Coordination of Benefits
(from p. 39)

Answer the following questions:

1. True or False: Retiree coverage always pays primary to Medicare Part D.

   a. True
   b. False

   ANSWER: b. False. Part D pays primary to retiree coverage. (p. 31)

2. The Part D Transaction Facilitation contractor, RelayHealth

   a. Facilitates Coordination of Benefits (COB) for Medicare Part D by reporting other insurer payments to Part D plans
   b. Captures enrollment data
   c. Supports tracking/calculating TrOOP ("true out-of-pocket") costs
   d. All the above

   ANSWER: d. All the above. The Part D Transaction Facilitator contractor manages the TrOOP tracking process and eligibility transactions for Medicare Part D. and ensures 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. (p. 37)

Acronyms

ADAPS	AIDS Drug Assistance Programs
AI/AN	American Indian/Alaska Native
CHIP	Children's Health Insurance Program
CMOP	Consolidated Mail Outpatient Pharmacy
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
HMO	Health Maintenance Organization
IHS	Indian Health Services
IRS	Internal Revenue Service
I/T/U	Indian Health Service, Tribal, and Urban Indian
MBD	Medicare Beneficiary Database
MMA	Medicare Modernization Act
MMSEA	Medicare, Medicaid, and SCHIP Extension Act
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
PAP	Prescription Assistance Program
SCHIP	State Children's Health Insurance Program
SHIP	State Health Insurance Assistance Program
SPAP	State Pharmacy Assistance Program
SSA	Social Security Administration
TFL	TRICARE for Life
TrOOP	True Out-of-Pocket (i.e., TrOOP Costs)
VA	Veterans Affairs
VDSA	Voluntary Data-Sharing Agreement
WCMSA	Workers' Compensation Medicare Set-aside Arrangement

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Inside back cover

Website: cms.gov/www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram

E-mail training@cms.hhs.gov

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244