

DEPARTMENT OF HEALTH & HUMAN SERVICES

 **National Medicare**

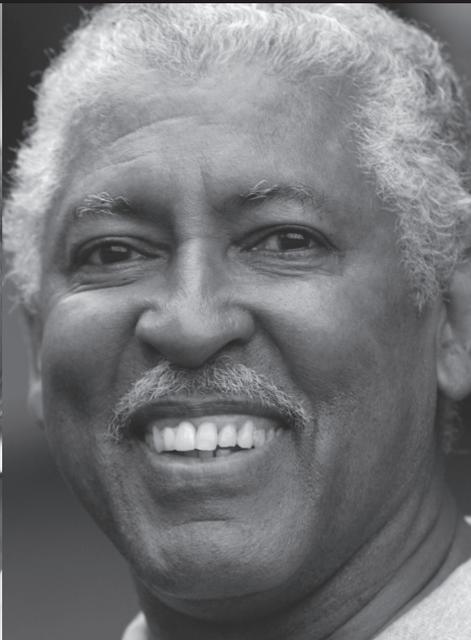
**TRAINING PROGRAM**

CENTERS FOR MEDICARE & MEDICAID SERVICES

# Coordination of Benefits Module 5



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



**2011 Workbook**



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

**Module Description**

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

The materials—up-to-date and ready-to-use—are designed for information givers/trainers that are familiar with the Medicare program, and would like to have prepared information for their presentations. Where applicable, updates from recent legislation are included. The New in 2011 icon is used to highlight changes based on the Affordable Care Act.



The following topics are included in this module:

Slides	1-12	Coordination of Benefits Overview
Slides	11-36	Health Coverage Coordination
Slides	37-59	Coordination of Benefits for Prescription Drug Coverage
Slides	60-66	Information Resources

**Objectives**

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

**Target Audience**

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

**Learning Activities**

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

**Handouts**

Slides 27 & 28 are provided as full page handouts in the Appendix of this workbook. You may want to refer to these during your training if you provide copies of the workbooks to attendees. Or, you may wish to make copies of the handouts and distribute them as learning aids.

**Time Considerations**

The module consists of 69 PowerPoint slides with corresponding speaker’s notes. It can be presented in about 2 hours. Allow approximately 30 more minutes for discussion, questions and answers and the learning activities.

**References**

*Medicare Coordination of Benefits*

- [www.cms.hhs.gov/COBGeneralInformation/](http://www.cms.hhs.gov/COBGeneralInformation/)
- [www.cms.hhs.gov/COBAgreement/](http://www.cms.hhs.gov/COBAgreement/)



## Coordination of Benefits: Module 5

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, and the Children's Health Insurance Program (CHIP). The information in this module was correct as of April 2011.



To check for updates on health care reform, visit [www.healthcare.gov](http://www.healthcare.gov)



To view the Affordable Care Act visit [www.ealthcare.gov/center/authorities/patient\\_protection\\_affordable\\_care\\_act\\_as\\_passed.pdf](http://www.ealthcare.gov/center/authorities/patient_protection_affordable_care_act_as_passed.pdf)



To check for an updated version of this training module, visit [www.cms.gov/NationalMedicareTrainingProgram/TL/list.asp](http://www.cms.gov/NationalMedicareTrainingProgram/TL/list.asp) on the web.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

## Session Objectives

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

- At the end of this session, you will be able to
  - Define coordination of benefits
  - Explain health and drug coverage coordination
  - Determine who pays first
  - Recognize where to get more information

## Lessons

1. Overview of Coordination of Benefits
2. Health Coverage Coordination
3. Prescription Drug Coverage Coordination
4. Knowledge Check

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The topics for this session include the following:

1. An overview of Coordination of Benefits
2. Health Coverage Coordination
3. Prescription Drug Coverage Coordination
4. Knowledge Check

## Lesson 1 – Coordination of Benefits Overview

- Coordination of Benefits (COB)
- Medicare Secondary Payer
- Identifying the Appropriate Payer
- COB Systems
- COB Contractors
- COB Agreement Program

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This section provides an overview of Coordination of Benefits and how it works.

- Coordination of Benefits
- Medicare Secondary Payer
- Identifying the Appropriate Payer
- COB Systems
- COB Contractors
- COB Agreement Program

## **Coordination of Benefits (COB)**

- The goal of COB is to ensure proper payment
  - Identify the available health benefits
  - Coordinate the payment process
  - Prevent mistaken payment of Medicare benefits
- COB contractor consolidates COB activities

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- The goal of Coordination of Benefits is to ensure proper payment by identifying the health benefits available to Medicare beneficiaries and coordinating the payment process to prevent mistaken payment of Medicare benefits.
- The Coordination of Benefits Contractor consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries.

## Coordination of Benefits (COB)

- Benefits everyone
  - Individuals and their caregivers
  - Healthcare providers
  - Healthcare system
- Ensures claims are paid correctly
- Ensures primary payer pays first
- Medicare Modernization Act expanded meaning
  - Requires tracking of TrOOP costs
  - Improved communication among providers

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- Coordination of Benefits benefits everyone:
  - Individuals and their caregivers experience less stress, knowing their claims are paid accurately.
  - Healthcare providers, by identifying all available health and drug benefits, streamlining the payment process, supporting Part D plans in tracking true out-of-pocket costs, and providing quality customer service.
  - It also benefits Medicare and our healthcare system by protecting the Medicare Trust Fund.
- The Coordination of Benefits program (COB) identifies all of the health care benefits available to a person with Medicare, ensures that claims are paid correctly, and that the primary payer, whether Medicare or other insurer pays first.
  - Medicare eligibility data is shared with other payers and Medicare-paid claims are transmitted to supplemental insurers for secondary payment. An agreement must be in place between CMS' Coordination of Benefits Contractor (COBC) and private insurance companies for the COBC to automatically cross over claims. In the absence of an agreement, the person with Medicare is required to coordinate secondary or supplemental payment of benefits with any other insurers he or she may have in addition to Medicare.
  - Plans are ensured that the amount paid in dual coverage situations does not exceed 100% of the total claim, avoiding duplicate payments.
- Under the Medicare Modernization Act (MMA), the meaning of COB expanded further:
  - Requires tracking of true out-of-pocket (TrOOP) costs, or "incurred costs" for people who enroll in Medicare prescription drug coverage. Tracking TrOOP determines when a person becomes eligible for catastrophic coverage. The COB process provides Part D plans with information they can use to calculate their members' TrOOP costs.
  - The law also introduced new ways to improve communication among multiple service providers for enhanced payment oversight, preventing mistaken payment of Medicare benefits and protecting the Medicare Trust Fund. Coordination of benefits results in higher quality services for people with Medicare and a more sound healthcare system.



See Section 1860D-2 of the Medicare Modernization Act (MMA) of 2003.

## What Is MSP?

- Medicare Secondary Payer law mandates
  - Certain insurance pays health care bills first
  - Medicare pays second
  - Identify other insurance that may pay first
- Medicare is primary
  - In the absence of other primary insurance
- States play a crucial role in MSP in some issues
  - Workers' Compensation
  - Liability insurance

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- Medicare Secondary Payer (MSP) law mandates that certain types of insurance pay health care bills first and that Medicare pay second.
- Other insurance that may pay first includes group health plan insurance, no-fault insurance, liability insurance, workers' compensation, and the Federal Black Lung Program. We will discuss each of these situations in more detail later.
- Medicare is primary in the absence of other primary insurance coverage.
- In most cases, except the situations just mentioned, Medicare is also primary for prescription drug coverage.
- States play a crucial role in MSP, for instance with Workers' Compensation and liability insurance.

## Identifying the Appropriate Payer

- Medicare may
  - Be primary payer
  - Be secondary payer
  - Not make payment
- Data sources include
  - Initial Enrollment Questionnaire (IEQ)
  - Doctors and other providers
  - Group health plans and other health insurers
  - Employers
- Mandatory reporting requirements from Medicare, Medicaid, SCHIP Extension Act

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- It is important to identify whether a person's medical costs are payable by other insurance before, or in addition to, Medicare. This information helps health care providers determine who to bill and how to file claims with Medicare. There are many insurance benefits a person could have and many combinations of insurance coverage to consider before determining who pays and when. Depending on the type of additional insurance coverage a person may have, Medicare may be the primary payer or secondary payer for a person's claim, or may not pay at all.
- CMS uses the Initial Enrollment Questionnaire (IEQ) to collect MSP information from all individuals prior to Medicare entitlement. The IEQ asks about other insurance that may be primary to Medicare. In addition to the IEQ and other information from the person with Medicare, Medicare receives health coverage information from doctors, other providers, group health plans, and employers.
- The Medicare, Medicaid, and SCHIP Extension Act (MMSEA) added new mandatory reporting requirements for group health plan (GHP) arrangements and for liability insurance (including self-insurance), no-fault insurance, and workers' compensation.



See Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173) and 42 U.S.C. 1395y(b)(7) & (8) for more information on mandatory reporting requirements.

## COB Systems

- IRS/SSA/CMS Data Match
- Databases maintained by multiple stakeholders
  - Federal agencies
  - States
  - Plans
  - Pharmacies
  - Assistance programs

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- COB relies on multiple databases maintained by multiple stakeholders, including Federal and state programs, plans that offer health insurance and/or prescription coverage, pharmacy networks, and a variety of assistance programs available for special situations and/or conditions.
- A key data source is the IRS/SSA/CMS Data Match. The law requires the Internal Revenue Service (IRS), the Social Security Administration (SSA), and CMS to share information about Medicare beneficiaries and their spouses. The Data Match identifies situations where another payer is primary to Medicare.
- In addition, CMS has entered into Voluntary Data Sharing Agreements with numerous Fortune 500 companies and other large employers. These agreements allow employers and CMS to send and receive group health plan enrollment information electronically. By law, employers are required to complete a questionnaire on the group health plan that Medicare-eligible workers and their spouses choose. Where discrepancies occur in the Voluntary Data Sharing Agreements, employers can provide enrollment/disenrollment documentation. This ensures the integrity of the Medicare program and has saved the Medicare Trust Funds more than \$3.5 billion.



See Social Security Act, Section 1862 (b)(5).

## COB Contractors

- Emblem Health (formerly GHI)
  - Consolidates activities to support other coverage
    - Collection, management and reporting
    - Payment process
  - Doesn't process claims, recovery, or claim specific inquiries
  - Centralizes COB for Medicare Secondary Payer
- RelayHealth
  - Centralizes COB for Medicare Part D
  - Acts as TrOOP facilitator

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- The Coordination of Benefits Contractor (COBC) consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The COBC does not process claims, nor does it handle any mistaken payment recoveries or claim specific inquiries. The Medicare intermediaries and carriers are responsible for processing claims submitted for primary or secondary payment. Contact the COBC to
  - Report employment changes, or any other insurance coverage information.
  - Report a liability, auto/no-fault, or workers' compensation case.
  - Ask general Medicare Secondary Payer (MSP) questions/concerns.
  - Ask questions regarding Medicare Secondary Development (MSP) letters and questionnaires.
- In May 2005, CMS awarded a single contract to NDCHealth (now RelayHealth) to facilitate the TrOOP tracking process and eligibility transactions for Medicare Part D. This service enables Part D plans to properly calculate TrOOP balances through electronic processing of claims at the pharmacy point of sale.

## COB Agreement Program

- COB Agreement (COBA) Program
  - Contract between COB Contractor and other health insurance organizations
    - National standard contract
    - Medigap plans, Part D Plans, Employer Group Health Plans (EGHPs), others
  - Consolidates Medicare crossover process
    - Enrollee eligibility data
    - Medicare paid claims data transmittals

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- The COBA program established a national standard contract between the Coordination of Benefits Contractor and other health insurance organizations for transmitting enrollee eligibility data and Medicare paid claims data. This means that Medigap plans, Part D plans, employer supplemental plans, self-insured plans, the Department of Defense, Title XIX state Medicaid agencies, and others rely on a national repository of information with unique identifiers to receive Medicare paid claims data for the purpose of calculating their secondary payment.



For more information about the COBA program, please visit [www.cms.gov/COBAgreement/](http://www.cms.gov/COBAgreement/)

## Lesson 2 - Health Coverage Coordination

- **Other Health Care Payers**
- **Determining Who Pays First**

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The topics for the next session on Health Coverage Coordination include

- Other Health Care Payers
- Determining Who Pays First

## Other Possible Health Care Payers

- No-fault or liability insurance
- Workers' compensation
- Federal Black Lung Program
- COBRA continuation coverage
- Employer/union/retiree group health plans
  - Federal Employee Health Benefits Program
  - Military coverage through veterans' benefits
    - VA
    - TRICARE For Life
  - Others

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- There are a number of other types of health coverage a person with Medicare might have including:
  - No-fault or liability insurance
  - Workers' compensation
  - Federal Black Lung Program
  - COBRA continuation coverage
  - Employer/union and retirement group health plans, including
    - Federal Employee Health Benefits Program
    - Military coverage through veterans' benefits (VA) and TRICARE for Life (TFL)
    - Others

## No-Fault Insurance

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

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- No-fault insurance is insurance that pays for health care services resulting from personal injury or damage to someone's property regardless of who is at fault for causing it. Types of no-fault insurance include the following:
    - Automobile insurance
    - Homeowners' insurance
    - Commercial insurance plans
  - Medicare is the secondary payer where no-fault insurance is available.
  - Medicare generally will not pay for medical expenses covered by no-fault insurance. However, Medicare may pay for medical expenses if the claim is denied for reasons other than not being a proper claim. Medicare will make payment only to the extent that the services are covered under Medicare. Also, if the no-fault insurance does not pay promptly (usually within 120 days), Medicare may make a conditional payment. A conditional payment is a payment for which Medicare has the right to seek recovery.
  - The money that Medicare used for the conditional payment must be repaid to Medicare when the no-fault insurance settlement is reached. If Medicare makes a conditional payment and the person with Medicare later resolves the insurance claim, Medicare will seek to recover the conditional payment from the person. He or she is responsible for making sure that Medicare gets repaid for the conditional payment.
-  The MMA (P.L. 108-173, Title III, Sec. 301) further clarifies language protecting Medicare's ability to seek recovery of conditional payments.

## Liability Insurance

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

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- Liability insurance is coverage that protects a party against claims based on negligence, inappropriate action, or inaction that results in injury to someone or damage to property. Liability insurance includes, but is not limited to
  - Homeowner's liability insurance
  - Automobile liability insurance
  - Product liability insurance
  - Malpractice liability insurance
  - Uninsured motorist liability insurance
  - Underinsured motorist liability insurance
- Medicare is the secondary payer in cases where liability insurance is available. If health care professionals find that the services they gave an individual can be paid by a liability insurer, they must attempt to collect from that insurer before billing Medicare. Medicare may make a conditional payment if the liability insurer will not pay promptly, usually within 120 days. When the liability insurer pays, Medicare recovers its conditional primary payment.
- Medicare will only pay to the extent services are covered under Medicare.

## Workers' Compensation

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

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- Medicare generally will not pay for an injury or illness/disease covered by workers' compensation. If all or part of a claim is denied by workers' compensation on the grounds that it is not covered by workers' compensation, a claim may be filed with Medicare. Medicare may pay a claim that relates to a medical service or product covered by Medicare if the claim is not covered by workers' compensation.
- Prior to settling a workers' compensation case, parties to the settlement should consider Medicare's interest related to future medical services and whether the settlement is to include a Workers' Compensation Medicare Set-aside Arrangement (WCMSA).



WCMSAs are discussed in detail at [www.cms.gov/WorkersCompAgencyServices/04\\_wcsetaside.asp](http://www.cms.gov/WorkersCompAgencyServices/04_wcsetaside.asp)



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

## Federal Black Lung Program

- Lung disease caused by coal mining
- Services under this program
  - Considered workers' compensation claims
  - Not covered by Medicare
- Beneficiary covered benefits
- For more information call 1-800-638-7072

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- Some people with Medicare can get Federal Black Lung Program medical benefits for services related to lung disease and other conditions caused by coal mining. Medicare doesn't pay for health services covered under this program. Black lung claims are considered workers' compensation claims. All claims for services that relate to a diagnosis of black lung disease are referred to the Division of Coal Mine Workers' Compensation in the U.S. Department of Labor.
- However, if the services are not related to black lung, Medicare will serve as the primary payer if all the following are true:
  - There is no other primary insurance
  - The individual is eligible for Medicare
  - The services are covered by the Medicare program
- Federal Black Lung Program beneficiaries are eligible for prescription drugs, in-patient and out-patient services, and doctors' visits. In addition, home oxygen and other medical equipment, home nursing services, and pulmonary rehabilitation may be covered with a doctor's prescription.



A toll-free number has been designated for each of nine Division of Coal Mine Workers' Compensation district offices located in PA, WV, KY, OH, and CO. A toll-free number, 1-800-638-7072, has been designated for the office that is responsible for the Black Lung Program's medical diagnostic and treatment services.



For more information about the Federal Black Lung Program, visit, [www.dol.gov/compliance/topics/benefits-comp-blacklung.htm](http://www.dol.gov/compliance/topics/benefits-comp-blacklung.htm)

## COBRA

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

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- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to let employees and their dependents keep their health coverage for a time after they leave their Employer Group Health Plan (EGHP), under certain conditions. This is called “continuation coverage.” The law applies to private sector and state and local government sponsored plans, but not to Federal government sponsored plans or the governments of the District of Columbia or any territory or possession of the U.S. or to certain church-related organizations. (The Federal Employee Health Benefits Program is subject to similar temporary continuation of coverage provisions under the Federal Employees Health Benefits Amendments Act of 1988).
- COBRA coverage can begin due to certain events, such as loss of employment or reduced working hours, divorce, death of an employee, or a child ceasing to be a dependent under the terms of the plan. For loss of employment or reduced working hours, COBRA coverage generally continues for 18 months. Certain disabled individuals and their non-disabled family members may qualify for an 11-month extension of coverage from 18 to 29 months. Other qualifying events call for continued coverage up to 36 months.
- Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since the participant pays both their part and the part of the premium their employer paid while they still worked. However, it usually costs less than individual health coverage.



For more information about continuation coverage, visit [www.cms.hhs.gov/COBRAContinuationofCov](http://www.cms.hhs.gov/COBRAContinuationofCov) and [www.cms.gov/HealthInsReformforConsume](http://www.cms.gov/HealthInsReformforConsume).

## COBRA and Medicare

- Medicare is usually primary
  - Secondary during 30-month coordination period for End-Stage Renal Disease (ESRD)
- State Health Insurance Assistance Program (SHIP) counselors can help

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- Medicare is usually primary to COBRA continuation coverage for aged and disabled individuals.
- Medicare is secondary to COBRA for individuals with ESRD during the 30-month coordination period.
- Before electing COBRA coverage, people may find it helpful to talk with a State Health Insurance Assistance Program (SHIP) counselor to better understand their options. For example, if a person who already has Medicare Part A chooses COBRA but waits to sign up for Medicare Part B until the last part of the 8-month Special Enrollment Period following termination of employment, the employer can make the person pay for services that Medicare would have covered if he or she had signed up for Part B earlier.
- In some states, SHIP counselors can also provide information about timeframes on COBRA and Medigap guaranteed issue rights in a given state. Timeframes may differ depending on state law.



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



You can view this publication at <https://www.medicare.gov/Publications/Pubs/pdf/02179.pdf>.

## Bankruptcy of Former Employer

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

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- If you have retiree health coverage after you retire and your former employer goes bankrupt or out of business, Federal COBRA rules may offer protection. These rules require any other company within the same corporate organization that still offers an EGHP to its employees to offer COBRA continuation coverage through that plan.
- If someone loses group health coverage after retirement because a former employer goes bankrupt, it may be possible to get “COBRA-for-life.” This means that the person can keep COBRA for the rest of his or her life or until the company ceases to exist. Like any other employer plan, benefits can change and the cost of coverage can go up.



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



You can view this publication at <https://www.medicare.gov/Publications/Pubs/pdf/02179.pdf>.

## **Federal Employee Health Benefits Program (FEHBP)**

- An Employer Group Health Plan (EGHP)
- Pays secondary when person retires
- Pays first
  - If person with Medicare or covered spouse still working
  - For person or spouse during first 30 months of eligibility due to ESRD

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- The Federal Employee Health Benefits Program (FEHBP) offers health coverage for current and retired Federal employees and covered family members. FEHBP plans also cover prescription drugs, routine physicals, emergency care outside of the United States, and some preventive services that Medicare doesn't cover. Some FEHBP plans also cover dental and vision care.
- Like any other group health plan, the FEHBP remains primary until a person retires.
- An FEHB plan must pay benefits first for an active Federal employee or reemployed annuitant with Medicare, or his/her covered spouse, unless the reemployment position is excluded from FEHBP coverage or the person is enrolled in Medicare Part B only.
- The FEHB plan must also pay benefits for the person during the first 30 months of eligibility for Part A benefits because of ESRD, regardless of employment status.
- Generally, FEHBP plans help pay for the same kind of expenses as Medicare. Retired people with an FEHB plan can choose whether or not to enroll in Medicare. Those who choose to enroll but do not do so within their initial enrollment period, must wait to enroll for a general FEHB enrollment period (January 1 to March 31 each year), and coverage will begin the following July 1st. It is important a person also understand that a retiree is qualified to enroll in Part B will receive a 10% premium penalty for each 12-month period for which they qualified to receive Part B but didn't enroll.



For more information on FEHBP, visit: [www.opm.gov/insure/](http://www.opm.gov/insure/).

## Veteran's Benefits (VA)

- People with Medicare and VA benefits
  - Can obtain treatment under either program
  - Must choose which benefit to use **each time**
- Generally
  - Medicare cannot pay for service authorized by VA
  - VA cannot pay for service covered by Medicare
- VA member could be subject to a penalty
  - For Medicare Part B late enrollment

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- People with both Medicare and Veterans' benefits can access healthcare treatment under either program. However, they must choose which benefit they will **use each time the person sees a doctor or receives health care**, e.g., in a hospital. Medicare will not pay for the same service that was authorized by the Department of Veterans Affairs; similarly, Veterans' benefits will not make primary payment for the same service that was covered by Medicare.
- To receive services under VA benefits, a person must receive their health care at a VA facility OR have the VA authorize services in a non-VA facility.
- Veterans could be subject to a penalty for enrolling "late" for Medicare Part B, even if they are enrolled in VA health care.



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

## TRICARE For Life (TFL)

- TRICARE's Medicare-wraparound coverage
  - Available to *all* Medicare-eligible TRICARE beneficiaries
- Medicare is primary
- TRICARE acts as secondary payer
  - Minimizes out-of-pocket expenses
  - Covers Medicare's coinsurance and deductible
- **MUST have Medicare Parts A and B**

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- TRICARE For Life (TFL) is TRICARE's Medicare-wraparound coverage available to *all* Medicare-eligible TRICARE beneficiaries, regardless of age, provided they have Medicare Parts A **and** B.
- While Medicare is your primary insurance, TRICARE acts as your secondary payer minimizing your out-of-pocket expenses. TRICARE benefits include covering Medicare's coinsurance and deductible.

## How TRICARE For Life Works with Medicare

- If you use a Medicare provider
  - Medicare provider will file claims with Medicare
  - Medicare pays its portion and forwards claim to TFL
  - TFL pays provider directly for TRICARE-covered services
- Services covered by both Medicare and TRICARE
  - Medicare pays first
  - TFL pays remaining
- Services covered by TRICARE but not by Medicare
  - TFL pays first
  - Medicare pays nothing

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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 TRICARE-covered services.

- For services covered by both Medicare and TRICARE, Medicare pays first and TFL pays your remaining coinsurance for TRICARE-covered services.
- For services covered by TRICARE but not by Medicare, TFL pays first and Medicare pays nothing. You must pay the TRICARE fiscal year deductible and cost shares.
- For services covered by Medicare but not by TRICARE, Medicare pays first and TFL pays nothing. You must pay the Medicare deductible and coinsurance.
- For services not covered by Medicare or TRICARE, Medicare and TRICARE pay nothing and you must pay the entire bill.
- When a TRICARE beneficiary receives services from a military hospital or any other Federal provider, TRICARE will pay the bills. Medicare does not usually pay for services received from a Federal provider or other Federal agency.

## When Medicare is Primary

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

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Coordination of Benefits

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- It is important to be able to determine who pays first if you have Medicare and another type of health care coverage.
- For most people with Medicare, Medicare is their primary payer, meaning Medicare pays first on their health care claims. Some situations where Medicare is the primary payer include
  - Medicare is the sole source of medical, hospital, or drug coverage
  - Medigap policy or other privately purchased insurance policy **is not** related to current employment (This type of policy covers amounts not covered by Medicare)
  - Coverage through Medicaid and Medicare (dual eligible beneficiaries), with no other coverage that could be primary to Medicare
  - Retiree coverage, in most cases (To know how a plan works with Medicare, check the plan's benefits booklet or plan description provided by the employer or union, or call the benefits administrator)
  - Health care services provided by Indian Health Service (IHS)
  - TRICARE For Life (Note: TRICARE pays for services from a military hospital or any other federal provider)
  - Coverage under COBRA, with one exception, End-Stage Renal Disease (ESRD) (We'll talk about this coverage shortly)

## When Medicare is Secondary

- To employer group health plans (EGHP)\*
  - 65+ and still working: EGHP 20 or more employees
  - Disability: EGHP 100 or more employees
  - ESRD: Any size EGHP after initial 30-months
- To non-EGHP involving
  - Workers' Compensation (WC)
  - Black Lung Program
  - No-fault/liability insurance

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- Some people with Medicare have other insurance or coverage that must pay individual benefits **before** Medicare pays its co-share. This applies no matter how the person receives benefits from Medicare, whether from Original Medicare or a Medicare Advantage Plan. Let's take a look at situations in which Medicare is the secondary payer.
- According to law, Medicare is generally the secondary payer in the following situations:
  - **Working Aged and EGHP** – A person age 65 or older who has Medicare and who is also covered through an Employer Group Health Plan and either the person or their spouse is actively employed – including self-employed) in a firm with **20 or more** employees; or if the employer is part of a multi-employer group health plan where at least one employer in the plan has **20 or more** employees.
  - **Disability and EGHP** – If a person with Medicare based on disability (under age 65) is covered through his or her current employer or a spouse's current employer in a large firm with **100 or more** employees.
  - **ESRD and EGHP** – If a person with Medicare based on ESRD is covered by a Employer Group Health Plan of any size, the group health plan is primary for an **initial 30-month coordination period**, after which Medicare becomes primary. The EGHP coverage does not need to be based on the current employment of the person, spouse, or family member.
- Medicare is also the secondary payer in most non-group health plan situations involving
  - **Workers' Compensation** – The person with Medicare is covered under Worker' Compensation and the illness or injury is job-related.
  - **Black Lung** – The person with Medicare has black lung disease and is covered under the Federal Black Lung Program.
  - **No-fault/liability** – The person with Medicare received health care that may be covered by no-fault or liability insurance, such as in the case of an automobile accident, injury in a public place, or malpractice.

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Other Health  
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Guide to Who  
Pays First, CMS  
Pub. #02179**

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

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**Note:** The presenter may choose to use this chart, and the chart on the following slide, to discuss coordination of benefits for health coverage. Refer the audience to this chart, which is provided in a larger size at the back of the corresponding workbook. Otherwise, you may wish to mention this is available as a resource, and continue through the module.

- This chart, and the chart on slide 28 provide a quick reference to who pays first depending on the situation. This chart is available as a handout in the corresponding workbook (see Appendix A).



This chart appears on page 6 of *Medicare and Other Health Benefits: Your Guide to Who Pays First*, CMS Product No. 02179.



You can view it at [medicare.gov/Publications/Pubs/pdf/02179.pdf](http://medicare.gov/Publications/Pubs/pdf/02179.pdf).

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CMS Pub.  
#02179**

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

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- This chart is also available as a handout in the corresponding workbook (see Appendix A).



This chart appears on page 7 of *Medicare and Other Health Benefits: Your Guide to Who Pays First*, CMS Product No. 02179.



You can view it at <https://www.medicare.gov/Publications/Pubs/pdf/02179.pdf>

## **Employer Group Health Plans (EGHP)**

- Offered by many employers and unions
  - Current employees
  - Retirees
  - Spouse or family members
- May be fee-for-service plan
- May be managed care plan
- Can choose to keep or reject

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- Let's discuss some situations where a person might be covered by an EGHP. Coordination of benefits is dependent on whether the person, or his/her spouse or family member, is currently working or retired, and on the number of employees of that company.
- Employer group health coverage is coverage offered by many employers and unions for current employees and/or retirees. A person may also get group health coverage through a spouse's or other family member's employer. If someone has Medicare and is offered coverage under an EGHP, he or she can choose to accept or reject the plan. The EGHP may be a fee-for-service plan or a managed care plan, like an HMO.

## EGHP and Working Aged

- Age 65 or older **and**
  - Working and covered by EGHP or
  - Covered by working spouse's EGHP
- Medicare is generally the secondary payer
  - If employer has 20 or more employees
  - For self-employed, if covered by EGHP of employer with 20 or more employees

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- Working aged means that a person is at least age 65 and is
  - Currently working and covered by an EGHP **OR**
  - Covered by an EGHP of a working spouse of any age
- Medicare is the secondary payer to an EGHP for the working aged if
  - The employer employs at least 20 employees **OR**
  - A smaller employer belongs to a multi-employer plan where at least one employer has 20 or more employees, unless the plan has formally requested to be exempt from making primary payments on behalf of that employer
- Medicare is also the secondary payer for self-employed individuals who are 65 or over and covered by an EGHP of an employer that has 20 or more employees.
- The employee or spouse may choose to drop EGHP coverage and elect Medicare as his or her primary payer. If the employee or spouse chooses to drop the EGHP coverage, **that employer cannot then offer, or subsidize, another plan that will pay as a supplement to Medicare.**

**Note:** Federal law requires employers with 20 or more employees to offer their employees age 65 or over and their spouses of any age the same coverage under the same conditions offered to employees and their spouses who are under age 65, (i.e., coverage that is primary to Medicare). This equal-benefit rule applies to coverage offered to full-time and part-time employees.

## **Large Employee Group Health Plan (LGHP) and Medicare Due to Disability**

- Medicare based on disability **and**
  - Working and covered by large EGHP (LGHP) or
  - Covered by LGHP of working spouse
    - Or other family member
- Medicare is secondary payer
  - If employer has 100 or more employees or
  - Self-employed, if covered by LGHP of employer with 100 or more employees

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- Medicare is the secondary payer for people who are under age 65 and entitled to Medicare because of a disability if they are covered by a large EGHP (LGHP) through current employment, either their own or that of a family member. In this instance, the employer must have 100 or more employees.
- Medicare is also secondary payer for people with Medicare who are under 65 and disabled if they are self-employed, or a family member is self-employed, and they are covered by an LGHP of an employer that has 100 or more employees.
- If any one employer within a multiple employer health plan has 100 or more employees, Medicare is secondary for all. This includes individuals associated with employers within the group that have less than 100 employees.

## EGHP and End-Stage Renal Disease

- Medicare and ESRD **and** covered by EGHP of any size
  - Coverage through self or family member
  - Need not be based on current employment
- Medicare is secondary payer
  - During 30-month coordination period
  - Unless Medicare is already primary to retiree plan

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- People with Medicare based on ESRD who have EGHP coverage on any basis may also have Medicare as a secondary payer, regardless of the number of employees and regardless of whether or not they or their spouse are currently employed. This applies both to people who have their own coverage and to those covered as family members.
- Medicare is secondary payer for the 30-month coordination period for these individuals. This period begins when the person is first eligible for Medicare because of ESRD, even if the person is not enrolled and does not have a Medicare card. At the end of the 30-month period, Medicare becomes the primary payer.
- Some people are already entitled to Medicare because of age or disability when they develop ESRD. If they are covered by an EGHP based on current employment that is primary payer to Medicare, the EGHP continues to be primary payer until the end of the 30-month coordination period, after which Medicare will be the primary payer. Medicare becomes primary after 30 months even for people who remain covered under their EGHP based on current employment.
- However, the MSP rules are different for people who are already entitled to Medicare based on age or disability and are covered under a retirement group health plan. If they become entitled to Medicare based on ESRD, Medicare remains primary payer (i.e., there is no 30-month coordination period).

## EGHP and ESRD

- EGHP primary payer for first 30 months
- Medicare becomes primary after 30 months
- Separate 30-month coordination periods
  - Each time eligible for Medicare based on ESRD
- Applies only to people with ESRD
- For details
  - <http://www.cms.gov/center/esrd.asp>

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- If a person is eligible to enroll in Medicare because of End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant), his or her EGHP will be the primary payer on hospital and medical bills for 30 months. The 30-month coordination period starts the first month the person is eligible to get Medicare because of kidney failure (usually the fourth month of dialysis), even if he or she is not yet enrolled in Medicare. At the end of the 30-month coordination period, Medicare becomes the primary payer. The EGHP coverage may pay for services not covered by Medicare.
- There is a separate 30-month coordination period each time a person is eligible for Medicare based on ESRD. For example, if a person gets a kidney transplant that continues to work for 36 months, his or her Medicare coverage will end. If the person later enrolls in Medicare again because he or she starts dialysis again or gets another transplant, Medicare coverage will start right away. However, there will be a new 30-month coordination period if the person has EGHP coverage.
- This applies only to people with ESRD, whether they have their own group health coverage or are covered as a family member.



For details please visit <http://www.cms.gov/center/esrd.asp>.

## Retiree Health Plans

- Medicare pays first
- Retiree coverage pays second
  - Might offer additional benefits
    - Prescription drug coverage
    - Routine dental care
  - Refer to plan's benefits booklet
    - Coverage for spouse
    - Employer/union may change benefits, change premiums, or cancel coverage

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- Generally, Medicare will pay first for health insurance claims, and the retiree coverage will be the secondary payer. Retiree coverage might fill some of the gaps in Medicare coverage and might offer additional benefits such as routine dental care. People who are not sure how their retiree coverage works with Medicare should get a copy of their plan's benefits booklet or look at the summary plan description provided by their employer or union. Workers approaching retirement should find out if employer coverage can be continued after they retire, and they should check the price and benefits, including benefits for a spouse. They should know what effect continuing coverage as a retiree will have on both their own and their spouse's insurance protections.
- Retiree coverage provided by an employer or union may have limits on how much it will pay. It may also provide "stop loss coverage," a limit on out-of-pocket costs. They can also call the benefits administrator and ask how the plan pays when a person has Medicare.
- Remember that the employer or union has control over the retiree insurance coverage it offers. The employer or union may change the benefits or the premiums and may also choose to cancel the insurance.
- The Federal Employee Health Benefit Program (FEHBP) will be discussed later.

**Note:** For retirees with Medicare based on ESRD, Medicare may be secondary to retiree coverage for the 30-month coordination period.

## Lesson 3 - Coordination of Prescription Drug Benefits

- Other Possible Drug Coverage
- Identifying the Appropriate Payer

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- *Coordination of Prescription Drug Benefits* explains how Medicare prescription drug coverage and other types of prescription drug coverage coordinate. It is important to know who pays first, and who may pay second.

## Other Possible Drug Coverage

- Medicaid programs
- State Pharmacy Assistance Programs (SPAPs)
- Patient Assistance Programs (PAPs) and charities
- AIDS Drug Assistance Programs (ADAPs)
- Safety-net providers
- Indian Health Service coverage
- Personal health savings accounts
- Part B drug coverage
- FEHBP
- VA
- TRICARE

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- There are a number of other types of prescription drug coverage that you may have in addition to Medicare prescription drug coverage.
- In addition to third-party group health plans, like employer/union plans, examples of such entities include:
  - State Medicaid programs
  - Various assistance programs for people with limited income or resources, such as
    - State Pharmacy Assistance Programs (SPAPs)
    - Charities and Patient Assistance Programs through drug manufacturers (PAPs)
    - AIDS Drug Assistance Programs (ADAPs)
  - Coverage through
    - Safety-Net Providers, such as Federally Qualified Health Centers and Rural Health Centers
    - Indian Health Service (IHS)
    - Personal health savings accounts, such as Health Savings Accounts (HSA) and Medical Savings Accounts (MSAs)
    - Medicare Part B
    - FEHBP
    - VA
    - TRICARE

## MMA Requirements

- Part D plans must coordinate benefits
  - With other payers of prescription drug coverage
  - Payment must take place at the pharmacy (or “point-of-sale”)
- MMA requires or encourages
  - Enrollment file sharing
  - Claims processing and payment coordination
  - Claims reconciliation reports
  - Protection against high out-of-pocket expenses and other tasks defined by CMS

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- The Medicare Modernization Act (MMA) requires Part D plans coordinate benefits with these other payers of prescription drug coverage. Coordination in the context of Part D means that coordination of benefits (payment of the primary/secondary/tertiary claims) take place at the pharmacy (or “point-of-sale”)
- MMA requires—or in some cases simply encourages—enrollment file sharing, claims processing and payment coordination; claims reconciliation reports; protection against high out-of-pocket expenses; and other tasks defined by CMS.

## Medicare Prescription Drug Coverage (Part D)

- Medicare is usually primary
  - Part D Plan pays first
- Situations involving Employer Group Health Plans
  - Part D Plan denies primary claims
- Non-group health plan situations
  - Part D Plan makes conditional primary payment
    - To ease burden on enrollee
    - Medicare is reimbursed

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- Generally, Medicare provides primary coverage for prescription drugs. Whenever Medicare is primary, the Part D Plan is billed and will pay first.
- When Medicare is the secondary payer, Part D Plans will always deny primary claims. Again, that would apply for
  - Working Aged (individuals 65+ and still working) with Medicare AND EGHP with fewer than 20 employees
  - A person with a disability with a large EGHP with fewer than 100 employees
  - ESRD with EGHP of any size after a 30-month coordination period
- When Medicare is the secondary payer to a non-group health plan, or when a plan does not know whether a covered drug is related to an injury, Part D plans will always make a “conditional” primary payment to ease the burden on the policyholder, unless certain situations apply. The Part D Plan will **not** pay if it is aware that the enrollee has workers’ compensation, Black Lung Program, or no-fault/liability coverage and has previously established that a certain drug is being used exclusively to treat a related illness or injury. For example, when an enrollee refills a prescription previously paid for by Worker’s Compensation, the Part D Plan may deny primary payment and default to MSP.
- The payment is “conditional” because it must be repaid to Medicare once a settlement, judgment, or award is reached.



The proposed settlement or update should be reported to Medicare by calling 1-800-MEDICARE and asking for the Medicare Coordination of Benefits Contractor, or by mailing relevant documents to COB contractor.

## Other Drug Coverage and Part D Enrollment Considerations

- Current coverage is creditable
  - Coverage as good as Medicare drug coverage
  - Can keep it as long as still offered
  - Won't pay penalty if enroll in Part D later
- Current coverage NOT creditable
  - Coverage not as good as Medicare drug coverage
    - Can enroll in Part D October 15 - December 7, 2011
    - Coverage begins January 1
  - Late enrollment may result in penalty

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- The Part D late enrollment penalty is an important consideration for people with other drug coverage. People who wait to enroll in Medicare drug coverage may have to pay a higher premium if their current coverage is not creditable. People should watch for the annual notice from the plan or talk to their benefits administrator for more information. The annual notice is generally sent in coordination with the EGHP's open enrollment period.
- If the other coverage is at least as good as Medicare drug coverage, people can keep it as long as it is still offered. They won't have to pay a higher premium if they enroll in Medicare drug coverage at a later date
- If the other coverage is NOT as good as Medicare drug coverage, people who don't enroll in a Medicare drug plan at their first opportunity can enroll October 15 – December 7 each year but may have to pay a higher monthly premium.
- Coverage begins January 1.

## Part D and Medicaid

- People with both Medicare and Medicaid
  - Get drug coverage from Medicare
  - Get low-income assistance (Extra Help)
- States may opt to cover non-Part D drugs
  - Does not count toward TrOOP
- COB between plans, states, and pharmacies
  - Not required
  - Part D plans may choose to share data
  - Some Special Needs Plans coordinate services for Medicaid recipients

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- Under the Medicare Modernization Act (MMA), state Medicaid programs no longer receive Federal funds for drugs covered under Medicare Part D. Consequently, people with both Medicare and full Medicaid benefits (called “full-benefit dual eligibles”) now receive drug coverage from Medicare instead of Medicaid. States still have the option of providing Medicaid coverage of drugs the MMA excludes from Part D coverage. To the extent that Medicaid covers those excluded drugs, the state can receive Federal funds for that coverage. However, coverage of non-Part D drugs by state Medicaid programs does not count as TrOOP costs toward the catastrophic coverage threshold.
- Many Medicaid programs chose to continue to provide coverage for some or all non-Part D drugs to ensure continuity of coverage for their constituents. However, the coordination of benefits between the pharmacy and state Medicaid programs is not part of the automated TrOOP facilitation process, because Medicaid is not an alternate payer of Part D claims. Nevertheless, Part D plans may develop a process to inform the pharmacy that Medicaid is a payer if a claim is denied as a non-Part D drug and there are no other payers for that claim. CMS cannot require data exchanges between Part D Plans and states, but encourages sharing of data on shared enrollees, consistent with HIPAA Privacy Rules.
- Some Medicare Special Needs Plans coordinate Medicare-covered services, including prescription drug coverage, for people with both Medicare and Medicaid.



*MMA reference: Section 1927(d)(2) of the Social Security Act*



*For more information about COB and Medicaid please visit [www.cms.hhs.gov/home/medicaid.asp](http://www.cms.hhs.gov/home/medicaid.asp).*

## Qualified State Pharmaceutical Assistance Program (SPAP)

- Coverage secondary to Part D
  - Contributions count toward TrOOP
- May opt to participate in COB and TrOOP facilitation, to help
  - Effectively wrap around Part D
  - Speed up reimbursement of erroneous payments
  - Facilitate timely access to prescriptions
- Some may enroll members in Part D
- Must be non-discriminatory

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- State Pharmaceutical Assistance Program (SPAP) coverage is secondary to Part D. Qualified SPAPs are unique among other payers because any payments they make on behalf of enrollees to supplement benefits available under Part D coverage before enrollees reach the annual out-of-pocket limit **will** count toward True Out-of-Pocket expenses (TrOOP).
- SPAPs are not required, but are encouraged to participate in COB and TrOOP facilitation data sharing. If they do, they can
  - Receive information on the low-income subsidy status of their enrollees to more effectively wrap around Part D coverage
  - Help Part D plans reimburse erroneous payments made by their enrollees to plans between the date of eligibility for low-income subsidy and the time the subsidy was processed by the plan
  - Facilitate pharmacy point-of-sale transactions for low-income enrollees who present at the pharmacy without their necessary ID cards.
- Certain SPAPs may have the authority to enroll members directly into Part D plans using an enrollment methodology approved by CMS.
- By definition, qualified SPAPs must be non-discriminatory with respect to outreach and enrollment and co-branding, and must follow CMS guidelines for these activities.



*For more information see [www.cms.gov/States/07\\_SPAPs.asp](http://www.cms.gov/States/07_SPAPs.asp).*

## **Patient Assistance Programs and Charities**

- Sponsored by
  - Pharmaceutical manufacturers
  - Other entities
- Provide for low-income patients
  - Financial assistance
    - Cost-sharing or premiums
  - Free products
  - Incomes below 200% Federal poverty level
  - No prescription drug coverage
  - Insufficient prescription drug coverage

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- Pharmaceutical manufacturers and other entities sponsor a number of patient assistance programs (PAPs) and charities to provide financial assistance (with cost-sharing or premiums) or free products (through in-kind product donations) to low-income patients, particularly those with incomes below 200% of the Federal poverty level who have no or insufficient prescription drug coverage.

## AIDS Drug Assistance Programs

- Help pay for HIV/AIDS drug treatments
- Contributions count toward TrOOP ← New  
in  
2011
  - Effective January 1, 2011
- Can choose to participate in COB either
  - Electronically at point-of-sale or
  - By submitting paper claims to TrOOP contractor

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- AIDS Drug Assistance Programs (ADAPs) are funded under the Ryan White CARE Act and are an integral component of the safety-net for HIV/AIDS patients. They fill coverage gaps in public and private insurance for critical HIV/AIDS drug treatments.
- Effective January 1, 2011, ADAP assistance with Part D cost-sharing counts as incurred (TrOOP) costs toward meeting the out-of-pocket threshold at which catastrophic coverage begins.
- When ADAPs voluntarily choose to participate in COB, they can do so electronically at the point-of-sale as a result of data-sharing agreements with CMS, or in the form of paper claims submitted in batches via the TrOOP contractor.



See section 3314 of The Patient Protection and Affordable Care Act (H.R. 3590) of 2010.

## Safety-Net Providers

- Serve low-income communities
- Examples include
  - Federally Qualified Health Centers
  - Rural Health Clinics
  - Critical Access Hospitals
- Offer services through a “closed pharmacy”
- Many in 340B Drug Pricing Program
  - Allows them to buy prescription drugs at lower prices

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- Safety-net provider organizations serve people who have limited income. These organizations typically include Federal, state, and local community health centers or clinics, many of which are deemed Federally Qualified Health Centers; public hospital systems; and local health departments. In some communities they also include teaching hospitals, community hospitals, and ambulatory care clinics. Other examples of the safety net are rural health clinics, small rural hospitals, critical access hospitals, clinics that receive Ryan White HIV/AIDS grant funding, and nurse-managed clinics.
- Many of these providers offer access to prescription drugs and pharmacy services to their own patients rather than the public at large. This access may be provided through a “closed pharmacy”—one that is not open to the general public and is smaller and less visible than the commonly identified retail pharmacies.
- An estimated 12,000 safety-net providers participate in the Health Resources and Services Administration’s 340B Drug Pricing Program, which allows them to buy prescription drugs at significantly discounted prices. Participation in the 340B Program can enable pharmacies to provide prescriptions to their patients at lower-than-market price.



For more information visit: [www.hrsa.gov/opa/introduction.htm](http://www.hrsa.gov/opa/introduction.htm)

## Employer/Union Drug Plan Options

- EGHP options
  - Take Retiree Drug Subsidy
  - Become a Medicare drug plan
  - Wrap around Medicare drug coverage
  - Pay enrollees' Medicare drug plan premium
- May change at any time during year
  - Not tied to specific enrollment period

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- The MMA allows employers and unions flexibility in designing their benefit packages and is intended to encourage them to keep, or even improve, the coverage they offer.
- Plans can choose from different options.
- EGHP options:
  - Many plans opt for the Retiree Drug Subsidy
  - These plans may require enrollees to choose between Medicare drug coverage or the EGHP
  - Some plans may choose to become Medicare drug plans
  - Some plans may choose to wrap around Medicare drug coverage
  - Some plans may choose to pay the Medicare drug coverage premium for their enrollees
- The option the EGHP chooses may change at any time during the year, because these plans are not required to make changes during a specific open or annual enrollment period.

## Important Considerations for People with Retiree Coverage

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

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- As discussed previously when discussing health coverage, people with Medicare who have employer or union retirement plans that cover prescription drugs must carefully consider their options. A person's needs may vary from year to year based on factors like health status and financial considerations. Options provided by employer or union retirement plans can also vary each year. Each plan is required by law to annually disclose to its members how it works with Medicare prescription drug coverage. If a person with Medicare loses "creditable" coverage, he/she has 63 days to find comparable coverage without incurring a late enrollment penalty. Contact the EGHP's benefits administrator for information, including how it works with Medicare drug coverage.
- 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.
  - You may not be able to drop drug coverage without also dropping 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.

## People With Retiree Coverage Who Qualify for Extra Help

- Those with limited income and resources
  - Income at or below 150% of Federal poverty level
- Pay very little for prescriptions in a Part D Plan
- CMS automatically enrolls people with Medicare and full Medicaid benefits
  - Including those with retiree drug coverage
  - May have to choose between Medicare drug coverage and retiree coverage

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- People with limited resources and income at or below 150% of the Federal poverty level may qualify for Extra Help with Medicare drug plan costs. The choice of plans for people in this category who also have employer/union coverage can be more involved than for other individuals. That's because
  - The Medicare Modernization Act (MMA) requires CMS to enroll all people entitled to Medicare and full Medicaid benefits (called dual eligibles) in Medicare Part D to ensure they continue to have prescription drug coverage, since Medicaid no longer covers their drugs. This provision does NOT include an exception for those with drug coverage from a former employer or union. However, those individuals can call 1-800-MEDICARE or the plan CMS chose for them if they want to opt out of Part D. CMS also enrolls other people who qualify for Extra Help, but not those whose employers or unions are claiming the Retiree Drug Subsidy.
  - Many employer/union plans claim the Retiree Drug Subsidy and inform their enrollees that they will only continue to receive benefits (in some cases both medical and drug benefits) if they do NOT enroll in a Medicare drug plan.
- These people may have to choose between enrollment in a Medicare drug plan and losing their (and their dependents') employer/union coverage, or keeping their employer/union retiree coverage and opting out of Medicare drug coverage, even though Medicare provides comprehensive drug coverage at minimal cost for those who qualify for Extra Help. In some cases, benefits such as Medicaid coverage of nursing home expenses and supplemental drug coverage from a State Pharmacy Assistance Program (SPAP) may also be affected.

## Retiree Coverage and Extra Help

- CMS encourages employers/unions to
  - Allow those disenrolling by mistake to re-enroll
  - Allow separate package for family members
  - Add supplemental coverage option
  - Help retirees who choose to opt out of Medicare drug coverage
  - Coordinate with state Medicaid or other assistance programs

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- To assist people with Medicare and limited income in their decision-making and minimize undesirable consequences, CMS encourages employers and unions to design their retiree benefits to be more flexible in certain areas:
  - Providing a flexible transition/correction period (allowing those who disenrolled by mistake to re-enroll)
  - Allowing spouses and dependents to continue receiving retiree coverage when the retiree enrolls in Medicare drug coverage
  - Adding a supplemental coverage option
  - Providing information to help retirees opt out of Medicare drug coverage, when that is what they choose
  - Coordinating with State Medicaid or other assistance programs

## How Prescription Assistance Programs and Charities Work with Part D

- Charities can wrap around the Part D benefit
- Charities can participate in COB either
  - Electronically at point-of-sale
  - Submitting paper claims to TrOOP contractor
- Manufacturer-sponsored PAPs can choose to operate outside the Part D benefit
  - No interaction with TrOOP
  - PAPs should still coordinate with Part D plans

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- Any financial assistance a charity provides on behalf of a Part D enrollee will count toward the TrOOP catastrophic threshold, unless it is a group health plan, insurance, a government-funded health program, or other third-party payment arrangement. Charitable program members may present a retail ID card at the point of sale to get financial assistance. Charities that choose to participate in electronic data exchange can expedite adjudication of claims at the point of sale. Some charities require enrollees to submit a paper claim and then send claims to the TrOOP contractor in batch form for accurate TrOOP recalculation.
- Consistent with recent OIG guidance, PAPs may choose to structure themselves in order to continue providing in-kind assistance to Part D enrollees, but outside the Part D benefit. In other words, the value of the in-kind assistance will not count toward a Part D enrollee's TrOOP and will be completely separate from the Part D benefit. CMS encourages PAPs to exchange eligibility files with CMS so that Part D plans are aware of their enrollee's eligibility for PAP assistance and can set their computer systems edits to reflect when the drugs are provided free under the PAP. (PAPs may charge a small copayment when providing this in-kind assistance, and this amount may count toward TrOOP. The person with Medicare will need to submit a paper claim to the drug plan, along with documentation of the copayment.



For more information see

[www.cms.gov/PrescriptionDrugCovGenIn/Downloads/PAPInfo\\_01.24.06.pdf](http://www.cms.gov/PrescriptionDrugCovGenIn/Downloads/PAPInfo_01.24.06.pdf) and  
[www.cms.gov/apps/files/factsheets/Tauzin%20PAP.pdf](http://www.cms.gov/apps/files/factsheets/Tauzin%20PAP.pdf).

## How Safety-Net Providers Work with Part D

- Part D plans encouraged to contract with safety-net providers
- Contributions by safety-net providers
  - Generally do not count toward TrOOP
  - Count toward TrOOP if unadvertised AND either
    - Offered in non-routine manner
    - Offered to Extra Help recipients

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- Part D sponsors are not required to contract with safety-net providers. However, CMS created an incentive for plans to do so by allowing them to count Federally Qualified Health Centers and rural health clinic pharmacies as part of their retail pharmacy network.
- The MMA added an exception to the anti-kickback statute so that they are permitted to waive or reduce cost-sharing within certain parameters. These parameters vary depending on whether or not a Part D enrollee receives the low-income subsidy (Extra Help). Generally, these waivers or reductions of cost-sharing will count toward TrOOP.
- However, outside the limited parameters established by this statute, safety-net wrap-around coverage will not count toward TrOOP. Most safety-net pharmacies are government-funded health programs. Government-funded programs cannot wrap around the Part D benefit and have those contributions count toward TrOOP. Therefore, in most other cases, safety-net pharmacy wrap-around payments will not count toward TrOOP.



For more information, see

[www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/InfoforPartDSponsorsonSafetyNetProviders.pdf](http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/InfoforPartDSponsorsonSafetyNetProviders.pdf)

## Indian Health Service (IHS)

- Copayments or deductibles
  - None for services obtained through IHS and Tribal pharmacies
  - May apply when received through Urban Indian pharmacies
  - Apply when services received from non-IHS/Tribal/Urban Indian pharmacies

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- By custom and regulation, American Indian/Alaska Native (AI/AN) people with Medicare cannot be charged any cost-sharing. Indian Health Service, Tribal, and Urban Indian (I/T/U) facilities must waive any copayments or deductibles that would have been applied by a Part D Plan.
- In certain areas, Tribal organizations using Tribal-only money to assist enrollees with Part D cost-sharing may count toward TrOOP. Part D Plans may have to set up manual processes to receive this information and adjust calculations accordingly.

## How IHS Works with Part D

- TrOOP

- Federal (IHS) funds count toward TrOOP ← 
- Effective January 1, 2011
- Tribal funds from non-Federal sources count
  - Funds used to pay copayments and deductibles
  - Part D Plans work with IHS and Tribal pharmacies to track

- All Part D pharmacy networks must

- Offer contract to all I/T/U pharmacies in region
- Provide convenient access

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- Effective January 1, 2011, assistance with Part D cost-sharing by I/T/U pharmacies counts as TrOOP costs toward meeting the catastrophic coverage threshold.
- COB with IHS and Tribes is tied to pharmacy network contracting. Regulations require all Part D sponsors to offer network contracts to all I/T/U pharmacies operating in their service area. Plans also must demonstrate to CMS that they provide convenient access to I/T/U pharmacies for AI/AN enrollees.
- An I/T/U is a pharmacy operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization, all of which are defined in section 4 of the Indian Health Care Improvement Act, 25 USC 1603.



*For more information, see [www.cms.gov/AIAN/](http://www.cms.gov/AIAN/).*

## Personal Health Savings Accounts

- Contributions count toward TrOOP when not structured as group health plan
  - Health Savings Accounts
  - Flexible Spending Accounts
  - Medicare Medical Savings Accounts
- Contributions do not count toward TrOOP
  - When structured as group health plan
    - Health Reimbursement Arrangements
  - Must participate in COB

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- Personal health savings vehicles structured as group health plans cannot count toward TrOOP, while those not structured as group health plans can count toward TrOOP. CMS regulations indicate that Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs) and Archer Medicare Savings Accounts (MSAs) are not group health plans and that distributions from these vehicles will count as incurred costs. Archer MSAs help self-employed individuals and employees of certain small employers meet the medical care costs of the account holder, his or her spouse, or dependent(s).
- **Medicare MSA** - Medicare pays for a high-deductible health insurance plan for enrollees, and puts money in the individual's account, usually at the beginning of the year. This money and its earnings are tax free if used to purchase allowable health care. After the yearly deductible is met, Medicare-covered services are covered by the health insurance plan. Amounts not used in one year remain for use in a future year to pay for qualified medical expenses, even if the person is no longer in a high deductible health plan.
- **Health Reimbursement Arrangements** - Considered group health plans subject to all requirements of payers providing prescription drug coverage. Distributions from these accounts will not count toward TrOOP. Participation in COB activities can take place electronically at the point-of-sale, or in the form of paper claims submitted in batches via the TrOOP contractor.



For more information see

[www.cms.gov/apps/media/press/release.asp?Counter=1894](http://www.cms.gov/apps/media/press/release.asp?Counter=1894)

## Medicare Part B and Part D

- Systems do not automatically coordinate
- Guidelines help differentiate
  - Part B-covered drugs
  - Part D-covered drugs
- Details available on CMS website

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- CMS did not establish automatic cross-over procedures for situations in which a Part B carrier denies a claim under Part B and then submits the claim to the appropriate Part D Plan (or its claims processing agent) via the TrOOP facilitation contractor. Future implementation would require changes in HIPAA reporting standards to accommodate data exchanges between Part B carriers and Part D plans. Changes to HIPAA standards may take several years to be approved.
- Guidelines have been established to help differentiate drugs covered by Medicare Part B from drugs covered by Medicare Part D.



See CMS Product No. 11315P *Information Partners Can Use on: Medicare Drug Coverage under Medicare Part A, Part B, and Part D* at



[www.cms.gov/partnerships/downloads/11315-P.pdf](http://www.cms.gov/partnerships/downloads/11315-P.pdf).

## How FEHB Works with Part D

- FEHB considered creditable drug coverage
  - As good as Medicare drug coverage
- People can have both FEHB and Part D
  - Adding Part D provides little, if any, savings
    - Unless you qualify for Extra Help
- COB contractor captures/maintains enrollment data

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- The Office of Personnel Management (OPM) has determined that the prescription drug coverage offered by FEHB plans is, on average, comparable to Medicare Part D coverage. Therefore, it is not necessary for people with an FEHB plan to enroll in Medicare Part D. However, people covered by FEHB can choose to enroll in Part D at any time without penalty and can keep their FEHB coverage.
- The only time enrolling in Part D would provide extra savings is for individuals with limited income and resources. People with limited income and resources should apply for Extra Help if they don't qualify automatically.
- For people with both a Medicare drug plan and an FEHB plan, the FEHB plan will coordinate benefits with Medicare. Information should be captured and maintained by the COB contractor and be made available to Part D plans as part of the COB process.

## How VA Works with Part D

- VA offers creditable drug coverage
  - As good as Medicare drug coverage
- People can choose which benefit to use
  - VA
  - Medicare
  - Single prescription cannot be covered by both
- COB contractor captures/maintains enrollment data

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- Because VA drug coverage is comprehensive, most people with Medicare and VA coverage do not need to enroll in Medicare Part D.
- People with VA coverage may want to consider joining a Medicare drug plan under certain circumstances: if they qualify for the Extra Help, if they live in a nursing home, or if their VA facility or pharmacy is not nearby. Because VA drug coverage is deemed “creditable coverage” by Medicare, people who wait to enroll in Part D will not have to pay a late enrollment penalty.
- An individual with both VA and Medicare Part D benefits can choose whether to have a prescription written and filled under the VA or Medicare, but the prescription can’t be covered by both plans at once. If a prescription is filled by a Medicare drug plan, it will not go to VA for any additional payment.
- Information for people with both VA coverage and Part D is captured and maintained by the COB contractor and be made available to Part D plans as part of the COB process.

## How TRICARE for Life Works with Part D

- TFL considered creditable drug coverage
  - As good as Medicare drug coverage
- People can have both TFL and Part D
  - Adding Part D may benefit people who qualify for Extra Help
- COB contractor captures/maintains enrollment data

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- Similar to VA drug coverage, TRICARE has a more generous pharmacy benefit than Part D. As a result it is NOT in the best interest of most TRICARE enrollees to join Part D.
- An exception to this is if a TRICARE beneficiary has limited resources and income, and may therefore qualify for Extra Help. These beneficiaries may find it beneficial to have both TRICARE and Part D. Since TRICARE wraps around Part D for drugs covered both by the Part D plan and TRICARE, it is worth looking into whether the Part D premium involved (if any) would be more than the benefit TRICARE would provide.
- Since TRICARE drug coverage is at least as good as Medicare, people who enroll in Part D after they are first eligible do not have to pay a penalty.
- The COB contractor captures and maintains enrollment data for those choosing both TRICARE and Part D coverage.



*For more information see [www.cms.gov/partnerships/downloads/tricare.pdf](http://www.cms.gov/partnerships/downloads/tricare.pdf).*

## Lesson 4 – Knowledge Check

- Who Pays First?

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Check your knowledge!

## Marilyn – Scenario 1

Marilyn is 66 and has Medicare Parts A & B and TriCare For Life (TFL). She is being treated as an outpatient for complications of diabetes by a physician who accepts assignment. Who pays first?

- A. Medicare Part A
- B. Medicare Part B
- C. TFL
- D. VA

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Marilyn is 66 and has Medicare Parts A & B and TriCare for Life (TFL). She is being treated as an outpatient for complications of diabetes by a physician who accepts assignment. Who pays first?

- A. Medicare Part A
- B. Medicare Part B
- C. TFL
- D. VA

### Answer

B. Medicare Part B

- Medicare Part A is hospital insurance and Marilyn is being treated as an outpatient.
- TRICARE For Life (TFL) is TRICARE's Medicare-wraparound coverage available to *all* Medicare-eligible TRICARE beneficiaries, regardless of age, provided they have Medicare Parts A **and** B. While Medicare is your primary insurance, TRICARE acts as your secondary payer.
- Marilyn is not a Veteran

## Jackie – Scenario 2

Jackie is 67, has EGHP and Medicare Part A and works for a small accounting firm with 15 employees. She is an inpatient following a car accident. Who pays first?

- A. Medicare Part A
- B. EGHP
- C. No Fault
- D. COBRA

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Jackie is 67, has EGHP and Medicare Part A and works for a small accounting firm with 15 employees. She is an inpatient following a car accident. Who pays first?

- A. Medicare Part A
- B. EGHP
- C. No Fault
- D. COBRA

### Answer

- C. No Fault

If a person with Medicare received health care that may be covered by no-fault or liability insurance (such as in the case of an automobile accident, injury in a public place, or malpractice), the no-fault or liability insurance pays first.

### Tom – Scenario 3

Tom had a knee replacement. He is 72, retired and has Medicare Parts A & B, Medigap and Medicaid coverage. Who pays first?

- A. Medicare
- B. Medicaid
- C. Medigap

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Tom had a knee replacement. He is 72, retired and has Medicare Parts A & B, Medigap and Medicaid coverage. Who pays first?

- A. Medicare
- B. Medicaid
- C. Medigap

#### Answer

- A. Medicare

For most people with Medicare, Medicare is their primary payer, meaning Medicare pays first on their health care claims. Some situations where Medicare is the primary payer include

- Medigap policy or other privately purchased insurance policy **is not** related to current employment (This type of policy covers amounts not covered by Medicare)
- Coverage through Medicaid and Medicare (dual eligible beneficiaries), with no other coverage that could be primary to Medicare

## Millie – Scenario 4

Millie is 58, retired and has Medicare Parts A & B due to a disability. She worked for the Federal government and has FEHB. Who pays first?

- A. FEHB
- B. Medicare
- C. Workers' Compensation
- D. COBRA

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Millie is 58, retired and has Medicare Parts A & B due to a disability. She worked for the Federal government and has FEHB. Who pays first?

- A. FEHB
- B. Medicare
- C. Workers' Compensation
- D. COBRA

### Answer

B. Medicare

Medicare pays first because there is no Worker's Compensation claim, Millie does not have ESRD and she is retired.

## Jim – Scenario 5

Jim is 68, still working and has Medicare Part A. He is also covered by his retired wife's EGHP and he is entitled to TFL. He is being treated for hypertension as an outpatient. Who pays first?

- A. TFL
- B. Part A
- C. EGHP
- D. VA

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Jim is 68, still working and has Medicare Part A. He is also covered by his retired wife's EGHP and he is entitled to TFL. He is being treated for hypertension as an outpatient. Who pays first?

- A. TFL
- B. Part A
- C. EGHP
- D. VA

### Answer

- C. EGHP

EGHP pays first because Medicare Part A does not cover outpatient care. Jim does not have Medicare Part B so he can not have TFL coverage.

## Jim – Scenario 5

Jim is 68, still working and has Medicare Part A. He is also covered by his retired wife's EGHP and he is entitled to TFL. He is being treated for hypertension. Who pays first?

- A. TFL
- B. Part A
- C. EGHP
- D. VA

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Jim is 68, still working and has Medicare Part A. He is also covered by his retired wife's EGHP and he is entitled to TFL. He is being treated for hypertension. Who pays first?

- A. TFL
- B. Part A
- C. EGHP
- D. VA

# Coordination of Benefits Resource Guide

## Resources

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

[www.CMS.gov](http://www.CMS.gov)

**Coordination of Benefits Contractor**  
 1-800-999-1118  
 (TTY 1-800-318-8782)  
[www.cms.gov/COBGeneralInformation/](http://www.cms.gov/COBGeneralInformation/)  
[www.cms.gov/COBAGreement/](http://www.cms.gov/COBAGreement/)

**Department of Labor**  
 1-866-4-USA-DOL  
 (1-866-487-2365)  
<http://www.dol.gov/dol/topics/health-plans/cobra.htm>

**Office of Personnel Management**  
 1-888-767-6738  
 (TTY 1-800-878-5707)

**Medicare/TRICARE Benefit Overview**  
[www.tricare.mil/mybenefit/home/overview/Plans](http://www.tricare.mil/mybenefit/home/overview/Plans)

**Department of Defense (To get information about TRICARE)**  
 1-877-363-1303  
 (TTY 1-877-540-6261)

**Department of Veterans Affairs**  
 1-800-827-1000  
 (TTY 1-800-829-4833 )

**Medicare Secondary Payer Recovery Contractor**  
 1-866-677-7220  
 (TTY 1-866-677-7294)

**Affordable Care Act**  
[www.healthcare.gov/center/authorities/patient-protection-affordable-care-act-acts-passed.pdf](http://www.healthcare.gov/center/authorities/patient-protection-affordable-care-act-acts-passed.pdf)

## Medicare Products

**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 [www.medicare.gov](http://www.medicare.gov)

Order multiple copies (partners only) at [productordering.cms.hhs.gov](http://productordering.cms.hhs.gov). You must register your organization.



If you	Situation	Pays first	Pays second	See page(s)
Are 65 or older and covered by a group health plan because you or your spouse is still working	Entitled to Medicare			
	The employer has 20 or more employees	Group Health Plan	Medicare	12
	The employer has less than 20 employees.*	Medicare	Group Health Plan	13
Have an employer group health plan after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree Coverage	14–16
Are disabled and covered by a large group health plan from your work, or from a family member who is working	Entitled to Medicare			
	The employer has 100 or more employees.	Large Group Health Plan	Medicare	16–17
	The employer has less than 100 employees.	Medicare	Group Health Plan	16
Have End-Stage Renal Disease (permanent kidney failure) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group Health Plan	Medicare	18
	After 30 months	Medicare	Group Health Plan	18
Have End-Stage Renal Disease (permanent kidney failure) and COBRA coverage	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare	31
	After 30 months	Medicare	COBRA	18
Are 65 or over OR disabled and covered by Medicare and COBRA coverage	Entitled to Medicare	Medicare	COBRA	30–31

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



If you	Situation	Pays first	Pays second	See page(s)
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or Liability insurance for services related to accident claim	Medicare	19–22
Are covered under workers' compensation because of a job-related illness or injury	Entitled to Medicare	Workers' compensation for services related to workers' compensation claim	Usually doesn't apply. However, Medicare may make a conditional payment.	22–26
Are a Veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	<p>Medicare pays for Medicare-covered services.</p> <p>Veterans' Affairs pays for VA-authorized services.</p> <p>Note: Generally, Medicare and VA can't pay for the same service.</p>	Usually doesn't apply	26–28
Are covered under TRICARE	Entitled to Medicare and TRICARE	<p>Medicare pays for Medicare-covered services.</p> <p>TRICARE pays for services from a military hospital or any other federal provider.</p>	TRICARE may pay second.	28–29
Have black lung disease and covered under the Federal Black Lung Program	Entitled to Medicare and Federal Black Lung Program	Federal Black Lung Program for services related to black lung	Medicare	29–30







**E-mail: [NMTP@cms.hhs.gov](mailto:NMTP@cms.hhs.gov)  
Website: [cms.gov/NationalMedicareTrainingProgram](https://cms.gov/NationalMedicareTrainingProgram)**

**Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Baltimore, MD 21244**