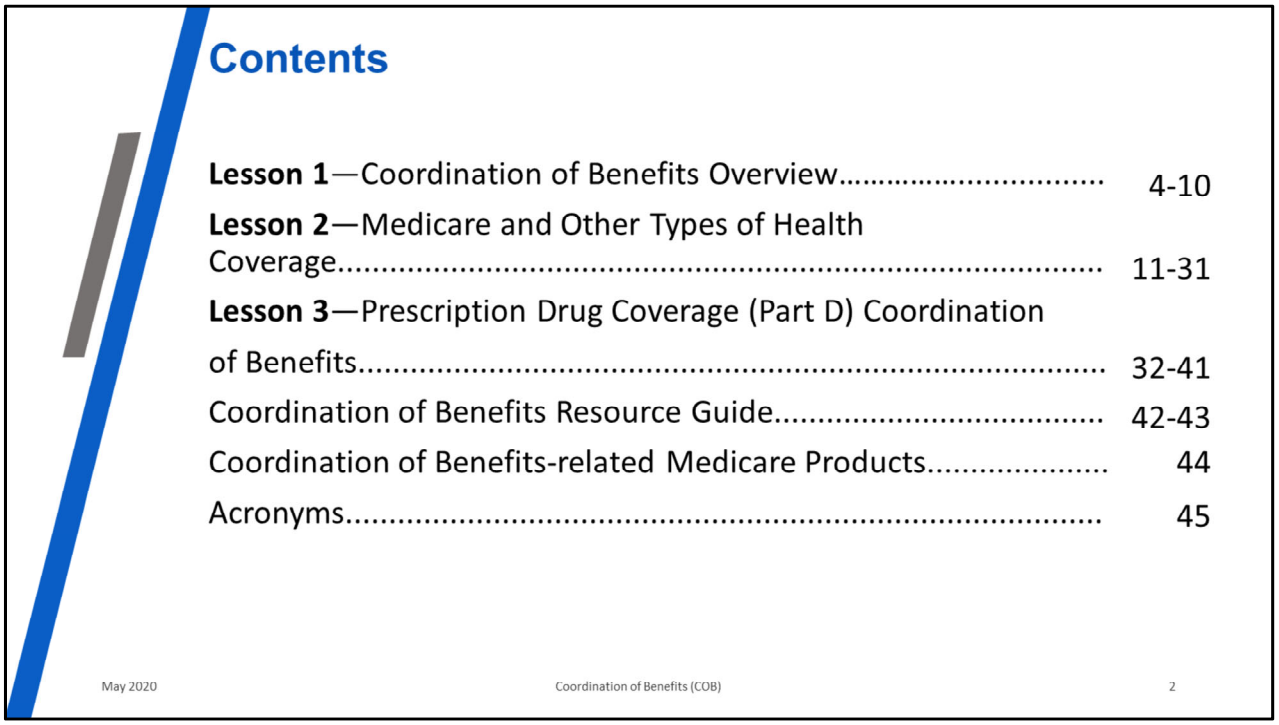
WA Note: In February 2021, SHIBA modified this CMS version slightly to be consistent with any options or wording that are specific to Washington state. Those modifications are indicated with "WA Note:" on the Notes slides. These WA Notes will also be displayed in red font in the Notes PDF version which is posted on My SHIBA.

Module 5, "Coordination of Benefits (COB)," explains the different payers' responsibilities when people have both 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 Health Insurance Marketplace.

The information in this (unmodified CMS) module was correct as of May 2020. To check for an updated version, visit CMSnationaltrainingprogram.cms.gov.

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.

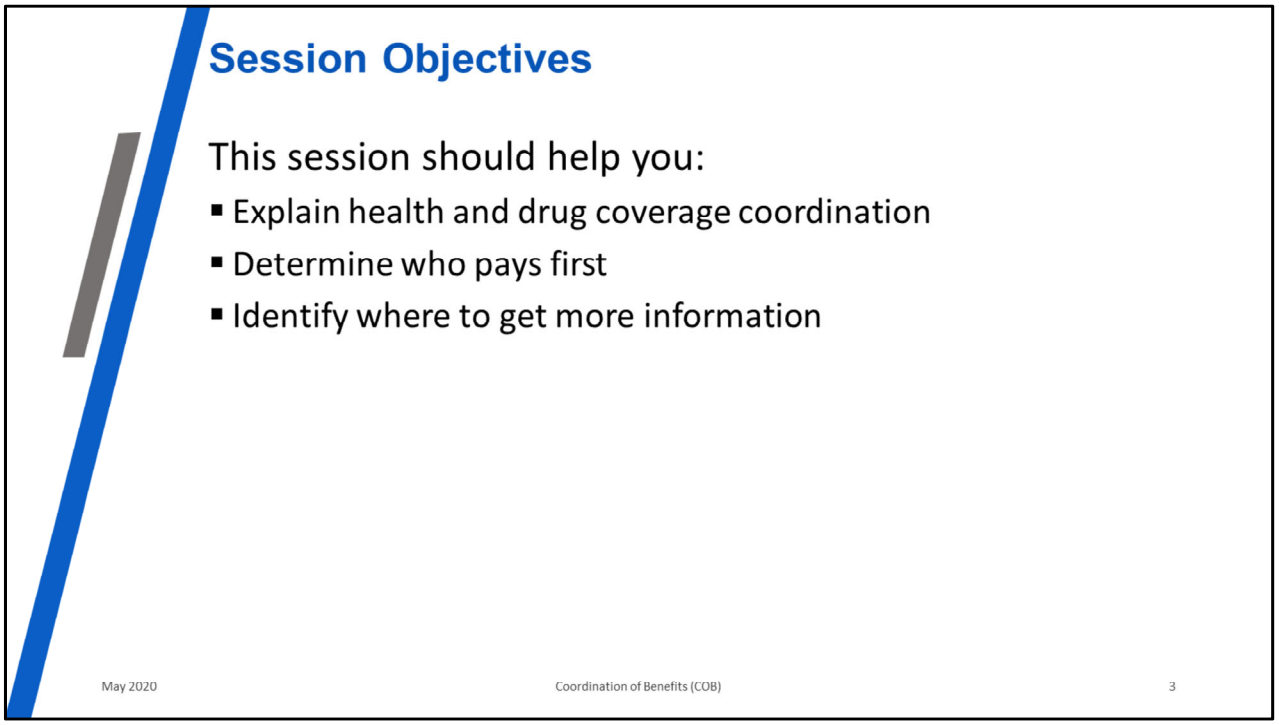
This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.



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

These materials are for information givers/trainers who are familiar with the Medicare program, and who use the information for their presentations.

The module consists of 41 slides and speaker's notes and include 5 check your knowledge questions. It takes about 45 minutes to present. Allow approximately 15 more minutes for discussion, questions, and answers. You should consider adding more time for additional activities you want to include.



In this session, we'll discuss coordination of benefits with Medicare. It will help you:

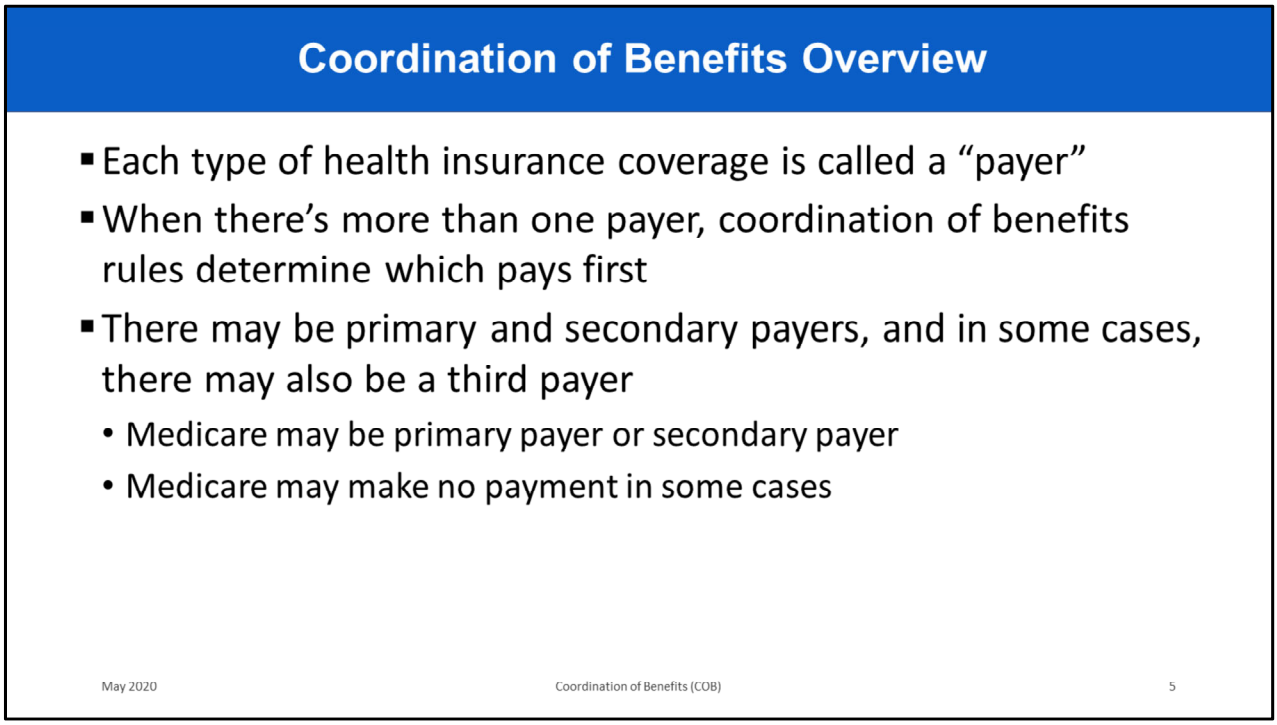
- Explain health and drug coverage coordination
- Determine who pays first
- Identify where to get more information

Lesson 1

COORDINATION OF BENEFITS OVERVIEW

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

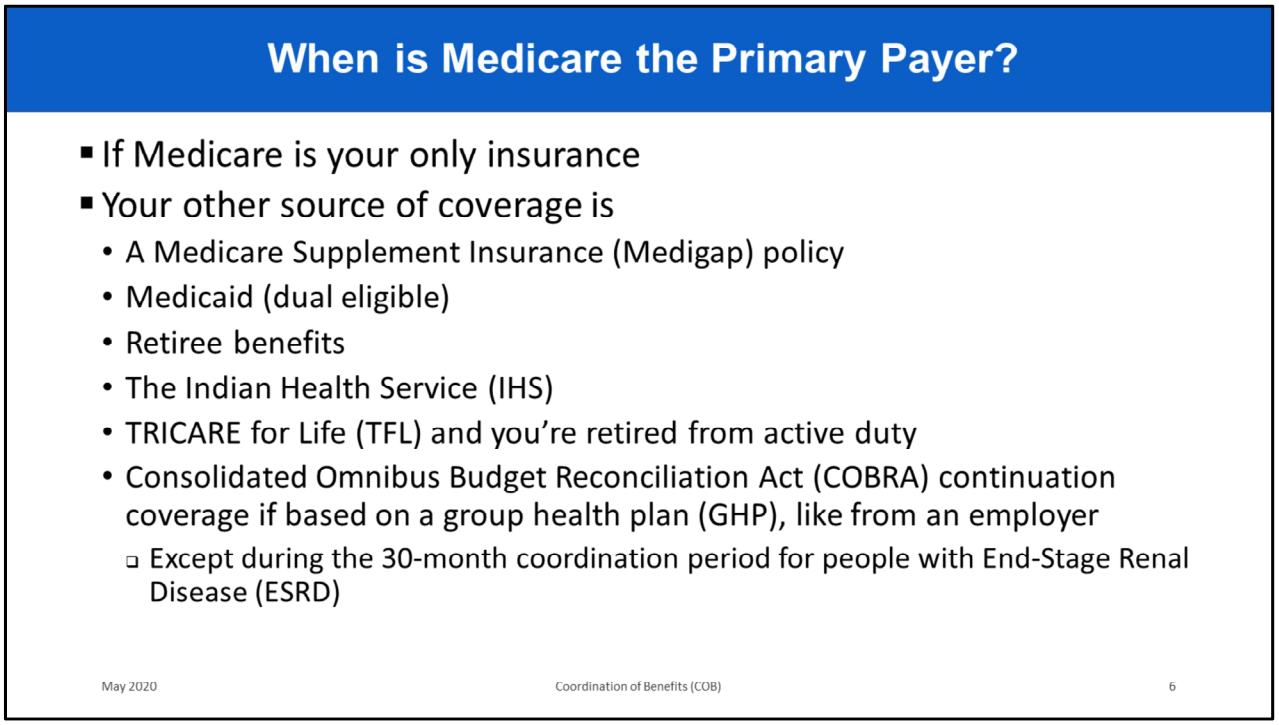
- Coordination of benefits
- Medicare as the primary payer
- Medicare as the secondary payer



If you have both Medicare and other health coverage and/or prescription drug coverage, each type of coverage is called a payer. When there's more than one payer, coordination of benefits rules determine which payer pays first. The primary payer pays what it owes on your bills first, up to the limits of its coverage, and then you or your provider submits the claim to the secondary payer if there are costs the primary payer didn't cover. In some rare cases, there may also be a third payer. Medicare doesn't automatically know if you have other coverage. However, insurers must report to Medicare when they're responsible to pay first on your medical claims.

Medicare may be the primary payer or the secondary payer—it depends on the circumstances.

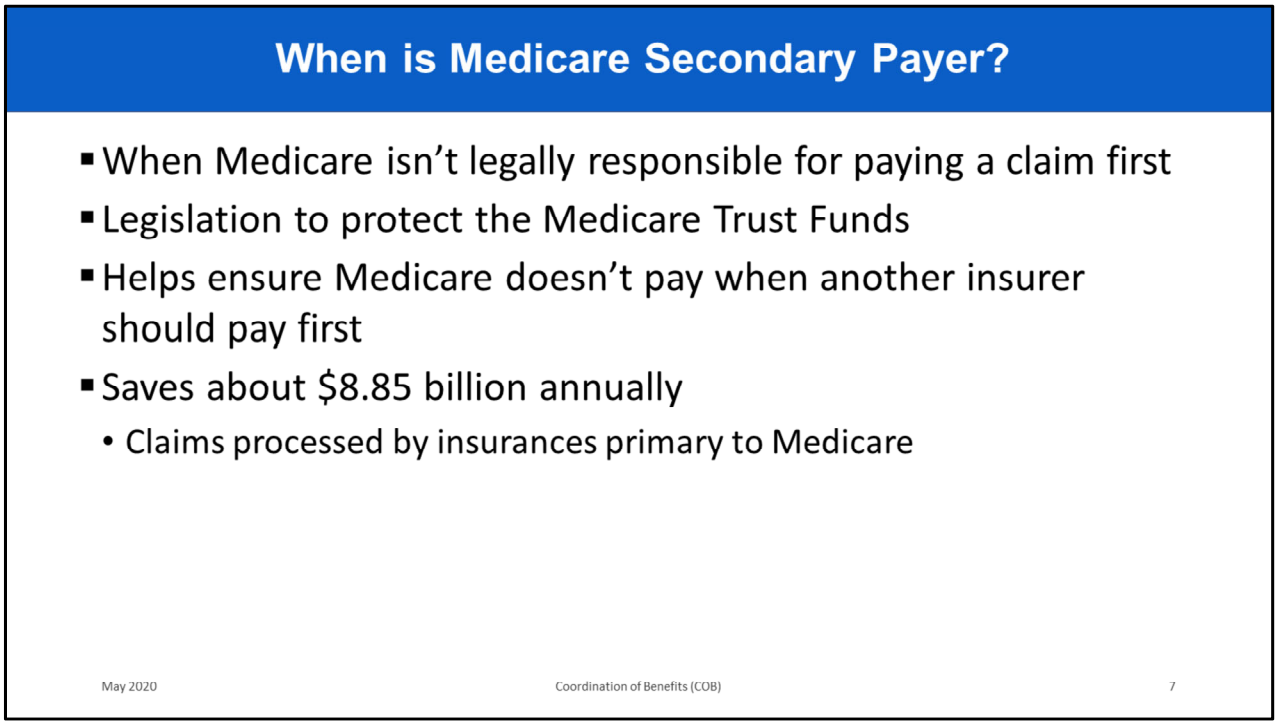
In some circumstances, Medicare may make no payment.



Medicare is the primary payer for most people with Medicare. This means Medicare pays first on health care claims.

Generally, 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 may cover amounts not fully covered by Medicare.
- **WA Note:** You have both Medicaid and Medicare **coverage—In Washington state, sometimes called "Apple Health"**. These people are known as "dual eligibles"—with no other coverage that may 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 (IHS).
- You have TRICARE for Life (TFL) and you're retired from active duty. **NOTE**: TRICARE is a health care plan for active-duty service members, military retirees, and their families. TFL provides expanded medical coverage to Medicare-eligible uniformed services retirees 65 or older, to their eligible family members and survivors, and to certain spouses.
- You're covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA), like from an employer. The exception is during the 30-month coordination period for people with End-Stage Renal Disease (ESRD).



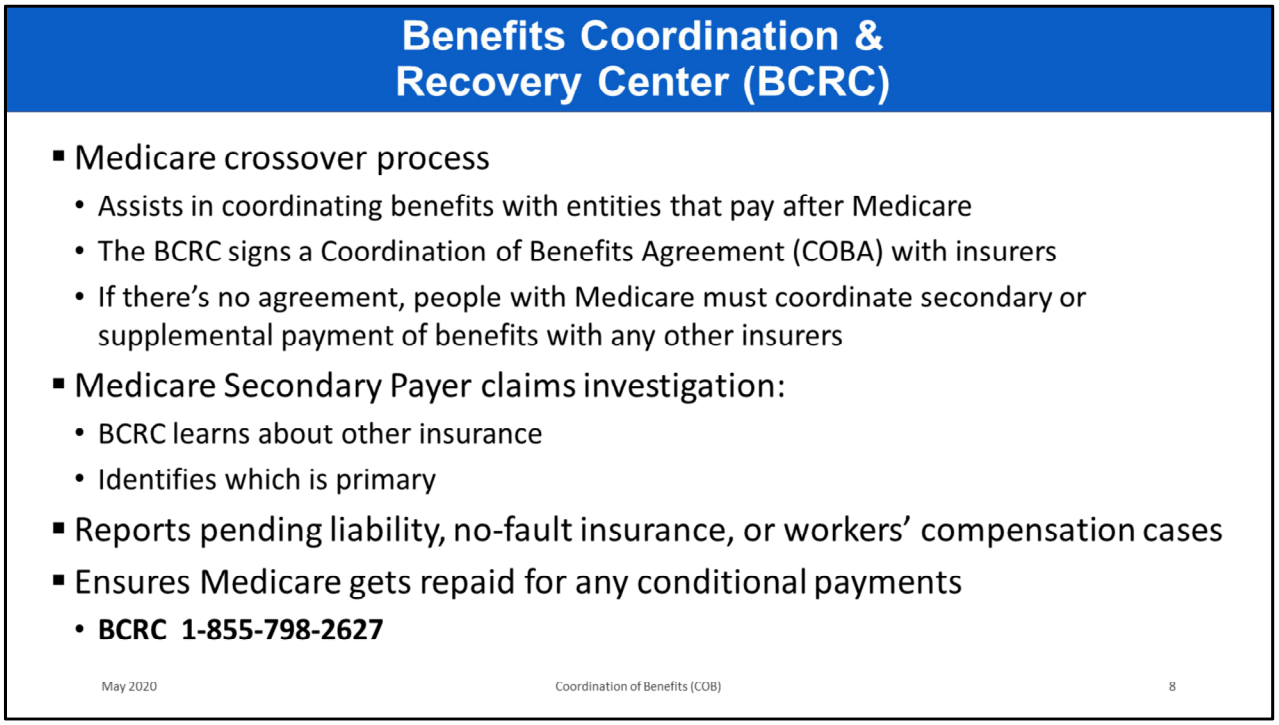
Medicare is the secondary payer when Medicare isn't legally responsible for paying a claim first. When Medicare started providing coverage in 1966, it was the primary payer for all claims except for those covered by workers' compensation, Federal Black Lung benefits, and Veteran's Administration (VA) benefits.

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

The Medicare secondary payer 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. These 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 about $8.85 billion annually on claims where another insurer is the primary payer before Medicare.

For detailed examples of when Medicare is the secondary payer, view the "How Medicare works with other coverage" chart in the Medicare publication "Your Guide to Who Pays First" at Medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf (CMS Product No. 02179). **WA Note: Note that the information is on pages 6 -9 of the August 2020 version and are not in chart form. They are presented as questions and answers called "Find your situation".**



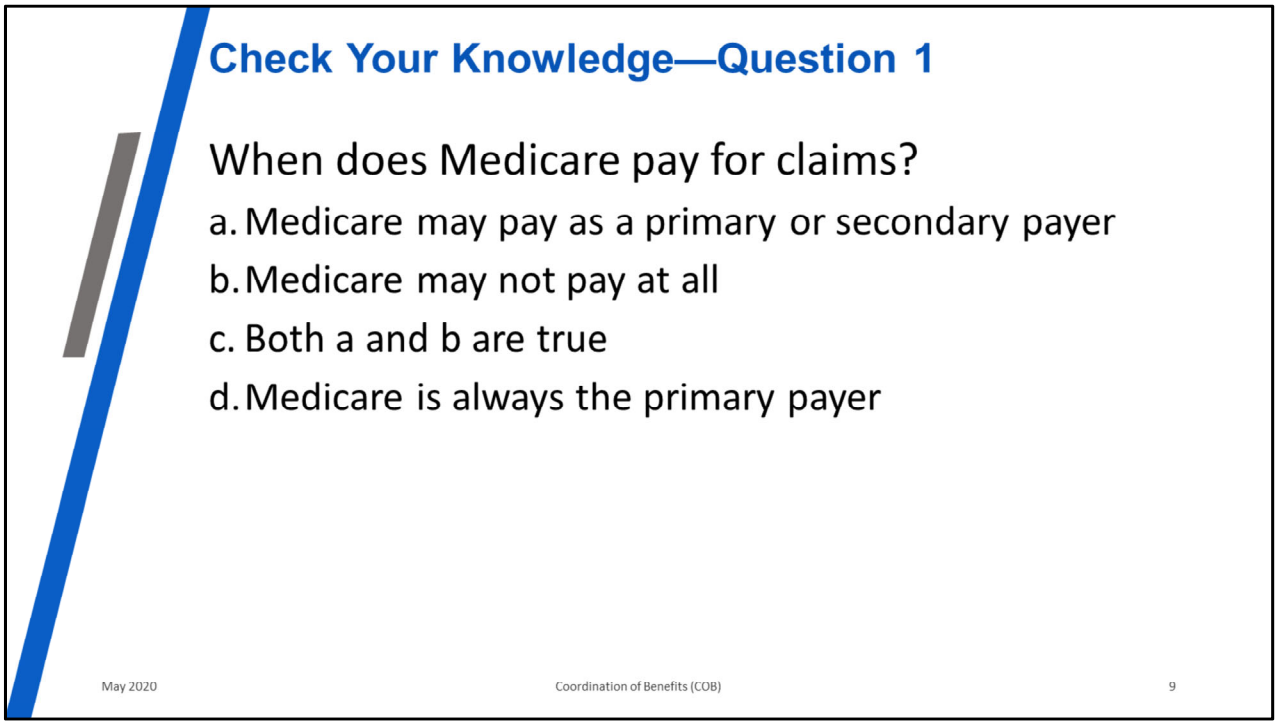
The coordination of benefits process determines the correct primary payer.

Medicare crossover process – To help Medicare coordinate benefits with private insurance companies and other entities that pay after Medicare, the Benefits Coordination & Recovery Center (BCRC) signs a Coordination of Benefits Agreement (COBA) with employer retiree plans, private insurance companies, and other entities, like Medicaid. Then these entities submit a bi-weekly or monthly eligibility file containing their covered members to the BCRC. The BCRC then makes this information available to Medicare's Common Working File (CWF) which causes the transfer of Medicare Part A and Part B Fee-for-Service claims to responsible payers. This process is commonly called the "Medicare crossover process," and it happens on a daily basis. If there's no 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.

Medicare Secondary Payer claims investigation – The BCRC initiates an investigation when it learns that a person with Medicare has other insurance. The investigation determines which insurance pays first. Medicare Secondary Payer information-gathering activities identify Medicare Secondary Payer situations quickly, making sure responsible parties are making correct payments. When another insurer is primary to Medicare, the BCRC creates Medicare Secondary Payer record on Medicare's CWF to make sure Medicare pays secondary when appropriate.

Medicare may make a conditional payment—a payment for services on behalf of a person with Medicare, when there's evidence on the claim that the primary plan isn't paying promptly—in certain circumstances, like when a person with Medicare is injured, involved in an accident, or incurs a work-related illness, injury, or disease. After a settlement, judgment, award, or other payment is secured in connection with a liability, no-fault, or workers' compensation case, Medicare then has the right to recover its conditional payment.

WA Note: See page 22 of M&Y 2021 for the phone number to BCRC. SHIBA volunteers may call with their SHIP Unique ID.



Check Your Knowledge—Question 1

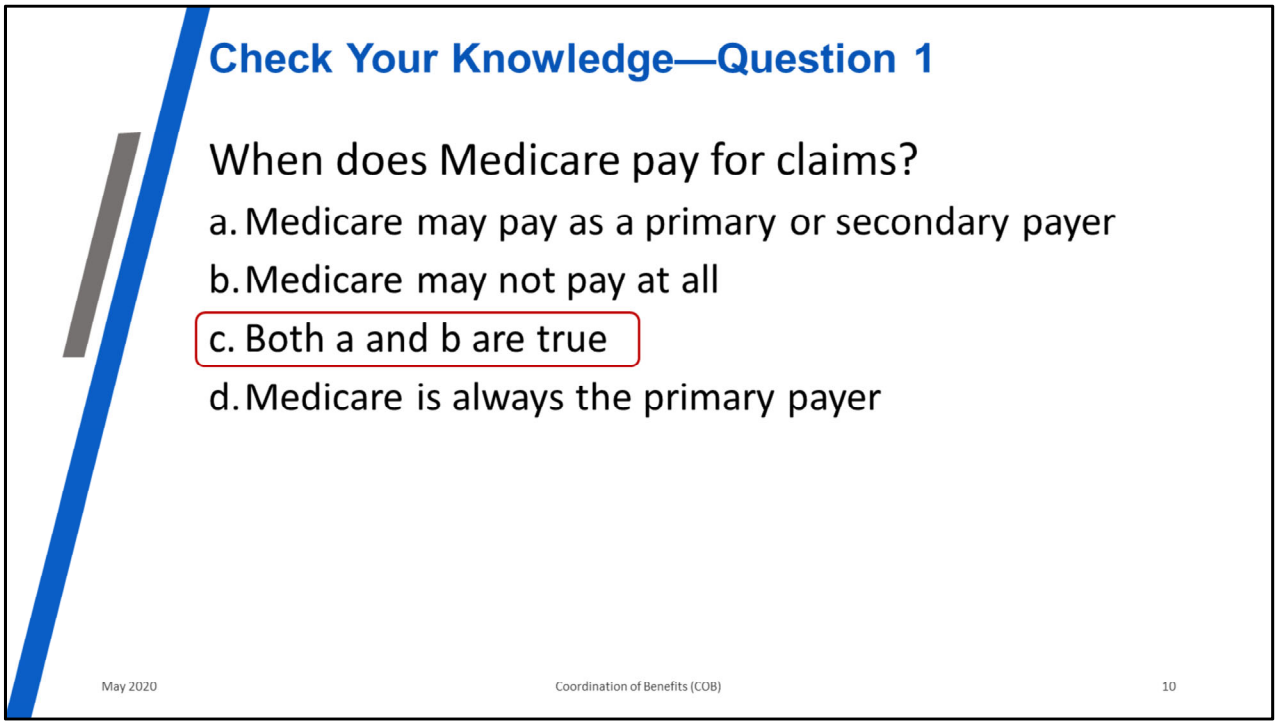
When does Medicare pay for claims?

a. Medicare may pay as a primary or secondary payer

b. Medicare may not pay at all

c. Both a and b are true

d. Medicare is always the primary payer



Check Your Knowledge—Question 1

When does Medicare pay for claims?

a. Medicare may pay as a primary or secondary payer

b. Medicare may not pay at all

c. Both a and b are true

d. Medicare is always the primary payer

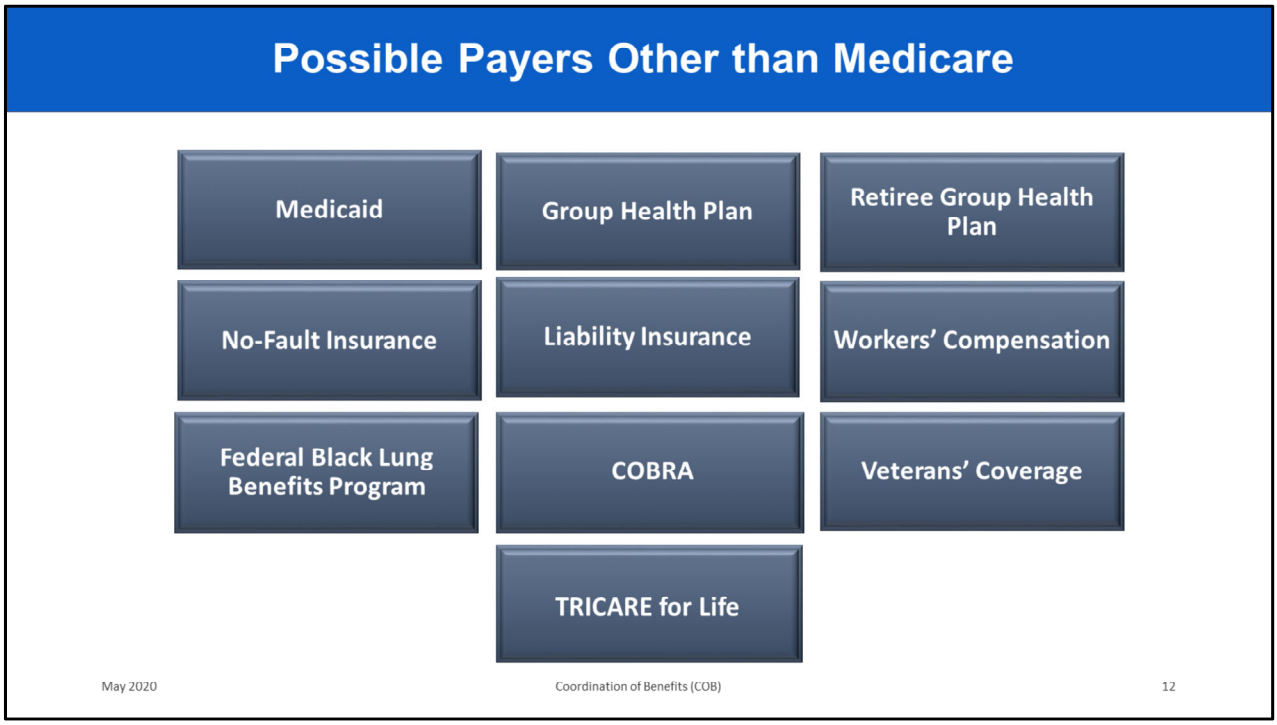
Answer: c. Both a and b are true. Medicare can be the primary payer, the secondary payer, or sometimes Medicare may not pay at all.

Lesson 2

MEDICARE AND OTHER TYPES OF HEALTH COVERAGE

Lesson 2, “Medicare and Other Types of Health Coverage,” explains:

- Medicare and the Marketplace
- Possible health claims payers and determining who pays first



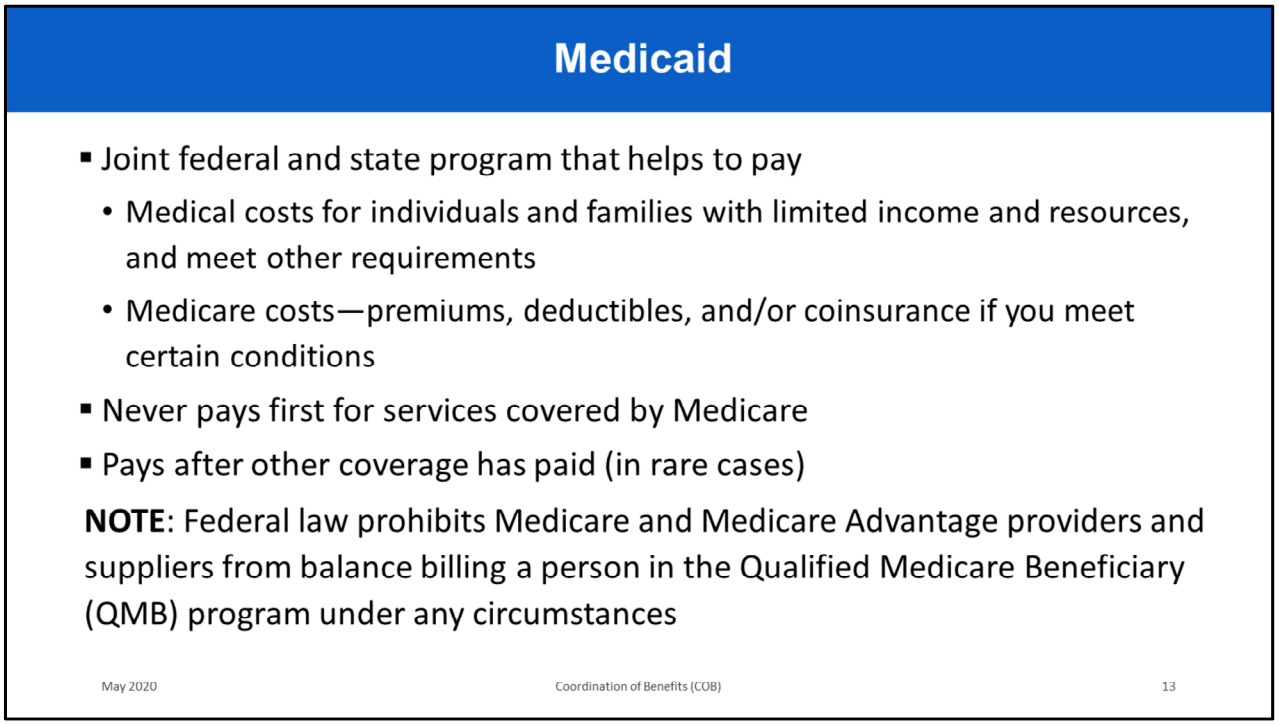
It's important to know whether your medical costs are payable by other insurance payers first. This information helps health care providers figure out who to bill and how to file claims with Medicare.

There are many insurance benefits and you could have many combinations of insurance coverage. Your particular combination will affect who pays and when.

Here's a list of possible health claims payers other than Medicare:

- Medicaid
- Group Health Plan (GHP)
- Retiree Group Health Plan
- No-Fault Insurance
- Liability Insurance
- **WA Note:** Workers' Compensation Insurance **In Washington state this is called LNI Short for WA state Department of Labor and Industries**
- Federal Black Lung Benefits Program
- Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage
- Veterans' Coverage
- TRICARE for Life

Depending on the type of additional insurance coverage you may have, Medicare may be the primary payer or secondary payer for your claim.



Medicaid is a joint federal and state program that helps pay medical costs for people and families who have limited income and resources, and meet other requirements. If you meet certain conditions, Medicaid can also help you pay Medicare costs like premiums, deductibles, and/or coinsurance through the Medicare Savings Program.

Medicaid never pays first for services covered by Medicare. It only pays after Medicare has paid. In rare cases where there's other coverage, Medicaid pays after the other coverage has paid.

NOTE: All Original Medicare and Medicare Advantage providers and suppliers–not only those that accept Medicaid–must not charge individuals enrolled in the Qualified Medicare Beneficiary (QMB) Program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill state Medicaid programs for these costs, but states can limit Medicare costs-sharing payments under certain circumstances.

Group Health Plans (GHPs)

- Coverage offered by many employers and unions, to
  - Current employees, spouses, and family members
  - Retirees, spouses, and family members
    - Retiree coverage may be employer-based MA or Part D plans
- Includes Federal Employee Health Benefits (FEHB) Program
- May be fee-for-service plan or managed care plan
- Employees usually can choose to keep or reject
- Businesses with 50 or fewer employees can offer Small Business Health Options Program (SHOP) plans

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

Many employers and unions offer group health plan (GHP) insurance to current employees and/or retirees. For example, the Federal Employee Health Benefits (FEHB) Program plan is a type of GHP. You may also get group health coverage through your spouse's or other family member's employer. If you have Medicare and you're offered coverage under a GHP, usually you can choose to accept or reject the plan. Generally, when the employer has fewer than 20 employees during the current and previous calendar year, Medicare pays first, so your employer may require that you enroll in Medicare too. The GHP may be a fee-for-service plan or a managed care plan, like an Health Maintenance Organization (HMO).

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

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

GHPs and Medicare

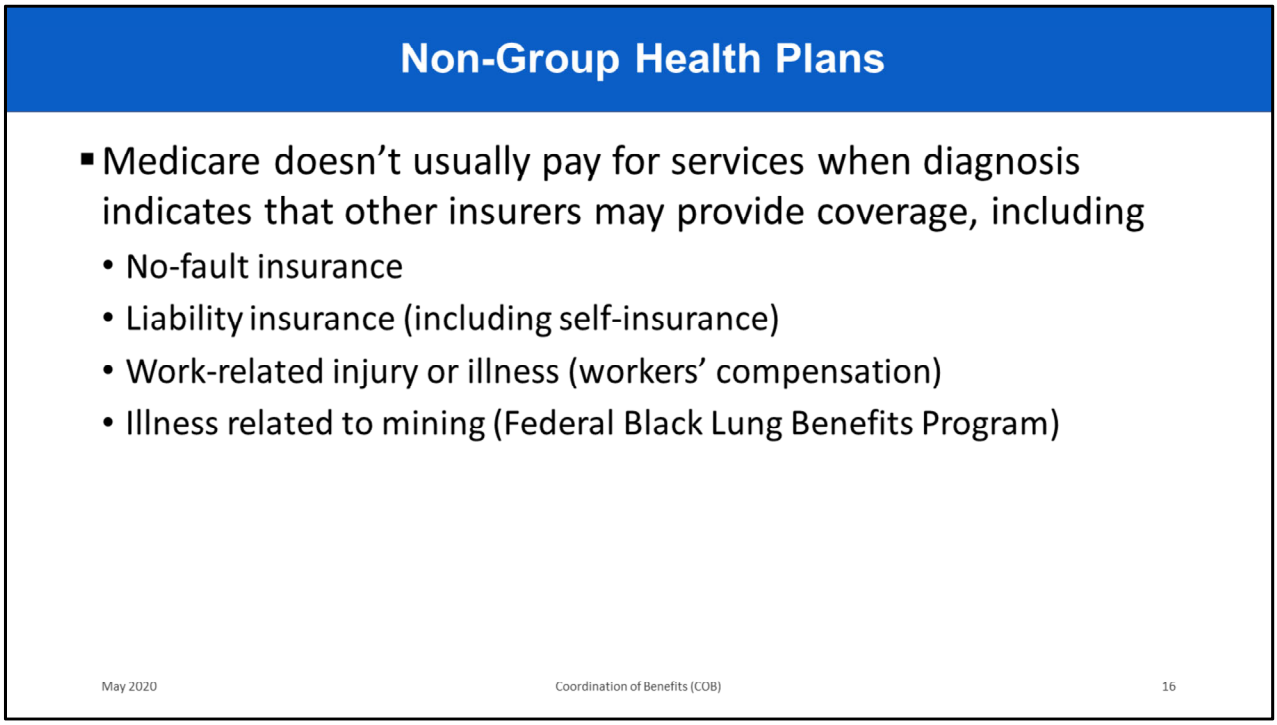
If You're	Does Medicare Pay First?
65 or older and have **retiree** coverage	Yes, as long as you don't have excluding conditions like black lung, or others specified on next slide
65 or older with **GHP** coverage through **current** employment (yours or your spouse's)	If the employer has fewer than 20 employees
Under 65 with a **disability** and have **GHP** coverage through **current** employment (yours or a family member's)	If the employer has fewer than 100 employees
Eligible for Medicare due to End-Stage Renal Disease (**ESRD)** and you have **GHP** coverage	When the 30-month coordination period ends, or if you had Medicare primary before you had ESRD

Medicare pays first if you have Group Health Plan (GHP) coverage, and you're:

- 65 or older and have retiree coverage
- 65 or older with GHP coverage through current active employment, either yours or your spouse's, and the employer has fewer than 20 employees
- Under 65, have a disability, and are covered by a GHP through current employment (either yours or a family member's), and your/their employer has fewer than 100 employees
- Eligible for Medicare due to End-Stage Renal Disease (ESRD) and has GHP coverage through current active employment, either yours or your spouse's, and the 30-month coordination period has ended.

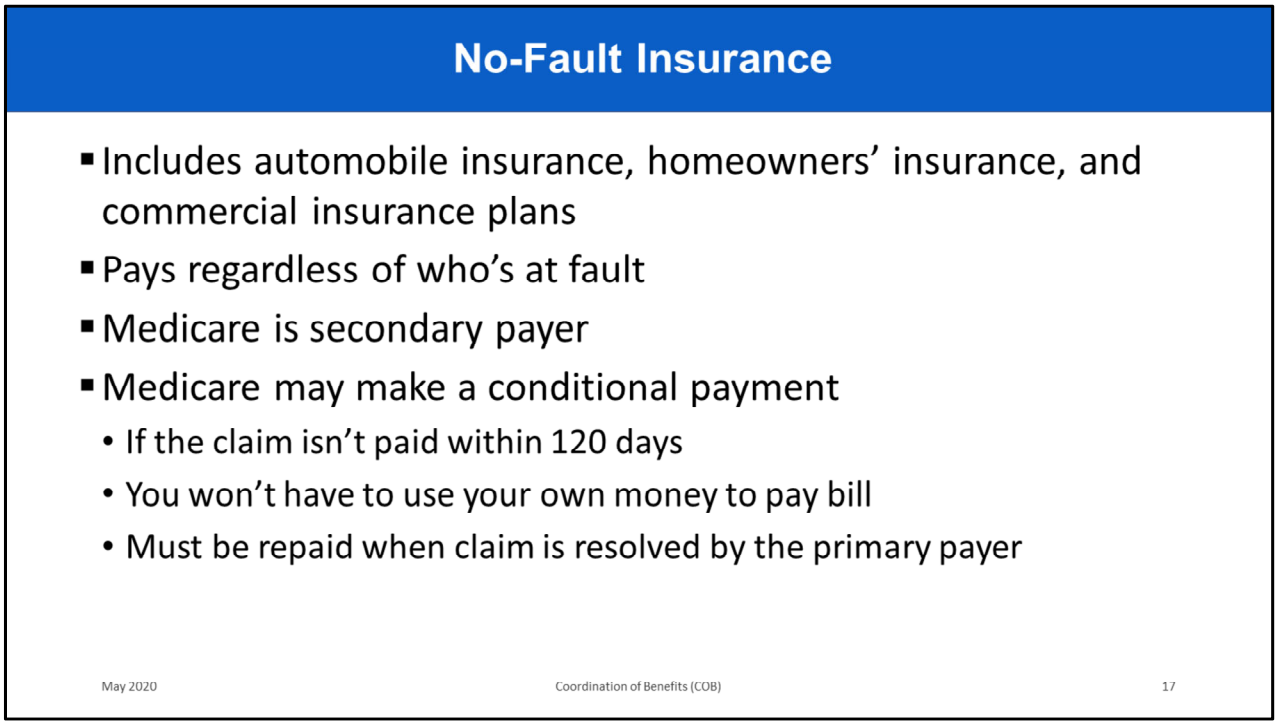
NOTE: If Medicare was their primary payer before the 30-month coordination period, Medicare will continue to be their primary insurance throughout the coordination period.

WA Note: See the chart on Page 21 of M&Y 2021.



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

- No-fault insurance
- Liability insurance (including self-insurance)
- **WA Note:** Work-related injury or illness (workers' compensation) **Also known as LNI or "L&I".**
- Illness related to mining (Federal Black Lung Benefits Program)
- **WA Note: When you go to the Doctor or ER, you are usually asked if your visit is related to an accident. This is so providers will bill the proper insurance.**



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

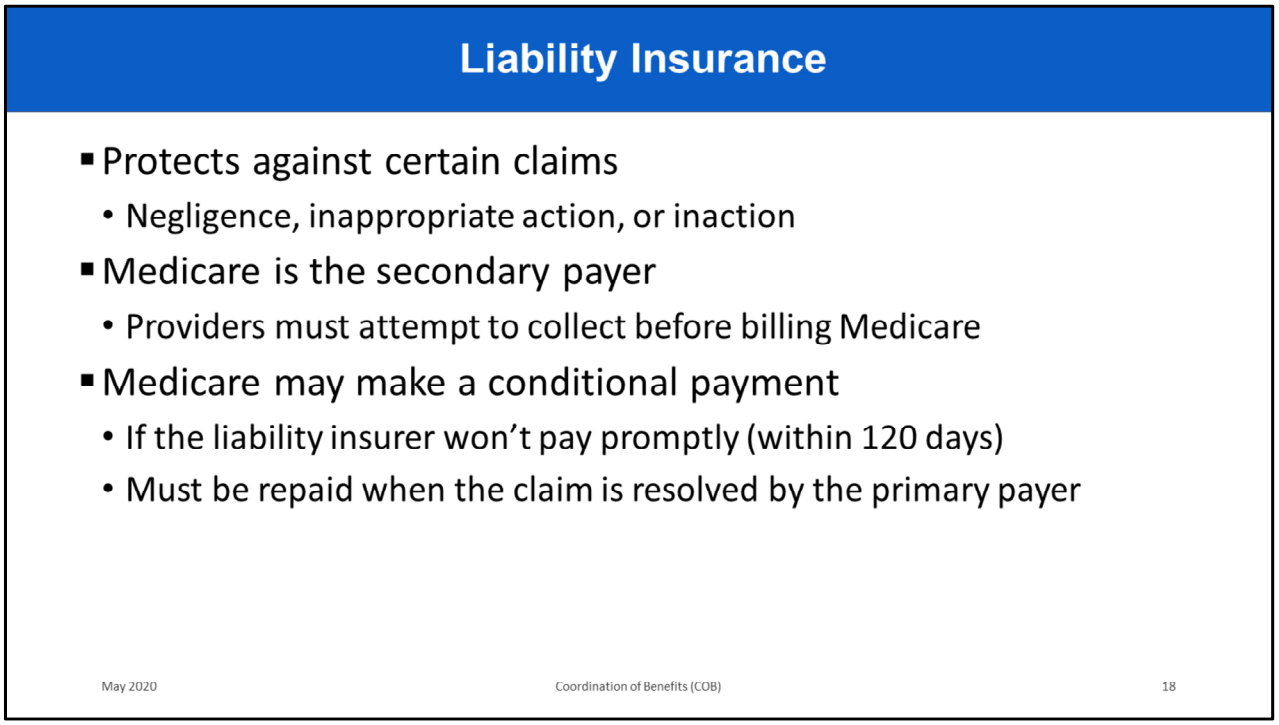
- Automobile insurance
- Homeowners' insurance
- Commercial insurance plans

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.

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 generally won't have to use your own money to pay the bill. If Medicare makes a conditional payment, and you get a settlement from an insurance company later, the conditional payment from your settlement needs to go to Medicare. You're responsible for making sure Medicare gets repaid for the conditional payment.

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

WA Note: Tip for counselors: If a client is having trouble getting Medicare claims paid, consider if their Medicare record shows another payer, such as the ones on this slide. You or client can call Medicare and ask: "Do you show a record that there is a payer that is primary to Medicare?"



Liability insurance is coverage that protects you against claims based on negligence, inappropriate action, or inaction that results in personal injury 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/underinsured motorist liability insurance

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

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 generally won't have to use your own money to pay the bill. If Medicare makes a conditional payment, and you get a settlement from an insurance company later, the conditional payment from your settlement needs to go to Medicare. You're responsible for making sure Medicare gets repaid for the conditional payment.

Medicare Part D (prescription drug coverage) will pay for covered prescriptions that aren't related to the accident or injury.

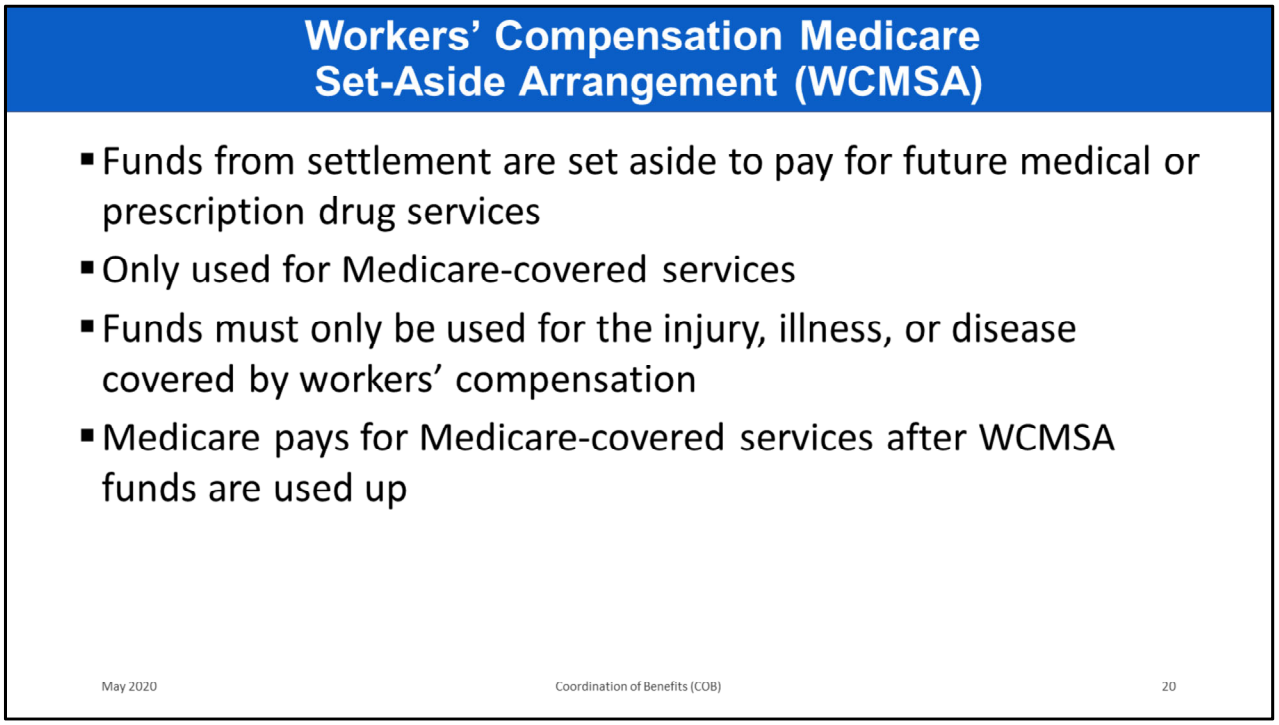
Workers' Compensation

- Medicare generally won't pay for health care related to workers' compensation claims
- If a workers' compensation claim is denied, a claim may be filed for Medicare payment
  - Medicare may pay a claim that relates to a service or item otherwise covered by Medicare
- Workers' compensation claims can be resolved by settlements, judgments, awards, or other payments

Medicare generally won't pay for an injury, illness or disease covered by workers' compensation. If workers' compensation denies all or part of a claim on the grounds that it's not covered by workers' compensation, you may file a claim with Medicare. Medicare may pay the denied claim for a medical service or item otherwise payable by Medicare.

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

WA Note: Counselor Tip: If a person with a Worker's Compensation claim has received a settlement, we would need to see the settlement to see what the terms are in order to help them with resolving primary and secondary payer issues.



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.

You can only use money placed in your WCMSA 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, care unrelated to Workers Compensation settlement, or any medical items or services that Medicare doesn't cover (like dental services).

If you're not sure what type of services Medicare covers, call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048, before you use any of the money that was placed in your WCMSA.

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.

Learn more about WCMSAs at CMS.gov/Medicare/Coordination-of-Benefits-and-Recovery/Workers-Compensation-Medicare-Set-Aside-Arrangements/WCMSA-Overview.html

For more information, see Section 1862(b)(2) of the Social Security Act of 1954 (42 USC 1395y(b)(2)) at ssa.gov/OP_Home/ssact/title18/1862.htm

Federal Black Lung Benefits Program

- Covers lung disease/conditions caused by coal mining
- Services under this program
  - Considered workers' compensation claims
  - Not covered by Medicare
- For more information, contact the U.S. Department of Labor (DOL)
  - Call 1-800-638-7072; TTY: 1-877-889-5627

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 (DOL).

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

- You have no other insurance primary to Medicare
- You're eligible for and entitled to Medicare
- The services you receive are covered by Medicare

If you get Federal Black Lung Benefits, you're 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.

For more information, call the U.S. DOL at 1-800-638-7072; TTY: 1-877-889-5627.

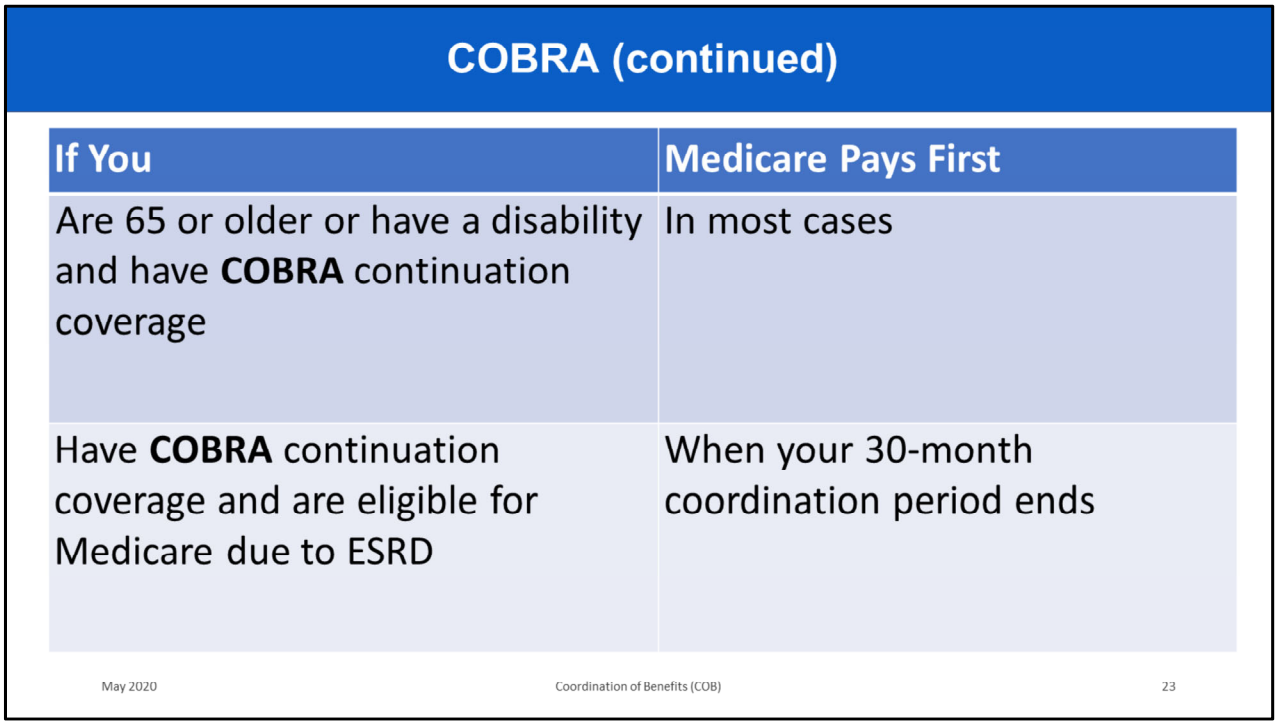
Consolidated Omnibus Budget Reconciliation Act (COBRA)

- Requires employers with 20 or more employees to let employees and dependents keep group health plan coverage under certain conditions
- Allows certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates
- Coverage can only begin when coverage is lost due to certain specific events
  - Generally for 18 months, but can be longer in special circumstances
- Person must pay the entire insurance premium

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 to 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 U.S., or certain church-related organizations. The FEHB 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 plan 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.



If you're 65 or older or have a disability, Medicare usually pays first before COBRA continuation coverage. Medicare pays second to the extent COBRA coverage overlaps the first 30 months of Medicare eligibility or entitlement based on End-Stage Renal Disease (ESRD).

Before electing COBRA coverage, you may find it helpful to talk with a State Health Insurance Assistance Program (SHIP) counselor to understand your options better. For example, if you already have Part A and choose COBRA, but wait to sign up for Part B until the last part of the 8-month Special Enrollment Period (SEP) following the end of employment, your employer can make you pay for services that Medicare would have covered if you had signed up for Part B earlier. You won't qualify for a Medicare SEP if you only have COBRA.

**WA Note: ***SHIP counselors can also give information about time frames on COBRA and Medicare Supplement Insurance (Medigap) policy guaranteed issue rights in a given state. Time frames may differ depending on state law.

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 ESRD, Part D pays first for covered prescription drugs once you're out of your 30-month coordination period.

*** This sentence has been updated for the WA version. See the CMS website for the CMS version.**

Veterans' Coverage

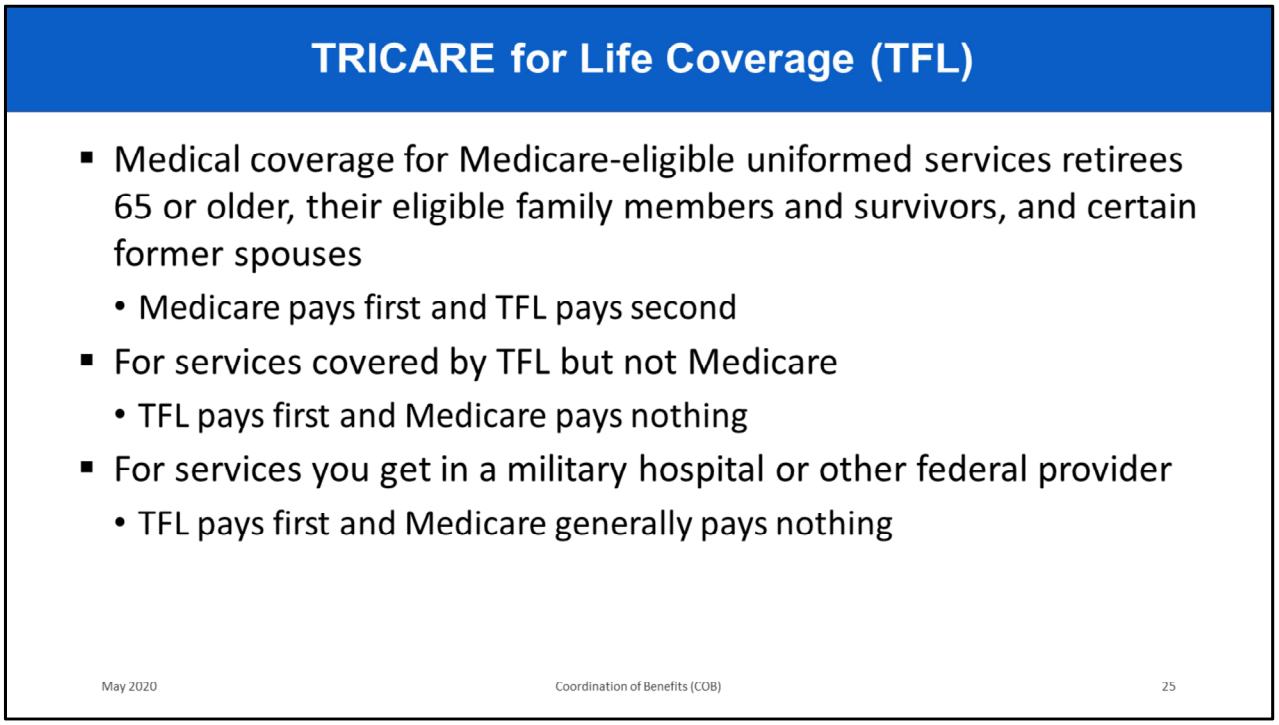
- If you have Medicare and Veterans' coverage, you
  - Can get treatment under either program
  - Must choose which benefit you'll use each time you get health care
- Medicare pays when you choose to get your benefits from Medicare
- To get services under Veterans' benefits
  - You must get your health care at a Veterans Affairs (VA) facility, or
  - Have the VA authorize, or agree to pay for, services in a non-VA facility

If you have both Medicare and Veterans' coverage, 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. 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 get 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 Part B, even if they're enrolled in VA health care.

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



TRICARE for Life (TFL) is expanded medical coverage for Medicare-eligible uniformed services retirees 65 or older, their eligible family members and survivors, and certain former spouses. If you have Medicare and 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. Coordination of benefits situations concerning TRICARE should be handled like other group health plans. However, Medicare may pay secondary to TRICARE in situations where people who get Medicare are serving on active duty.

If you use a Medicare provider, the provider 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.

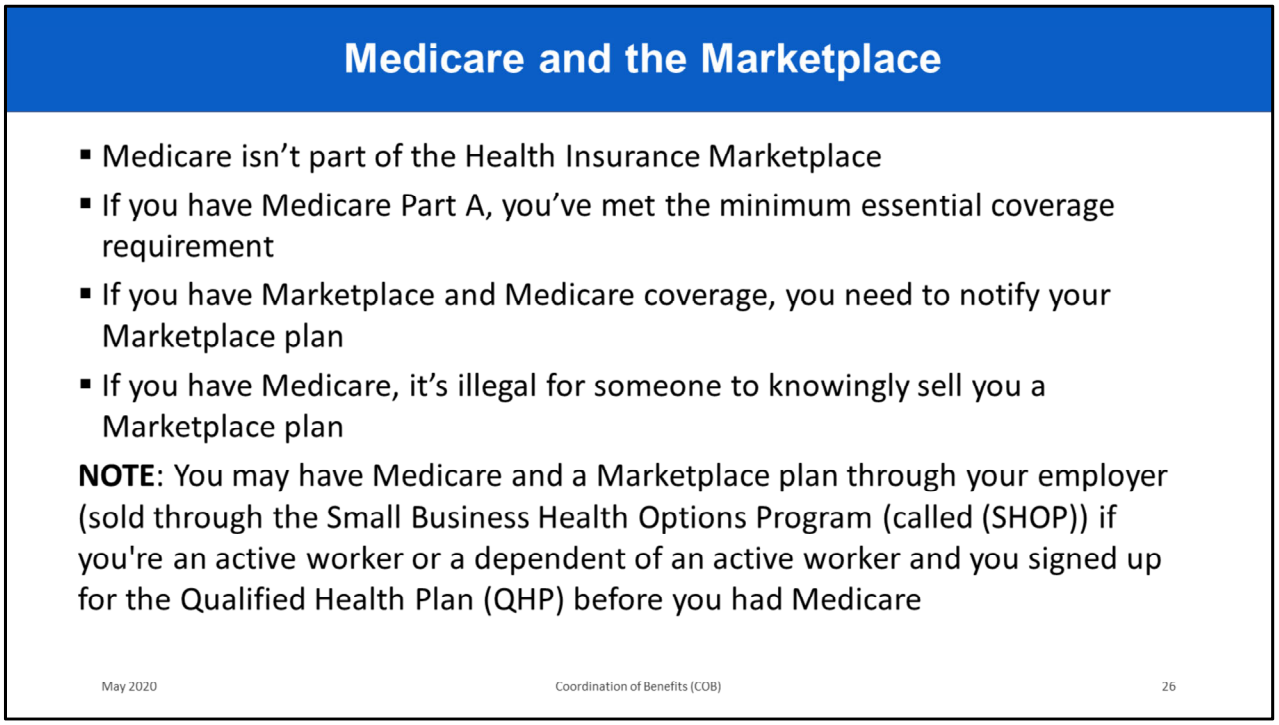
For services covered by TFL but not by Medicare, TFL pays first and Medicare pays nothing. You must pay the TFL fiscal year deductible and cost shares.

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.

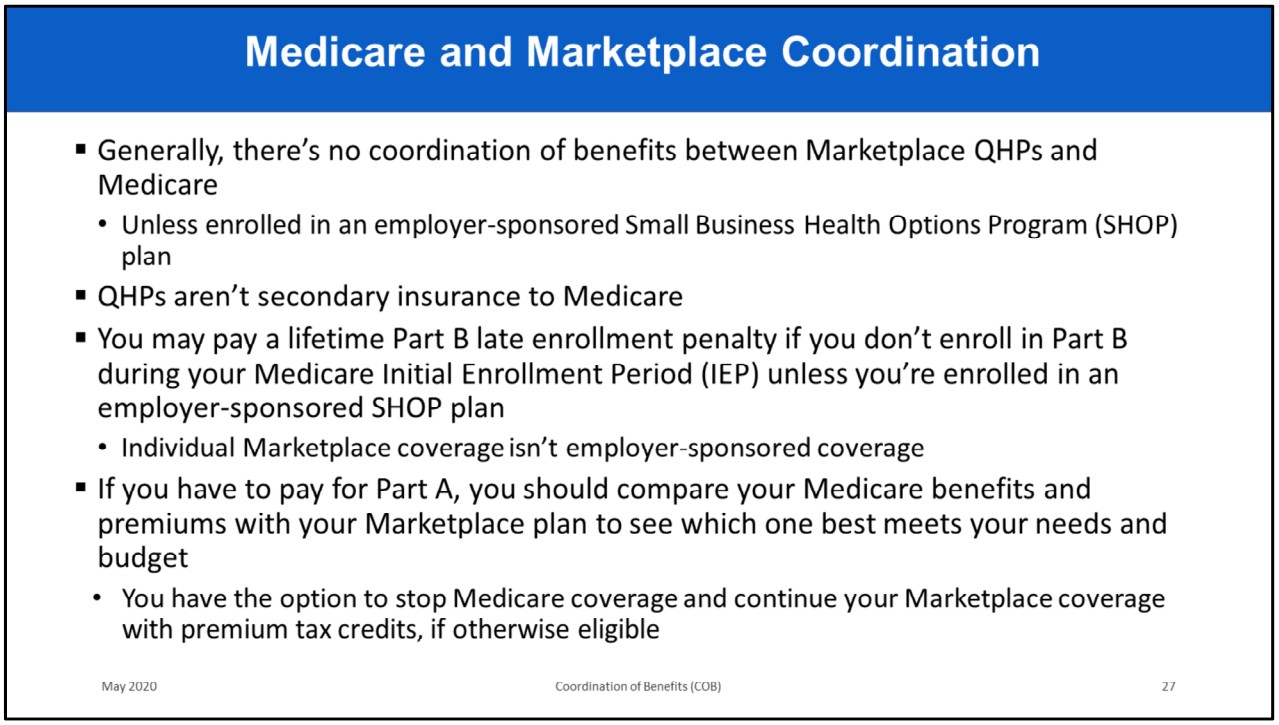
NOTE: TFL is coverage for all TRICARE beneficiaries 65 or older who have both Part A and Part B. TRICARE insurance covers active-duty personnel.



Medicare isn't part of the Health Insurance Marketplace. **WA Note: In Washington, this is sometimes called HealthPlanFinder or the Health Benefits Exchange (HBE).** If you have Part A, you don't need to do anything related to the Marketplace (you're considered covered under the minimum essential coverage requirement). If you have coverage through the Marketplace and through Medicare, you need to contact the Marketplace plan and end any subsidies, like premium tax credits or cost-sharing reductions paid on your behalf, no matter how you get Medicare (whether Original Medicare or a Medicare Advantage (MA) Plan.

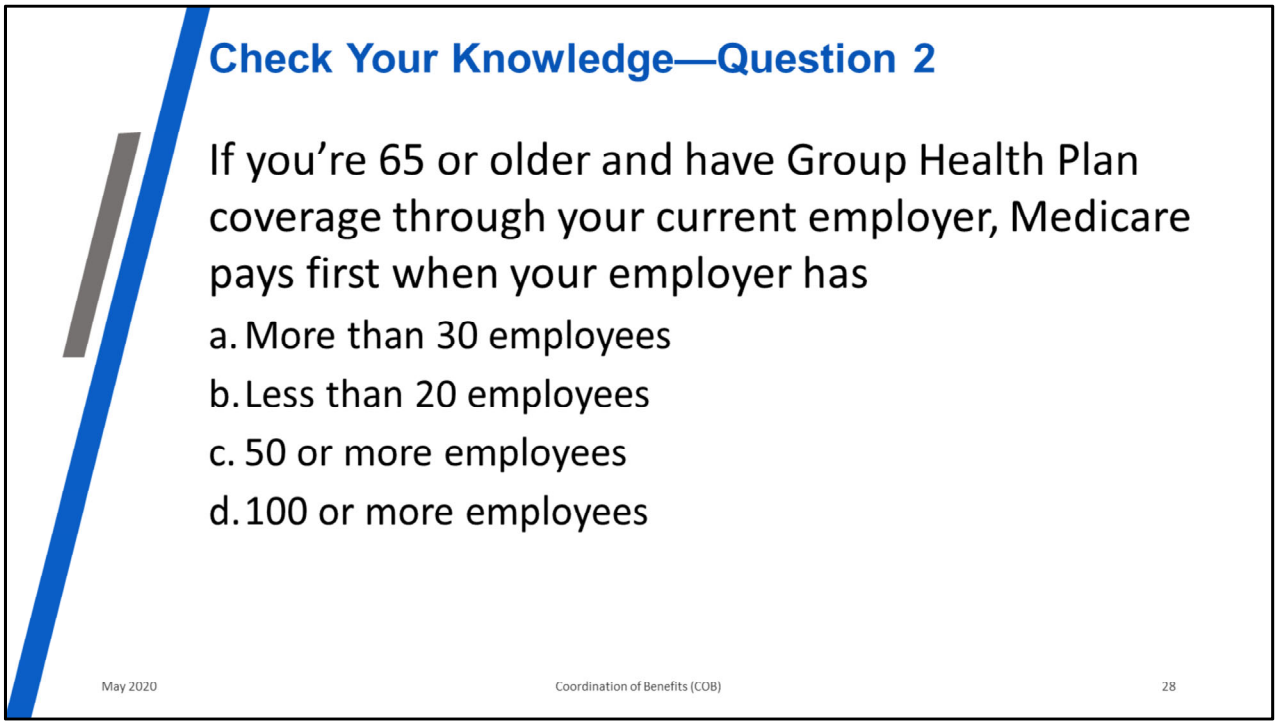
Also, your Marketplace coverage might not be renewed at the end of the benefit year. In cases where you get Part A retroactively, you lose premium tax credits once you're notified of the retroactive entitlement. If you have Medicare, it's illegal for someone to knowingly sell you a Marketplace plan.

NOTE: You may have Medicare and a Marketplace plan through your employer (sold through the Small Business Health Options Program (called (SHOP)) if you're an active worker or a dependent of an active worker and you signed up for the Qualified Health Plan (QHP)) before you had Medicare.



Generally, there's no coordination of benefits between Medicare and an individual Marketplace QHP that you buy through the Health Insurance Marketplace. You should consider several important factors when deciding whether to stay in a QHP after you enroll in 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 isn't based on current employment. If you have individual Marketplace coverage and only enroll in Part A during your Medicare Initial Enrollment Period (IEP), you won't be able to enroll in Part B later using a Special Enrollment Period (SEP). You'll have to wait for the General Enrollment Period (GEP) (January 1–March 31 each year), and you'll have to pay a lifetime Part B late enrollment 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.
- If you have to pay for Part A, you should compare your Medicare benefits and premiums with your Marketplace plan to see which one best meets your needs and budget.
  - You have the option to stop Medicare coverage and continue your Marketplace coverage with premium tax credits, if otherwise eligible.
  - You may have to pay back all or some of your premium tax credits paid on your behalf for the months you were also enrolled in Part A, when you file your federal income tax.
- Only individuals enrolled in the Small Business Health Options Program (SHOP) in the Marketplace will have coordination of benefits because SHOP coverage is based on current employment. These individuals have GHP coverage and Medicare will pay secondary to the GHP coverage. In addition, if these individuals consider delaying enrollment in Part B, they won't get a late enrollment penalty because SHOP employer-sponsored coverage is based on current employment. Visit HealthCare.gov for more information about the Marketplace.



Check Your Knowledge—Question 2

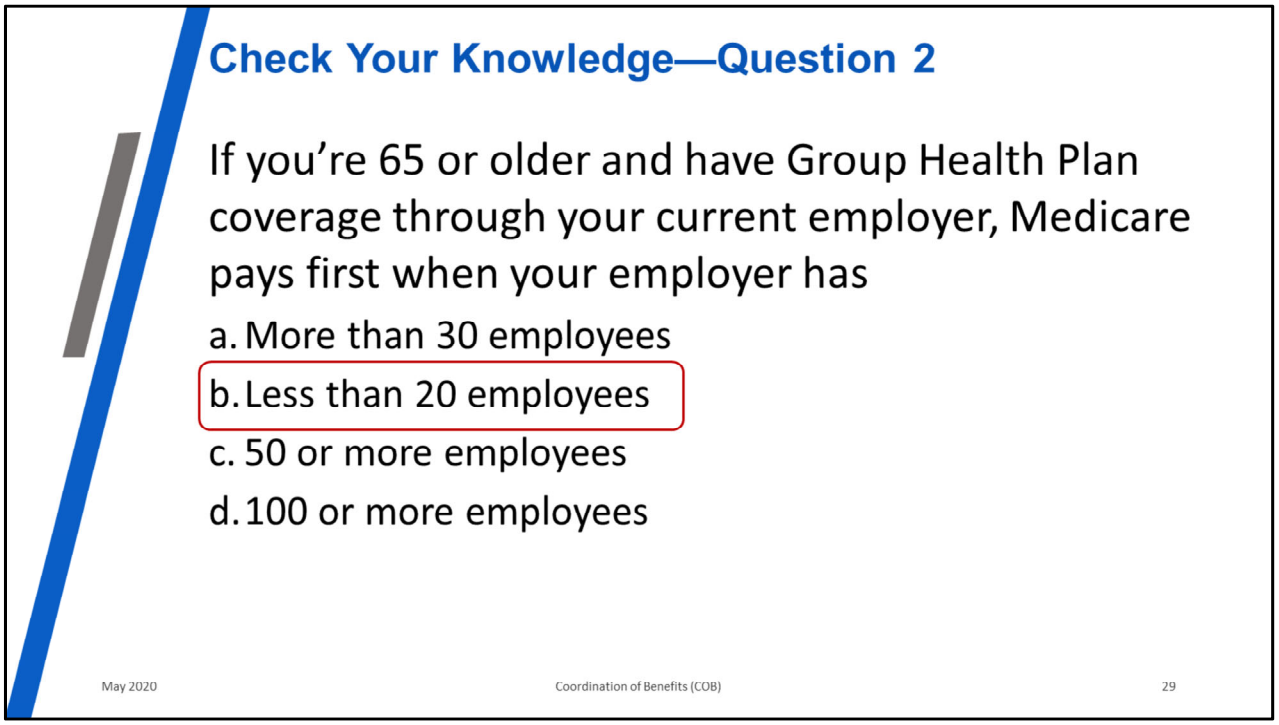
If you're 65 or older and have Group Health Plan (GHP) coverage through your current employer, Medicare pays first when your employer has

a. More than 30 employees

b. Less than 20 employees

c. 50 or more employees

d. 100 or more employees



Check Your Knowledge—Question 2

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

a. More than 30 employees

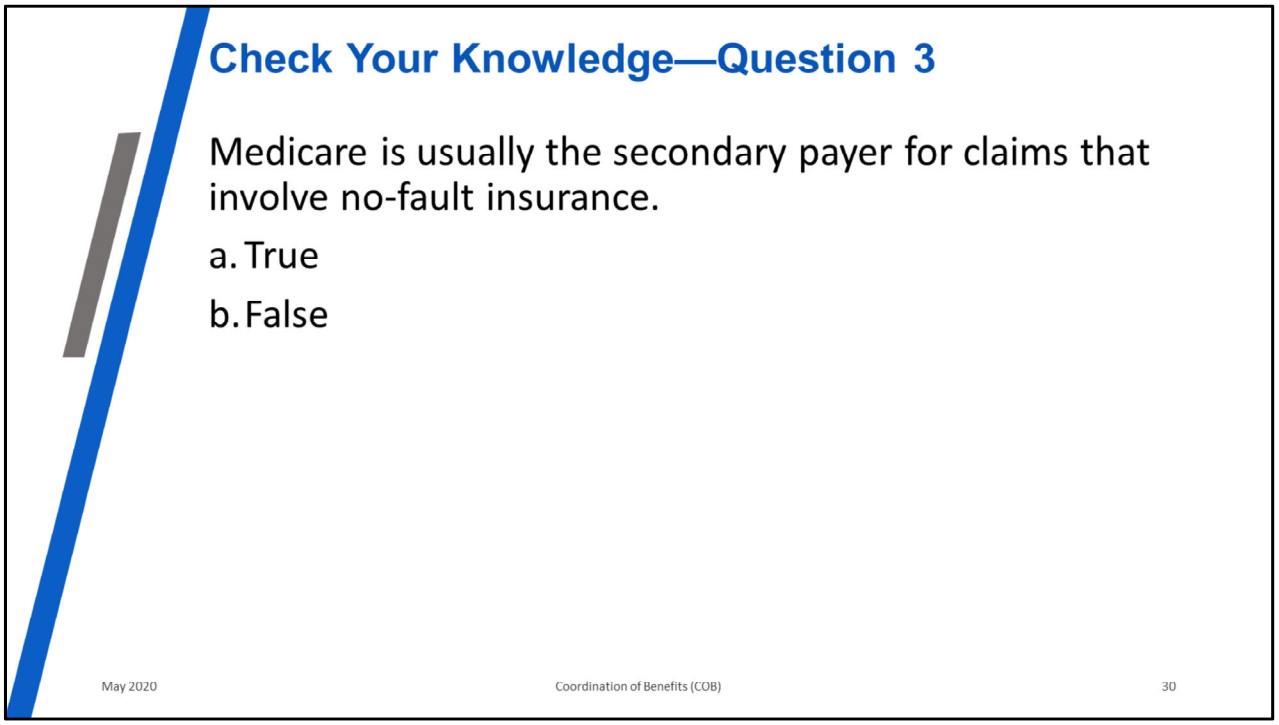
b. Less than 20 employees

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 GHP coverage through current active employment (either yours or your spouse’s), and the employer has less than 20 employees.

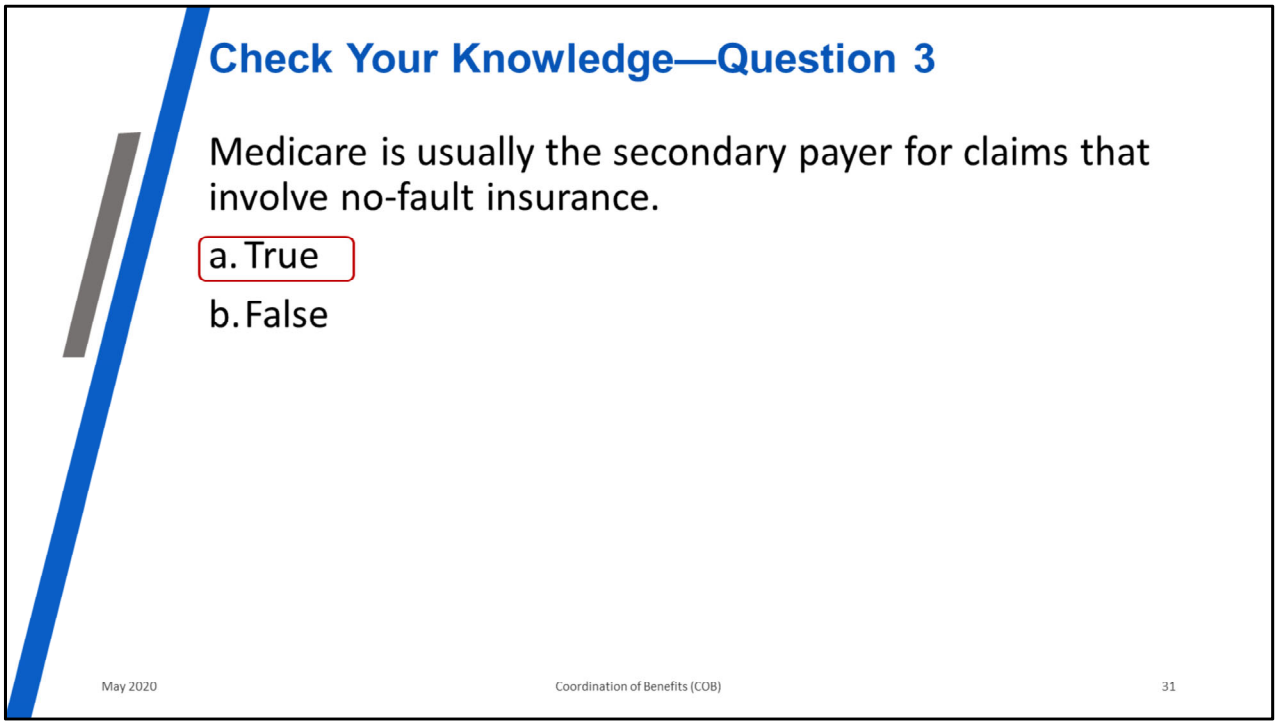


Check Your Knowledge—Question 3

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

a. True

b. False



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

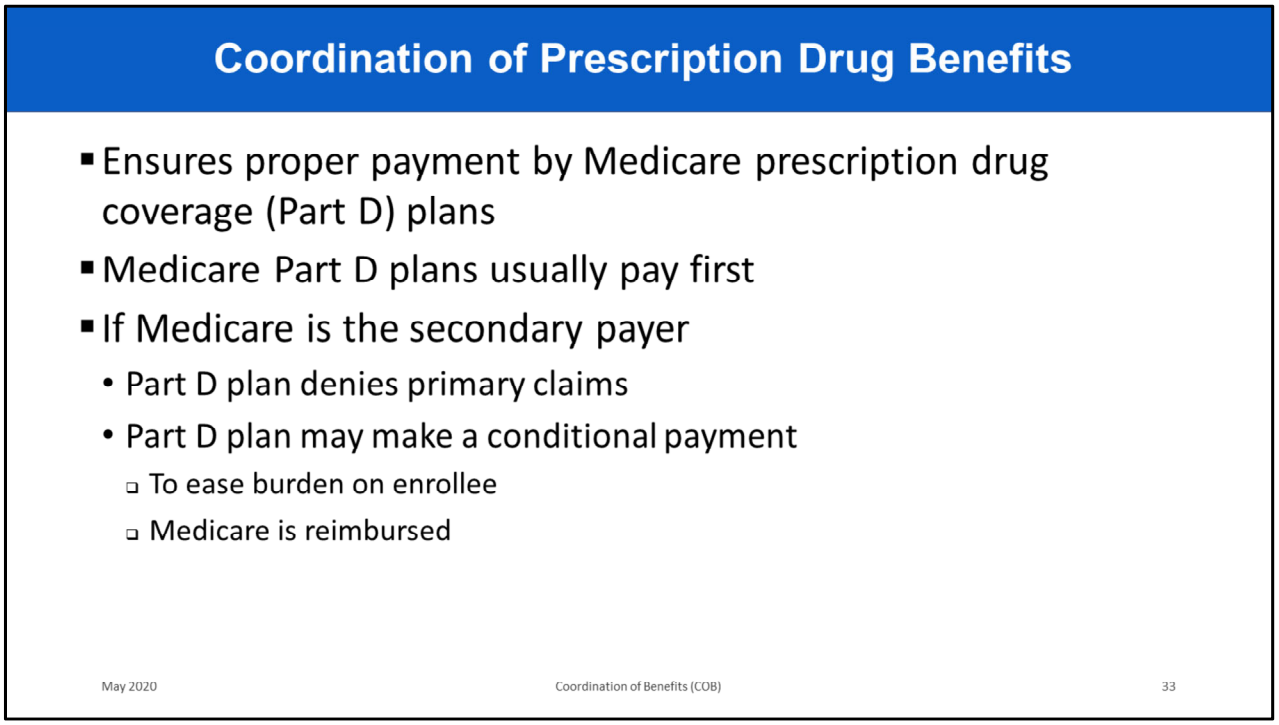
Medicare is the secondary payer when no-fault insurance is available. Medicare generally won't pay for medical expenses covered by no-fault insurance. However, Medicare may pay for medical expenses if the claim is denied for reasons other than not being a proper claim. Medicare will make payment only 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. A conditional payment is a payment for which Medicare has the right to seek recovery.

Lesson 3

MEDICARE PRESCRIPTION DRUG COVERAGE (PART D) COORDINATION OF BENEFITS

Lesson 3, “Medicare Prescription Drug Coverage (Part D) Coordination of Benefits,” explains the following:

- Coordination of prescription drug benefits
- Other possible payers
- When Part D pays first

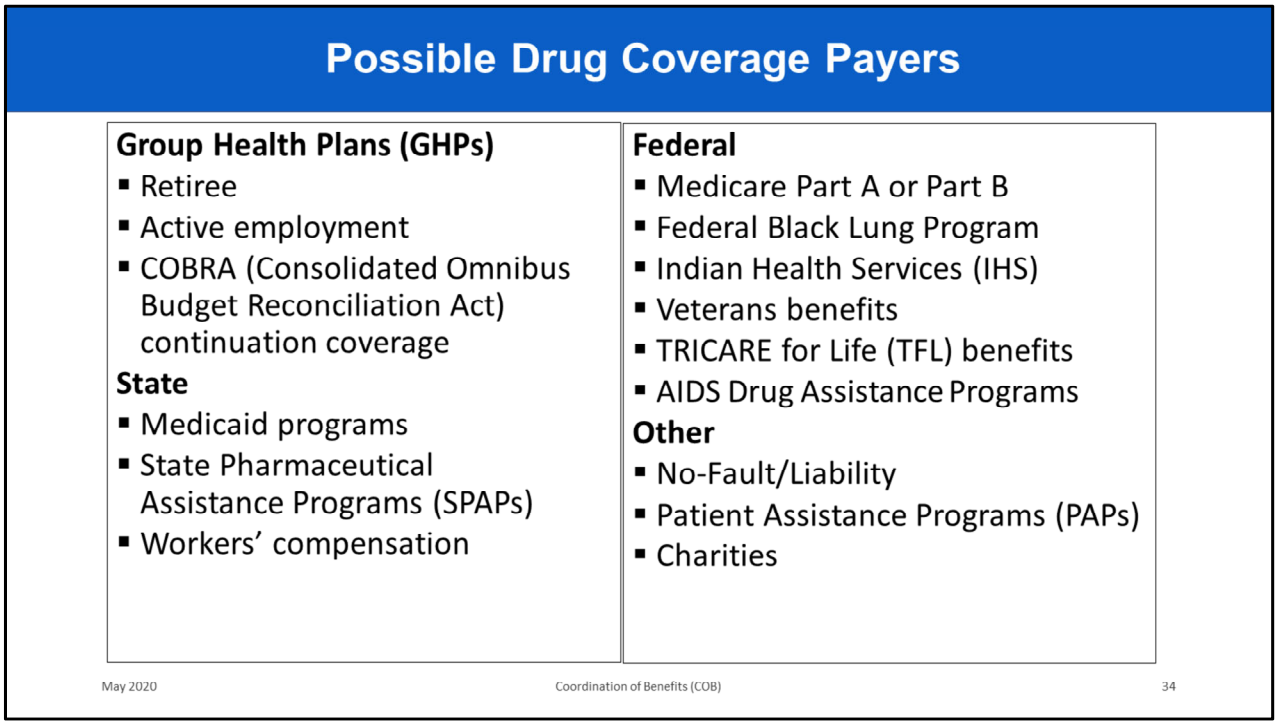


Generally, Medicare Part D provides primary coverage for prescription drugs. Whenever Medicare is primary, the Medicare prescription drug coverage is billed and will pay first.

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 usually 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. You should report the proposed settlement or update to Medicare by calling the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627; TTY: 1-855-797-2627, or by mailing relevant documents to the BCRC at P.O. Box 138832, Oklahoma City, OK 73113.



Possible drug coverage payers include:

Group Health Plans (GHPs)

- Retiree
- Active employment
- COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation coverage

State

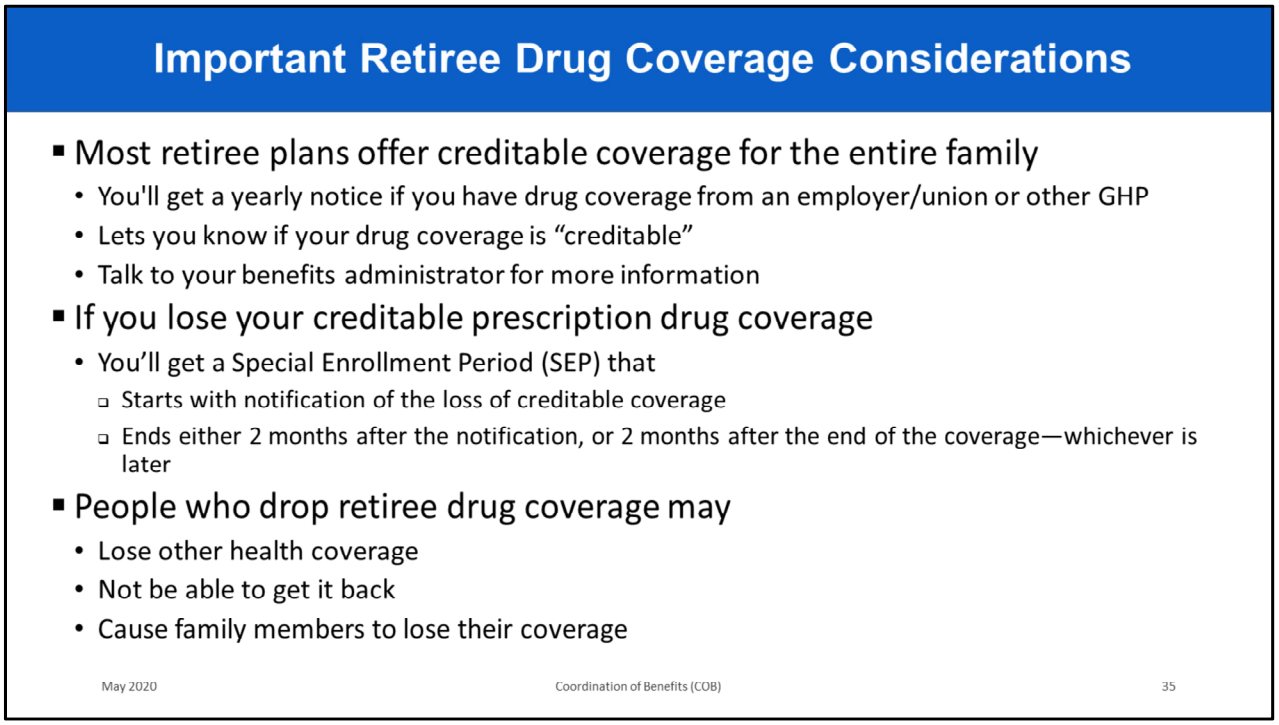
- Medicaid programs
- State Pharmaceutical Assistance Programs (SPAPs)
- Workers' compensation

Federal

- Medicare Part A or Part B (in limited situations)
- Federal Black Lung Program
- Indian Health Services (IHS)
- Veterans benefits
- TRICARE for Life (TFL) benefits
- AIDS Drug Assistance Programs (ADAPs)

Other

- No-Fault/Liability insurance
- Patient Assistance Programs (PAPs) **WA Note: Such as the Washington Prescription Drug Assistance Foundation**
- Charities



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. Employer or union retirement plans may also vary their options each year. You'll get a notice of creditable coverage each year if you have drug coverage from an employer/union or other group health plan. This notice will let you know whether your drug coverage is "creditable." Creditable coverage is coverage that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Each year, your plan is required to notify you if your prescription drug coverage is still creditable.

If you lose creditable coverage, you'll have a Special Enrollment Period (SEP) to get Part D coverage. The SEP starts when you're notified 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. Contact your GHP's benefits administrator to find out how your plan works with Medicare prescription drug coverage. When making a decision on whether to keep or drop coverage through an employer or union retirement plan, consider these important points:

- Employer/union retirement plans may offer drug 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

Coordination of Drug Benefits with Part D

Type of Plan	Situation	Does Part D Pay First for Medically-Necessary Part D-Covered Prescriptions?
Group Health Plan (GHP)	You're 65 or older and have retiree coverage	Usually, but you must check with your plan
	You're 65 or older with GHP coverage through current active employment (yours or your spouse's)	If the employer has fewer than 20 employees
	You're under 65 with a disability and have GHP coverage through current employment (yours or a family member's)	If the employer has fewer than 100 employees
	You're eligible for Medicare due to End-Stage Renal Disease (ESRD) and you have GHP coverage	When the 30-month coordination period ends, or if you had Medicare before you had ESRD
COBRA	You're 65 or older or have Medicare due to 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

WA Note: The slide has been edited for WA training.
CMS version:

- **Type of Plan: Group Health Plan (GHP)**
- **Situation: You're 65 or older and have retiree coverage**
- **Does Part D Pay First for Medically Necessary Part D-Covered Prescriptions?: Yes**

WA version:

- **Type of Plan: Group Health Plan (GHP)**
- **Situation: You're 65 or older and have retiree coverage**
- **Does Part D Pay First for Medically Necessary Part D-Covered Prescriptions?: Usually, but you must check with your plan**

Part D usually pays first if you're 65 or older and have retiree coverage.

If you have group health plan (GHP) coverage—Part D pays first if:

- You're 65 or older; you or your covered spouse is still working and you have Medicare **and have** GHP coverage from an employer with **fewer than 20** employees
- You're under 65 with a disability and have GHP coverage—if the employer has **fewer than 100** employees
- You're eligible for Medicare due to End-Stage Renal Disease (ESRD) and have GHP coverage—**after** the 30-month coordination period ends, or if you had Medicare before you had ESRD

If you have Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage—Part D pays first

- Generally for people 65 and older as well as those under 65 who have a disability
- If you're eligible for Medicare due to ESRD—once your 30-month coordination period ends

NOTE: Federal Employees Health Benefits (FEHB) is a type of GHP. 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.

Coordination of Drug Benefits with Part D (continued)

Type of Plan	Situation	Does Part D Pay First for Medically-Necessary Part D-Covered Prescriptions?
Federal Black Lung Program	If you get these benefits	Yes, for prescriptions not related to lung disease and other conditions caused by coal mining.
Indian Health Insurance Services (IHS)	You get benefits from the Indian Health Service	Yes, even if you get your drugs from IHS, Tribal, or Urban Indian clinics.
Veterans Affairs (VA)	You have coverage through the Department of Veterans Affairs	There's no coordination of benefits. A prescription must be covered solely by either the VA or Medicare.

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) pharmacies—that is, 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—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 prove to Medicare that they offer AI/AN enrollees convenient access to I/T/U pharmacies.

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 (TrOOP) 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 enrolling 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.

Coordination of Benefits with Part D

Type of Plan	Situation	Does Part D Pay First for Medically-Necessary Part D-Covered Prescriptions?
TRICARE for Life (TFL)	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	Yes, for all Part D-covered drugs. States may provide Medicaid coverage of drugs excluded from Part D coverage.
State Pharmaceutical Assistance Programs (SPAPs)	You get assistance from a State Pharmaceutical Assistance Program	N/A in Washington state

WA Note: The slide has been edited for WA training.
CMS version:

- **Type of Plan: State Pharmaceutical Assistance Programs (SPAPs)**
- **Situation: You get assistance from a State Pharmaceutical Assistance Program**
- **Does Part D Pay First for Medically Necessary Part D-Covered Prescriptions?: Yes. The state may help pay some Part D costs for prescriptions, deductibles, and copayments.**

WA version:

- **Type of Plan: State Pharmaceutical Assistance Programs (SPAPs)**
- **Situation: You get assistance from a State Pharmaceutical Assistance Program**
- **Does Part D Pay First for Medically Necessary Part D-Covered Prescriptions?: N/A in Washington state**

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 Part D 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 (SNPs) 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 pays first. The state may help pay your Part D costs for prescriptions, drug plan premium's and/or other drug costs. Find out if your state has a State Pharmaceutical Assistance Program. **WA Note: Washington state does not have a State Pharmaceutical Assistance Program. We refer to Pharmaceutical Assistance Programs which are different.**

Coordination of Benefits with Part D (continued)

Type of Plan	Situation	Does Part D Pay First for Medically-Necessary Part D-Covered Prescriptions?
Workers' Compensation	If you're covered under workers' compensation	Yes, for prescriptions other than those for the job-related illness or injury. Medicare may make a conditional payment.
Manufacturer-sponsored Patient Assistance Program (PAP)	If you get help from a Manufacturer-sponsored PAP	Yes
Charity	If you get help from a charitable program	Yes
No-fault/ Liability Insurance	If you're covered by No-Fault/Liability insurance, like for an automobile accident, injury in a public place, or malpractice	For prescriptions covered by Part D not related to the accident or injury.

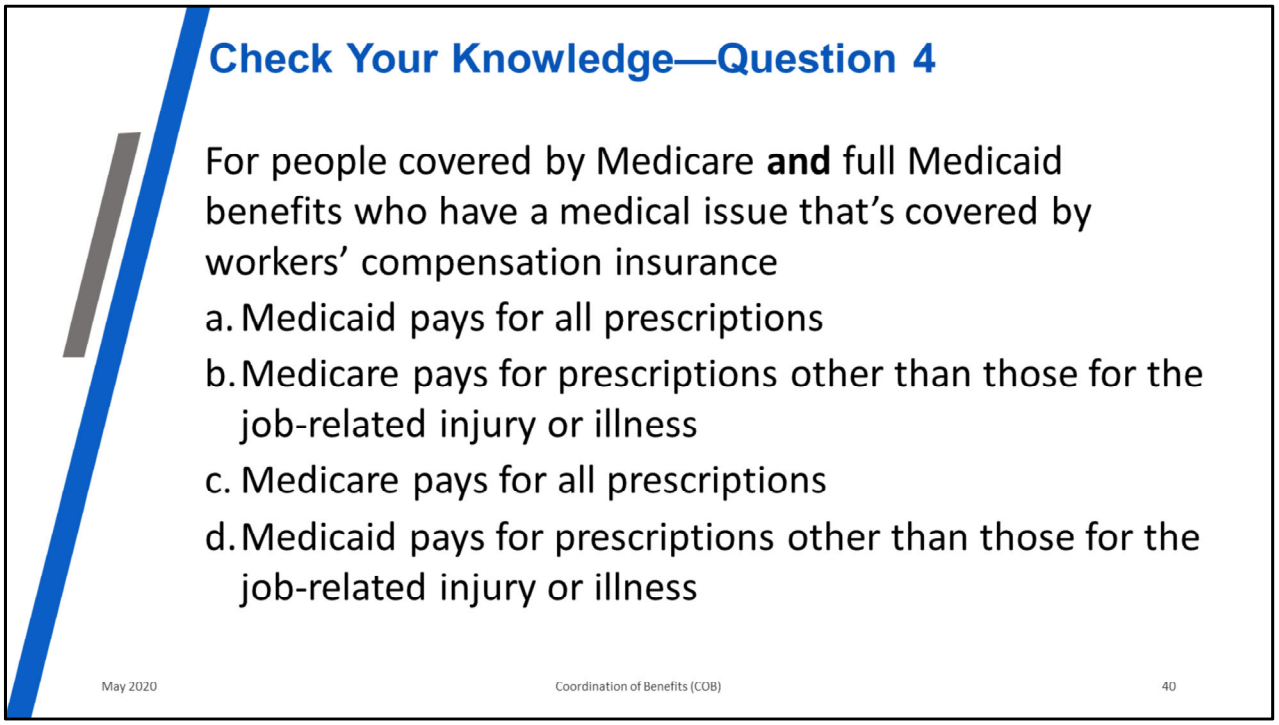
If you're covered under **Workers' Compensation**, Medicare will pay first for covered prescriptions that aren't related to the job-related illness or injury. Medicare drug plans will always make a conditional primary payment to ease the burden on the policyholder, unless certain situations apply. The 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 Program (PAP)**, that assistance won't count toward your TrOOP costs. Medicare encourages PAPs to exchange eligibility files with Medicare so that Medicare drug plans are aware of your eligibility for PAP assistance and can set their computer system's edits to show when you get the drugs for free under the PAP. PAPs may charge a small copayment when giving this in-kind assistance, and this amount may count toward TrOOP. You'll 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 the 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 GHP, government-funded health program, or other third-party payment arrangement.

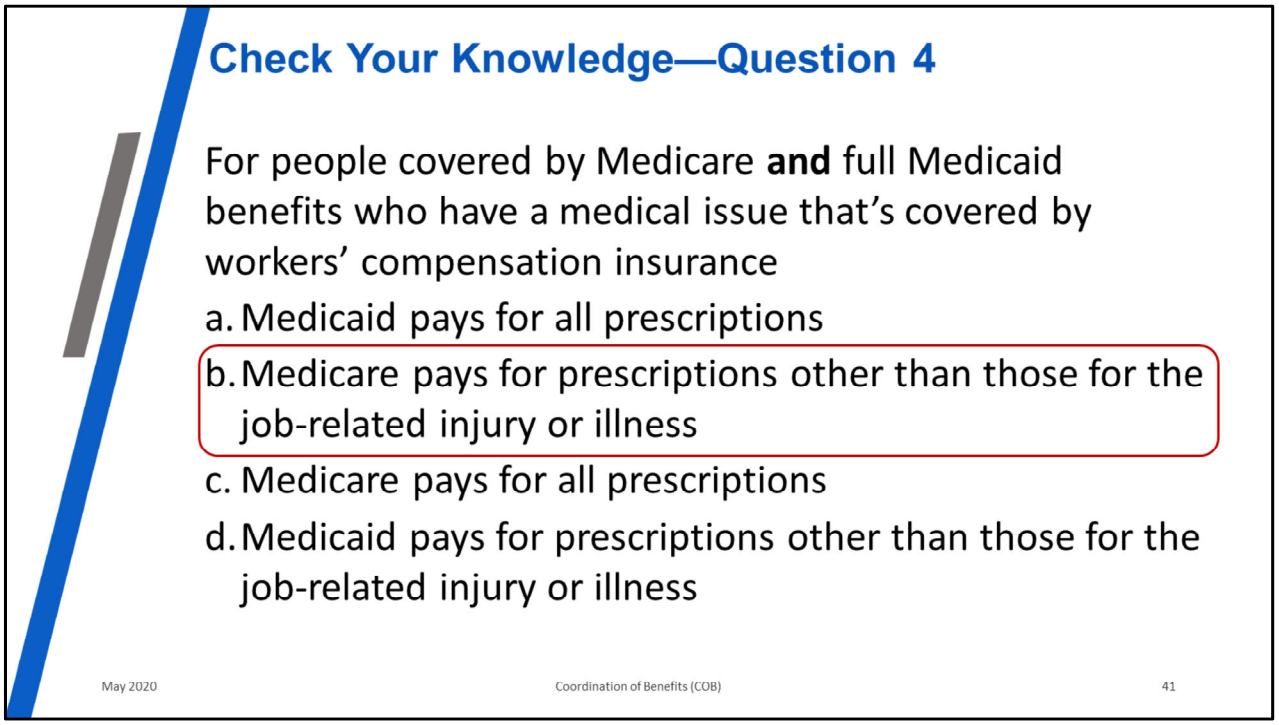
If you're covered by **no-fault/liability insurance**, like an automobile accident, injury in a public place, or malpractice, Medicare pays first for prescriptions covered by Part D that aren't related to the accident or injury.



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



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 (MMA) established that people with both Medicare and full Medicaid benefits get drug coverage from Medicare rather than Medicaid.

Resource Guide

Centers for Medicare & Medicaid Services (CMS)	▪ Call 1-800-633-4227 (1-800-MEDICARE); TTY: 1-877-486-2048 ▪ Medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance ▪ CMS.gov
Benefits Coordination & Recovery Center	▪ Call 1-855-798-2627; TTY: 1-855-797-2627. Mail: P.O. Box 138832 Oklahoma City, OK 73113.
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
Washington State Department of Labor & Industries	▪ https://www.lni.wa.gov/
Medicare/TRICARE Benefit Overview	▪ tricare.mil/Plans/Eligibility?sc_database=web

WA Note: The slide has been edited for WA training.

- **Removed: The CMS slide had information for the Patient Assistance Program Center**
- **Added: This WA slide version now has information for the Washington State Department of Labor & Industries**

Resource Guide (continued)

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	▪ Call 1-800-638-7072. TTY: 1-877-889-5627 ▪ dol.gov/owcp/dcmwc

Coordination of Benefits—Medicare Products

1. "Medicare and Other Health Benefits: Your Guide to Who Pays First" (CMS Product No. 02179)	▪ Medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf
2. "Medicare & You" handbook (CMS Product No. 10050)	▪ Medicare.gov/Pubs/pdf/10050-Medicare-and-You.pdf

To access other helpful products:

- View or download 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

BCRC Benefits Coordination & Recovery Center

CMS Centers for Medicare & Medicaid Services

COB Coordination of Benefits

COBA Coordination of Benefits Agreement

COBRA Consolidated Omnibus Budget Reconciliation Act

CSR Cost-Sharing Reductions

CWF Common Working File

ESRD End-Stage Renal Disease

FEHB Federal Employee Health Benefits

GHP Group Health Plan

IHS Indian Health Services

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

MMA Medicare Modernization Act

NTP National Training Program

PAP Patient Assistance Program

QHP Qualified Health Plan

SEP Special Enrollment Period

SHIP State Health Insurance Assistance Program

SNP Special Needs Plan

SPAP State Pharmaceutical Assistance Programs

TFL TRICARE for Life

TrOOP True Out-Of-Pocket

VA Veterans Affairs

WCMSA Workers' Compensation Medicare Set-Aide Arrangement

Stay connected. Visit CMSnationaltrainingprogram.cms.gov to view NTP training materials and to subscribe to our email list. Contact us at training@cms.hhs.gov.