

## **Module 5 – Coordination of Benefits**

### *Section Objectives*

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

### **Lesson 1: Coordination of Benefits Overview**

#### *When Does Medicare Pay?*

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 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.

#### **Resources:**

- [ecfr.gov/cgi-bin/textidx?SID=4197918d7a58c79361d4f698fa25219e&mc=true&node=se42.2.411\\_120&rgn=div8](http://ecfr.gov/cgi-bin/textidx?SID=4197918d7a58c79361d4f698fa25219e&mc=true&node=se42.2.411_120&rgn=div8) (42 C.F.R., Chapter IV, Section 411.20, Paragraph 2)
- [Medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf](http://Medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf)

#### *When Medicare Is Primary Payer*

Medicare is the primary payer for most people with Medicare, which means Medicare pays first on their health care claims. Medicare pays first when:

- Medicare is your only source of medical, hospital, or drug coverage.
- You have a Medicare supplement insurance (Medigap) policy or other privately purchased insurance policy that isn't related to current employment. A Medigap policy covers amounts not covered by Medicare.
- You have both Medicaid and Medicare coverage (dual eligible beneficiaries), with no other coverage that could be primary to Medicare.
- You have 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.
- You get health care services from the Indian Health Service.
- You have veteran's benefits.

- You have 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.)
- You're covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) except if you have End-Stage Renal Disease. We'll talk about this coverage shortly.

### *Medicare Secondary Payer*

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

When Medicare started providing coverage in 1966, it was the primary payer for all claims except for those covered by workers' compensation, the Federal Black Lung Benefits Program, and the U.S. Department of Veterans Affairs.

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's Trust Funds by making sure 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 person's primary health insurance coverage or in situations where another entity has been identified as the primary payer.

Medicare saves almost \$9 billion annually on claims processed by insurance coverage that pay first before Medicare.

For detailed examples of when Medicare is the secondary payer, view the How Medicare works with other coverage chart in Your Guide to Who Pays First ([Medicare.gov/Pubs/pdf/02179.pdf](https://www.medicare.gov/Pubs/pdf/02179.pdf)).

### *Benefits Coordination & Recovery Center*

The Coordination of Benefits program determines correct primary payer.

Medicare eligibility data are shared with other payers, and Medicare-paid medical claims are transmitted to supplemental insurers for secondary payment. An agreement must be in place between the Centers for Medicare & Medicaid Services (CMS) 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 must coordinate secondary or supplemental payment of benefits with any other insurers he or she may have in addition to Medicare.

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 paying the person with Medicare's health care costs. The goal of these Medicare Secondary Payer (MSP) information-gathering activities is to identify MSP situations quickly, making sure responsible parties are making correct payments.

If Medicare makes a conditional payment (a payment made by Medicare for services on behalf of a person with Medicare when there is evidence that the primary plan does not pay promptly), the money must be repaid to Medicare when a settlement, judgment, award, or other payment is secured.

**Resources:**

- [CMS.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefitsand-Recovery-Overview/Coordination-of-Benefits/Coordination-of-Benefits.html](https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefitsand-Recovery-Overview/Coordination-of-Benefits/Coordination-of-Benefits.html)
- [CMS.gov/medicare/coordination-of-benefits-and-recovery/coordination-of-benefitsand-recovery-overview/msprp/downloads/conditional-payments.pdf](https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/coordination-of-benefitsand-recovery-overview/msprp/downloads/conditional-payments.pdf)

## Lesson 2: Health Coverage Coordination

### *Medicare and the Marketplace*

Medicare isn't part of the Health Insurance Marketplace. If you have Medicare Part A, you don't need to do anything related to the Marketplace; you're considered covered with regard to the minimum essential coverage requirement. 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 need to contact the Marketplace and end any subsidies, such as Advanced Premium Tax Credits (APTC) or Cost-Sharing Reductions, which are being paid on your behalf. That's because Part A is considered minimum essential coverage. You will have to pay back any tax credits received during months in which you had both Medicare Part A (or Part C) and a group health plan through the Marketplace.

Also, your Marketplace coverage might not be renewed at the end of the benefit year. In cases where Medicare Part A is awarded retroactively, APTC is lost when you are notified of the retroactive entitlement. If you have Medicare, it's illegal for someone to knowingly sell you a Marketplace plan.

**NOTE:** You may have Medicare and Marketplace coverage at the same time, only if you had your Marketplace coverage before you had Medicare.

### *Medicare and Marketplace Coordination*

Generally, there's no coordination of benefits (COB) between Medicare and an individual Marketplace Qualified Health Plan (QHP) that you buy through the Health Insurance Marketplace. You should consider several important factors when deciding about whether or not to stay in a QHP after you enroll in Medicare Part A.

- The QHP isn't secondary insurance, and it isn't required to pay any costs toward your coverage if you have Medicare.
- Individual Marketplace coverage isn't employer-sponsored coverage and it's not based on current employment. If you have individual Marketplace coverage and only enroll in Part A during your Medicare Initial Enrollment Period, you won't be able to enroll in Part B later using a Special Enrollment Period. You'll have to wait for the General Enrollment Period (January 31–March 31 each year), and you'll have to pay a lifetime Part B penalty if you went without Part B for more than 12 months.
- Once your Part A coverage starts, any premium tax credits and cost-sharing reductions you may have qualified for through the Marketplace will stop. That's because Part A is considered minimum essential coverage, not Part B.

You may decide to choose Marketplace coverage instead of Medicare if you have to pay a premium for Part A. If you're already paying a premium for Part A, you can drop your Part A and Part B coverage and get a Marketplace plan instead. If you only have Part B and would have to pay a premium for Part A, you can drop Part B and get a Marketplace plan instead.

Only individuals enrolled in the Small Business Health Options Program (SHOP) program in the Marketplace will have COB because that coverage is based on current employment. These individuals have group health plan coverage and Medicare will pay secondary to the QHP coverage. In addition, these individuals can consider delaying enrolling in Part B enrollment and not get a penalty because SHOP employer-sponsored coverage is based on current employment.

Visit [HealthCare.gov](https://www.healthcare.gov) for more information about the Marketplace.

### *Important Retiree Coverage Considerations*

As discussed previously, 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 offered 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 or she has 63 days to enroll in a Part D plan without incurring a late enrollment penalty. Contact the employer group health plan's benefits administrator for information, including how it works with Medicare drug coverage. Creditable coverage is coverage that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

When deciding on whether to keep or drop coverage through an employer or union retirement plan, consider these important points:

- 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

### *Possible Health Claims Payers*

It's important to identify whether your medical costs are payable by other insurance payers first, or payable 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 and many combinations of insurance coverage you could have. These will affect who pays and when:

- Medicare
- No-Fault Insurance
- Liability Insurance
- Workers' Compensation Insurance
- Federal Black Lung Program
- Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage
- 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 their claim, or may not pay at all.

### *Employer Group Health Plans*

Coordination of benefits depends on whether you, your spouse or a family member, is currently working or retired, and on the number of employees of that company.

Employer group health plan (EGHP) coverage is offered by many employers and unions for current employees and/or retirees. For example, the Federal Employee Health Benefits Program plan is a type of EGHP. You may also get group health coverage through your spouse's or other family member's employer. If you have Medicare and are offered coverage under an EGHP, usually you can choose to accept or reject the plan. When the employer has less than 20 employees, Medicare pays first, so your employer may require that you enroll in Medicare too. The EGHP may be a fee-for-service plan or a managed care plan, like a Health Maintenance Organization.

Employers/unions may also arrange for their Medicare-eligible retirees, spouses, and dependents to get Medicare Part C managed health care and/or Part D prescription drug coverage through employer group waiver plans.

Business with 50 or fewer employees can offer Small Business Health Options Program plans from the Health Insurance Marketplace.

If You Are	Medicare Pays First
65 or older and have <b>retiree</b> coverage	Yes (as long as you don't have excluding conditions such as black lung, or others specified on next page)
65 or older with <b>EGHP</b> coverage through <b>current</b> employment (yours or your spouse's)	If the employer has less than 20 employees
Under 65 with a <b>disability</b> and have <b>EGHP</b> coverage through <b>current</b> employment (yours or a family member's)	If the employer has less than 100 employees
Eligible for Medicare due to <b>End-Stage Renal Disease (ESRD)</b> and you have <b>EGHP</b> coverage	When the 30-month coordination period ends, or if you had Medicare primary before you had ESRD

### *Non-Group Health Plans*

Medicare doesn't 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
- Work-related injury or illness (workers' compensation)

### *No-Fault Insurance*

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

- Automobile insurance
- Homeowners' insurance
- Commercial insurance plans

Medicare is the secondary payer when 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 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 you later resolve the insurance claim, Medicare will seek to recover the conditional payment from you. You're responsible for making sure that Medicare gets repaid for the conditional payment.

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. Part D plans will pay for covered prescriptions that aren't related to the accident or injury.

### *Liability Insurance*

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:

- 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 for services for which another payer is responsible, so you won't have to use your own money to pay the bill. The payment is conditional because the person with Medicare is responsible for making sure Medicare is repaid when a settlement judgment, award, or other payment is made.



## *Workers' Compensation*

Medicare generally won't pay for an injury, illness or disease covered by workers' compensation. If all or part of a claim is denied by workers' compensation on the grounds that it's 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.

Workers' compensation claims can be resolved by settlements, judgments, awards, or payments.

## *Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)*

A Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) is a financial agreement that assigns a portion of a workers' compensation settlement to pay for future medical services related to the workers' compensation injury, illness, or disease.

- Money placed in your WCMSA is only for paying future medical and/or prescription drug expenses related to your work injury, illness, or disease, and only if the expense is for a treatment that Medicare would cover.
- You can't use the WCMSA to pay for any other work injury or any medical items or services that Medicare doesn't cover (for example, dental services).
- If you're not sure what type of services Medicare covers, call 1-800-MEDICARE before you use any of the money that was placed in your WCMSA. TTY: 1-877-486-2048.
- After you use all of your WCMSA money appropriately, Medicare can start paying for Medicare-covered services related to your work-related injury, illness, or disease.

You may learn more about WCMSAs at [go.cms.gov/wcmsa](http://go.cms.gov/wcmsa).

*For more information, see Section 1862(b)(2) of the Social Security Act of 1954 (42 USC 1395y(b)(2)).*

## *Federal Black Lung Program*

Some people with Medicare can get medical benefits through the Federal Black Lung Benefits Program 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:

- You have no other primary insurance
- You are eligible for Medicare
- The services you receive are covered by the Medicare Program



Federal Black Lung Benefits Program beneficiaries are eligible for prescription drugs, inpatient 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.

Federal Black Lung Benefits Program beneficiaries can call 1-800-638-7072 for medical diagnostic treatment services. TTY: 1-877-889-5627.

### *Consolidated Omnibus Budget Reconciliation Act (COBRA)*

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 plans and state and local government-sponsored plans. It doesn't apply to federal government-sponsored plans, the government of the District of Columbia, any territory or possession of the United States, or 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, like 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.

You can replace COBRA coverage with Marketplace coverage. If your COBRA coverage ends outside the annual Marketplace Open Enrollment Period (November 1 – January 31), you may qualify for a Special Enrollment Period (SEP). To find out if you qualify for an SEP, visit [HealthCare.gov/coverage-outside-open-enrollment/](https://www.healthcare.gov/coverage-outside-open-enrollment/). This means you can enroll in a private health plan through the Marketplace outside of Open Enrollment. If you end your COBRA coverage early and you are outside the annual Open Enrollment Period, you can't enroll in a Marketplace plan at all. During the annual Open Enrollment Period, you can drop your COBRA coverage and get a plan through the Marketplace, even if your COBRA coverage hasn't run out.

Medicare usually pays first before Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage for aged and disabled individuals. Medicare pays second 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 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 end 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. COBRA doesn't provide for a Medicare Special Enrollment Period.

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

Medicare Part D plans generally pay first before COBRA coverage for people 65 and older and for those who have a disability. If you have COBRA and have ESRD, Medicare Part D pays first once you're out of your 30-month coordination period.

If You	Medicare Pays First
Are 65 or older or have a disability and have <b>COBRA</b> continuation coverage	In most cases
Have <b>COBRA</b> continuation coverage and are eligible for Medicare due to End-Stage Renal Disease	When your 30-month coordination period ends

May 2015 Coordination of Benefits

### *Veterans Affairs (VA) Coverage*

If you have both Medicare and Veterans' benefits, you can get health care treatment under either program. However, you must choose which benefit you'll use each time you see a doctor or get health care (for example, in a hospital). Medicare won't pay for the same service authorized by Veterans Affairs (VA); similarly, VA coverage won't pay for the same service covered by Medicare. To receive VA services, you must get your 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 given to people who: a) served in the active military, naval, or air service and were honorably discharged or released or b) 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 the 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.

### *TRICARE for Life Coverage (TFL)*

If you have Medicare and TRICARE for Life (TFL), 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 you get services from a military hospital or any other federal provider, TFL will pay the bills. Medicare doesn't usually pay for services you get from a federal provider or from another federal agency.

**NOTE:** TFL is coverage for all TRICARE beneficiaries 65 or older who have both Medicare Part A and Part B. Active-duty personnel are covered by TRICARE insurance. Coordination of benefits situations concerning TRICARE should be handled like other employer group health plans.

## Lesson 3: Medicare Part D Coordination of Benefits

### *Coordination of Prescription Drug Benefits*

Generally, Medicare Part D provides primary coverage for prescription drugs. Whenever Medicare is primary, the 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, payment to ease the burden on you, unless certain situations apply.

The Part D plan won't pay if it's aware that you have 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 you refill 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 (1-800-633-4227) , TTY: 1-877-486-2048, and asking for the Benefits Coordination & Recovery Center (BCRC) or by mailing relevant documents to the BCRC. Visit [CMS.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html](https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html) for additional contact information for the BCRC.

### *Possible Drug Coverage Payers*

<b>Employer Group Health Plans</b> <ul style="list-style-type: none"><li>▪ Retiree</li><li>▪ Active employment</li><li>▪ Consolidated Omnibus Budget Reconciliation Act</li></ul>	<b>Federal</b> <ul style="list-style-type: none"><li>▪ Medicare Part A or Part B</li><li>▪ Federal Black Lung Program</li><li>▪ Indian Health Service</li><li>▪ Veterans Affairs</li><li>▪ TRICARE for Life</li><li>▪ AIDS Drug Assistance Programs</li></ul>
<b>State</b> <ul style="list-style-type: none"><li>▪ Medicaid programs</li><li>▪ State Pharmaceutical Assistance Programs</li><li>▪ Workers' Compensation</li></ul>	<b>Other</b> <ul style="list-style-type: none"><li>▪ No-Fault/Liability</li><li>▪ Patient Assistance Programs</li><li>▪ Charities</li></ul>

May 2016 Coordination of Benefits

### *Important Retiree Drug Coverage Considerations*

As mentioned earlier, people with Medicare who have employer or union retirement plans that cover prescription drugs must carefully consider their options. Your 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 you lose creditable coverage, you have a Special Enrollment Period (SEP) to pick up Part D coverage. The SEP starts with notification of the loss of creditable coverage and ends either 2 months after the notification or 2 months after the end of the coverage, whichever is later. Creditable coverage is coverage that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Contact the Employer Group Health Plan's benefits administrator for information, including how it works with Medicare drug coverage. When making a decision on whether to keep or drop coverage through an employer or union retirement plan, consider these important points:

- Most employer/union retirement plans offer prescription coverage comparable to Medicare drug coverage and often offer 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.

Type of Plan	Situation	Part D Pays First for Medically-Necessary Part D Covered Prescriptions
<b>Employer Group Health (EGHP)</b>	You're 65 or older and have retiree coverage	Yes
	You're 65 or older with EGHP coverage through current employment (yours or your spouse's)	If the employer has less than 20 employees
	You're 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
<b>Consolidated Omnibus Budget Reconciliation Act (COBRA)</b>	You're 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
	You're 65 or older and have a disability and have COBRA continuation coverage	In most cases
	You have COBRA continuation coverage and are eligible for Medicare due to ESRD	When your 30-month coordination period ends

Type of Plan	Situation	Then Part D Pays First for Medically Necessary Part D Covered Prescriptions
<b>Federal Black Lung Program</b>	If you get these benefits, Part D plans may make a conditional payment	For prescriptions not related to lung disease and other conditions caused by coal mining
<b>Indian Health Services (IHS)</b>	You get benefits from the IHS	Even if you get your drugs from IHS, Tribal, or Urban Indian clinics
<b>Department of Veterans Affairs (VA)</b>	You have coverage through the VA	There's no coordination of benefits. A prescription must be paid solely by either the VA or Medicare.
<b>TRICARE for Life</b>	You have TRICARE for Life benefits	You generally won't need to enroll in a Part D plan
<b>State Medicaid Programs</b>	You're enrolled in your state's Medicaid program	For all Part D-covered drugs. States may provide Medicaid coverage of drugs the Medicare Modernization Act excludes from Part D coverage
<b>State Pharmaceutical Assistance Programs</b>	You get assistance from a State Pharmaceutical Assistance program	Yes. The state just helps pay your Part D costs.
May 2015	Coordination of Benefits	

Type of Plan	Situation	Then Part D Pays First for Medically Necessary Part D Covered Prescriptions
<b>Workers' Compensation</b>	If you're covered under Workers' Compensation	For prescriptions other than those for the job-related illness or injury. Medicare may make a conditional payment.
<b>Manufacturer-sponsored Patient Assistance Program</b>	If you get help from a Manufacturer-sponsored Patient Assistance Program	Yes
<b>Charity</b>	If you get help from a charity	Yes
<b>No-fault/Liability Insurance</b>	If you're 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
May 2016	Coordination of Benefits	



# Coordination of Benefits Resource Guide

## Resources

### Centers for Medicare & Medicaid Services (CMS)

- Call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048
- [Medicare.gov](http://Medicare.gov)
- [CMS.gov](http://CMS.gov)

### Benefits Coordination & Recovery Center

- Call 1-855-798-2627. TTY: 1-855-797-2627

### U.S. Department of Labor

- Call 1-866-4-USA-DOL (1-866-487-2365). TTY: 1-877-889-5627
- [dol.gov/dol/topic/health-plans/cobra.htm](http://dol.gov/dol/topic/health-plans/cobra.htm)

### Office of Personnel Management (Federal Employees Health Benefit Program)

- [opm.gov/healthcare-insurance/healthcare/](http://opm.gov/healthcare-insurance/healthcare/)

### Patient Assistance Program Center

- [rxassist.org](http://rxassist.org)

### Medicare/TRICARE Benefit Overview

- [tricare.mil/Plans/Eligibility?sc\\_database=web](http://tricare.mil/Plans/Eligibility?sc_database=web)

### TRICARE

- [TRICARE.mil/](http://TRICARE.mil/)

### Department of Veterans Affairs

- Call 1-800-827-1000. TTY: 1-800-829-4833
- [va.gov/opa/publications/benefits\\_book.asp](http://va.gov/opa/publications/benefits_book.asp)
- [benefits.va.gov/benefits/](http://benefits.va.gov/benefits/)

### Black Lung Program

- [dol.gov/compliance/topics/benefits-comp-blacklung.htm](http://dol.gov/compliance/topics/benefits-comp-blacklung.htm)
- Call 1-800-638-7072. TTY: 1-877-889-5627



## Coordination of Benefits Resource Guide (continued)

### Medicare Products

1. **“Medicare & You Handbook”** (CMS Product No. 10050)
2. **“Your Medicare Benefits”** (CMS Product No. 10116)
3. **“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 [Medicare.gov/publications](https://www.medicare.gov/publications).
- Order multiple copies (partners only) at [Productordering.cms.hhs.gov](https://productordering.cms.hhs.gov).  
*You must register your organization.*

# Acronyms

<b>AI/AN</b> American Indian/Alaska Native	<b>I/T/U</b> Indian Health Service, Tribal, and Urban Indian
<b>APTC</b> Advanced Premium Tax Credits	<b>MMA</b> Medicare Modernization Act
<b>BCRC</b> Benefits Coordination & Recovery Center	<b>MSP</b> Medicare Secondary Payer
<b>CHIP</b> Children's Health Insurance Program	<b>NTP</b> National Training Program
<b>CMS</b> Centers for Medicare & Medicaid Services	<b>PAP</b> Patient Assistance Program
<b>COB</b> Coordination of Benefits	<b>QHP</b> Qualified Health Plan
<b>COBRA</b> Consolidated Omnibus Budget Reconciliation Act	<b>SEP</b> Special Enrollment Period
<b>CSR</b> Cost Sharing Reductions	<b>SHIP</b> State Health Insurance Assistance Program
<b>EGHP</b> Employer Group Health Plan	<b>TFL</b> TRICARE for Life
<b>ESRD</b> End-Stage Renal Disease	<b>TrOOP</b> True Out-Of-Pocket
<b>FEHB</b> Federal Employee Health Benefits	<b>VA</b> Veterans Affairs
<b>IHS</b> Indian Health Services	<b>WCMSA</b> Workers' Compensation Medicare Set-Aide Arrangement