

Centers for Medicare and Medicaid Services
Employers
Open Door Forum
Moderator: Jill Darling
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1:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are on listen-only mode for today's conference until the question and answer session. At that time if you'd like to ask a question, you may do so by pressing Star 1. This conference is being recorded. If you have any objections, you may disconnect at this time.

I'll now turn the meeting over to Jill Darling. Thank you, Jill. Please begin.

Jill Darling All right, thank you (Gabrielle). Good morning and good afternoon everyone. I'm Jill Darling in the CMS office of communications and thank you for joining us today for the Employer's Open Door Forum. Before we get into today's presentation, I have one brief announcement. This open-door forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

And now we'll begin our presentation with (Michelle Wineinger) who will go over the coordination of benefits.

(Michelle Wineinger): Thank you everyone, and thank you, Jill, for introducing me. Again, my name is (Michelle Wineinger) and I am a health insurance specialist in the

CMS Kansas City regional office. And I want to thank everyone for taking time out of their busy day to join for today's call.

I'm just today going to be providing a general overview of Medicare and the coordination of benefits. And the slides, the information I'll be talking about today should have been made available to you on the agenda. So following the presentation, or hopefully you downloaded them before the presentation, but if you did not they are available on the CMS site.

The information today, again, I'll be sharing will explain more about the coordination of benefits when people have Medicare and certain other types of health and insurance coverage and direct coverage. So the session today, hopefully when the session is over today you'll have a better understanding of health and drug coverage coordination, be able to determine who's going to pay first in certain situations and identify where you can get more information.

So I'm going to start a little bit. I'm going to start this out by explaining a little bit more about coordination of benefits in general. So if a person has Medicare and other health coverage, each type of coverage's that they have is called a payer. And when there's more than one payer, coordinating of benefits rules decide which payer will pay first. The primary payer pays what is owed on a bill first up to the limit of its coverage, and then the provider submits the claim to the secondary payer if their cost that their primary payer does not cover. And in some cases, there may also be a third payer.

I will say that I have had instances and when I've been out and speaking with public, where I've seen people that have five insurances. So there are - there is a possibility of having multiple payers. Now Medicare may be the primary payer or the secondary payer. It just depends on the circumstances.

So Medicare is the primary payer for most people with Medicare which means that Medicare pays first on all healthcare claims. Generally, Medicare pays first when Medicare is the only source of medical, hospital or drug coverage. They pay first if someone has a Medicare supplemental insurance or what we call a Medigap policy. Or if they have other privately purchased insurance policy that is not related to current employment. And current is the keyword here.

Medicare's also primary. If a person has Medicare and Medicaid coverage which we in the agency call dual eligible. And they have no other coverage that might be primary to Medicare. Medicare's primary if someone has retiree coverage in most cases. And it's important that someone understand how a plan works with Medicare by checking the plan benefits booklet. Or a plan description that should be provided by the employer or union or they can also call the plans administrator or the benefit's administrator.

Medicare's primary if someone is receiving their healthcare services from the Indian Health Services. Medicare is also primary if someone has TRICARE for life and they are retired from active duty. And you'll notice I said earlier current employment was the key to that term. Well TRICARE for life is similar, because TRICARE is the US Department of Defense's health program for active duty service members which means they're currently serving. So they're active duty and TRICARE for life provides that expanded medical coverage to someone who is retired from the military. So they - that is not based on active employment.

Also Medicare is primary if someone's covered under the Consolidated Omnibus Budget Reconciliation Act or COBRA except if they have end stage renal disease, ESRD. We love our acronyms here. And they're COBRA

coverage is based on a group health plan like from an employer and I'm going to talk a little bit more about that here in just a moment.

Now, Medicare secondary payer or MSP is the term that we generally use when Medicare isn't legally responsible for playing - paying a claim first. So when Medicare started providing coverage in 1966, it was the primary payer for all claims except for those covered by Workers' Compensating and the Federal Black Lung's benefit program. However, in 1980, congress passed some legislation that made Medicare the secondary payer to certain primary plans. And this was done in an effort to shift the cost from the Medicare to the appropriate other sources of payment. So it's against the law to shift the burden of someone's healthcare to Medicare if they should be the primary payer.

Now the MSP provisions were put into place and they have protected Medicare's trust funds, by making sure that Medicare does not pay for services and items that certain health coverage is primarily responsible for paying. And we'll talk a little bit more about this in just a moment. But the MSP provisions apply to situations when Medicare isn't the person's primary health insurance coverage or in situations again where another entity has been identified as the primary payer. And Medicare, on average, saves about \$9 billion and that's with the big B, annually on claims where other insurer is the primary payer for Medicare. And I don't know about you, but I hope Medicare is still around when I turn 65, so that makes me very happy when I see what we're doing things that we can do to ensure the viability of the Medicare trust fund.

So the next question that's probably burning in your mind right now is gosh, how does Medicare determine who's going to be primary, who's going to be secondary? And are there any other payers involved? Well the coordination

of benefits program determines who the correct primary payer will be. And there are two pieces to this program.

The first one would be the Medicare crossover process. And to assist in the coordination of benefits with private insurance companies and other entities that pay after Medicare. The benefits coordination and recovery center or the BCRC signs a coordination of benefits agreement or COBA or C-O-B-A with employer retiree plans, private insurance companies and other entities like Medicaid. As these entities then submit biweekly or monthly, they submit eligibility files containing their covered members to the BCRC.

So the BCRC then takes those files and makes this information available on behind the scenes with Medicare's common working file which is where a Medicare beneficiary's main record is contained. So we upload that information into the common working file for the purposes of turning a transfer of Medicare Part A and Part B fee for service claims to supplemental payers. So there's a lot of action that goes on behind the scenes. It's ideally set up though so it's a very smooth transition, a seamless transition and almost an invisible transition for not only the providers but the beneficiaries.

This process you may have heard of it before. It's called the Medicare crossover process. And it happens daily. In the absence of such an agreement, however a person with Medicare must coordinate the secondary or supplemental payment of benefits with any insurer that he or she may have in addition to Medicare. So if it's really important that if a payer has - wants to do it that they sign up and do a COBA with Medicare. So that there's that seamless transition of payment.

Now the second piece of the coordination of benefits program is what we call the MSP and MSP again means secondary payer. But MSP claims

investigation. So the BCRC initiates an investigation when it learns that a person has other insurance. And this investigation figures out whether it's Medicare or the other insurance that has the primary responsibility for paying the person with Medicare's healthcare costs. And the goal of these MSP information gather activities that they conduct are to identify situations or MSP situations very quickly making sure that the responsible parties are making correct payments.

And the BCRC includes in its investigation results on the Medicare CWF file, again the common working file or the beneficiary's file. To make sure that Medicare makes those payments correctly when appropriate. This is very similar to if you may - and you may have seen this. If you have a - if you go to the doctor and you - there's something that may have been accident related, you may get a letter from your insurance company. Can you tell us whether the accident related or not?

The BCRC does something very similar Medicare beneficiaries. Sometimes will receive claim from a provider that will show that they received payment from another pair. In that case the BCRC will also investigate to see whether that is truly the case and whether we need to update the beneficiary's record. So there are several ways that BCRC will investigate those claims.

Now Medicare in some cases will make a conditional payment which is the payment for services on behalf of a person with Medicare when there's evidence on a claim that the primary care for the primary plan is not paying promptly. And I'm going to talk more about that in a moment. Certain circumstances when a person with Medicare is injured or they're involved in an accident they incur work-related, injury or disease, that is the circumstance will Medicare might make a conditional payment. Again will talk about that more in a moment. But after a settlement generally Medicare look to once a

settlement or judgment award or other payment is secured in a situation, then Medicare has the right to recover those payments.

I just want to stress on that that if you have employees or if you are aware of anyone or you see anyone that is involved in any of the situation, it's very imperative that it as quickly as possible that information be conveyed to the BCRC because that will eliminate a lot of headaches for provides as well as for your employee or for patients with Medicare. The really important that BCRC be notified immediately when the situations take - occur.

So I talked about how Medicare works with other types of insurance, so now I'm going to talk a little bit more in detail about those other types of health coverage including Medicare on the marketplace. I'm going to talk about retiree coverage considerations. So if you have someone who one of your employees that nearing retirement or they're currently working and 65 or getting ready to turn 65. And then going to talk about those other possible health claim payers and how we determine who's going to pay first.

So I missed our first the Medicare on the marketplace with the health insurance marketplace. You may have heard both ways. But Medicare is not part of the health insurance marketplace. So someone has Medicare Part A, they don't need to do anything related to the marketplace. So if somebody comes to you and they say do I need to sign up? They don't have to do anything if they already have Medicare. They are considered covered with regards to what we call minimum essential coverage.

And if they have covers to the marketplace and to Medicare, they need to contact the marketplace plan and any subsidies they may be receiving like premium tax credit or cost-sharing reductions paid on their behalf no matter how they choose Medicare. Not just for employees, but there may be other

family members that you may be working with as well. So it's really important that they understand that.

That's because if the Part A, because Part A is considered minimum essential coverage, if they continue to have Part A and the marketplace plan and they're receiving any type of cost-sharing reductions for any subsidies, they're going to have to pay back any tax credit they got during the month. They have both Medicare Part A and a group health plan through the marketplace. Or if they had a plan to the marketplace. So that's really important for them to understand that. Not a nice surprise, tax surprise -tax time isn't fun anyway, but that surprise isn't fun either.

The also it's important to note that if someone has marketplace coverage, they may not be renewed at the end of the benefit year. Some cases with a may get Part A retroactively, they will lose premium tax credit once they're identified as a retroactive enrollment. It's also important to note that if someone has Medicare, it's illegal for someone to sell them and marketplace plan.

Now generally, there's no coordination of benefits between Medicare and an individual marketplace. Qualifying health plan, which I'll call QHP that they purchased the health insurance marketplace. Someone to consider several important factors though, when deciding whether or not to say in a QHP after they enroll in Medicare Part A. So the QHP is not secondary insurance is not required to pay any costs towards coverage if they have Medicare. So they do not ornate at all.

Individual marketplace coverage is not employer sponsored coverage is not based on current employment. So as someone is Medicare eligible and they don't sign up during their initial enrollment. Because they have a marketplace plan, they won't be able to enroll in Part B later during a special enrollment

period. And all have to wait for a general enrollment period to enroll which could potentially cause them to have a Part B late enrollment penalty. Once their Part A coverage starts, any premium tax credit again and of cost-sharing reductions will stop if they're not notified that they receive, again if they receive both while they have both coverage's, they will have to repay any of those cost sharings.

Someone could decide to choose the marketplace coverage instead of Medicare if they have to pay the premium for Part A. That's very rare. It's usually if they don't have enough credit for working quarters to have to pay that premium. So they do have that option, but that's - we don't see that very much unless, again, they don't have enough working quarters.

Only individuals who are enrolled in a small business health options program or SHOP plan through the marketplace will have coordination of benefits because that covers is based on coverage employment. It's kind of a recurring theme here whether something is based on current employment or retiree coverage. So because SHOP plans are to the marketplace but there based on current employment, they do coordinate with Medicare. And those individuals that have the group health coverage through the SHOP marketplace and Medicare will pay secondary to that GHP coverage.

In addition, if the individual considers delaying enroll in Part B when their first eligible to do so because they have coverage under a SHOP plan then they won't have the late enrollment penalty once they lose that covers and decide to enroll in Part B.

Now it's really important for someone to understand whether medical costs are going to be payable by other insurance payers first. And I, kind of, want to talk a little bit more about those other types of insurance. And there several

kind of combination of who's going to pay and when. You know, a lot of it with the employer plans have to do with the current - whether someone currently actively working or their spouse is actively working.

So again, another list of the - another list of possible health claims payers, we talked about Medicaid just a moment ago. There's no fault insurance, liability, workers' compensation insurance. I mentioned the Federal Black Lung Benefits Program earlier. COBRA, there can be retiree group health plans. There's veteran's benefits involved. TRICARE for life again and the group health plans. And so many options and so many payers out there, but again, depending on the type of the additional insurance coverage that someone may have, Medicare may be primary or secondary payer on the claim.

I want to talk a little bit more. We talked about the marketplace. So again, I want to talk a little bit more about those other types of payers. We're going to start with Medicaid. Which is the joint, federal and state program that helps pay medical costs for certain people and families who have limited income and resources. And they do meet other requirements. If someone meets the conditions to be Medicaid eligible, Medicaid and also help pay for some Medicare costs like the Medicare premiums, deductibles, co-insurance. Those are through programs called the Medicare savings program. And someone would need to check with their individual state to determine the qualification levels to qualify for those programs.

Now Medicaid never pays first for services that are covered by Medicare. As a matter of fact, Medicaid is the payer of last resort. So it only pays after Medicaid and the other payer who may be involved comes into play, they would be the payer of last resort.

Now I don't need to probably go into great detail what a group health plan is with all of you. But the coordination of benefits depends whether they employee, their spouse, or a family member is currently working or retired. And it also depends though on the number of employees that are employed under their current employer.

So many - as you know, many employers and unions do offer group health plan insurance to their current employees and/or their retirees. And I'm, for an example, the federal employee health benefits or FEHB program is a type of GHP. Someone can also get coverage, group health coverage through their spouse or their other family member's employer. If someone has Medicare, and they are offered coverage under a group health plan, usually they can choose to accept or reject the plan. And generally when the employee has less than 20 employees, that's full and/or part time which is an important thing to know, during the curtain -- current, not current, not curtain -- but current and previous calendar year, Medicare does pay first.

So the employer does have the right and may require that a person turning 65 also enroll in Medicare. We do get that question quite a bit in our office. We do hear where my employer is requiring me to enroll in Medicare. And in that certain circumstance they do have the right to do so.

Now employers or unions may also arrange for their Medicare eligible retirees stuff as independence to get a Part C, a Medicare Part C managed healthcare plan and/or prescription drug coverage through employer group waiver plans. That's a whole other presentation. We won't go into great detail about that. So the most important thing to remember here is that - is that the coverage has to be based on active employment and then it's dependent on some - there are some requirements based on the number of employees that are covered.

Now businesses, we talked a little bit - a moment ago about the SHOP plan, but businesses with 50 or fewer employers can offer those SHOP plans from the health insurance marketplace. And remember that those coordinate like any other group health plan, not like a regular marketplace plan. So the SHOP plans would coordinate with Medicare.

Now in general, Medicare pays first for people with group health plans if they are 65 or older and they have retiree coverage, if they are 65 or older with group health plan coverage through current employment either theirs or their spouses and the employer has less than 20 employees. Medicare will pay first for someone with a group health plan if they are under 65, they have a disability, and they're covered by a group health plan through current employment; again that can be under their own employment or spouse or family member's employment, and their employer has less than 100 employees.

So the difference here is 65 or older. It's less than 20 employees. If it's under 65 based on disability, then it's less than 100 employees.

Medicare is also going to pay first for people with a group health plan. If they are eligible for Medicare due to end stage renal disease and the group health plan coverage, again based on theirs or their spouses or family member's coverage, and they have in the 30-month coordination period has ended. So there is a 30-month coordination period when someone becomes eligible for Medicare because of ends stage renal disease.

The caveat here is if Medicare was their primary payer before that 30-month coordinating period started, then Medicare will continue to be their primary insurance throughout the coordination period. So again, if someone is already on a group health plan and they have ends stage renal disease and then they

qualify for Medicare, Medicare will not pay primary until a 30-month coordination period has ended. And we do get that question quite a bit in our office as well.

So I'm going to move on now to non-group health plans and when Medicare, how those types of plans impact when Medicare pays. So Medicare generally doesn't pay for services when a diagnosis indicates that other insurers may provide coverage. So that could include no fault insurance, liability insurance which includes self-insurance, work-related injury or illness, workers' compensation insurance and then there's also illness related to mining which is covered under the Federal Black Lung Benefits Program. We find out about these types of claims based on, and you heard me talk about diagnosis. A lot of times on a claim, a provider will put a certain diagnosis code that triggers the BCRC to develop to figure out whether a particular service was related to an accident. And again there's certain diagnosis codes that do indicate to us that that is a possibility.

So we'll talk a little bit more about no fault insurance which is insurance that pays for healthcare services that are needed because of personal injury or damage to someone's property regardless of who's at fault for causing it. There are several types of no fault insurance. That includes automobile, home owners and commercial insurance plans that cover no fault. Medicare is the secondary payer when no fault insurance is available. Again, it's against the law to shift that burden of that healthcare when someone else should be paying those expenses. It's against the law to shift that to Medicare.

So Medicare generally won't, again, pay for those expenses when they're related to that. However, Medicare may pay for medical expenses if the claim is denied for reasons other than being a proper claim. So Medicare will make

payment on for services that would normally be covered under Medicare. So it has to be a Medicare covered service as well.

And also, we also understand that sometimes things can get caught up when you're dealing with another payer. So if the no fault insurance doesn't pay promptly and we define promptly as within 120 days, then Medicare may make a conditional payment for which we then have the right to seek recovery of those payments from that other payer.

A person with Medicare must repay the Medicare the money it made for those conditional payments once a settlement has been reached. And if Medicare makes the conditional payment and someone later gets a settlement, a judgment, an award or any other type of payment, we will seek to recover that condition payment. And we will seek to recover that condition payment from the patient, from the person with Medicare and/or their representative who are responsible for - we look to them for the responsibility of repaying Medicare.

Now liability insurance is coverage that protects someone against claims based on negligence or inappropriate action or possible inaction that can result in personal injury or damage to property. And there again are several types of liability insurance. And that is very similar to the no fault. You have your home owners, you have your automobile. But there's also product liability insurance, malpractice liability insurance, and then on your automobile, you may have under insured and uninsured motorist liability insurance. So those are several types of liability insurance.

Again, very similar to the no fault insurance. We are not going to make payment when liability insurance is available. We look to the providers and to the insurers to let us know when that occurs, but we also look to the providers to develop for that information. Similar to them submitting a claim to us with

a diagnosis code on it. We also ask them if they -if someone comes in with a broken arm; was it because of an accident? We want them to develop for their information. So we can make sure we're not making improper payments.

But we also have the caveat with the liability insurance that we understand that there are circumstances where an insurer will not pay promptly. So we again, give the 120 days and if they still have not paid then the provider can then bill Medicare and we will make a conditional payment with again, the understanding that we - if there is a settlement later on that we are repaid those monies.

Now, workers' compensation is a little bit different, not much, but a little bit. Medicare, again, generally will not pay for any injury, illness or disease that's covered by workers' compensation. And if any - if all or a part of the claim is denied by workers' compensation on the grounds that is not covered by workers' compensation, a person may file a claim with Medicare. Medicare may pay that claim that relates to the medical service or item covered by Medicare. Again, it has to be a Medicare covered service, if the claim isn't covered by workers' compensation as long as the serviced, again, is payable by Medicare.

Now, there are several ways that, again, that workers' compensation cases can be resolved. That's by settlements, judgments awards, or any other type of payment. So in that case, in workers' compensation cases, we have what we call workers' compensation Medicare set aside arrangements. It's a huge mouthful. WCMSA is what we call them. And that is a financial agreement that assigns a portion of a workers' compensation settlement to pay for future medical services related to that specific workers' compensation injury, illness or disease.

So we expect that money placed in this set aside arrangement is only for paying future medical and/or prescription drug expenses that are related to that workers' compensation related injury, illness or disease and only if the expenses for treatment for Medicare that - for treatment that Medicare would cover. Someone cannot use the funds in the set aside to pay for any other work injury or any other medical items or services that Medicare doesn't cover. For example, dental or vision or things that are statutorily excluded from Medicare covering.

If someone wants to know whether a service is covered by Medicare, they can call 1-800-Medicare to determine that, which is 1-800-633-4227. We recommend that if someone has a set aside and they have any question that they call that number before they use the money out of their set aside account.

Once someone has depleted all of the moneys out of that account, Medicare and they have to document that. They have to prove that. And they have to account for all the funds, then Medicare will start paying for Medicare cover services related to their work-related injury, illness or disease. Now while they're paying for the services or they're receiving those services related to the workers' compensation injury, Medicare will continue to pay for non-injury related covered services.

So if there - if, you know, I'll give you an example. I worked a case a few years ago where a gentleman fell off the roof and he got a \$10 million settlement, broke his neck. Got a \$10 million settlement. He had a \$1 million set aside, but if he caught a cold that had nothing to do with his workers' compensation injury or that broken neck, Medicare would have paid for the services out of traditional Medicare out of original Medicare for his cold. But if he had to see someone because of something having to do with his broken

neck, then he would have had to pay for those services out of that workers' compensation set aside that he had.

So the next thing I'm going to talk about just very briefly is the Federal Black Lung Benefits Program. And there are some people with Medicare who can get these benefits. And these are for services related to lung disease and other conditions that were caused by coal mining. We don't pay for healthcare services covered under this program because they are considered workers' compensation claims. And all claims services that relate to that diagnosis, go to the division of coal mine workers' compensation with the US Department of Labor.

Very similar to the other like the no fault, the liability, the workers' compensation. If the services are not related to the Black Lung Medicare will serve as the primary payer and we will pay for those services that are not related to those particular instances. Federal lunch - Federal Black Lung Benefits Program people who are eligible for that program, are eligible for prescription drugs. They're eligible for inpatient and outpatient services, doctor visits. They also are eligible for home oxygen and other medical equipment or DME. Home nursing services and any pulmonary rehab that may be covered with a doctor's prescription.

If you have someone or you know someone or an employee or one of their family members who should be covered under this program or are covered under this program, if they have any questions, they can call 1-800-638-7072.

Now COBRA, we're going to talk a little about COBRA now. Requires employers with 20 or more employees to let their employees and their dependents keep their health coverage for a time after they leave their employer group health plan under certain conditions. And this is called the

COBRA continuation coverage. And the law applies to private sector plans, as well as state and local government sponsored plans. It does not apply to federal government sponsored plans. The government of the District of Columbia or any territory or possession of the United States are there are certain territory related organizations that are not covered under COBRA.

COBRA coverage can begin due to certain events like loss of employment or reduced working hours. It can begin, a life event might be divorce or death of an employee or a child ceasing to be a dependent under the terms of the plan. So for loss of employment or reduced working hours, coverage - COBRA coverage generally continues for 18 months. There are certain disabled individual and their nondisabled family members who may qualify for an 11-month extension from 18 to 29 months. And other qualifying events call for continued coverage up to 36 months.

Now group health coverage for COBRA participants is usually more expensive than health coverage for those active employees. Since the participants pays both his or her part and the part of the premium that his or her player paid while they were still working.

So for people who are disabled or agents of Medicare, Medicare usually pay first before COBRA continuation coverage. Medicare pays second to the extent that COBRA covers overlaps the first 30 months of the Medicare eligibility or entitlement based on ESRD. So again, Medicare is going to pay first before the COBRA continuation coverage. We're going to pay second while someone's going through that 30-month coordination. If you are eligible for Medicare based on ESRD.

So before someone elects Cobra coverage and if you're working with someone who's considering it, we recommend that they talk with - there's an

organization called the State Health Insurance Assistance Program. And I'm going to find you the website here in a minute. I'll get to the website for - I'll give you the link to find that. But I would recommend that they visit with the State Health Insurance Assistance Program counselor to understand their options. For example, if a person who already has Medicare Part A season COBRA, but they wait to sign up for Part B until the last month of the eighth month vessel enrollment period following the end of employment, the employer can make a person pay for services that Medicare will cover if they had signed up for Part B earlier. Because COBRA doesn't provide for, excuse me.

In some states those ship counselors can give information about timeframes on the COBRA and Medicare supplemental insurance or Medigap policy guarantee issue rights in a given state. And timeframes may differ depending on state law. So it's really important that someone who's eligible or is looking at considering getting COBRA that they understand that impact to their rights when they become qualified for - when they become eligible for Medicare.

Now Medicare Part D or prescription drug plans generally pay first before COBRA coverage for people who are 65 and older and those who have a disability. And again, very similar to Part - Medicare Part A and Part B, if they have COBRA and they have ESRD, then Medicare Part D will pay first once they're out of their 30-month coordination period - of benefits period.

I'm going to talk a little bit about veterans' coverage. If someone has Medicare and veteran's benefits, they get healthcare treatment under either program. However, they must choose which benefit they use each time they see a doctor or get healthcare. Medicare will not pay for the same services authorized by the VA and similarly VA coverage won't pay for the same services covered by Medicare.

VA is - they don't - they're two federal programs. They don't work together. So and they don't coordinate. It's very rare that they coordinate. I have yet to see an example. They say that they will in very rare circumstances, but I have yet to see where it does. But there are some circumstances where Medicare would cover someone who has VA. Let's say VA authorizes or there is no VA facility available for someone. If they have Medicare, then they could go to any Medicare provider or facility that accepts the assignment.

Let's now talk about a little bit more. I talked about TRICARE for life just a minute ago. But again, it's military retiree coverage for someone who has retired for the military, not someone who's just been discharged. They must have retired from the military. And they have to be 65 or older.

What's really important if you have anyone who's working - if you have an employee who is turning 65, this is where we tend to see multiple payers involved. But if you have someone who's retired from the military, they've decided to come - they retired when they were 40 years old and they decided they wanted to work an additional 20 years. Once they turn 65, if they do not sign up for Medicare Part A and Part B, they lose their TRICARE for life.

So they would - if - and a lot of times we see that when they have a group health plan. They just stay with the group health plan, but they don't understand why they lost their TRICARE for life. So it's really important for them to understand. Now they don't lose it forever. So eventually if they retired and they enrolled in Medicare at that point, they could get their TRICARE for life back at that point. But some people don't understand when they think that they still have TRICARE. They do not. So it's really important that they understand they have to have both Medicare Part A and Part B to continue with Tricare for life.

So the next thing I'm going to talk about now is Medicare Part D which is the prescription drug coverage, how it coordinates. It's very similar to how Medicare Part A and Part B coordinates. They do the - they have the same segregation rights that Medicare Part A and Part B when it comes to no fault, liability, workers' compensation insurance. So they also can make condition payments, and then they will go back and seek to recover those funds.

Now again, possible drug coverage payers, very similar to what we talked about earlier. You have a group health plan, whether it retiree or active employment. They can have it through COBRA. There are Medicaid programs they can get - someone can get drug coverage through the Medicaid program. They can also get covers. State pharmaceutical assistance program. Or through workers' compensation, they can also get it through patient assistance programs like through the drug manufacturers themselves. And sometimes charities can provide prescription drug coverage.

What's really important for people who are getting ready to retire, people with Medicare who have employee union retirement plan that covered construction drug, they really have to carefully consider their options. And those can vary from year to year based on factors like health status and financial considerations. So we recommend that someone who is trying to make that decision that they understand. They work with a group health plan benefits administrator. They work with their employer. They work with their union. Whoever it is that offering that coverage, the employer, the union, that they understand the implication of thing in that plan or dropping that plan and enrolling into a Medicare prescription Part D plan. But sometimes retiree plan are tied- health benefits are also tied to the drug coverage. Someone can't just drop one piece of that. So it's really important that employees at people who

are getting ready to retire or retiree understand the implications of those choices.

Again, Medicare Part D is going to pay very similar to what we just talked about with the Medicare Part A and Part B. They have the same requirements, they will pay first again for those working aged individual who are 65 and older with Medicare and a group health plan with less than 20 employees. Or a person with disability under age 55 with a group health plan with less than 100 employees. And then if they have ESRD with a group health plan of any size after the 30-month coordination. In's on that one. Ends on that one.

We talked a little bit about the Federal Black Lung Program and who was going to pay first on that one. So we know that when a workers' compensation plan. So the Part D plan will pay primary for the prescriptions that are not related to lung disease. Here part the will also pay primary, again similar to Part A and Part B. If they get - if someone gets their drug from Indian Health Services, there are - there's no coordination of benefits because Veteran's coverage and Medicare Part D plans. For people who have TRICARE of life, most people generally do not need to enroll in art D plan because prescription drug covered under TRICARE for life.

Medicare Part e will pay primary to some of the state pharmaceutical assistance programs. Medicare will pay first on those. The state just helps pay part of those Part D costs. One of the things I did want to talk about that we haven't talked about, again, how people getting that assistance the most turtle program they may present a retail card when they go to the pharmacy for that financial help. They can - charities can at that point choose to participate in the electronic data exchanges to speed up the settlement of the claim at the point-of-sale. So you have the ability to set that up electronically,

so someone can prove that. But that point Medicare will pay primary for those prescriptions and then the charity would then help out with those costs.

Now just before we open it up for questions, I do want to just, kind of talk a little bit about the resources that are available regarding coordination of benefits and Medicare secondary payer. In the presentation in the slides, the link that was shared with you in the agenda. The last three slides of that presentation have some fantastic resources. Starts off - we have to pad ourselves first. So your first resource is going to be the Centers for Medicare and Medicaid Services. There's some great information on there, the 1-800 number for Medicare. The number, the phone number for the benefits coordination recovery center, so any questions you have regarding the obligation of the employer to report or if you want to sign up for that coordination of benefits agreement.

Or we have what's called the voluntary data sharing agreement which is where you can share your records so that we know who in your - on your - in your employment who's eligible for Medicare. You can share with us who your employees are. And then we can share with you hey, you've got somebody, especially if you're a smaller employer and you want to know - and you have that caveat where you say when you turn 65, you have to enroll in Medicare. If you have that agreement with us, then we can say hey, (Joe Smith) is getting ready to turn 65. You, as an employer can see that information. So you can speak with them regarding that voluntary data sharing agreement.

There are small employer exceptions. Something that you can get into if you want to explore that. You are more than welcome to do that. But again, the benefits coordination recovery center is your go to organization to do that. And their phone number is listed on that resource slide, but their number is 1-855-798-2627. There's information on the Department of Labor who again

handles the Federal Black Lung Program. Also they do COBRA. They can answer COBRA questions.

So there's all kinds of really great resources for you in that slide presentation information as well about TRICARE and the VA. We not only share resources, internet resources with you and phone numbers but we also had publications available. We have a couple great publications available. And any of the publications that CMS produces are available to you at no cost in the quantity that you need. If we publish them, otherwise you can download them in PDF form and print them off if you've got an employee that's sitting there, and they have a question about who's paying first, what do; I need to do next.

We have some really great publications available. And information on how to order this publication, again, available to you at no cost and they're shipped to you at no cost. Those are available on those slides as well. And then in case I didn't overwhelm you with too many acronyms, or you forgot what the acronym I was talking about meant, there's a great slide in there that outlines the acronyms that were used in this presentation.

So with that, I am more than happy to take questions.

Coordinator: Thank you.

Jill Darling All right, thank you (Michelle). (Gabrielle) please open the lines for Q&A, please.

Coordinator: Of course, at this time to ask your question over the phones, first please ensure your phone is unmuted then press Star 1 and record your name when

prompted. Once again that is Star 1 if you'd like to ask a question. Questions do take a few moments to come through. Please stand by.

(Felicia): (Michelle) while we're waiting, this is (Felicia). I have a question for you. Is there a timeframe for enrollment in Medicare for TRICARE members that have - that they may have before they lose their TRICARE for life? So is there like- I know with Medicare, you have three months before the time your birthday and then three months after to enroll. Is there something similar to that for TRICARE when they - before they can- they lose their TRICARE for life.

(Michelle Wineinger): Yes, TRICARE will send out a notice to them. Because they do have records as well. And so they'll show that this person is getting ready turn 65 and they'll notify them that if they do not enroll in Medicare during their initial enrollment period, that they will lose the TRICARE benefits. I've actually seen one of the letters. I've done a few military retiree appreciation days and a couple of the - at a couple of the bases here in our region. And I have seen this issue come up before. But yes, they do issue a letter and they notify military retiree.

(Felicia): Thank you.

Coordinator: And we do have a question here from the phone lines. Once again as a reminder that is Star 1. Our question is coming from (Joe Paul). Your line is open.

(Joe Paul): Yes, we have had an ongoing discussion in North Carolina regarding an individual over age 65 who is working for a company of less than 20 employees. It's always been our understanding that they must enroll in

Medicare or face penalties later. They run the risk of having those funds withdrawn back by the original company and having to refile with Medicare.

Social security is stating that is not the case. Even if they have less than 20 employees, they can keep that plan primary and face no penalties or anything when they do sign for Medicare. Which is correct?

(Michelle Wineinger): That is true. The employer has the plan or I'm sorry. The employer, yes the employer has the plan. The employer has the option of requiring their Medicare beneficiaries to enroll in Medicare. But they don't have to require them to do that.

(Joe Paul): Okay.

Coordinator: And I do have no further questions from the phone lines.

Jill Darling Okay. I do want to - I followed. I said that I would talk about how you could find out where your state health - or your state health insurance assistance program. The - on the Medicare.gov site, G-O-V site, under Medicare helpful contacts; you can search by your state. You can search by - yes, it'll just pop up the - under helpful contacts, the results list shows the ship's state health insurance assistance program. There is one in every state. And it has the toll free number.

And it's the information that they share is - it's at no cost. It's at no charge. I mean they don't charge any fees for their services and for the assistance that they provide to - if you have a retiree who needs some assistance, feel free to refer them to your state's ship program. And they can also call 1-899-Medicare which is again 1-800-633-4227 and ask for the number for the state health insurance assistance program in their state.

Coordinator: We did have one other question come into the phone lines here. It's coming from (Susan Boswell). Your line is open (Susan).

(Susan Boswell): Hi, thank you. It is my understanding from my experience that whenever I have somebody question about under 20 employees is to - I always advise them to check with the broker, because if it is a multi-employer group plan which I believe they group together to make it over 20 employees that those plans usually are considered credible coverage. If you can confirm that understanding. And then my question actually is, if you could please briefly repeat what you stated about the COBRA does not - is not applicable to federal jobs, but does apply to local and state government employment? If I wrote that correctly.

(Michelle Wineinger): Well, for the first part, yes. Small employers can band together or get together and sometimes they will do that to get better rates for their employees. But if they do that, if they're part of that - if they do decide to do that, then they could qualify as a large group health plan at that point. Which would change again the status of who's going to pay primary because of the number of employees. So you're right, they need to check with the benefits administrator or the employer.

Like if it's the employer asking then they need to check with their benefits administrator to see if they meet that qualification. So you are correct. There are circumstances where small employers may band together especially to get better rates, better coverage, things like that. That might be reasons why they would do that.

Yes, COBRA and then to answer your COBRA question, the law applies to, again, the private sector plans and state and local government sponsored

plans. It does not apply to the federal government sponsored plans to the government of the District of Columbia, territory or possession of the United States. And there are some certain church related organizations.

I would suggest if you have any additional or you need additional clarification on that, definitely the Department of Labor are the ones who administer the COBRA plans. And have jurisdiction over that. So my recommendation would be you can contact the Department of Labor. If you'd like me to, as a matter of fact, I'll just do it right now. The number that's on the resource slide that is in the back of the presentation that was provided in that link to you. The Department of Labor number is 1-866-487-2365. And they also have in that resource slide a link to their specific page that talks about COBRA.

(Susan Boswell): Thank you very much.

(Michelle Wineinger): Sure.

Coordinator: We have no further questions.

Felicia Verrett: Well I'd like to thank everyone. And thank you (Michelle) for your presentation. It was so chocked full of information. I think everybody would agree that they got a lot of great resources out and information out of your presentation. I just wanted to thank everyone for attending CMS' employer open door forum today. If you have any questions or have topics that you would like to hear presented in the forum, please email us at partnership@cms.hhs.gov and partnership is in all capitals.

Thank you and I'd like to say have a great day to everyone. This ends our Employer Open Door Forum.

Coordinator: Once again with that, we'll conclude today's conference. Thank you for participating, and you may disconnect your lines at this time.

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