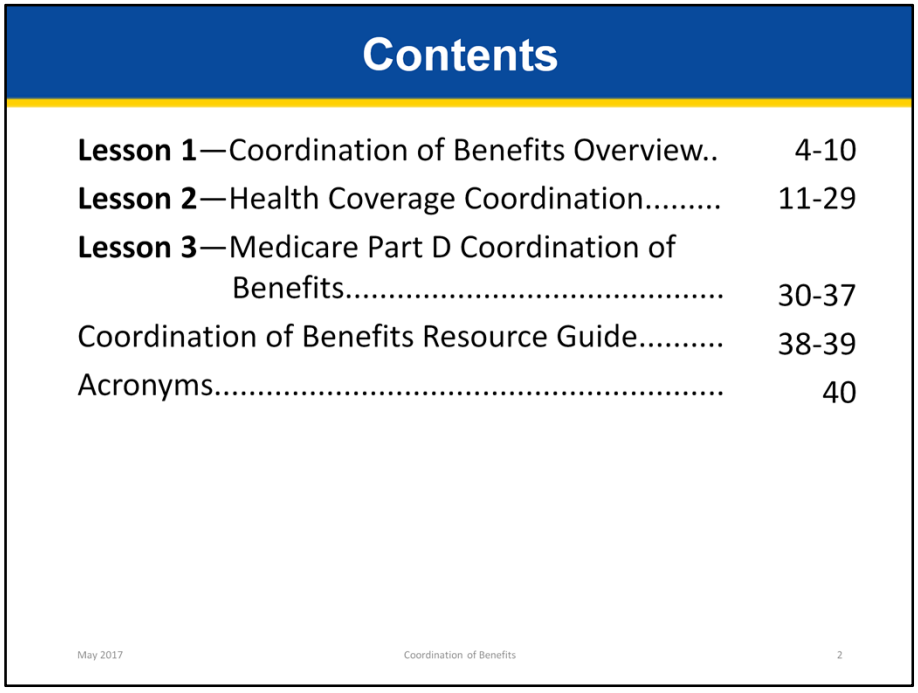
Module 5, Coordination of Benefits, explains the rules that govern the payers' responsibility when people have Medicare and certain other types of health and/or prescription drug coverage. This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace.

The information in this module was correct as of May 2017. To check for an updated version, visit CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html.

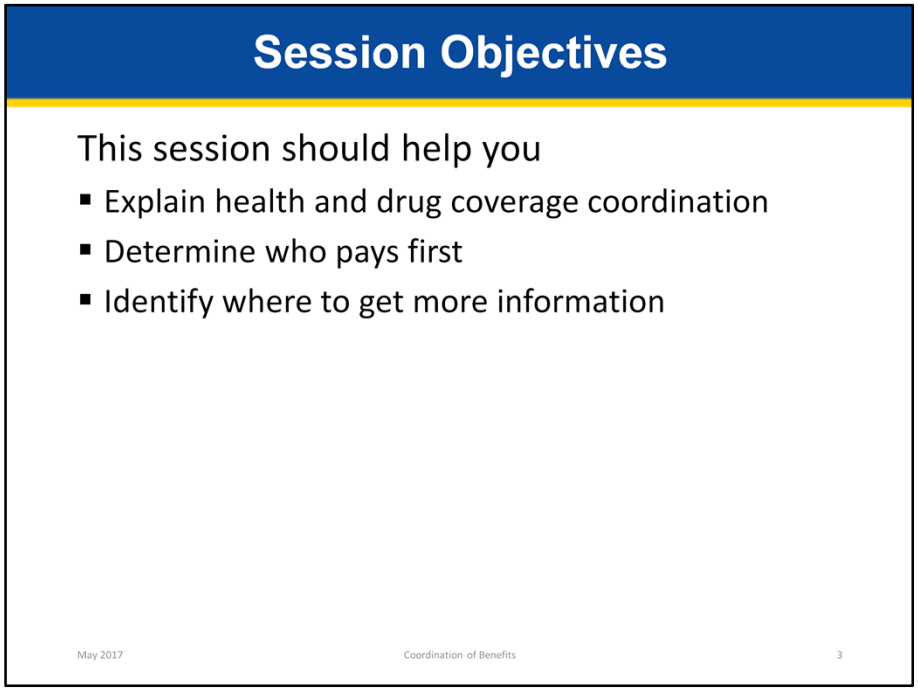
The CMS National Training Program provides this as an informational resource for our partners. It's not a legal document or intended for press purposes. The press can contact the CMS Press Office at press@cms.hhs.gov. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.



The lessons explain the coordination of benefits when people have Medicare and certain other types of health and drug coverage.

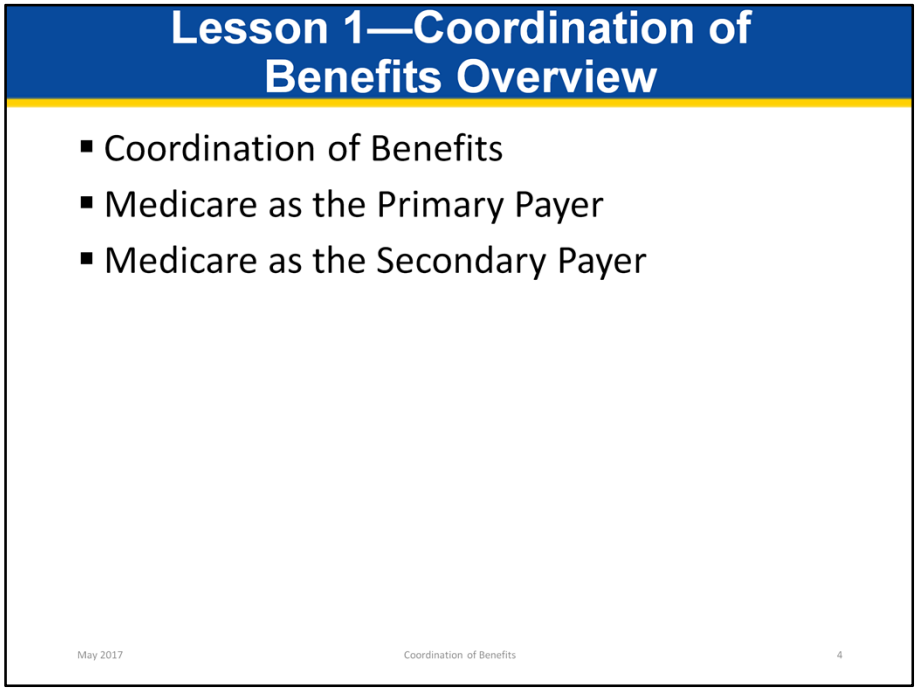
The materials are designed for information givers/trainers who are familiar with the Medicare Program, and would like to have prepared information for their presentations.

The module consists of 41 PowerPoint slides with corresponding speaker's notes, activities, and 5 check-your-knowledge questions. It can be presented in about 45 minutes. Allow approximately 15 more minutes for discussion, questions, and answers. Additional time may be added for add-on activities.



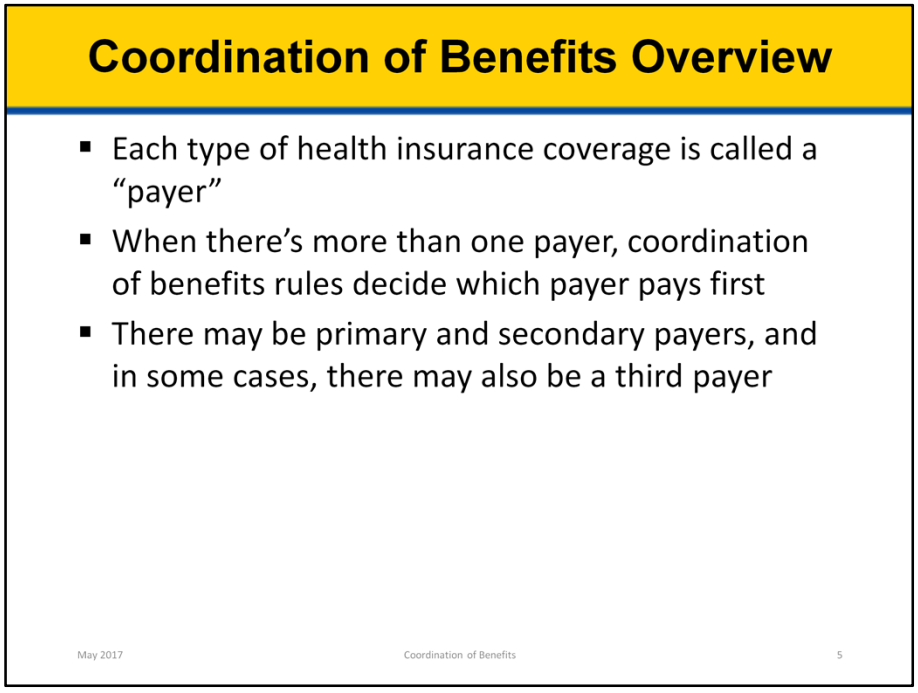
This session should help you

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

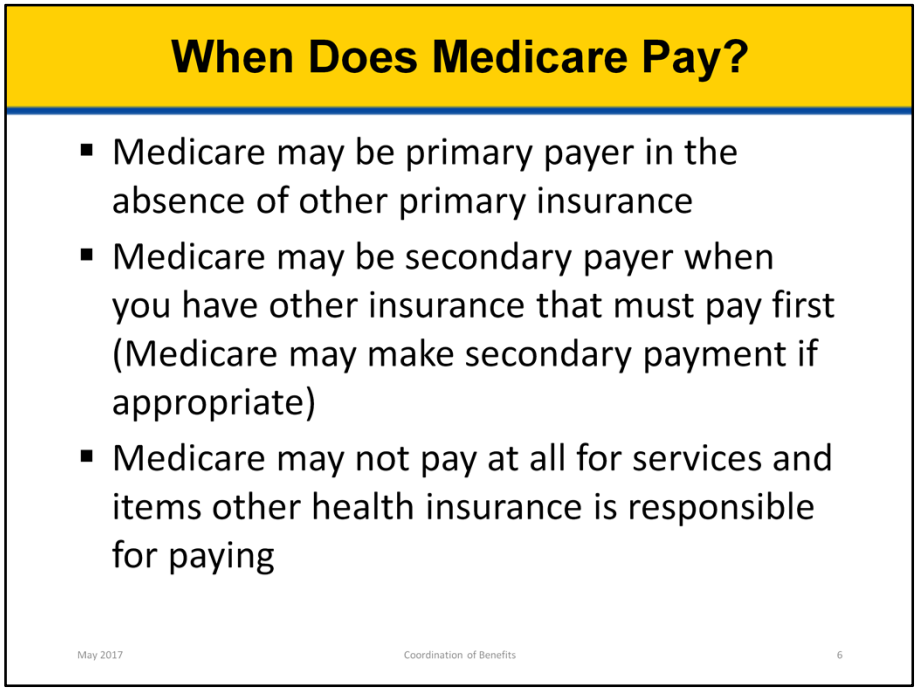


Lesson 1, “Coordination of Benefits Overview,” covers:

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



If you have Medicare and other health coverage, each type of coverage is called a payer. When there's more than one payer, coordination of benefits rules decide which payer pays first. The primary payer pays what it owes on your bills first, and then your provider sends the rest to the secondary payer to pay. In some cases, there may also be a third payer.



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

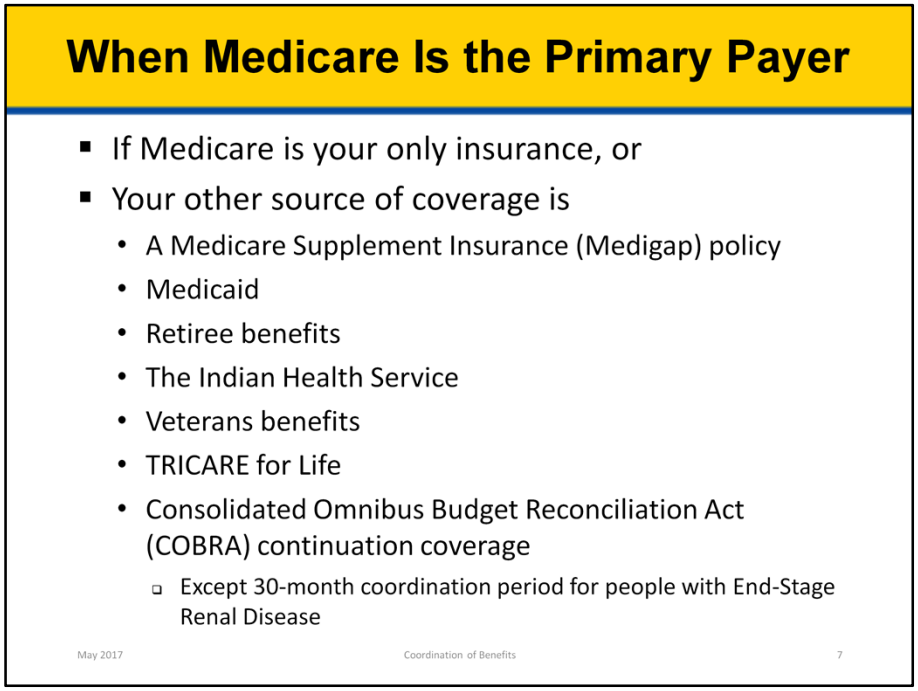
Medicare may be the primary payer if you don't have other insurance or if Medicare is primary to your other insurance.

Medicare may be the secondary payer 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.

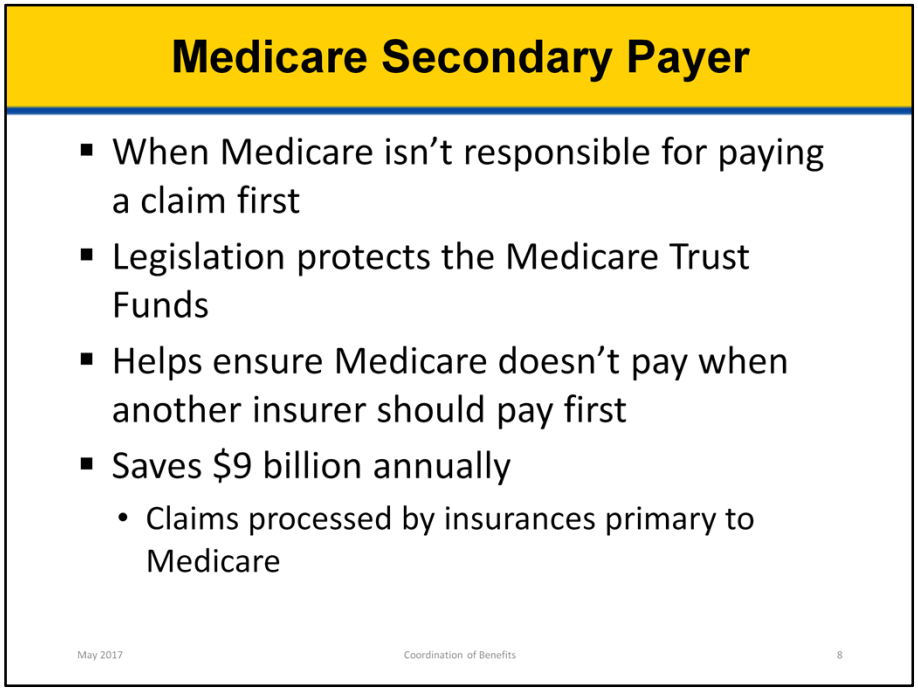
Resources:

- ecfr.gov/cgi-bin/text-idx?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



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

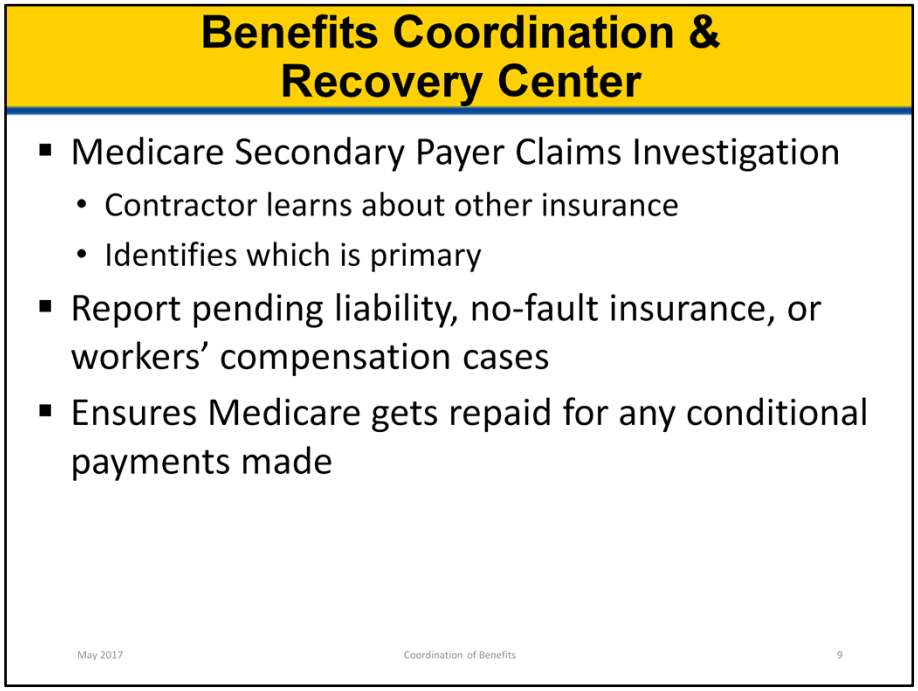
When Medicare started providing coverage in 1966, it was the primary payer for all claims except for those covered by workers' compensation, the Federal Black Lung Benefits Program, and the U.S. Department of Veterans Affairs.

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 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).



The Coordination of Benefits program determines the correct primary payer.

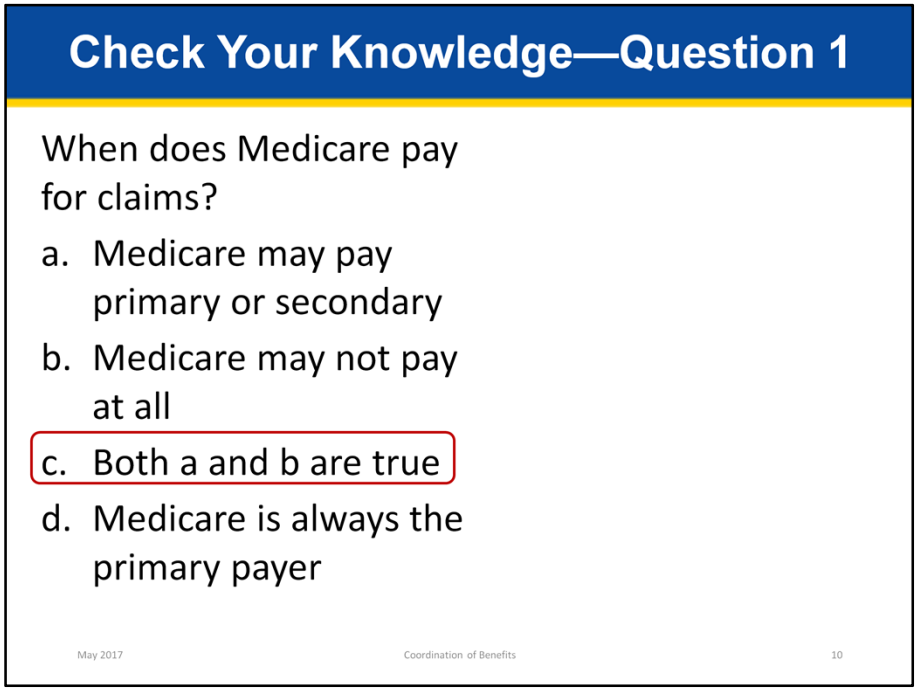
Medicare eligibility data are shared with other payers, and Medicare-paid medical claims are transmitted to supplemental insurers for secondary payment. An agreement must be in place between the Centers for Medicare & Medicaid Services (CMS) Benefits Coordination & Recovery Center (BCRC) and private 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-Benefits-and-Recovery-Overview/Coordination-of-Benefits/Coordination-of-Benefits.html
- CMS.gov/medicare/coordination-of-benefits-and-recovery/coordination-of-benefits-and-recovery-overview/msprp/downloads/conditional-payments.pdf



Check Your Knowledge—Question 1

When does Medicare pay for claims?

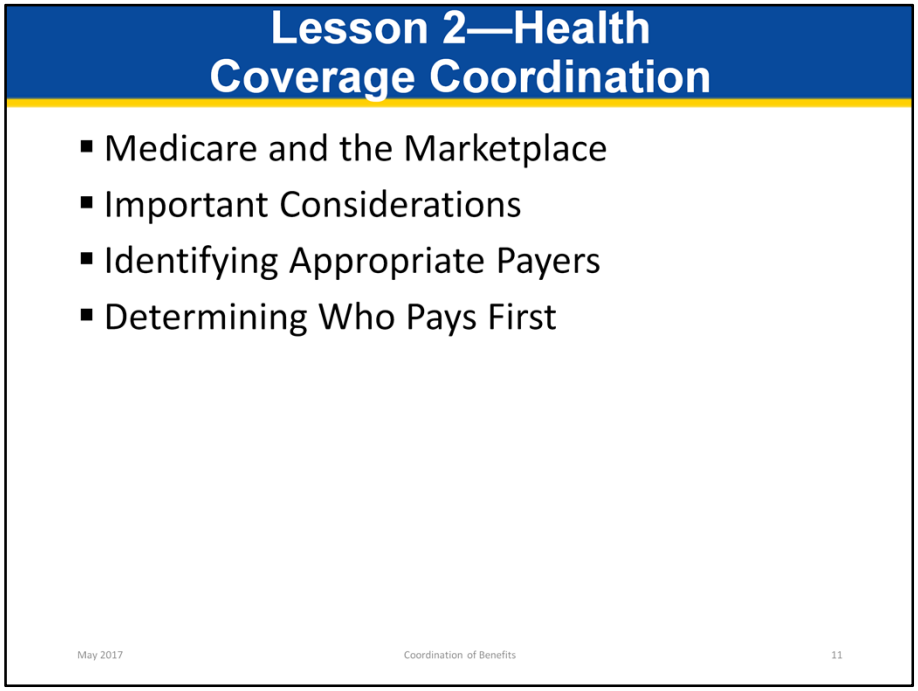
a. Medicare may pay primary or secondary

b. Medicare may not pay at all

c. Both a and b are true

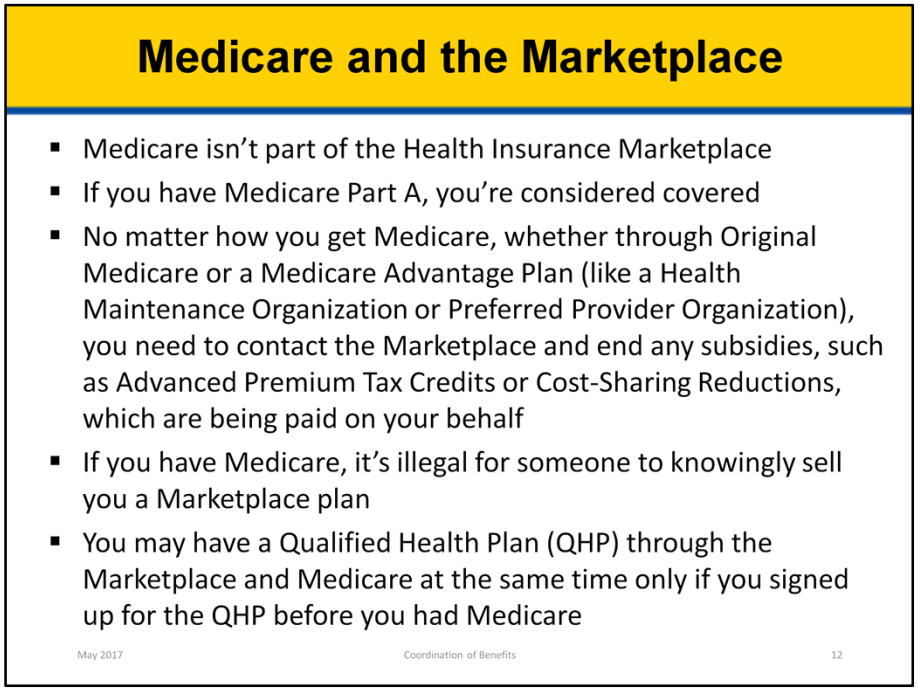
d. Medicare is always the primary payer

Answer: c. Both a and b are true. Medicare can be the primary payer, the secondary payer, or sometimes Medicare may not pay at all for services and items that other insurers are responsible for paying.



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

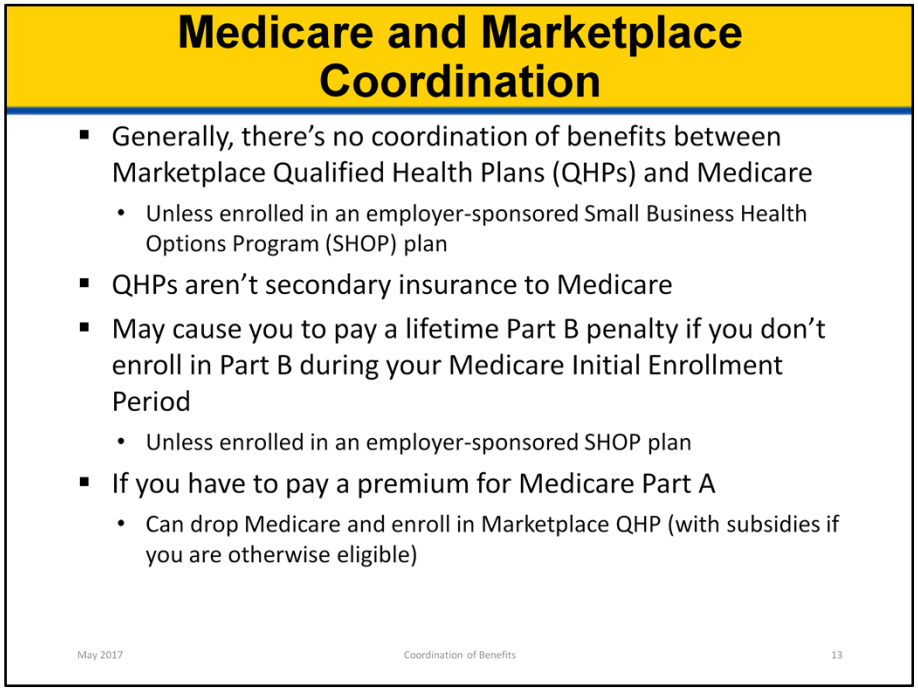
- Medicare and the Marketplace
- Important Considerations
- Identifying Appropriate Payers
- Determining Who Pays First



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.

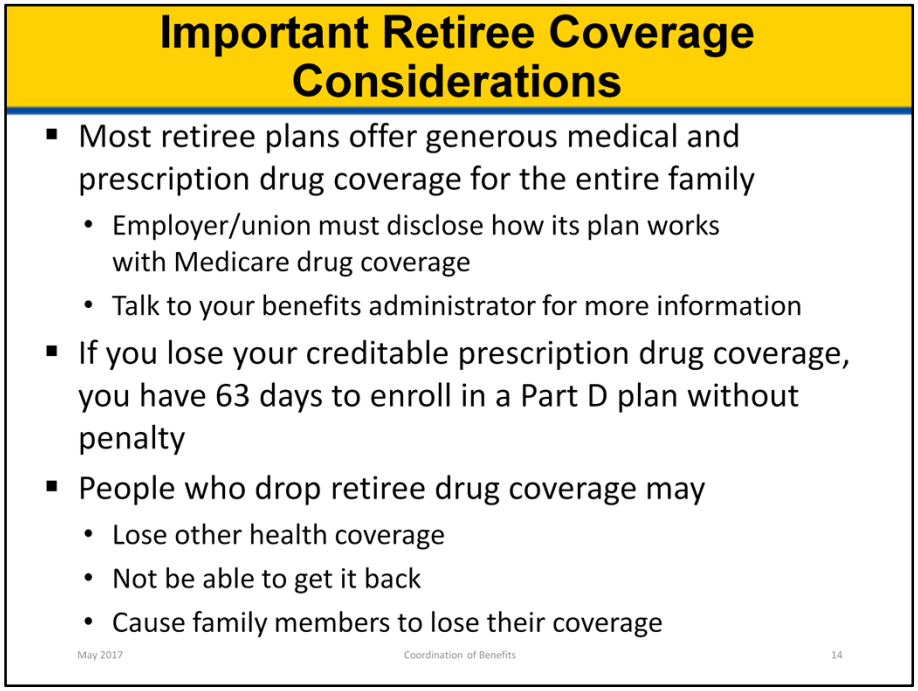


Generally, there's no coordination of benefits (COB) between Medicare and an individual Marketplace Qualified Health Plan (QHP) that you buy through the Health Insurance Marketplace. You should consider several important factors when deciding whether or not to stay in a QHP after you enroll in Medicare 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 1–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. Visit HealthCare.gov for more information about the Marketplace.

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 and not get a penalty because SHOP employer-sponsored coverage is based on current employment. Visit HealthCare.gov for more information about the Marketplace.

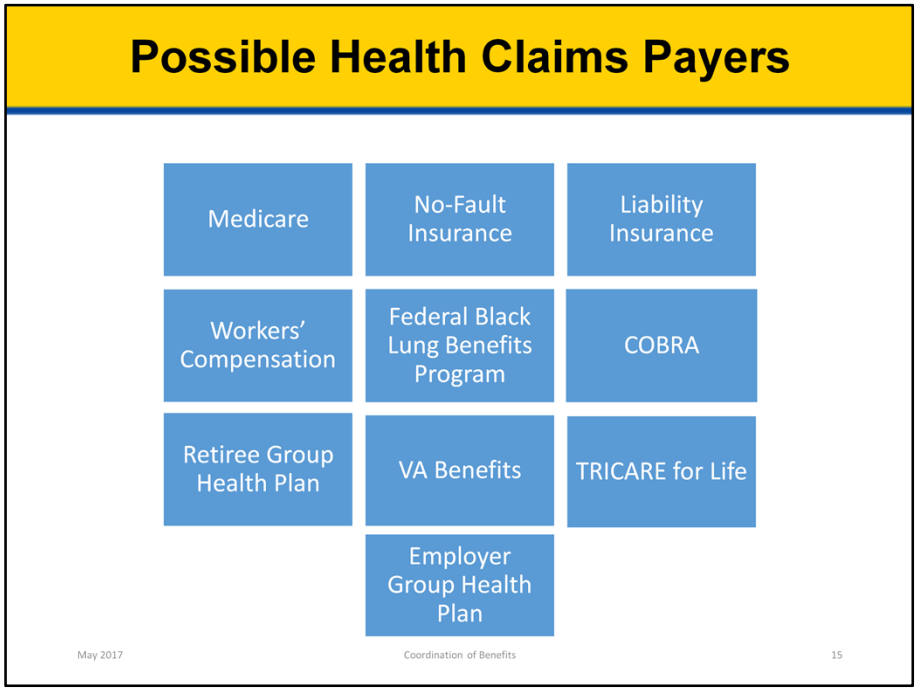


As discussed previously, people with Medicare who have employer or union retirement plans that cover prescription drugs must carefully consider their options. A person's needs may vary from year to year based on factors like health status and financial considerations. Options offered by employer or union 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 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



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 Benefits 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.

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.

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

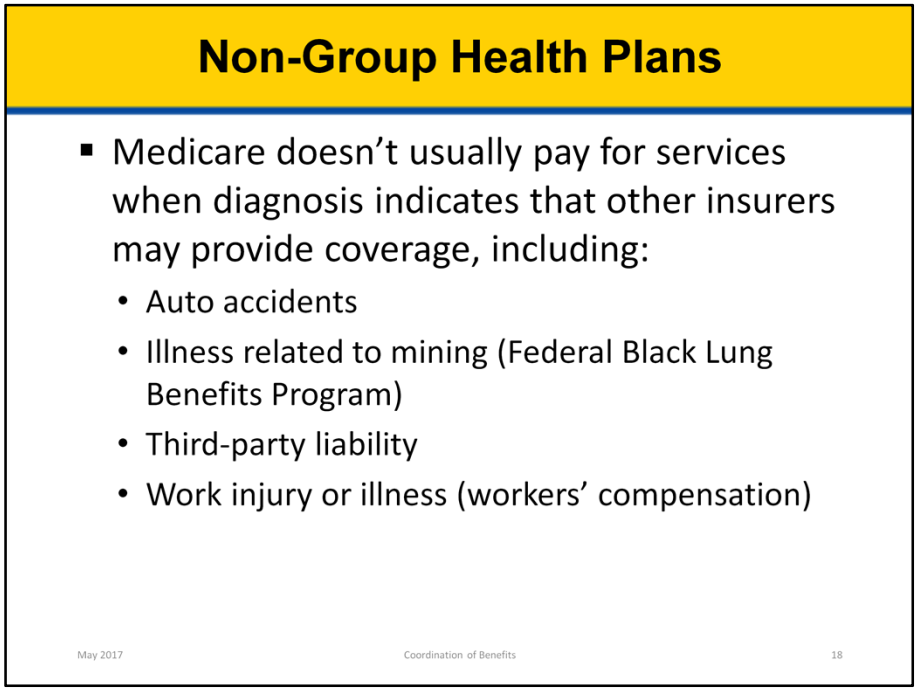
Employer Group Health Plans (EGHP) Continued

If You Are	Medicare Pays First
65 or older and have **retiree** 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 **employer group health plans (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 (ERSD)** and you have **EGHP** coverage	When the 30-month coordination period ends, or if you had Medicare primary before you had ESRD

Medicare pays first for people with employer group health plans (EGHPs) if they're

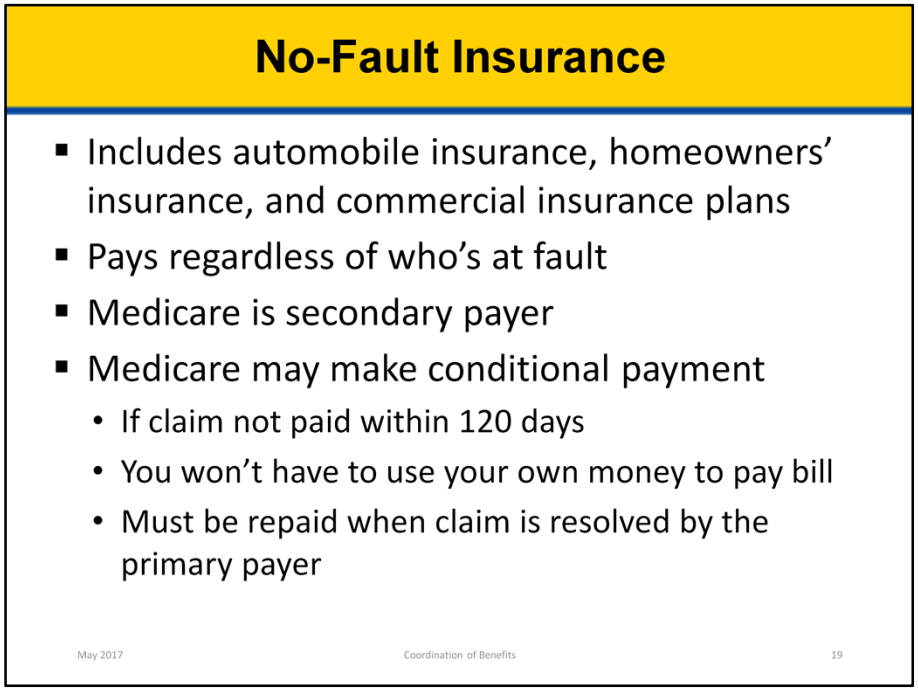
- 65 or older and have retiree coverage
- 65 or older with EGHP coverage through current employment, either theirs or their spouse's, and the employer has less than 20 employees
- Under 65, have a disability, and are covered by an EGHP through current employment (either yours or a family member's), and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

Exclusions are listed on the next page.



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 Benefits Program)
- Third-party liability
- Work-related injury or illness (workers' compensation)



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

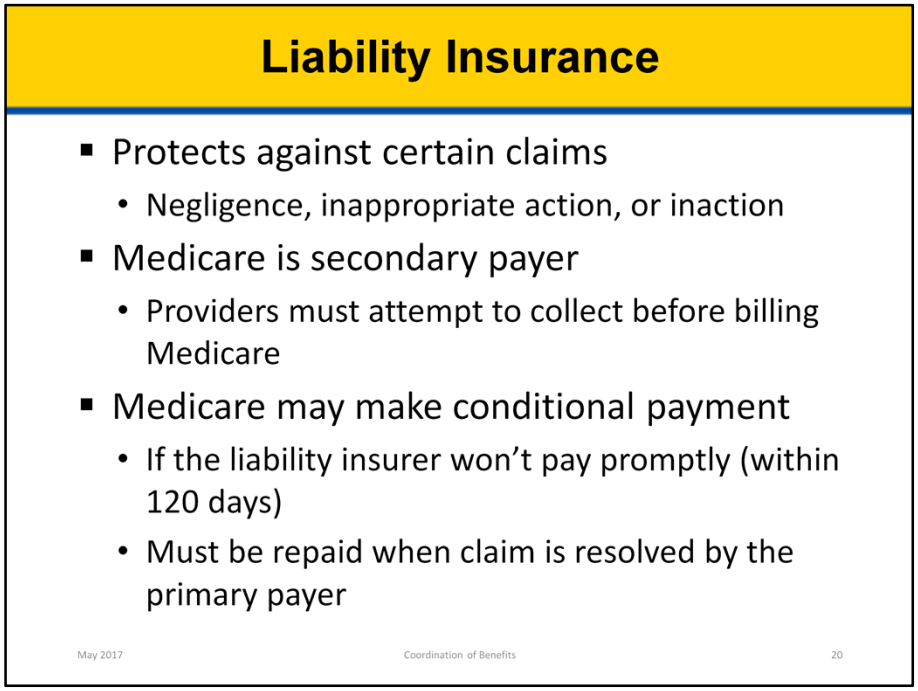
- Automobile insurance
- Homeowners' insurance
- Commercial insurance plans

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.

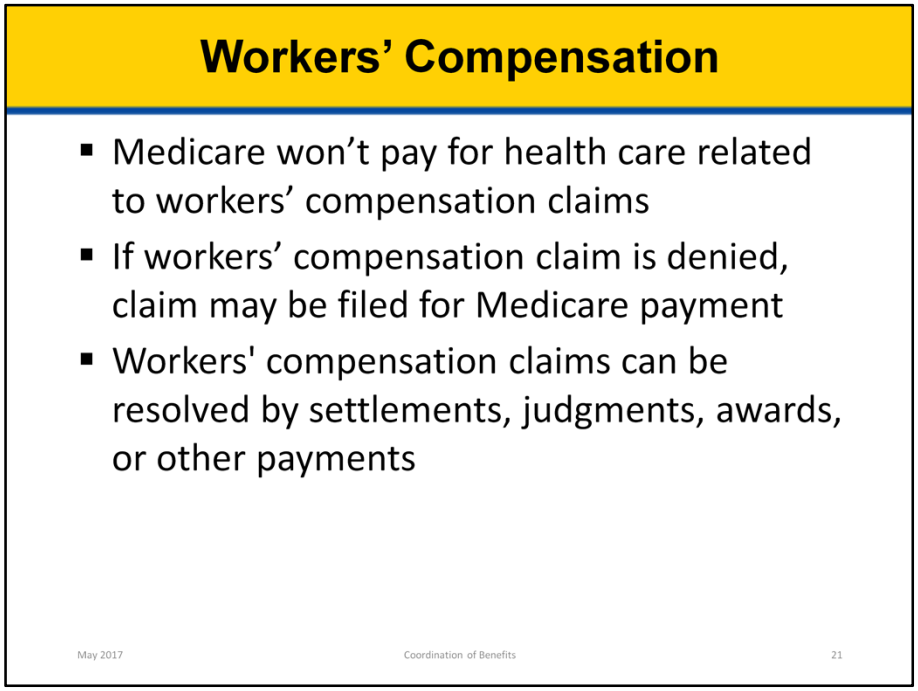
Part D plans will pay for covered prescriptions that aren't related to the accident or injury.



Liability insurance 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:

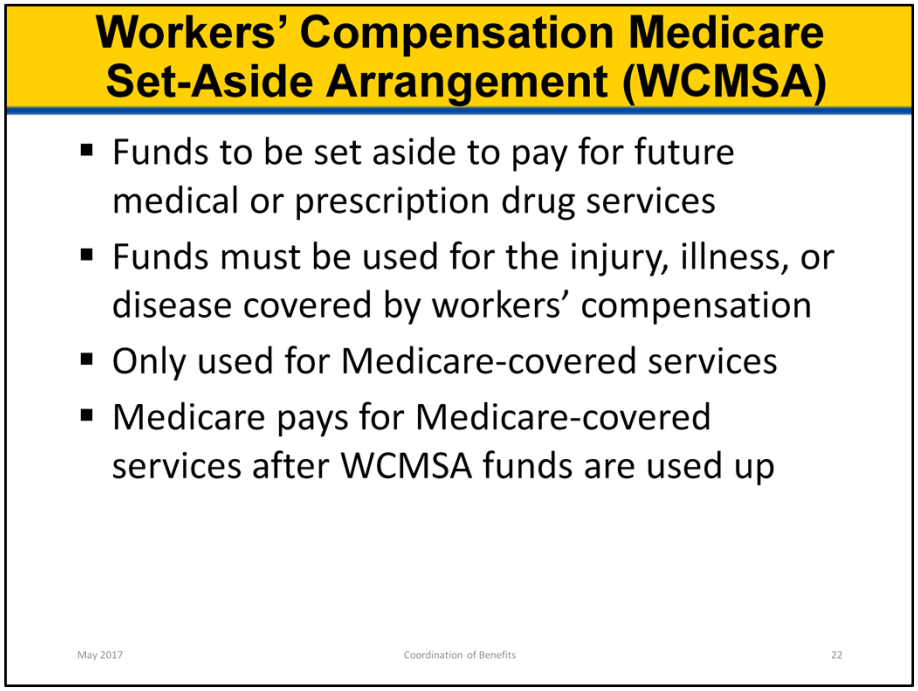
- Homeowners' liability insurance
- Automobile liability insurance
- Product liability insurance
- Malpractice liability insurance
- Uninsured motorist liability insurance
- Underinsured motorist liability insurance

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.



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 other payments.

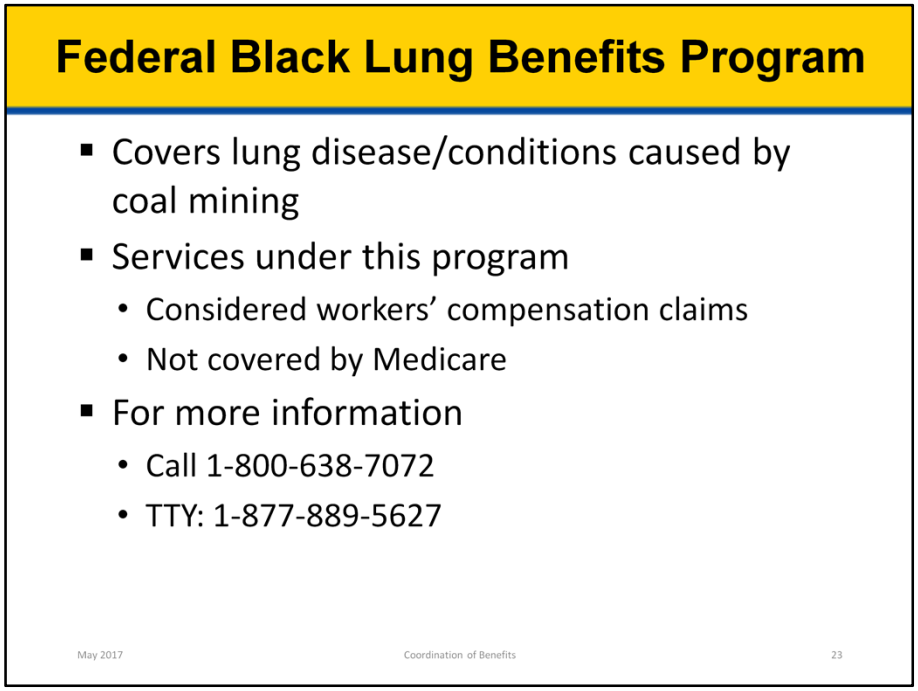


A Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) is a financial agreement that assigns a portion of a workers' compensation settlement to pay for future medical services related to the workers' compensation injury, illness, or disease.

- 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.

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



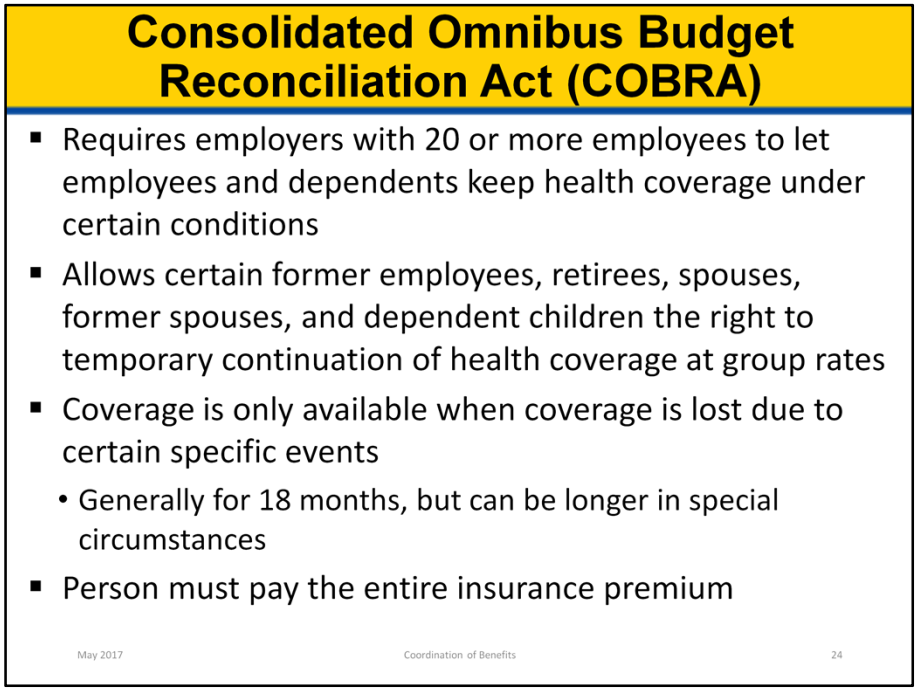
Some people with Medicare can get medical benefits through the Federal Black Lung Benefits Program for services related to lung disease and other conditions caused by coal mining. Medicare doesn't pay for health services covered under this program. Black lung claims are considered workers' compensation 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 outpatient 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.

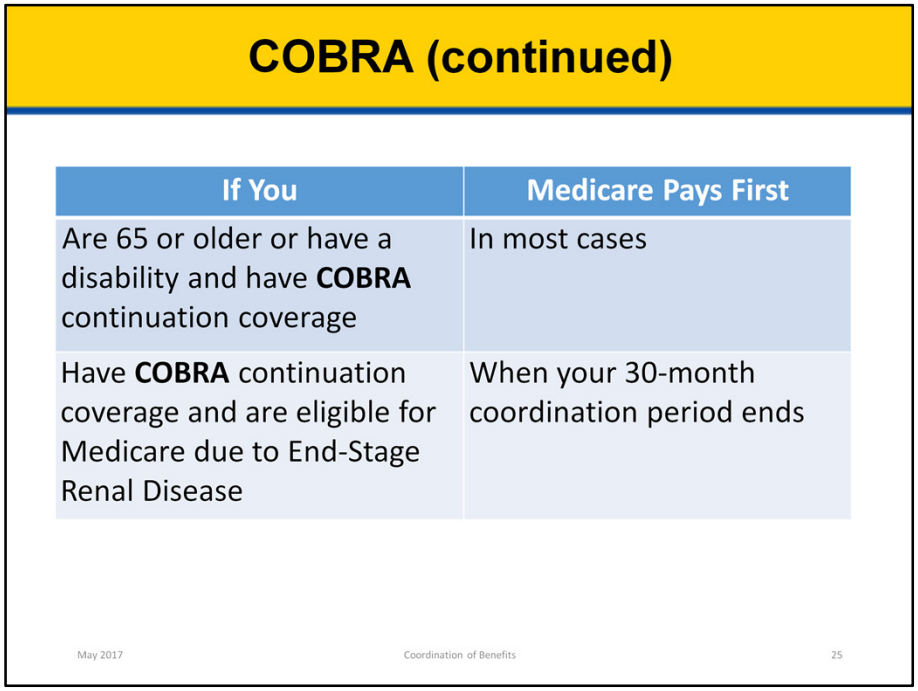
Federal Black Lung Benefits Program beneficiaries can call 1-800-638-7072 for medical diagnostic treatment services. TTY: 1-877-889-5627.



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.



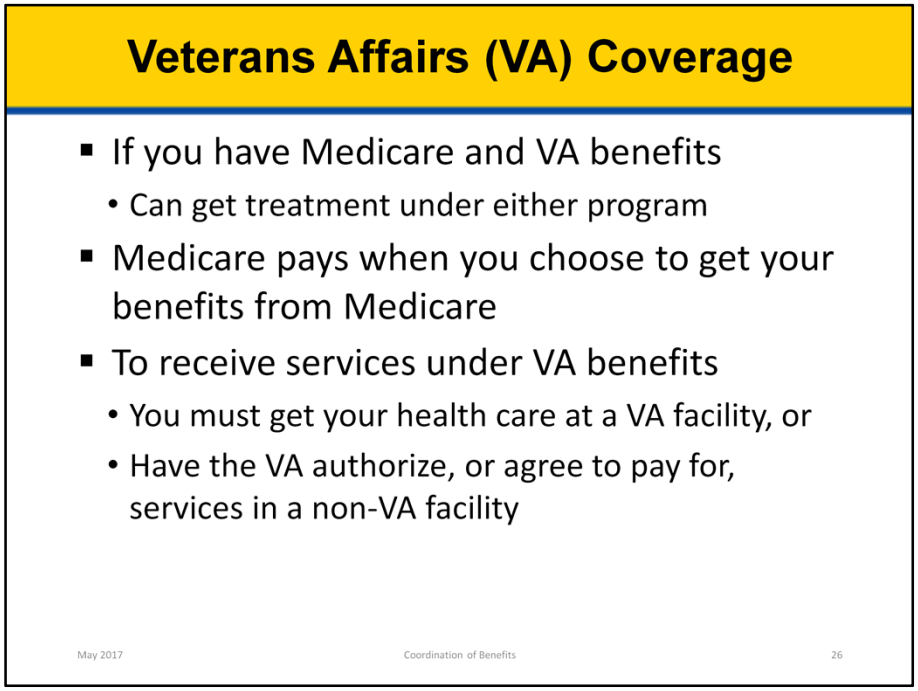
Medicare usually pays first before Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage for aged and disabled individuals. Medicare pays second to COBRA for individuals with End-Stage Renal Disease (ESRD) during the 30-month coordination period.

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.

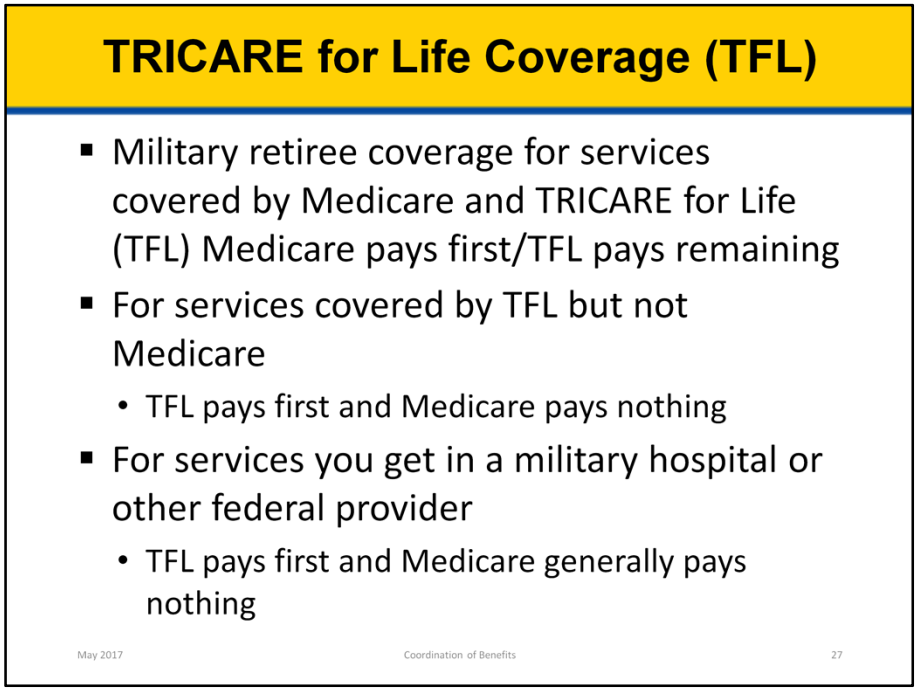


If you have both Medicare and Veterans' benefits, you can get health care treatment under either program. However, you must choose which benefit you'll use each time you see a doctor or get health care (for example, in a hospital). Medicare won't pay for the same service authorized by Veterans Affairs (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, 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.



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.

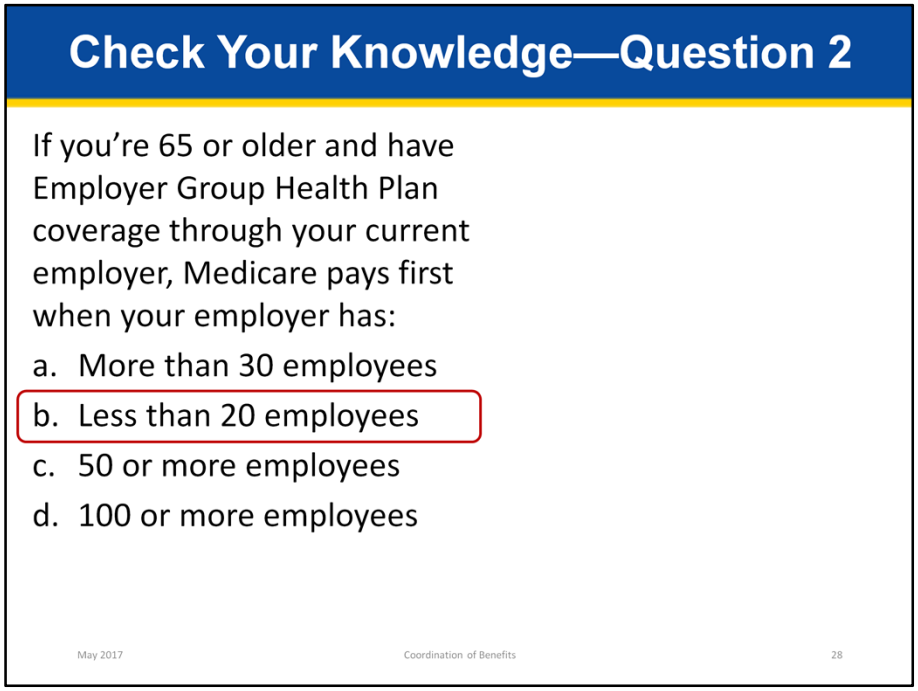
For services covered by TFL but not by Medicare, TFL pays first and Medicare pays nothing. You must pay the TFL fiscal year deductible and cost shares.

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.



Check Your Knowledge—Question 2

If you're 65 or older and have Employer Group Health Plan (EGHP) coverage through your current employer, Medicare pays first when your employer has

a. More than 30 employees

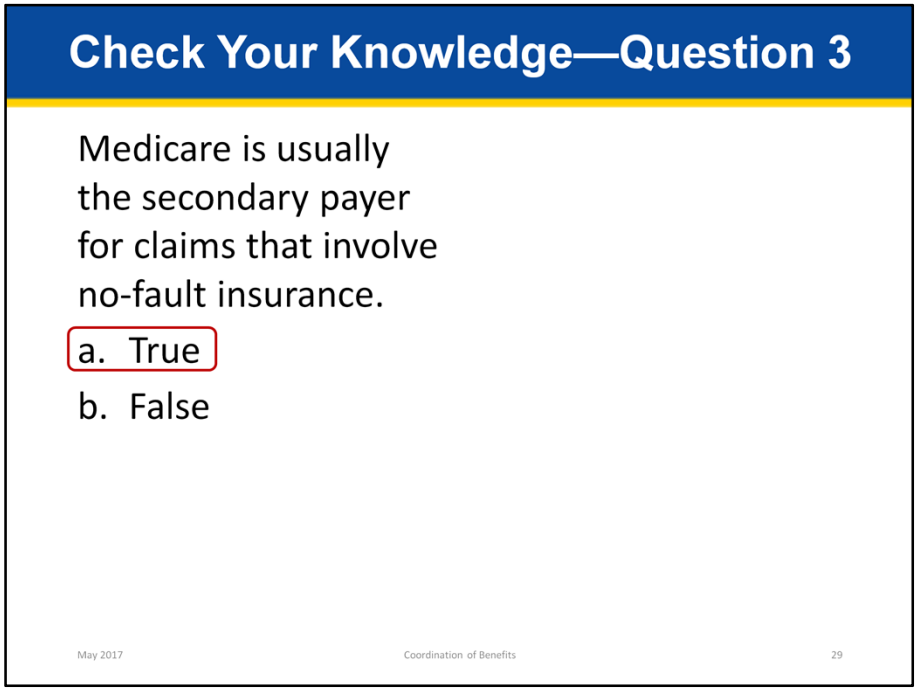
b. Less than 20 employees

c. 50 or more employees

d. 100 or more employees

Answer: b. less than 20 employees

Medicare will pay first if you're 65 or older with EGHP coverage through current employment, (either yours or your spouse's), and the employer has less than 20 employees.



Check Your Knowledge—Question 3

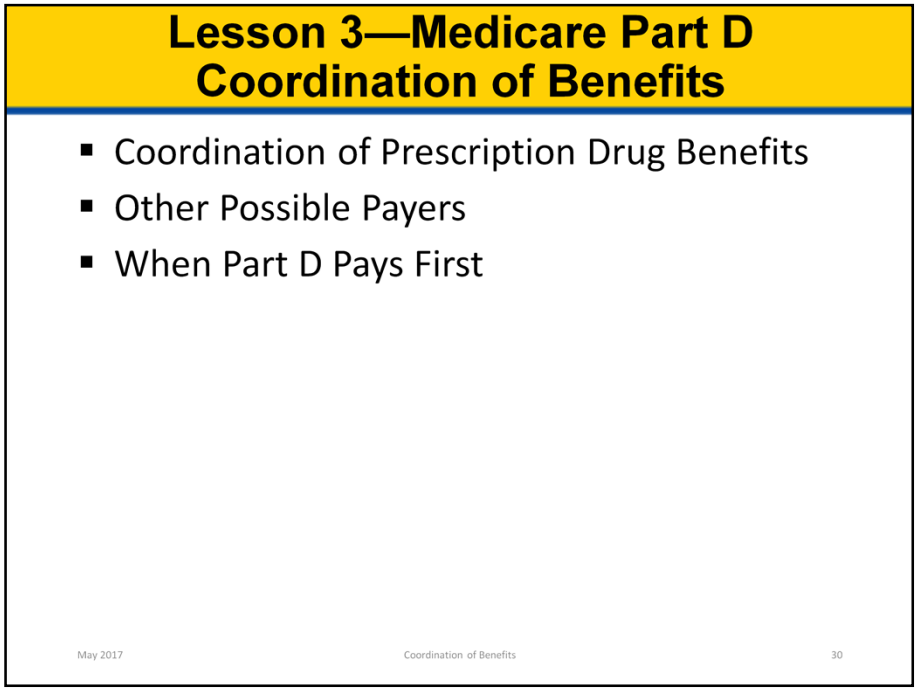
Medicare is usually the secondary payer for claims that involve no-fault insurance.

a. True

b. False

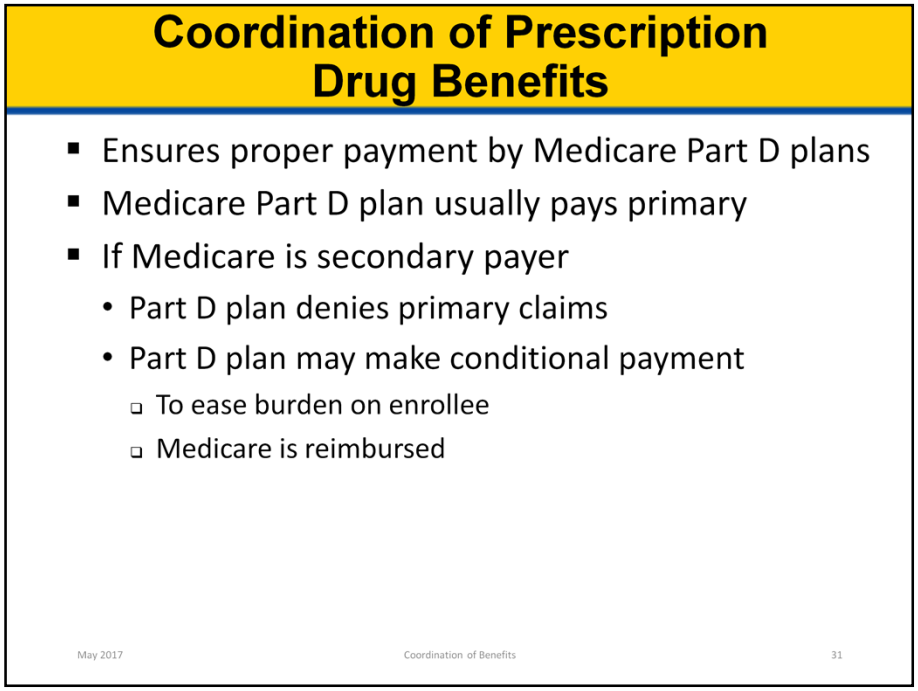
Answer: a. True

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



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

- Coordination of Prescription Drug Benefits
- Other Possible Payers
- When Part D Pays First

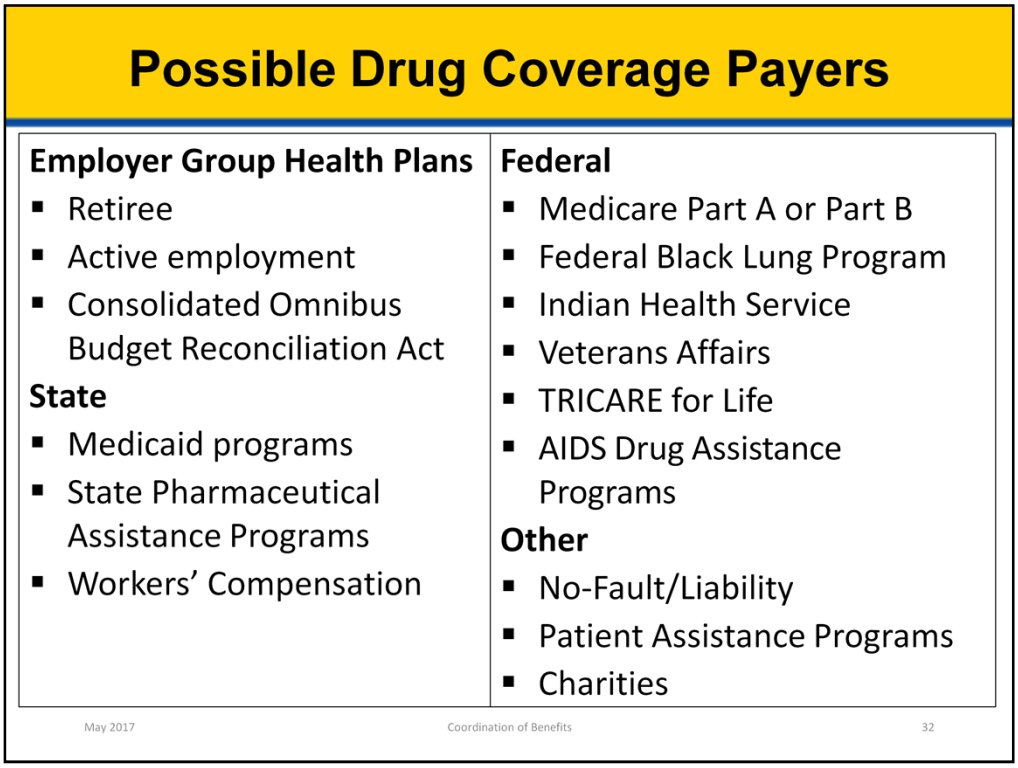


Generally, Medicare Part D provides primary coverage for prescription drugs. Whenever Medicare is primary, the Medicare prescription drug coverage is billed and will pay first.

When Medicare is the secondary payer, Part D plans will generally deny primary claims.

When Medicare is the secondary payer to a non-group health plan, or when a plan doesn't know whether a covered drug is related to an injury, Part D plans will always make a conditional primary payment to ease the burden on 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 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 for additional contact information for the BCRC.



Possible drug coverage payers include:

Employer Group Health Plans

- Retiree
- Active employment
- Consolidated Omnibus Budget Reconciliation Act continuation coverage

State

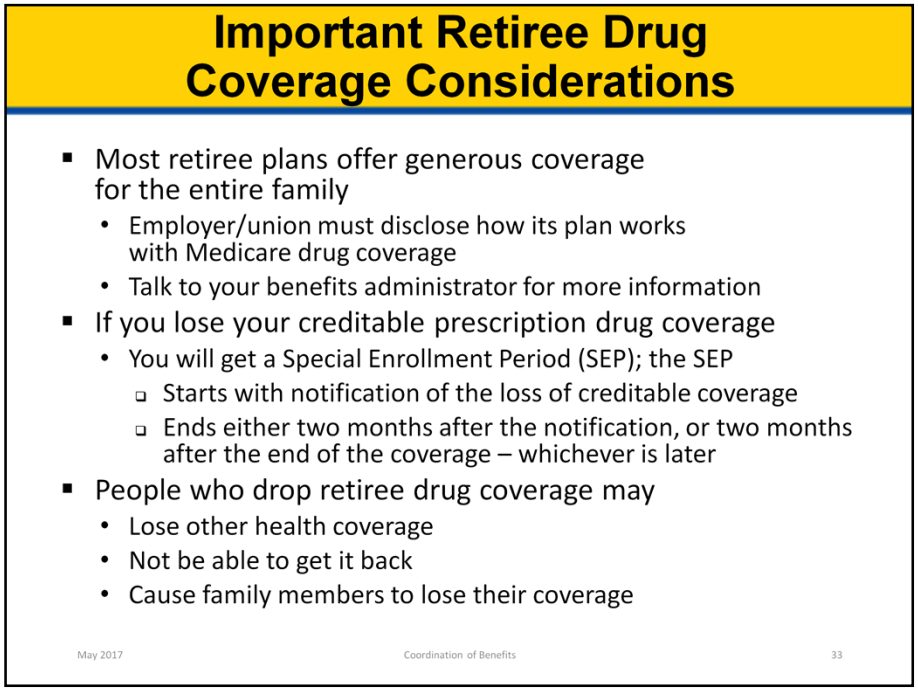
- Medicaid programs
- State Pharmaceutical Assistance Programs
- Workers' compensation

Federal

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

Other

- No-Fault/Liability insurance
- Patient Assistance Programs
- Charities



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
Employer Group Health (EGHP)	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
	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
Consolidated Omnibus Budget Reconciliation Act (COBRA)	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

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

Medicare Part D pays first also for:

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

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

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

Medicare Part D pays first, if you have COBRA and have ESRD, once you're out of your 30-month coordination period.

Type of Plan	Situation	Then Part D Pays First for Medically-Necessary Part D-Covered Prescriptions
Federal Black Lung Program	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
Indian Health Services (IHS)	You get benefits from the Indian Health Service	Even if you get your drugs from IHS, Tribal, or Urban Indian clinics
Department of Veteran's Affairs	You have coverage through the Department of Veteran's Affairs	There's no coordination of benefits. A prescription must be paid solely by either the VA or Medicare.
TRICARE for Life	You have TRICARE for Life benefits	You generally won't need to enroll in a Part D plan
State Medicaid Programs	You're enrolled in your state's Medicaid program	For all Part D-covered drugs. States may provide Medicaid coverage of drugs excluded from Part D coverage
State Pharmaceutical Assistance Programs	You get assistance from a State Pharmaceutical Assistance program	Yes. The state just helps pay your Part D costs.
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The **Federal Black Lung Program** covers people with lung disease from coal mining. If you get Federal Black Lung Program benefits, Medicare prescription drug coverage won't cover prescriptions related to lung disease and other conditions caused by coal mining. It will pay first for all other covered prescriptions.

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

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

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

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

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

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

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

If you get help from a **State Pharmaceutical Assistance Program**, Medicare pays first. The states just helps pay your Part D costs.

Type of Plan	Situation	Then Part D Pays First for Medically-Necessary Part D-Covered Prescriptions
Workers' Compensation	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.
Manufacturer-sponsored Patient Assistance Program	If you get help from a Manufacturer-sponsored Patient Assistance Program	Yes
Charity	If you get help from a charity	Yes
No-fault/Liability Insurance	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

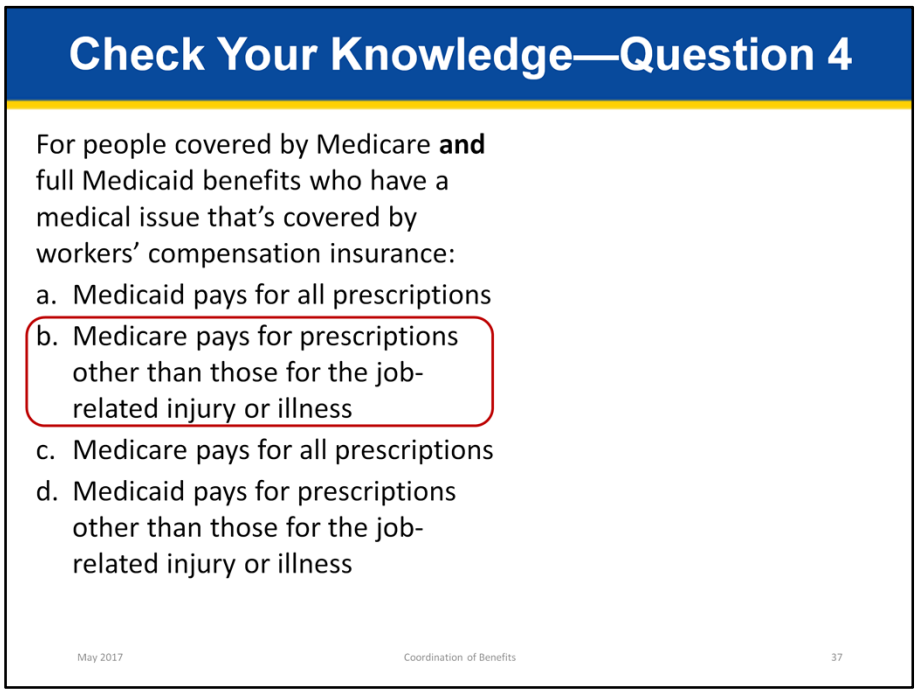
If you're covered under **Workers' Compensation**, Medicare will pay first for covered prescriptions that aren't related to the job-related illness or injury. Medicare drug plans will always make a conditional primary payment to ease the burden on the policyholder, unless certain situations apply. The Medicare drug 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 you refill a prescription previously paid for by workers' compensation, the Medicare drug 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.

If you get help from a **manufacturer-sponsored Patient Assistance Programs (PAPs)**, that help won't count toward your true out-of-pocket (TrOOP) costs. The Centers for Medicare & Medicaid Services (CMS) encourages PAPs to exchange eligibility files with CMS so that Medicare drug plans are aware of your eligibility for PAP assistance and can set their computer system's 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. You will need to submit a paper claim to the drug plan, along with copayment documentation.

If you get help from a **charitable program**, you may present a retail ID card at the point of sale to get financial help. Charities that choose to participate in electronic data exchange can speed up settlement of claims at the point of sale. Some charities require you to submit a paper claim and then send claims to the TrOOP contractor in a batch form so that the TrOOP costs can be calculated accurately.

Any financial help a charity gives on your behalf will count toward the TrOOP catastrophic threshold, unless it's a group health plan, insurance, government-funded health program, or other third-party payment arrangement.

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



Check Your Knowledge—Question 4

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

a. Medicaid pays for all prescriptions

b. Medicare pays for prescriptions other than those for the job-related injury or illness

c. Medicare pays for all prescriptions

d. Medicaid pays for prescriptions other than those for the job-related injury or illness

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

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
- 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

Office of Personnel Management (Federal Employees Health Benefit Program)

- opm.gov/healthcare-insurance/healthcare/

Patient Assistance Program Center

- rxassist.org

Medicare/TRICARE Benefit Overview

- tricare.mil/Plans/Eligibility?sc_database=web

TRICARE

- TRICARE.mil/

Department of Veterans Affairs

- Call 1-800-827-1000. TTY: 1-800-829-4833
- va.gov/opa/publications/benefits_book.asp
- benefits.va.gov/benefits/

Black Lung Program

- 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.
- Order multiple copies (partners only) at Productordering.cms.hhs.gov.
  You must register your organization.

Acronyms

AI/AN American Indian/Alaska Native

APTC Advanced Premium Tax Credits

BCRC Benefits Coordination & Recovery Center

CHIP Children's Health Insurance Program

CMS Centers for Medicare & Medicaid Services

COB Coordination of Benefits

COBRA Consolidated Omnibus Budget Reconciliation Act

CSR Cost Sharing Reductions

EGHP Employer Group Health Plan

ESRD End-Stage Renal Disease

FEHB Federal Employee Health Benefits

IHS Indian Health Services

I/T/U Indian Health Service, Tribal, and Urban Indian

MMA Medicare Modernization Act

MSP Medicare Secondary Payer

NTP National Training Program

PAP Patient Assistance Program

QHP Qualified Health Plan

SEP Special Enrollment Period

SHIP State Health Insurance Assistance Program

TFL TRICARE for Life

TrOOP True Out-Of-Pocket

VA Veterans Affairs

WCMSA Workers' Compensation Medicare Set-Aide Arrangement

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