



Module 5: Coordination of Benefits

National Medicare TRAINING PROGRAM

...helping people with Medicare make
informed health care decisions



Centers for Medicare & Medicaid Services
National Train-the-Trainer Workshops
Instructor Information Sheet
Module 5: *Coordination of Benefits*

Module Description

The Coordination of Benefits program (COB) identifies all of the health care benefits available to a person with Medicare, ensures that claims are paid correctly, and that the primary payer, whether Medicare or other insurer, pays first. This module describes why it is important to identify whether a person's medical costs are payable by other insurance before, or in addition to, Medicare. You'll learn how this information helps health care providers determine who to bill and how to file claims with Medicare.

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

Where applicable, updates from recent legislation are included.

The following topics are included in this module:

Slides	1-12	Coordination of Benefits Overview
Slides	13-33	Health Coverage Coordination
Slides	34-47	Coordination of Benefits for Prescription Drug Coverage
Slides	48-50	Information Resources

Objectives

- Review Health Coverage Coordination
- Describe the other health care payers that may coordinate with Medicare
- Recognize information sources

Target Audience

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

Learning Activities

This module contains ten interactive learning questions that give participants the opportunity to apply the module concepts in a real-world setting.

Time Considerations

The module consists of 50 PowerPoint slides with corresponding speaker's notes. It can be presented in about one to 1 ½ hours. Allow approximately 30 more minutes for discussion, questions and answers and the learning activities.

References

- www.cms.hhs.gov/COBGeneralInformation/
- www.cms.hhs.gov/COBAgreement/
- *Medicare and Other Health Benefits: Your Guide to Who Pays First*, CMS Product No. 02179



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


This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and Pre-Existing Condition Insurance Plans. The information in this module was correct as of April 2012.

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

To view the Affordable Care Act visit <http://www.healthcare.gov/law/full/index.html>

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

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.



Session Overview

- This session will help you
 - Understand coordination of benefits
 - Explain health and drug coverage coordination
 - Determine who pays first
 - Learn where to get more information


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This session will help you to

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



Lessons

1. Overview of Coordination of Benefits
2. Medicare Health Coverage Coordination
3. Medicare Prescription Drug Coverage Coordination


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The topics for this lesson include the following:

1. Overview of Coordination of Benefits
2. Medicare Health Coverage Coordination
3. Medicare Prescription Drug Coverage Coordination



Lesson 1 – Coordination of Benefits Overview

- Coordination of Benefits (COB)
- Medicare as the Primary Payer
- “Medicare Secondary Payer” (MSP)

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This lesson provides an overview of Coordination of Benefits and how it works, including

- Coordination of Benefits (COB)
- Medicare as the Primary Payer
- “Medicare Secondary Payer” (MSP)

When Does Medicare Pay?

- Medicare may be primary payer
 - In the absence of other primary insurance
- Medicare may be secondary payer
 - May have other insurance that must pay first
- Medicare may not pay at all
 - For services and items other health insurance is responsible for paying

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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.

When Medicare is Primary Payer

- If Medicare is your only insurance
- Your other source of coverage is
 - A Medigap policy
 - Medicaid
 - Retiree benefits
 - The Indian Health Service
 - Veterans benefits or TRICARE for Life
 - COBRA continuation coverage
 - Except 30-month coordination period for people with End-Stage Renal Disease (ESRD)

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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

- 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 or TRICARE For Life (Note: TRICARE pays for services from a military hospital or any other federal provider.)
- Coverage under COBRA, with one exception, End-Stage Renal Disease (ESRD) (We'll talk about this coverage shortly.)

Medicare Secondary Payer (MSP)

- Term Medicare Secondary Payer is used
 - When Medicare isn't responsible for paying a claim first
 - Legislation that protects the Medicare Trust Funds
 - Helps ensure Medicare doesn't pay
 - When another insurer should
 - Saves \$8 billion annually
 - Claims processed by insurances primary to Medicare

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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 Federal Black Lung Program claims.

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. 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.

Gathering Secondary Payer Info

- Mandatory reporting requirements for insurers
 - Use secure web portal to facilitate transfer of data
- IRS/SSA/CMS Claims Data Match
 - Employers complete an online questionnaire
 - With info on workers entitled to Medicare
 - Or married to a Medicare beneficiary
- Voluntary Data Sharing Agreements (VDSA)
 - Mutual exchange of data between CMS

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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. The Data Match identifies situations where another payer is primary to Medicare.

Voluntary Data Sharing Agreements (VDSA) - CMS has entered into VDSA with numerous large employers. These agreements allow employers and CMS to send and receive group health plan enrollment information electronically.

By law, employers are required to complete a questionnaire on the group health plan that Medicare-eligible workers and their spouses choose. Where discrepancies occur in the Voluntary Data Sharing Agreements, 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.

Gathering Secondary Payer Info

- Initial Enrollment Questionnaire
 - Receive notification to complete online
 - Sent three months prior to Medicare entitlement date
 - Asks about current employer, liability and workers' compensation insurance coverage
 - Use MyMedicare.gov
 - By phone with COB contractor
- MSP Claims Investigation
 - Contractor learns about other insurance
 - Identifies which is primary

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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's group health plan cover prescription drugs?
- Are you receiving Black Lung Benefits or Worker's 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 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.

COB Contractor

- Identifies health benefits available to people with Medicare
- Coordinates claims
 - To ensure claims are paid by correct payer
- Responsible for identifying
 - Medicare Secondary Payer (MSP) situations
 - Claims that should crossover to supplemental insurers

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The Coordination of Benefits Contractor consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries.

The purposes of the 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.

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 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.

COB Contractor

- Emblem Health for Medicare Parts A and B
 - Collects insurance information
 - Establishes MSP records on CMS Common Working File (CWF)
 - Transmits data to the Medicare Beneficiary Database for the proper coordination of Rx benefits

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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.

Review

Which one of the following is not true about Medicare Secondary Payer?

- A. It is legally mandated
- B. Saves \$8 billion annually
- C. Applies when Medicare is the primary payer
- D. Protects the Medicare Trust Funds

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Which one of the following is not true about Medicare Secondary Payer?

- A. It is legally mandated
- B. Saves \$8 billion annually on claims processed by insurances that are primary to Medicare
- C. Applies to situations where Medicare is the primary payer.
- D. Protects the Medicare Trust Funds

Answer: C

Medicare Secondary Payer is the term generally used when Medicare is not responsible for paying a claim first.



Lesson 2 - Health Coverage Coordination

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

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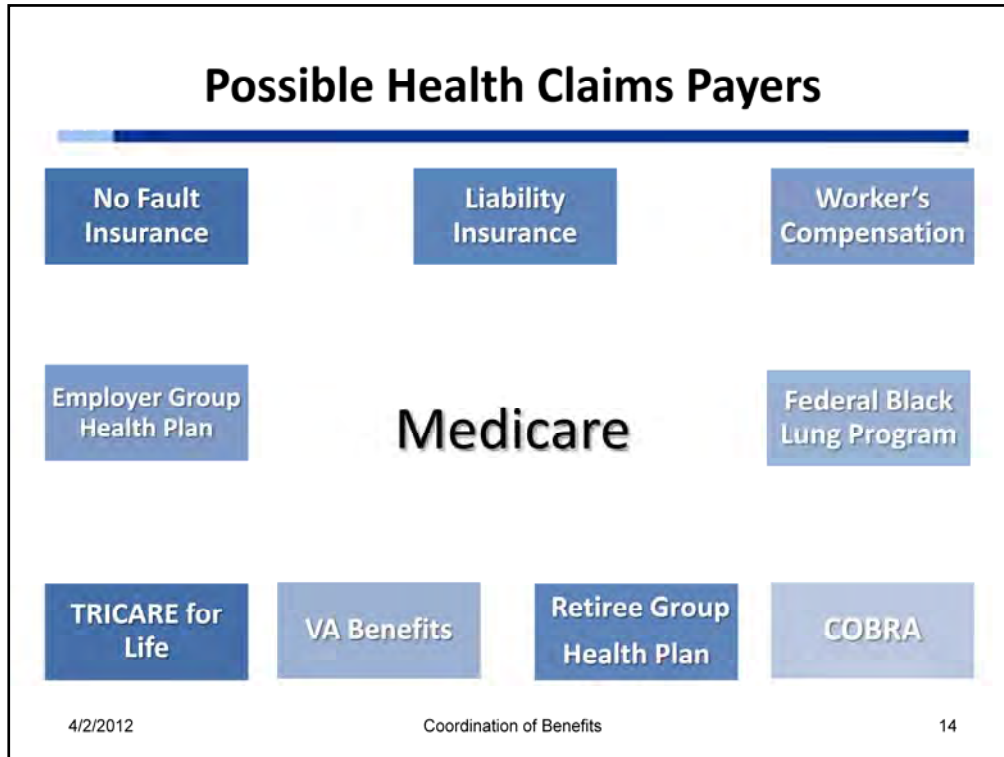
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The topics for the next lesson on Health Coverage Coordination includes

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

NOTE: See Appendix A for a 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
- Worker’s Compensation insurance
- Federal Black Lung Program
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Retiree Group Health Plan
- Veteran’s 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.

Employer Group Health Plans (EGHP)

- Coverage offered by many employers and unions
 - To current employees, spouse and family members
 - To retirees, spouse and family members
 - Includes Federal Employee Health Benefits Plans
- May be fee-for-service plan
- May be managed care plan
- Employees can choose to keep or reject

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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 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 an HMO.

Employee Group Health Plans

If You Are	Medicare 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.

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

Medicare pays first if

- If you are 65 or older and have retiree coverage
- If you are 65 or older with employee group health plan coverage through current employment, either yours or your spouses, and the employer has more than 20 employees
- If you are under age 65, have a disability and are covered by an employee group health plan through current employment, either yours or a family members, 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 spouses, and the 30-month coordination period has ended, or if you had Medicare before you had ESRD

Coordination Scenario

Lillian is under 65 and has Medicare due to a disability. She has EGHP coverage through her husband's current employer. Medicare pays first if the employer has

- A. Less than 20 employees
- B. More than 100 employees
- C. Less than 100 employees

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Lillian is under 65 and has Medicare due to a disability. She has EGHP coverage through her husband's current employer. Medicare pays first if the employer has

- A. Less than 20 employees
- B. More than 100 employees
- C. Less than 100 employees

Answer

C. Medicare pays first if the employer has less than 100 employees.

Coordination Scenario

Lillian is now 65. She has retiree EGHP coverage through her husband's previous employer. Medicare pays first if the employer has

- A. Less than 20 employees
- B. More than 100 employees
- C. More than 200 employees
- D. Any number of employees

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Lillian is under 65 and has Medicare due to a disability. She has EGHP coverage through her husband's current employer. Medicare pays first if the employer has

- A. Less than 20 employees
- B. More than 100 employees
- C. More than 200 employees
- D. Any number of employees

Answer

D. Medicare pays first regardless of the number of employees.

Non Group Health Plans

- Medicare does not usually pay for services
 - When diagnosis indicates that other insurers may provide coverage, including:
 - Auto accidents
 - Illness related to mining (Federal Black Lung Program)
 - Third party liability
 - Work injury or illness (Worker's compensation)

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- 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
 - Work related injury or illness (Worker's compensation)

No-Fault Insurance

- Pays regardless of who is at fault
- Medicare is secondary payer
- Medicare may make conditional payment
 - If claim not paid within 120 days
 - Person won't have to use own money to pay bill
 - Must be repaid
 - When claim is resolved by the primary payer

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

- Automobile insurance
- Homeowners' insurance
- Commercial insurance plans

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

Medicare generally 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.

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

- Protects against certain claims
 - Negligence, inappropriate action, or inaction
- Medicare is secondary payer
 - Providers must attempt to collect before billing Medicare
- Medicare may make conditional payment
 - If the liability insurer will not pay promptly
 - Within 120 days
 - Medicare recovers conditional payment

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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
- 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. Medicare may make a conditional payment if the liability insurer will not pay promptly, within 120 days. When the liability insurer pays, Medicare recovers its conditional primary payment.

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

Coordination Scenario

Dennis was in a car accident. Who pays first for his injuries?

- A. Medicare
- B. No-Fault/Liability Insurance
- C. Medigap

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Dennis was in a car accident. Who pays first for his injuries?

- A. Medicare
- B. No-Fault/Liability Insurance
- C. Medigap

Answer

B. No-Fault/Liability Insurance

The no-fault/liability insurer is the primary payer when the claim for a diagnosis is related to the injury sustained in an accident.

Coordination Scenario

Would Medicare ever pay before No-Fault/Liability insurance for Dennis' care for injuries he received in the car accident?

- A. Yes
- B. No

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Would Medicare ever pay before No-Fault/Liability insurance for Dennis' care for injuries he received in the car accident?

- A. Yes
- B. No

Answer

A. Yes

Medicare would make a conditional payment if the No-Fault/Liability insurer didn't pay within 120 days.

Workers' Compensation

- Medicare will not pay for health care
 - Related to Workers' compensation claims
- If Workers' compensation claim denied
 - Claim may be filed for Medicare payment
- Settlement may include a Worker's Compensation Medicare Set-aside Arrangement (WCMSA)

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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).

WCMSAs are discussed in detail at www.cms.gov/WorkersCompAgencyServices/04_wcsetaside.asp

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

Federal Black Lung Program

- Covers lung disease/conditions
 - Caused by coal mining
- Services under this program
 - Considered Workers' compensation claims
 - Not covered by Medicare
- Beneficiary covered benefits
- For more information call 1-800-638-7072

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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
- 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.

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, www.dol.gov/compliance/topics/benefits-comp-blacklung.htm

Coordination Scenario

Esther is covered by Medicare, and by Worker's compensation for a condition she developed due to chemical exposure at her old job. She was recently in the hospital for the flu. Will Worker's compensation pay for her inpatient stay?

- A. Yes
- B. No

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Esther is covered by Medicare, and by Worker's compensation for a condition she developed due to chemical exposure at her old job. She was recently in the hospital for the flu. Will Worker's compensation pay for her inpatient stay?

- A. Yes
- B. No

Answer:

- B. No

Medicare would pay first for claims with a diagnosis that is not related to the job-related illness or injury.

Coordination Scenario

Jed has emphysema. Will Medicare cover his care for this condition?

- A. Yes, if his emphysema was caused by coal mining.
- B. No, if his emphysema was caused by smoking.
- C. No, if his emphysema was caused by coal mining.

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Jed has emphysema. Will Medicare cover his care for this condition?

- A. Yes, if his emphysema was caused by coal mining.
- B. No, if his emphysema was caused by smoking.
- C. No, if his emphysema was caused by coal mining.

Answer:

C. No, if his emphysema was caused by coal mining.

The Federal Black Lung Program covers lung disease caused by coal mining.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

- Allows employees and dependents to keep health coverage after leaving their EGHP
 - If private or state/local government employer
 - With 20 or more employees
 - Called “continuation coverage”
 - Continues for 18, 29, or 36 months
 - Depending on the qualifying event
- Person must pay entire premium

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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.

For more information about continuation coverage, visit www.cms.hhs.gov/COBRAContinuationofCov or www.cms.gov/HealthInsReformforConsumer

Bankruptcy of Former Employer

- COBRA rules may offer protection
 - May require continued coverage by another company under same corporate structure
- May be able to get “COBRA-for-life”
 - Benefits can change
 - Cost of coverage can go up

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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.

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

COBRA Coverage

If You	Medicare pays first
Are 65 or older or have a disability and have COBRA continuation coverage	In most cases
Have COBRA continuation coverage and are eligible for Medicare due to End-Stage Renal Disease (ESRD)	When your 30-month coordination period ends

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Medicare is usually primary to COBRA continuation coverage for aged and disabled individuals. Medicare is secondary to COBRA for individuals with 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.

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

Veteran's Administration (VA) Coverage

- Veteran's Administration (VA) Coverage
 - People with Medicare and VA benefits
 - Can obtain treatment under either program.
 - Medicare pays first when you choose to get your benefits from Medicare
 - To receive services under VA benefits
 - You must receive your health care at a VA facility or
 - Have the VA authorize services in a non-VA facility

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People with both Medicare and Veterans' benefits can access healthcare 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 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.

For more information on VA coverage, visit: <https://www1.va.gov/health/>

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 Veteran's Administration at 1-877-222-VETS (8387).

TRICARE For Life Coverage (TFL)

- TRICARE For Life Coverage
 - Military retiree coverage
 - For services covered by Medicare and TFL
 - Medicare pays first/TFL pays remaining
 - For services covered by TFL but not Medicare
 - TFL pays first and Medicare pays nothing
 - For services received in a military hospital or other Federal provider
 - TFL pays, Medicare generally pays nothing

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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. COB situations concerning TRICARE should be handled like other employer group health plans.

Coordination Scenario

Maria has Medicare and TRICARE For Life. She goes to the VA hospital for an outpatient procedure.

- A. Medicare pays first, TFL pays second
- B. TFL pays first, Medicare pays second
- C. Medicare pays, TFL pays nothing
- D. TFL pays , Medicare pays nothing

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Maria has Medicare and TRICARE For Life. She goes to the VA hospital for an outpatient procedure.

- A. Medicare pays first, TFL second
- B. TFL pays first, Medicare pays second
- C. Medicare pays, TFL pays nothing
- D. TFL pays, Medicare pays nothing

Answer:

D. TFL pays, Medicare pays nothing

For services received in a military hospital or other Federal provider, TFL pays, Medicare generally pays nothing.

 **Lesson 3 – Part D Coordination of Benefits**

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

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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

Coordination of Prescription Drug Benefits

- Ensures proper payment by Part D Plans
- Tracks Part D True Out-of-Pocket costs (TrOOP)
- Medicare Part D Plan is usually primary
- If Medicare is Secondary Payer
 - Part D Plan denies primary claims
 - Part D Plan may make conditional payment
 - To ease burden on enrollee
 - Medicare is reimbursed

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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.

Possible Drug Coverage Payers

- Employer Group Health Plans
 - Retiree
 - Active employment
 - COBRA
- State
 - Medicaid programs
 - State Pharmacy Assistance Programs (SPAPs)
 - Worker's Compensation
- Federal
 - Medicare Part A or B
 - Federal Black Lung Program
 - Indian Health Service
 - VA
 - TRICARE For Life
- Other
 - No Fault\Liability
 - Patient Assistance Programs
 - Charities

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Employer Group Health Plans

- Retiree
- Active employment
- COBRA

Federal

- Medicare Part A or Part B (limited)
- Federal Black Lung Program
- Indian Health Service
- VA
- TRICARE For Life

State

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

Other

- No Fault\Liability
- Patient Assistance Programs
- Charities

Important Considerations for People with Retiree Coverage

- Most retiree plans offer generous coverage for entire family
 - Employer/union must disclose how its plan works with Medicare drug coverage
 - Talk to benefits administrator for more information
- People who drop retiree drug coverage
 - May lose other health coverage
 - May not be able to get it back
 - Family members may lose coverage

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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 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 (EGHP) 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** EGHP with **fewer than 20** employees
- A person with a disability with a GHP with **100 or less** employees
- 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.

Part D and COBRA

If You	Part D pays first*
Are 65 or older or have a disability and have COBRA continuation coverage	In most cases
Have COBRA continuation coverage and are eligible for Medicare due to End-Stage Renal Disease (ESRD)	When your 30-month coordination period ends

*For medically-necessary Part D covered prescriptions.

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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 ESRD once you are out of your 30-month coordination period.

Part D and Federal Programs

If You	Part D Pays First*
Get benefits from the Federal Black Lung Program Part D plans may make a conditional payment.	For prescriptions not related to lung disease and other conditions caused by coal mining.
Are getting benefits from the Indian Health Service (IHS)	Even if you get your drugs from IHS, Tribal or Urban Indian clinics.

*For medically-necessary Part D covered prescriptions.

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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.

For more information, see www.cms.gov/AIAN/.

VA & TRICARE for Life Coverage

If You	
Have coverage through the Veteran’s Administration (VA)	There is no coordination of benefits. A prescription must be paid solely by either VA or Medicare.
Have TRICARE For Life (TFL)	You generally won’t need to enroll in Part D.

Both VA and TRICARE For Life provide ‘creditable coverage’, meaning both are as good as or better than Medicare Part D.

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Veteran’s Administration (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 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.

Part D and State Programs

If You	Part D Pays First*
Are enrolled in your state's Medicaid program	For all Part D covered drugs. States may provide Medicaid coverage of drugs the MMA excludes from Part D coverage.
Get help from a State Pharmaceutical Assistance Program (SPAP)	Yes. The state just helps pay your Part D costs.
Are covered under Worker's compensation	For prescriptions other than those for the job-related illness or injury. Medicare may make a conditional payment.

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*For medically-necessary Part D covered prescriptions.
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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 Worker’s 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 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. For more information see www.cms.gov/PrescriptionDrugCovGenIn/Downloads/PAPInfo_01.24.06.pdf and www.cms.gov/apps/files/factsheets/Tauzin%20PAP.pdf.

For more information about COB and Medicaid please visit <http://www.medicaid.gov/index.html>

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 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.

Part D COB Contractor

- RelayHealth

- Centralizes COB for Medicare Part D
- Captures enrollment data
- Supports tracking/calculating TrOOP* costs
 - Automates transfer of balances
 - If member changes plan

*True out-of-pocket costs - Expenses that count toward Part D out-of-pocket threshold (\$4,700 in 2012).

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CMS awarded a single contract to RelayHealth 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.

Which Payment Sources Count Toward TrOOP?

Sources That Count	Sources That Don't Count
<ul style="list-style-type: none"> • Your payments • Payments by family members or other individuals • Most state pharmacy assistance programs (SPAPs) • Extra Help • Charities (not if established/controlled by employer/union) • Indian Health Services • AIDS drug assistance programs • Payments by manufacturers under coverage gap discount program 	<ul style="list-style-type: none"> • Group Health Plans (including employer and union retiree coverage) • Government-funded programs (including TRICARE and VA) • Manufacturer Patient Assistance Programs (PAPs) • Other third-party payment arrangements

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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
- 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 VA
- 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. A list of PAPs is available at www.rxassist.org
- Other third-party payment arrangements

Coordination Scenario

Retiree drug coverage always pays primary to Medicare Part D.

- A. True
- B. False

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Retiree coverage always pays primary to Medicare Part D.

- A. True
- B. False

Answer:

B. False.

Part D pays primary to retiree coverage.

Coordination Scenario

The Part D COB contractor, RelayHealth

- A. Centralizes COB for Medicare Part D
- B. Captures enrollment data
- C. Supports tracking/calculating TrOOP costs
- D. All the above

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The Part D COB contractor, RelayHealth

- A. Centralizes COB for Medicare Part D
- B. Captures enrollment data
- C. Supports tracking/calculating TrOOP costs
- D. All the above

Answer:

D. All the above.

Who To Call To...			
COB Contractor	Insurance Carrier	1-800-MEDICARE	SSA
Report employment changes, or any other insurance coverage information.	Answer your questions regarding Medicare claim or service denials and adjustments.	Obtain general Medicare information.	Enroll in the Medicare program.
Report a liability, auto/no-fault, or workers compensation case.	Answer your questions concerning how to bill for payment.	Obtain information about Medicare Health Plan choices.	Replace your Medicare card.
Ask general Medicare Secondary Payer (MSP) questions/concerns.	Process claims for primary or secondary payment.	Order Medicare publications.	Change your address.
Ask about Medicare Secondary Development (MSP) letters and questionnaires.	Accept the return of inappropriate Medicare payment.		Verify Medicare coverage.

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The 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.
- Ask questions regarding Medicare Secondary Development (MSP) letters and questionnaires.

Coordination of Benefits Resource Guide

Resources		Medicare Products
<p>Centers for Medicare & Medicaid Services (CMS) 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048) www.medicare.gov</p> <p>www.CMS.gov</p> <p>Coordination of Benefits Contractor 1- 800-999-1118 (TTY 1-800-318-8782) www.cms.gov/COBGeneralInformation/ www.cms.gov/COBAgreement/</p> <p>Department of Labor 1-866-4-USA-DOL (1-866-487-2365) http://www.dol.gov/dol/topics/health-plans/cobra.htm</p> <p>Office of Personnel Management 1-888-767-6738 (TTY 1-800-878-5707)</p>	<p>Medicare/TRICARE Benefit Overview www.tricare.mil/mybenefit/home/overview/Plans</p> <p>Department of Defense (To get information about TRICARE) 1-877-363-1303 (TTY 1-877-540-6261)</p> <p>Department of Veterans Affairs 1-800-827-1000 (TTY 1-800-829-4833)</p> <p>Medicare Secondary Payer Recovery Contractor 1-866-677-7220 (TTY 1-866-677-7294)</p> <p>Affordable Care Act www.healthcare.gov/center/authorities/patient_protection_affordable_care_act_as_passed.pdf</p>	<p>Medicare & You Handbook CMS Product No. 10050)</p> <p>Your Medicare Benefits CMS Product No. 10116</p> <p>Medicare and Other Health Benefits: Your Guide to Who Pays First CMS Product No. 02179</p> <p>To access these products View and order single copies at www.medicare.gov</p> <p>Order multiple copies (partners only) at www.productordering.cms.hhs.gov. You must register your organization.</p>



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Section 1: When You Have Other Health Coverage

If you	Situation	Pays first	Pays second
Are covered by Medicare and Medicaid	Entitled to Medicare and Medicaid	Medicare	Medicaid, but only after other coverage (such as employer group health plans) has paid
Are 65 or older and covered by a group health plan because you or your spouse is still working	Entitled to Medicare The employer has 20 or more employees	Group health plan	Medicare
	The employer has less than 20 employees*	Medicare	Group health plan
Have an employer group health plan after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree coverage
Are disabled and covered by a large group health plan from your work, or from a family member who is working	Entitled to Medicare The employer has 100 or more employees	Large group health plan	Medicare
	The employer has less than 100 employees	Medicare	Group health plan
**Have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan
Have ESRD and COBRA coverage	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
	After 30 months	Medicare	COBRA

* If your employer participates in a plan that is sponsored by two or more employers, the rules are slightly different.

** If you originally got Medicare due to your age or a disability other than ESRD, and Medicare was your primary payer, it still pays first when you become eligible due to ESRD.

Section 1: When You Have Other Health Coverage

If you	Situation	Pays first	Pays second	
Are 65 or over OR disabled and covered by Medicare and COBRA coverage	Entitled to Medicare	Medicare	COBRA	
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or liability insurance for services related to accident claim	Medicare	
Are covered under workers' compensation because of a job-related illness or injury	Entitled to Medicare	Workers' compensation for services related to workers' compensation claim	Usually doesn't apply. However, Medicare may make a conditional payment.	
Are a veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare-covered services. Veterans' Affairs pays for VA-authorized services. Note: Generally, Medicare and VA can't pay for the same service.	Usually doesn't apply	
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services. TRICARE pays for services from a military hospital or any other federal provider .	TRICARE may pay second.	
Have black lung disease and are covered under the Federal Black Lung Benefits Program	Entitled to Medicare and the Federal Black Lung Benefits Program	The Federal Black Lung Benefits Program for services related to black lung	Medicare	



E-mail: NMTP@cms.hhs.gov

Website: cms.gov/Outreach-and-Education/Training/NationalMedicareProgTrain/

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