

Centers for Medicare & Medicaid Services (CMS)
National Training Program (NTP)
Instructor Information Sheet

Module 5—Coordination of Benefits

Module Description

The lessons in this Coordination of Benefits training module explain the coordination of benefits when people have Medicare and certain other types of health coverage.

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

Objectives

This session should help you

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

Target Audience

This module is designed for presentation to trainers and other information givers. It can be easily adapted for presentations to groups of beneficiaries.

Time Considerations

The module consists of 41 PowerPoint slides with corresponding speaker's notes, activities, and five Check Your Knowledge questions. It can be presented in about 45 minutes. Allow approximately 15 more minutes for discussion, questions, and answers. Additional time may be allocated for add-on activities.

Course Materials

Additional materials available:

Job Aid—[Common Situations Where Medicare Pays First](#)

Module 5: Coordination of Benefits

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2015 National Training Program

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Module 5

Coordination of Benefits

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 the Federally-facilitated Health Insurance Marketplace.

The information in this module was correct as of May 2015. To check for an updated version, visit CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html.

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

Session Overview

This session should help you

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

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This session should help you

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

Lesson 1—Coordination of Benefits Overview

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

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

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

Coordination of Benefits Overview

- Each type of health insurance coverage is called a “payer”
- When there’s more than one payer, coordination of benefits rules decide which pays first
- There may be primary and secondary payers, and in some cases there may also be a third payer

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Coordination of Benefits

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

When Does Medicare Pay?

- Medicare may be primary payer
 - In the absence of other primary insurance
- Medicare may be secondary payer
 - You 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 shouldn't pay at all.

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

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

Medicare may not pay at all for services and items that other health insurers are responsible for paying.

When Medicare Is the Primary Payer

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

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For most people with Medicare, Medicare is their primary payer, which means Medicare pays first on their health care claims. Medicare pays first in the following situations:

- Medicare is your only source of medical, hospital, or drug coverage.
- You have a Medigap (Medicare supplement insurance) policy or other privately purchased insurance policy that isn't 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 the Indian Health Service.
- Veterans benefits.
- TRICARE. (Note: TRICARE is the U.S. Department of Defense health program for active-duty service members and their families. TRICARE for Life is the program for military retirees and their families.)
- Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), with one exception: End-Stage Renal Disease. We'll talk about this coverage shortly.

Medicare Secondary Payer

- When Medicare isn't responsible for paying a claim first
- Legislation protects the Medicare Trust Funds
- Helps ensure Medicare doesn't pay when another insurer should
- Saves \$9 billion annually
 - Claims processed by insurances primary to Medicare

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

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

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

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

Medicare saves almost \$9 billion annually on claims processed by insurances that pay primary to Medicare.

Gathering Secondary Payer Information

- Initial Enrollment Questionnaire
 - Sent 3 months prior to Medicare entitlement date
 - Receive notice to complete online
 - Asks about current employer, liability, and workers' compensation insurance coverage
 - Can complete at MyMedicare.gov
 - By phone with the Benefits Coordination & Recovery Center
 - 1-855-798-2627
 - TTY 1-855-797-2627

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If you're already getting Social Security benefits (for example, getting early retirement), you'll automatically be enrolled in Medicare Part A and Part B without an additional application. Three months before Medicare coverage begins, you're sent a notice asking you to complete the Initial Enrollment Questionnaire online. It asks the questions below about other health insurance you have, like group health coverage from your or a family member's employer, liability insurance, or workers' compensation.

- 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?
- Will you be getting any group health plan coverage through the current employment of your husband/wife on your Medicare eligibility date?
- How many employees work for your husband's or wife's employer?
- Are you receiving Federal Black Lung Benefits Program benefits or workers' compensation benefits?
- Are you receiving treatment for an injury or illness that another party could be held responsible for, or could be covered under no-fault, automobile, or liability insurance?

If you're not getting retirement benefits from Social Security or Railroad Retirement Board, you must sign up to get Medicare. As a new Medicare enrollee, you're 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, and more. You may complete the questionnaire online at MyMedicare.gov, or over the phone by calling the Benefits Coordination & Recovery Center at 1-855-798-2627. TTY users should call 1-855-797-2627.

Gathering Secondary Payer Information From Employers

- Mandatory reporting requirements for insurers
 - Use secure web portal to facilitate transfer of data
 - Penalty up to \$1,000/day per beneficiary for failure to report data
- Internal Revenue Service/Social Security/Centers for Medicare & Medicaid Services Claims Data Match
 - Employers complete an online questionnaire for their employees
 - Entitled to Medicare
 - Married to a Medicare beneficiary
- Voluntary Data-Sharing Agreements
 - Between CMS and large employers

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Coordination of benefits relies on multiple databases kept by several 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 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 of 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 the transfer of data.

Internal Revenue Service (IRS)/Social Security (SSA)/Centers for Medicare & Medicaid Services (CMS) Claims Data Match—The law requires the IRS, SSA, and CMS to share information about Medicare beneficiaries and their spouses. A key data source is the IRS/SSA/CMS Claims Data Match. By law, employers are required to complete a questionnaire on the GHP that Medicare-eligible workers and their spouses choose. The Claims Data Match identifies situations where another payer is primary to Medicare.

Voluntary Data-Sharing Agreements (VDSAs)—CMS has entered into VDSAs with numerous large employers. These agreements allow employers and CMS to send and receive GHP enrollment information electronically. Where discrepancies occur in the VDSAs, employers can provide enrollment/disenrollment documentation. The VDSA program includes Part D information, letting VDSA partners submit records with prescription drug coverage, be it primary or secondary to Medicare prescription drug coverage (Part D).

Benefits Coordination & Recovery Center

- Identifies health benefits available to people with Medicare
- Coordinates claims to ensure they're paid by correct payer
- Responsible for identifying
 - Medicare Secondary Payer (MSP) situations
 - Claims that should cross over to supplemental insurers
- MSP Claims Investigation
 - Contractor learns about other insurance
 - Identifies which is primary

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The Coordination of Benefits program identifies the health benefits available to a Medicare beneficiary, and coordinates 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 the Centers for Medicare & Medicaid Services (CMS) Benefits Coordination & Recovery Center (BCRC) and private insurance companies for the contractor to automatically cross over medical claims. In the absence of an agreement, the person with Medicare 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 doesn't exceed 100% of the total claim, avoiding duplicate payments.

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

Check Your Knowledge—Question 1

How many possible different payers could there be for an insurance claim?

- a. One
- b. Two
- c. Three

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Check Your Knowledge—Question 1

How many possible different payers could there be for an insurance claim?

- a. One
- b. Two
- c. Three

ANSWER: c. Three.

The primary payer pays what it owes on your bills first, and then your provider sends the rest to the secondary payer to pay. In some cases there may also be a third payer.

Lesson 2—Health Coverage Coordination

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

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

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

Medicare and the Marketplace

- Medicare isn't part of the Health Insurance Marketplace
- If you have Medicare Part A, you're considered covered
- No matter how you get Medicare, whether through Original Medicare or a Medicare Advantage Plan (like an HMO or PPO), you won't have to make any changes related to the Marketplace
- If you have Medicare, it's illegal for someone to sell you a Marketplace plan
- You may have a Qualified Health Plan (QHP) through the Marketplace and Medicare if you signed up for the QHP first

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Medicare isn't part of the Health Insurance Marketplace, so if you have Medicare Part A you don't need to do anything related to the Marketplace; you're considered covered. No matter how you get Medicare, whether through Original Medicare or a Medicare Advantage Plan (like a Health Maintenance Organization or a Preferred Provider Organization), you won't have to make any changes related to the Marketplace. If you have Medicare, it's illegal for someone to sell you a Marketplace plan.

NOTE: You may have Medicare and Marketplace coverage concurrently, only if you had your Marketplace coverage before you had Medicare.

Medicare and Marketplace Coordination

- Generally, no coordination between Marketplace Qualified Health Plan (QHP) and Medicare
 - Unless enrolled in employer-sponsored Small Business Health Options Program (SHOP) plan
- QHPs aren't secondary insurance to Medicare
- May cause you to pay a lifetime Part B penalty if you don't enroll in Part B during your Medicare Initial Enrollment Period
 - Unless enrolled in employer-sponsored SHOP plan
- If you have to pay a premium for Medicare Part A
 - Can drop Medicare and enroll in QHP

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Generally, there is no coordination of benefits between Medicare and an Individual Marketplace Qualified Health Plan (QHP) that you purchase through the Health Insurance Marketplace. There are several important factors to consider when you're making the decision about whether or not to remain in a QHP after you enroll in Medicare Part A.

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

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

Only individuals enrolled in the Small Business Health Options Program (SHOP) program in the Marketplace will have coordination of benefits, because that coverage is based on current employment. These individuals have group health plan coverage and Medicare will pay secondary to the QHP coverage. In addition, these individuals can consider delaying Part B enrollment (without penalty) because SHOP employer-sponsored coverage is based on current employment.

Important Retiree Coverage Considerations

- Most retiree plans offer generous coverage for the entire family
 - Employer/union must disclose how its plan works with Medicare drug coverage
 - Talk to your benefits administrator for more information
- If you lose your creditable prescription drug coverage, you have 63 days to enroll in a Part D plan without penalty
- People who drop retiree drug coverage may
 - Lose other health coverage
 - Not be able to get it back
 - Cause family members to lose their coverage

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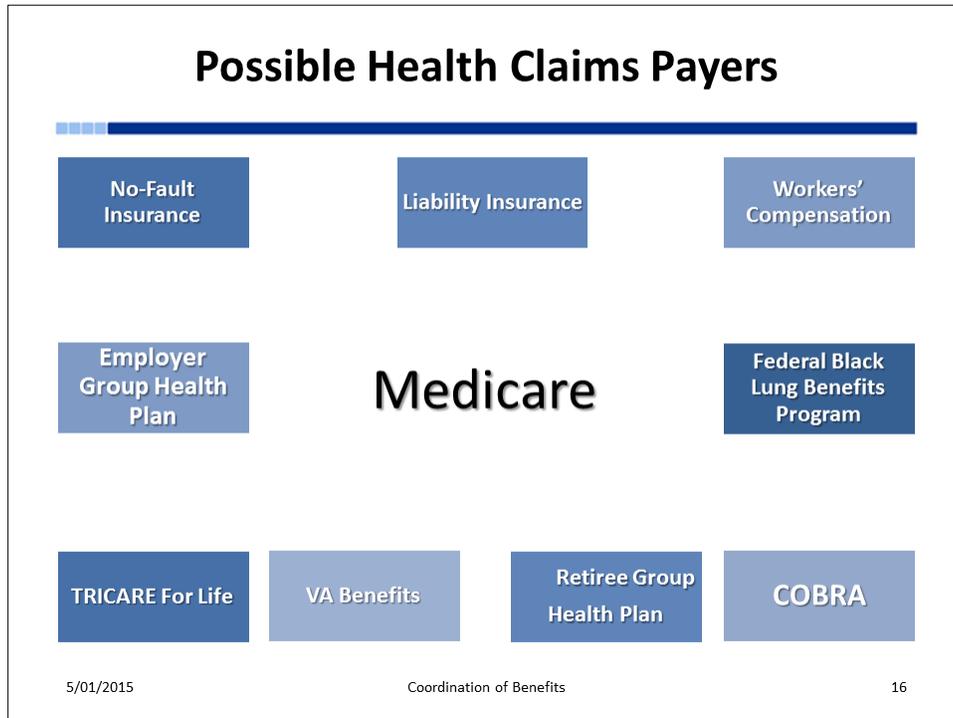
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As discussed previously, people with Medicare who have employer or union retirement plans that cover prescription drugs must carefully consider their options. A person's needs may vary from year to year based on factors like health status and financial considerations. Options 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" drug coverage, he/she has 63 days to enroll in a Part D plan without incurring a late enrollment penalty. Contact the employer group health plans 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.



It's important to identify whether your 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 you could have and many combinations of insurance coverage to consider before determining who pays and when:

- No-Fault Insurance
- Liability Insurance
- Retiree Group Health Plan
- Veterans Affairs Benefits
- 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 your claim, or may not pay at all.

Employer Group Health Plans

- 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
- Businesses with 50 or fewer employees can offer Small Business Health Options Program (SHOP) plans

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Coordination of benefits is dependent on whether you, or your spouse or family member, is currently working or retired, and on the number of employees of that company. The Federal Employee Health Benefits program is a type of employer group health plan (EGHP).

EGHP coverage is coverage offered by many employers and unions for current employees and/or retirees. You may also get group health coverage through your spouse's or other family member's employer. If you have Medicare and are offered coverage under an EGHP, you can choose to accept or reject the plan. The EGHP may be a fee-for-service plan or a managed care plan, like a Health Maintenance Organization.

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

Employer Group Health Plans (EGHP) Continued

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 primary before you had ESRD

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

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

Non-Group Health Plans

- Medicare doesn't usually pay for services when diagnosis indicates that other insurers may provide coverage, including
 - Auto accidents
 - Illness related to mining (Federal Black Lung Benefits Program)
 - Third-party liability
 - Work injury or illness (workers' compensation)

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

- Auto accidents
- Illness related to mining (Federal Black Lung Benefits Program)
- Third-party liability
- Work-related injury or illness (workers' compensation)

No-Fault Insurance

- Pays regardless of who's at fault
- Medicare is secondary payer
- Medicare may make conditional payment
 - If claim not paid within 120 days
 - You 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's 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 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.

The money that Medicare used for the conditional payment must be repaid to Medicare when the no-fault insurance settlement is reached. If Medicare makes a conditional payment and you later resolve the insurance claim, Medicare will seek to recover the conditional payment from you. You're responsible for making sure that Medicare gets repaid for the conditional payment.

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

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

Liability Insurance

- 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 won't pay promptly (within 120 days)
 - Medicare recovers conditional payment

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Liability insurance is coverage that protects you against claims based on negligence, inappropriate action, or inaction that results in injury to someone or damage to property. Liability insurance includes, but isn't limited to, the following:

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

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

Sometimes this can take a long time. If the insurance company doesn't pay the claim promptly (usually within 120 days), your doctor or other provider may bill Medicare. Medicare may make a conditional payment to pay the bill. A conditional payment is a payment Medicare makes for services for which another payer is responsible. Medicare makes this conditional payment so you won't have to use your own money to pay the bill. The payment is conditional because it must be repaid to Medicare when a settlement judgment, award, or other payment is made.

Workers' Compensation

- Medicare won't pay for health care related to workers' compensation claims
- If workers' compensation claim is denied, claim may be filed for Medicare payment
- Workers' compensation claims can be resolved by settlements, judgments, or awards

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Medicare generally won't 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 isn't covered by workers' compensation, a claim may be filed with Medicare. Medicare may pay a claim that relates to a medical service or product covered by Medicare if the claim isn't covered by workers' compensation.

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

Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)

- Funds to be set aside to pay for future medical or prescription drug services
- Funds must be used for the injury, illness, or disease covered by workers' compensation
- Only used for Medicare-covered services
- Medicare pays for Medicare-covered services after WCMSA funds are used up

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

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

WCMSAs are discussed in detail at go.cms.gov/wcmsa.

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

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 call
 - 1-800-638-7072
 - TTY 1-877-889-5627

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Some people with Medicare can get Federal Black Lung Benefits 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 aren't 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 Benefits Program beneficiaries are eligible for prescription drugs, inpatient and out-patient services, and doctors' visits. In addition, home oxygen and other medical equipment, home nursing services, and pulmonary rehabilitation may be covered with a doctor's prescription.

A toll-free number, 1-800-638-7072, has been designated for the office that's responsible for the Federal Black Lung Benefits Program's medical diagnostic and treatment services. TTY users should call 1-877-889-5627.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

- Requires employers with 20 or more employees to let employees and dependents keep health 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 is only available 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

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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 and state and local government–sponsored plans, but not to federal government–sponsored plans, the governments of the District of Columbia, any territory or possession of the United States, 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 his/her part and the part of the premium his/her employer paid while he/she still worked.

You can replace COBRA coverage with Marketplace coverage. If your COBRA coverage ends outside the annual Marketplace Open Enrollment Period (November 1, 2015 – January 31, 2016), you may qualify for a Special Enrollment Period (SEP). To find out if you qualify for an SEP, visit [HealthCare.gov/coverage-outside-open-enrollment/](https://www.healthcare.gov/coverage-outside-open-enrollment/). This means you can enroll in a private health plan through the Marketplace outside of Open Enrollment. If you end your COBRA coverage early and you are outside the annual Open Enrollment Period, you can't enroll in a Marketplace plan at all. During the annual Open Enrollment Period, you can drop your COBRA coverage and get a plan through the Marketplace, even if your COBRA coverage hasn't run out.

Consolidated Omnibus Budget Reconciliation Act Coverage (COBRA)

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	When your 30-month coordination period ends

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

Before electing COBRA coverage, people may find it helpful to talk with a State Health Insurance Assistance Program (SHIP) counselor to understand their options better. For example, if a person who already has Medicare Part A (Hospital Insurance) chooses COBRA, but waits to sign up for Medicare Part B (Medical Insurance) until the last part of the 8-month Special Enrollment Period following termination of employment, the employer can make the person pay for services that Medicare would've covered if he or she had signed up for Part B earlier.

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

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

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

Veterans Affairs (VA) Coverage

- If you have Medicare and VA benefits
 - Can get treatment under either program
- Medicare pays first when you choose to get your benefits from Medicare
- To receive services under VA benefits
 - You must get your health care at a VA facility or
 - Have the VA authorize services in a non-VA facility

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If you have both Medicare and Veterans' benefits, you can access health care treatment under either program. However, you must choose which benefit you'll use each time you see a doctor or receive health care (e.g., in a hospital). Medicare won't pay for the same service that was authorized by Veterans Affairs (VA); similarly, VA coverage won't pay for the same service that was covered by Medicare.

To receive VA services, you must get your health care at a VA facility **or** have the VA authorize services in a non-VA facility. Veterans could be subject to a penalty for enrolling late for Medicare Part B, even if they're enrolled in VA health care.

VA benefits are given to people who 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.

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

TRICARE for Life Coverage (TFL)

- 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 and Medicare generally pays nothing

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If you have Medicare and TRICARE for Life (TFL), Medicare is your primary insurance. TFL acts as your secondary payer, minimizing your out-of-pocket expenses. TFL benefits include covering Medicare's coinsurance and deductibles.

If you use a Medicare provider, he or she will file your claims with Medicare. Medicare pays its portion and electronically forwards the claim to the TFL claims processor. TFL pays the provider directly for TFL-covered services.

For services covered by both Medicare and TFL, Medicare pays first and TFL pays the remaining coinsurance for TRICARE-covered services.

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

For services covered by Medicare but not by TFL, Medicare pays first and TFL pays nothing. You must pay the Medicare deductible and coinsurance.

For services not covered by Medicare or TFL, Medicare and TFL pay nothing and you must pay the entire bill.

When you receive services from a military hospital or any other federal provider, TFL will pay the bills. Medicare doesn't usually pay for services received from a federal provider or other federal agency.

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

Check Your Knowledge—Question 2

Which of the following is a true statement about WCMSA funds?

- a. WCMSA funds can be used to cover all medical expenses
- b. WCMSA funds must be used within 1 year
- c. WCMSA funds can be used to cover all of your prescription drug expenses
- d. Medicare will pay for all Medicare-approved expenses after all WCMSA funds are used

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Check Your Knowledge—Question 2

Which of the following is a true statement about Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) funds?

- a. WCMSA funds can be used to cover all medical expenses
- b. WCMSA funds must be used within 1 year
- c. WCMSA funds can be used to cover prescription drug expenses
- d. Medicare will pay for all Medicare-approved expenses after all WCMSA funds are used

ANSWER: d. Medicare will pay for all Medicare-approved expenses after all WCMSA funds are used

Why isn't answer "a" correct? Funds placed in your WCMSA is for paying future medical and/or prescription drug expenses related to your work injury or illness/disease that otherwise would have been covered by Medicare.

Why isn't answer "b" correct? Funds placed in your WCMSA may be used to pay future medical and/or prescription drug expenses related to your work injury or illness/disease, that otherwise would have been covered by Medicare, until those funds have been used up ("exhausted" or "depleted").

Why isn't answer "c" correct? You can't use the WCMSA to pay for prescription drugs that aren't related to your work injury or illness.

Check Your Knowledge—Question 3

Who pays John's bill first?
He is 34 years old. He has
End-Stage Renal Disease,
Consolidated Omnibus
Budget Reconciliation Act
(COBRA) coverage, and has
been enrolled in Medicare
for 8 months.

- a. Medicare
- b. COBRA

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Check Your Knowledge—Question 3

Who pays John's bill first? He is 34 years old. He has End-Stage Renal Disease (ESRD), Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, and has been enrolled in Medicare for 8 months.

- a. Medicare
- b. COBRA

ANSWER: b. COBRA

For people with ESRD, COBRA pays first and Medicare pays second during the 30-month coordination period. COBRA coverage generally continues for 18 months. Medicare will become primary payer when COBRA coverage ends, even if that happens before the 30-month period ends.

Lesson 3—Medicare Part D Coordination of Benefits

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

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

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

Coordination of Prescription Drug Benefits

- Ensures proper payment by Medicare Part D plans
- Medicare Part D plan usually pays 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 and Benefits Coordination & Recovery Center is advised

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Generally, Medicare Part D provides primary coverage for prescription drugs. Whenever Medicare is primary, the Part D (Medicare prescription drug coverage) plan is billed and will pay first. When Medicare is the secondary payer, Part D plans will generally deny primary claims.

When Medicare is the secondary payer to a non-group health plan, or when a plan doesn't know whether a covered drug is related to an injury, Part D plans will always make a conditional primary payment, unless certain situations apply. The Part D plan won't pay if it's aware that the enrollee has workers' compensation, Federal Black Lung Benefits Program benefits, or no-fault/liability coverage and has previously established that a certain drug is being used exclusively to treat a related illness or injury.

For example, when an enrollee refills a prescription previously paid for by workers' compensation, the Part D plan may deny primary payment and default to Medicare Secondary Payer. The payment is conditional because it must be repaid to Medicare once a settlement, judgment, or award is reached. The proposed settlement or update should be reported to the Benefits Coordination & Recovery Center.

Possible Drug Coverage Payers

Employer Group Health Plans

- Retiree
- Active employment
- Consolidated Omnibus Budget Reconciliation Act

State

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

Federal

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

Other

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

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There are a number of possible drug coverage payers.

Employer Group Health Plans

- Retiree
- Active employment
- Consolidated Omnibus Budget Reconciliation Act

State

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

Federal

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

Other

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

Type of Coverage	Situation	Part D Pays First for Medically Necessary Part D Covered Prescriptions
Employer Group Health (EGHP) Plan	You're 65 or older and have retiree coverage	Yes
	You're 65 or older with EGHP coverage through current employment (yours or your spouse's)	If the employer has less than 20 employees
	You're under 65 with a disability and have EGHP coverage through current employment (yours or a family member's)	If the employer has less than 100 employees
	You're eligible for Medicare due to End-Stage Renal Disease (ESRD) and you have EGHP coverage	When the 30-month coordination period ends, or if you had Medicare before you had ESRD
Consolidated Omnibus Budget Reconciliation Act (COBRA)	You're 65 or older, have a disability, and have COBRA continuation coverage	In most cases
	You have COBRA continuation coverage and are eligible for Medicare due to ESRD	When your 30-month coordination period ends
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Part D (Medicare prescription drug coverage) usually pays first if you have retiree coverage.

Medicare Part D pays first also for

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

NOTE: The Federal Employee Health Benefits (FEHB) program is a type of EGHP. It covers participating current and retired federal employees. There is usually not much benefit to having 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 (Medicare prescription drug coverage) generally pays first before Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage for people 65 and older and those who have a disability.

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

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

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 Indian Health Services (IHS) and Tribes is tied to pharmacy network contracting. Regulations require all Part D sponsors to offer network contracts to all IHS, tribes and tribal organizations, and urban Indian organization (I/T/U) provider pharmacies operating in their service area.

Veterans Affairs (VA) benefits, including prescription drug coverage, are separate and distinct from benefits provided under Part D (Medicare prescription drug coverage). Legally, the VA can't bill Medicare. You may be eligible to receive VA prescription drug benefits and enroll in a Part D plan, but you can't use both benefits for a single prescription. VA prescriptions generally must be written by a VA doctor 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 prescription drug coverage is creditable coverage, you won't face a penalty if you delay enrollment in a Part D plan. However, if you get less than full VA prescription drug benefits, you may benefit from enrollment in a Part D plan—particularly if you're eligible for Extra Help.

TRICARE for Life (TFL) coverage includes prescription drug benefits. These benefits qualify as creditable coverage. 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 won't be charged a late enrollment penalty.

Under the Medicare Modernization Act (MMA), if you have both Medicare and full Medicaid benefits (called "full-benefit dual eligibles") you 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.

Type of Coverage	Situation	Part D Pays First for Medically Necessary Part D Covered Prescriptions
State Pharmaceutical Assistance Programs	You get assistance from a State Pharmaceutical Assistance program	Yes. The state just helps pay your Part D costs.
Workers' Compensation	If you're covered under Workers' Compensation	For prescriptions other than those for the job-related illness or injury. Medicare may make a conditional payment.
Manufacturer-sponsored Patient Assistance Program	If you get help from a Manufacturer-sponsored Patient Assistance Program	Yes
Charity	If you get help from a charity	Yes
No-fault/Liability Insurance	If you're covered by No-Fault/Liability insurance, such as for an automobile accident, injury in a public place, or malpractice	For prescriptions covered by Part D not related to the accident or injury.
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If you get help from a State Pharmaceutical Assistance Program, Medicare Part D pays first.

If you're covered under workers' compensation, Part D will pay first for covered prescriptions that aren't 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 won't pay if it's aware that the enrollee has workers' compensation, Federal Black Lung Benefits 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, if 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.

Medicare Part D plans pay first for medically necessary Part D covered prescriptions, and manufacturer-sponsored patient assistance programs and charities can help you with the remaining costs. Charitable program members may present a retail ID card at the point of sale to get financial assistance.

If you're 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 aren't related to the accident or injury.

Check Your Knowledge—Question 4

It's important to make an informed decision about whether to keep or drop coverage through an employer or union retirement plan because

- a. If you drop retiree group health coverage you may not be able to get it back
- b. If you drop drug coverage you may also lose doctor and hospital coverage
- c. Family members covered by the same policy may also be affected
- d. All the above

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Check Your Knowledge—Question 4

It's important to make an informed decision about whether to keep or drop coverage through an employer or union retirement plan because

- a. If you drop retiree group health coverage you may not be able to get it back
- b. If you drop drug coverage you may also lose doctor and hospital coverage
- c. Family members covered by the same policy may also be affected
- d. All the above

ANSWER: d. All of the above.

Check Your Knowledge—Question 5

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

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Check Your Knowledge—Question 5

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

- a. Medicaid pays for all prescriptions
- b. Medicare pays for prescriptions other than those for the job-related injury or illness
- c. Medicare pays for all prescriptions
- d. Medicaid pays for prescriptions other than those for the job-related injury or illness

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

The Medicare Modernization Act established that people with both Medicare and full Medicaid benefits will receive drug coverage from Medicare rather than Medicaid.

Coordination of Benefits Resource Guide

Resources

Centers for Medicare & Medicaid Services (CMS)
 1-800-MEDICARE
 (1-800-633-4227)
 TTY 1-877-486-2048
[Medicare.gov](http://www.Medicare.gov)
[CMS.gov](http://www.CMS.gov)

Benefits Coordination & Recovery Center
 1-855-798-2627
 TTY 1-855-797-2627

U.S. Department of Labor
 1-866-4-USA-DOL
 (1-866-487-2365)
dol.gov/dol/topic/health-plans/cobra.htm

Office of Personnel Management (Federal Employees Health Benefit Program)
opm.gov/healthcare/insurance/healthcare/

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Medicare Products

Patient Assistance Program Center
rxassist.org

Medicare/TRICARE Benefit Overview
TRICARE.mil/welcome/eligibility.aspx

TRICARE
TRICARE.mil/

U.S. Department of Veterans Affairs
 1-800-827-1000
 TTY 1-800-829-4833
va.gov/opa/publications/benefits_s_book.asp

Veterans Affairs
benefits.va.gov/benefits/

Federal Black Lung Benefits Program
dol.gov/compliance/topics/benefits-comp-blacklung.htm
 1-800-638-7072
 TTY 1-877-889-5627

“Medicare & You” Handbook
 CMS Product No. 10050

“Your Medicare Benefits”
 CMS Product No. 10116

“Medicare and Other Health Benefits: Your Guide to Who Pays First”
 CMS Product No. 02179

To access these products
 View and order single copies at Medicare.gov/publications

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

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Acronyms

BCRC	Benefits Coordination & Recovery Center
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
EGHP	Employer Group Health Plan
ESRD	End-Stage Renal Disease
FEHB	Federal Employee Health Benefits
GHP	Group Health Plan
IHS	Indian Health Services
IRS	Internal Revenue Service
I/T/U	Indian Health Service, Tribal, and Urban Indian
MMA	Medicare Modernization Act
MSP	Medicare Secondary Payer
NTP	National Training Program
QHP	Qualified Health Plan
SHIP	State Health Insurance Assistance Program
SHOP	Small Business Health Options Program
SPAP	State Patient Assistance Program
SSA	Social Security
TFL	TRICARE for Life
VA	Veterans Affairs
VDSA	Voluntary Data-Sharing Agreement
WCMSA	Workers' Compensation Medicare Set-aside Arrangement

CMS National Training Program (NTP)

To view all available NTP training materials, or to subscribe to our email list, visit

[CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html](https://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html)

For questions about training products email

training@cms.hhs.gov

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