National Medicare
TRAINING PROGRAM

Module 5

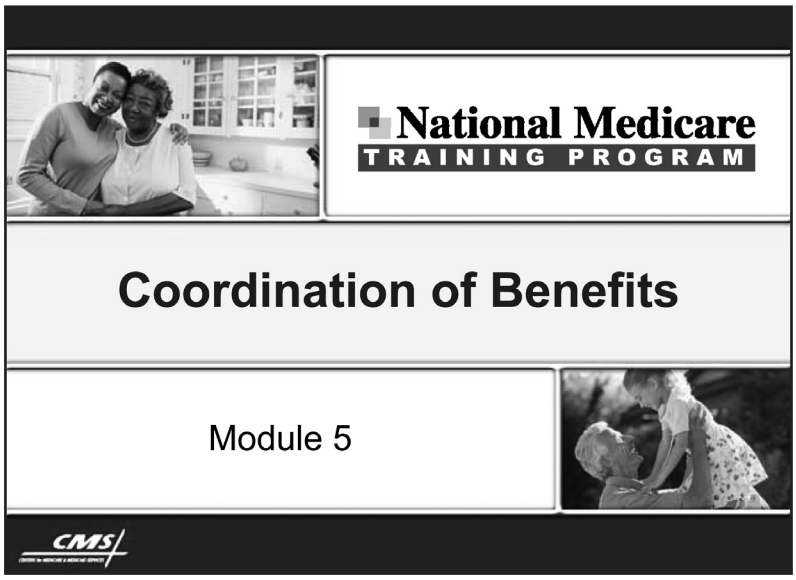
Coordination of Benefits

Training Workbook

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Revised: April 2008

Module 5: Coordination of Benefits



NOTE: This training module is intended for use with partners who already have a basic understanding of Medicare.

This module will cover how to determine whether Medicare is the primary payer or the secondary payer, and communication improvements among multiple health service providers, including Medicare prescription drug plans.

NOTE: Key references for this module are shown at the end.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare and Medicaid. The information in this module was correct as of April 2008. To check for an updated version of this training module, visit *www.cms.hhs.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.

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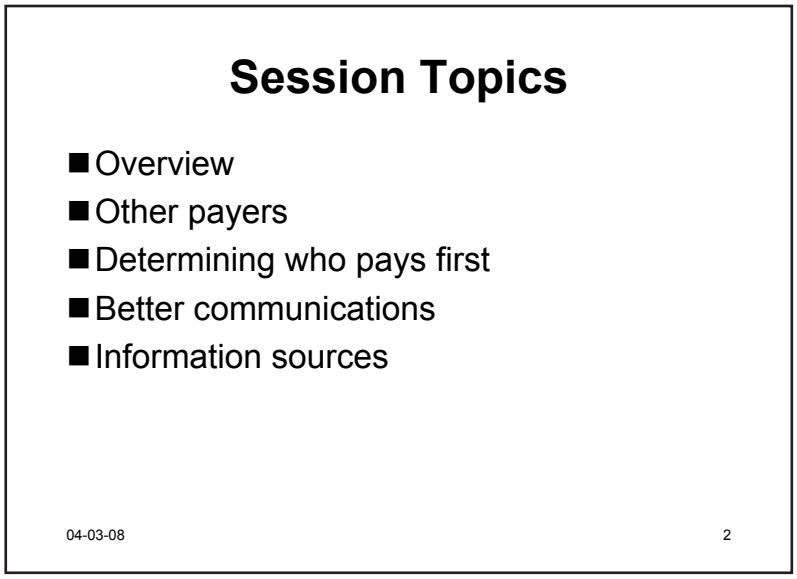
Module 5: Coordination of Benefits



It is not unusual for a person with Medicare to have health insurance coverage through more than one insurer. Coordination of benefits (COB) allows plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities. This process avoids mistaken payments and prevents Medicare from paying first when other insurance should pay first, thus protecting the Medicare trust funds for future generations. Within the context of Medicare drug coverage, known as Part D, COB also provides the mechanism for calculating and tracking "true out-of-pocket" costs that trigger catastrophic coverage.

After a brief overview, we will discuss:

- Payers other than Medicare
- Determining who pays first
- Communication improvements under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (often called the Medicare Modernization Act or MMA)
- Additional information sources

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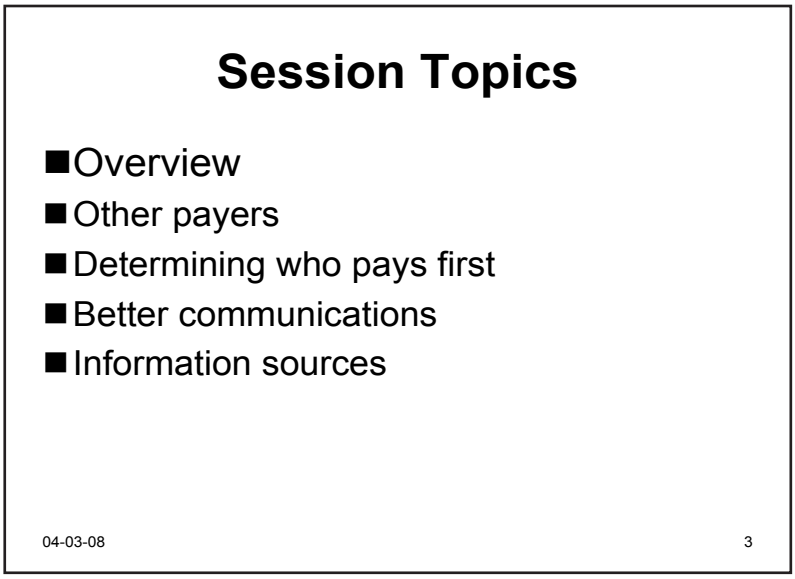

Let's start with an overview.

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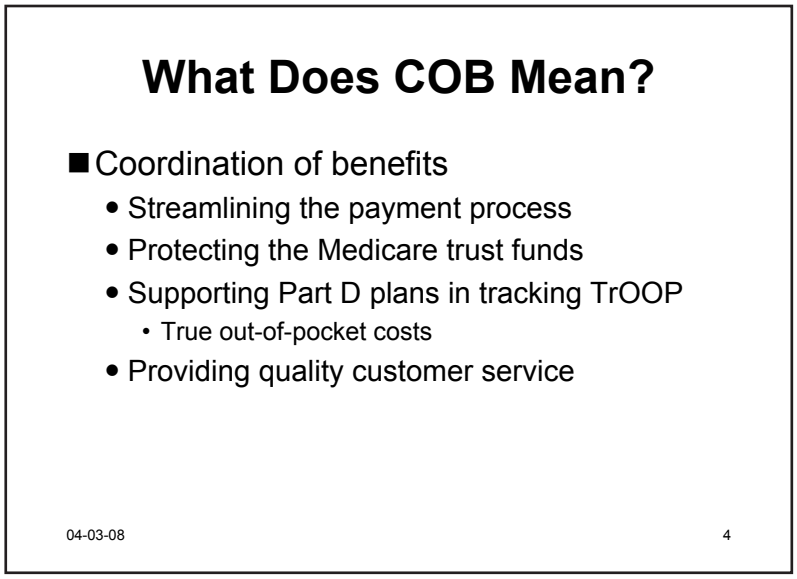

The purpose of the Coordination of Benefits (COB) program is to identify the health care benefits available to a person with Medicare and to prevent mistaken payment of Medicare benefits. What does coordination of benefits (COB) mean? Coordination of benefits means:

- Ensuring claims are paid correctly, and ensuring the **primary payer**, whether Medicare or other insurance, pays first.
- Sharing Medicare eligibility data with other payers and transmitting Medicare-paid claims 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.
- Ensuring that the amount paid by plans in dual coverage situations does not exceed 100% of the total claim, to avoid duplicate payments.

Under the Medicare Modernization Act, the meaning of COB expanded further:

- Section 1860D-2 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 someone 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, so that in addition to payment oversight, coordination results in high quality services for people with Medicare.

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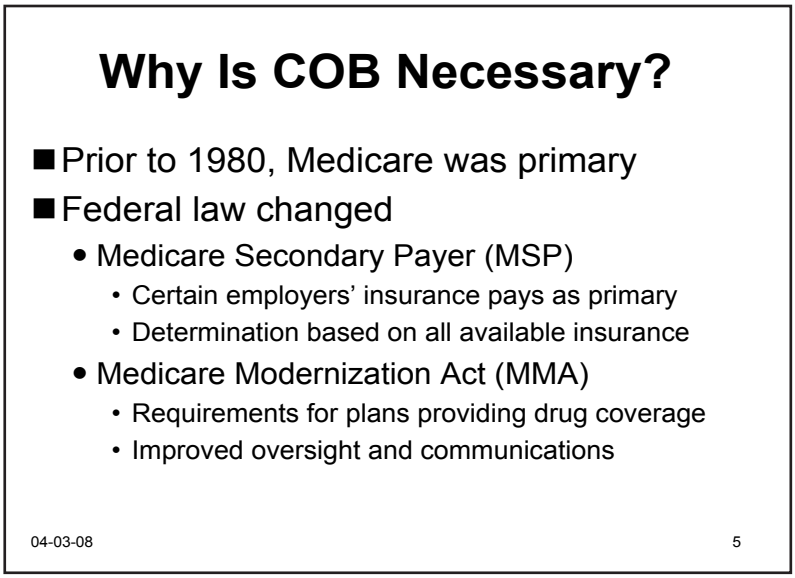

Why is Medicare coordination of benefits necessary?

Before the Medicare Secondary Payer (MSP) provisions of the law were enacted in 1980, Medicare was usually the primary payer for all people with Medicare, whether or not they were insured elsewhere.

The MSP provisions require that:

- Certain group health plans and other (non-group health plan) insurance sources pay as the primary insurer AND
- The primary payment determination be based on all available insurance.

In addition, provisions of the Medicare Modernization Act (MMA):

- Require plans that provide prescription drug coverage to coordinate their health insurance benefits with Medicare prescription drug coverage. MMA also requires Part D plans to coordinate with other entities that provide prescription drug coverage.
- Establish new ways to improve sharing of information and oversight for coordination activities, like electronic prescribing.

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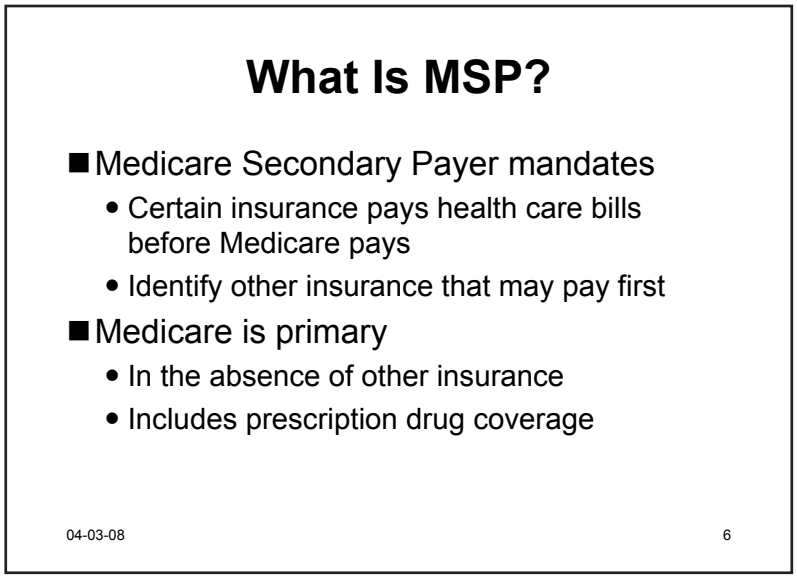

MSP mandates that certain types of insurance pay health care bills first and that Medicare pay second.

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.

In the absence of other insurance, Medicare is always primary.

In most cases, except the situations just mentioned, Medicare is also primary for prescription drug coverage.

Reference:
COB Fact Sheets: MSP Claims Investigation Fact Sheet for Providers

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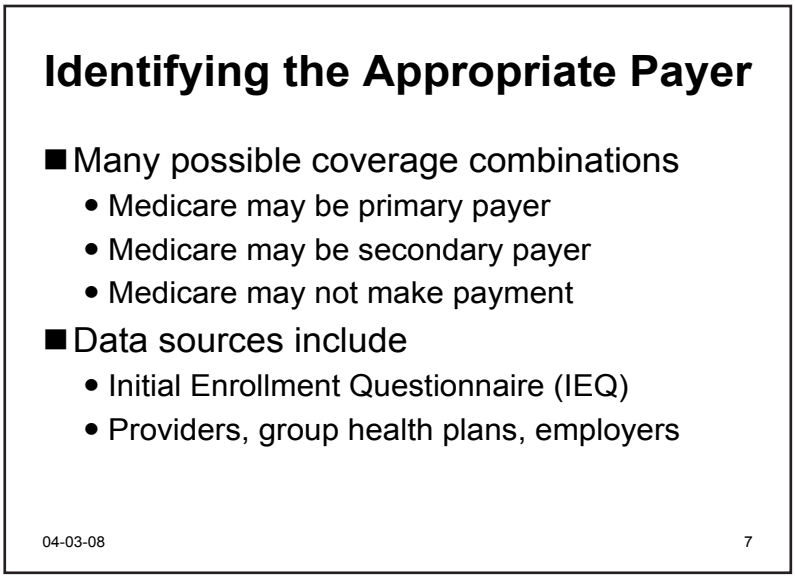

It is important to identify whether a person's medical costs are payable by other insurance before, or in addition to, Medicare. This information helps health care providers determine who to bill and how to file claims with Medicare. As we have already said, there are many insurance benefits a person could have and many combinations of insurance coverage to consider before determining who pays and when. Depending on the type of any additional insurance coverage a person has, 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.

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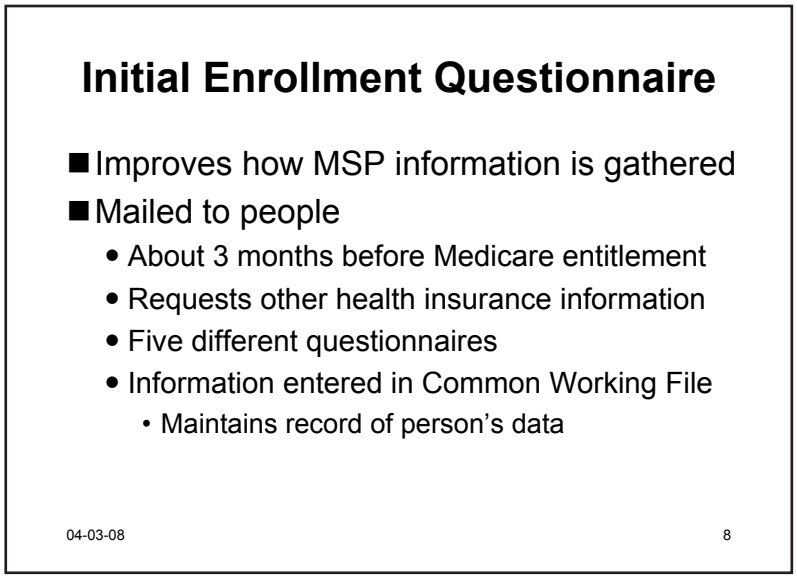

The Initial Enrollment Questionnaire (IEQ) is mailed to people about 3 months before they become entitled to Medicare. (People who are already receiving Social Security benefits will receive the IEQ and be enrolled in Medicare automatically). This questionnaire asks about any other health care coverage that may be primary to Medicare, including the person's own health insurance and coverage under a family member's insurance.

There are five different IEQs that relate to the reason for Medicare entitlement. The five questionnaires are: Working Aged, End-Stage Renal Disease, Disability, Disabled Widow/ Widowers, and Disabled Adult with Childhood Disabilities. Only one questionnaire is mailed to each beneficiary based on his or her reason for entitlement to Medicare.

The IEQ responses are processed, and a record is established indicating if there is other insurance primary to Medicare or if there is no other insurance.

The information is entered in the Common Working File (CWF) MSP Auxiliary Record. The CWF is a database that maintains a record of beneficiary data. It is important to have this information in place to ensure claims are paid correctly.

Reference:
www.cms.hhs.gov/MedicareInitialEnrolQuest/ and *www.cms.hhs.gov/ProviderServices/*

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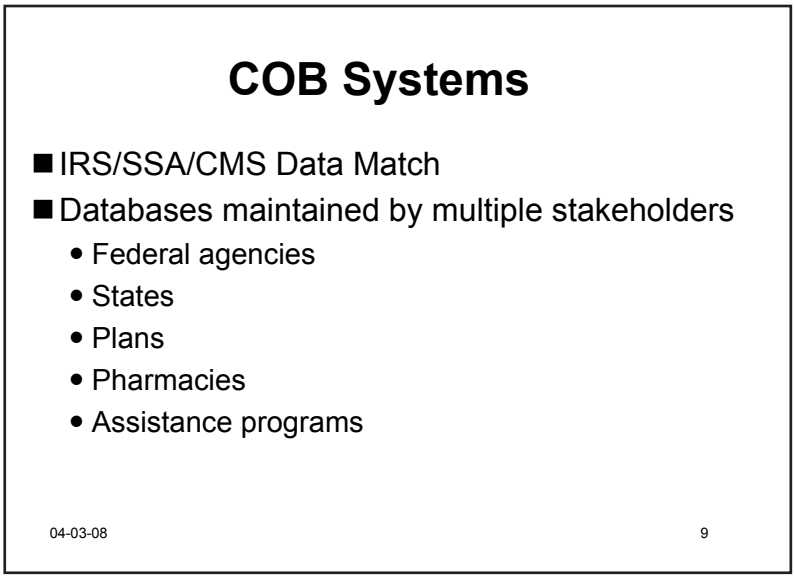

COB relies on many databases maintained by multiple stakeholders including Federal and state programs, plans that offer health insurance and/or prescription coverage, pharmacy networks, and a variety of assistance programs available for special situations or conditions.

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 activity ensures the integrity of the Medicare program and has saved the Medicare trust funds more than 3.5 billion dollars.

Reference:
Social Security Act, Section 1862 (b)(5)

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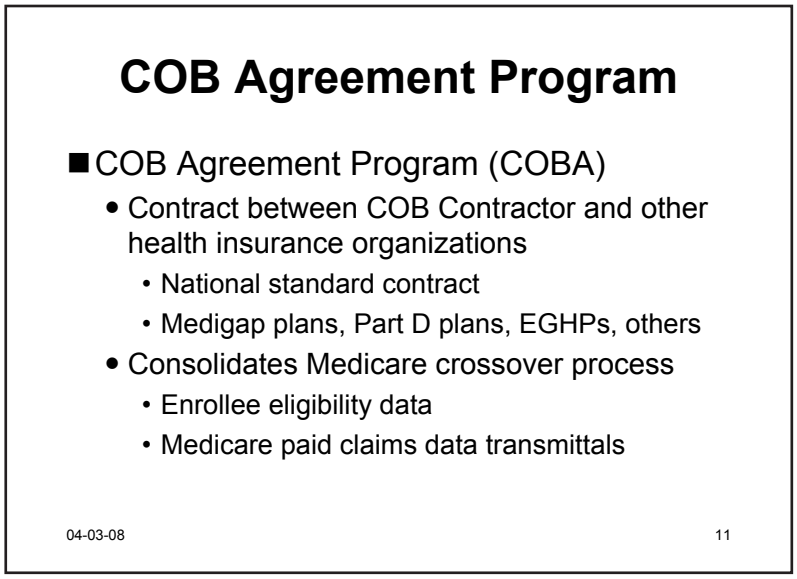

Prior to 1999, COB activities were carried out by fiscal intermediaries and carriers. In 1999, a single contractor was chosen to eliminate the overlap and redundancies of using multiple contractors and to help protect the Medicare trust funds. In this role, Group Health Incorporated (GHI) coordinates activities to support the collection, management, and reporting of all health insurance coverage information for people with Medicare, and coordinates Medicare benefits with all other insurance sources.

In May 2005, CMS awarded a single contract to RelayHealth (also known as Per-Se) 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.

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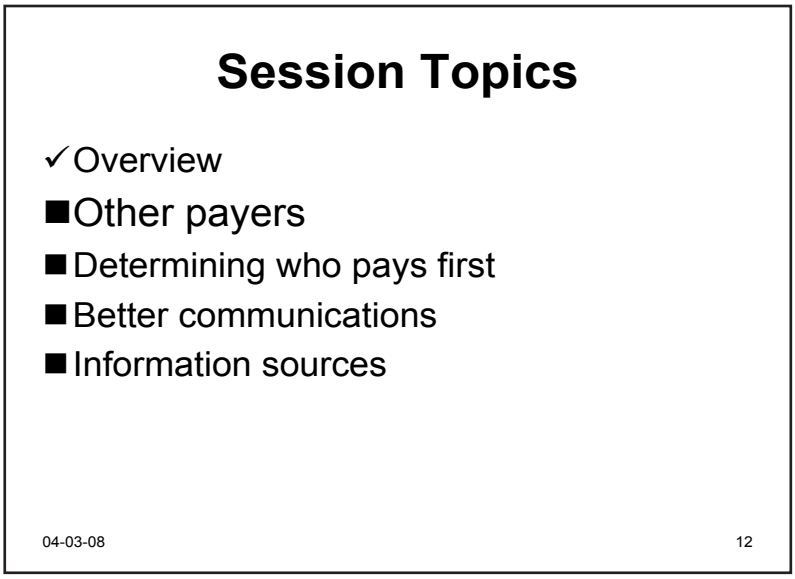

CMS consolidates the Medicare paid claim crossover process through the COB Agreement (COBA) program. The COBA program established a national standard contract between the Coordination of Benefits Contractor and other health insurance organizations for transmitting enrollee eligibility data and Medicare 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.

Reference:
www.cms.hhs.gov/COBAgreement/

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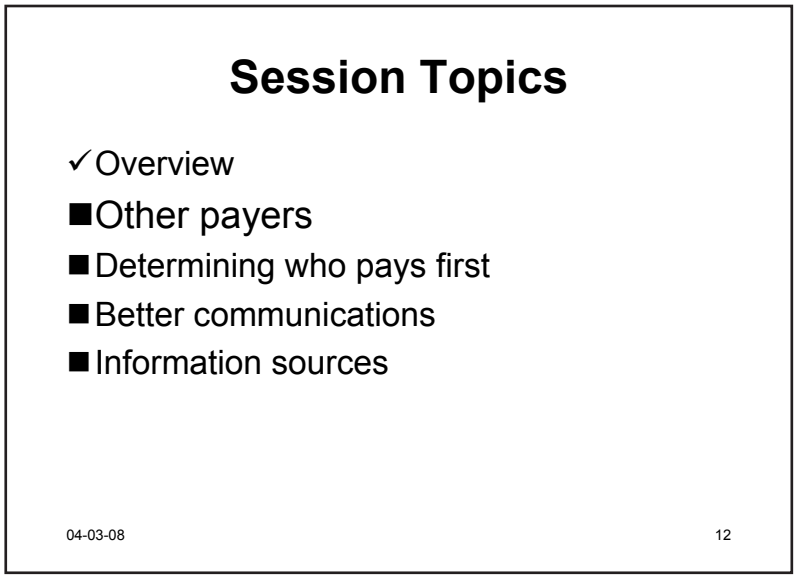

Now let's look at who some of the other payers, in addition to Medicare, might be.

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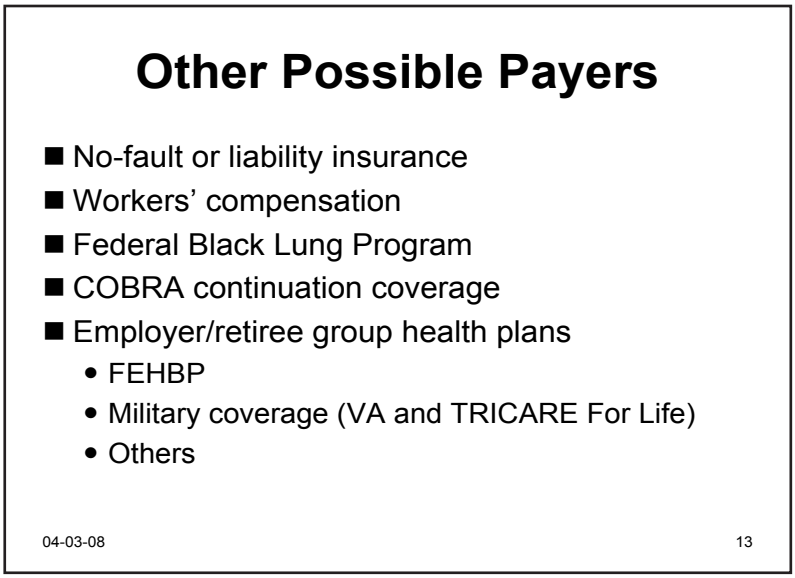

Other types of coverage a person with Medicare might have include:

- 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

Reference:
www.cms.hhs.gov/COBAgreement/

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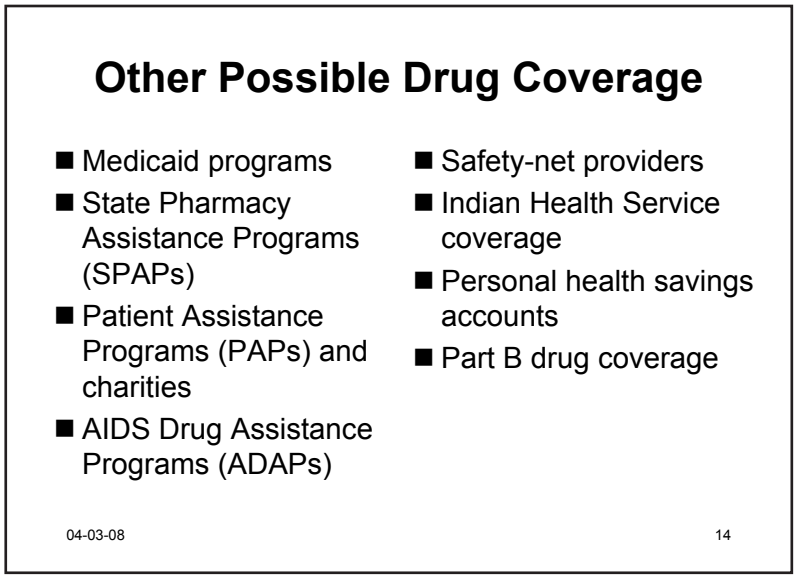

With Medicare drug coverage, COB and data-sharing activities expanded to many new entities that provide prescription drug coverage. The MMA requires other (non-Part D) plans to inform policyholders every year whether their coverage is as good as Medicare drug coverage, or "creditable." Part D plans must permit these other entities to coordinate benefits with them.

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

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.

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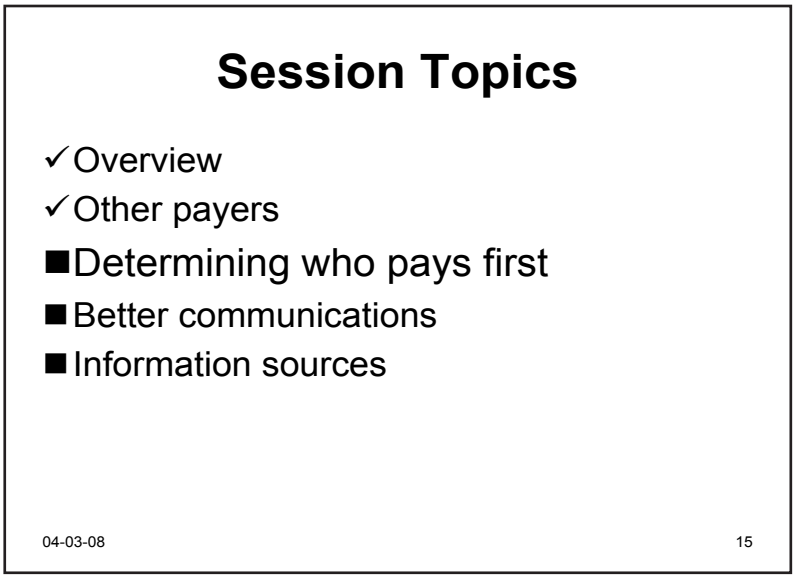

Now let's look at some situations involving these other payers and learn more about who pays first and how these payers work with Medicare, including Medicare prescription drug coverage.

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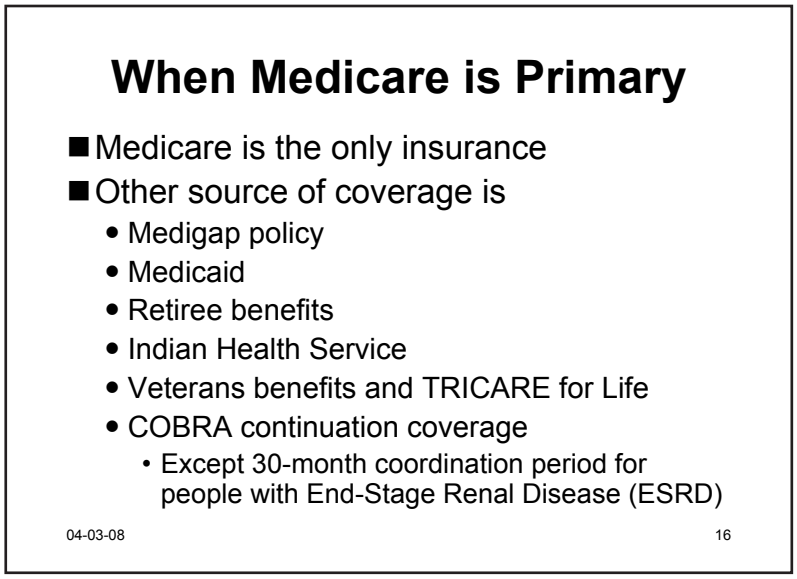

It is important to understand who pays first. Let's first review when Medicare is primary.

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
- A Medigap policy or other privately purchased insurance policy not related to current employment covers amounts not covered by Medicare
- Coverage is through Medicaid and Medicare, with no other coverage primary to Medicare
- Retiree coverage, in most cases. To find out 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
- TRICARE For Life
- Veterans health care coverage
- Coverage under COBRA, except for people entitled to Medicare based on End-Stage Renal Disease (ESRD) who are still within their 30-month coordination period. (We'll talk more about this coverage later.)

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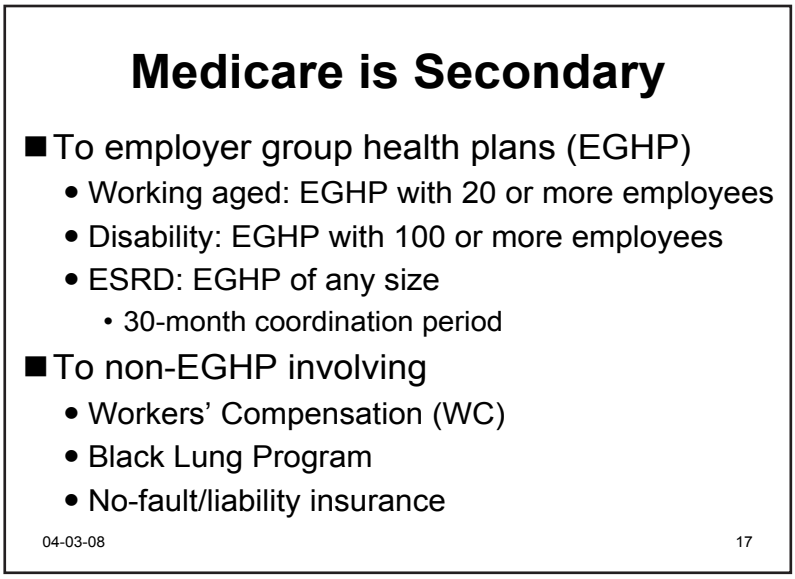

Some people with Medicare have other insurance or coverage that must pay before Medicare pays its share. This applies no matter how the person receives benefits from Medicare, whether from Original Medicare or a Medicare Advantage Plan. Let's take a look at situations in which Medicare is the secondary payer.

According to law, Medicare is generally the secondary payer in the following situations:

- **Working Aged and EGHP** – A person with Medicare based on being age 65 or older iscovered through current employment of him/herself or a spouse by 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 is covered through his or her current employment or a family member's current employment in an large firm with 100 or more employees.
- **ESRD and EGHP** – If a person with Medicare based on ESRD is covered by an EGHP of any size, the plan is primary for an initial 30-month coordination period, and then 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-GHP situations involving

- **Workers' Compensation** – The person with Medicare is covered under WC due to jobrelated illness, injury, or disease.
- **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 accident.

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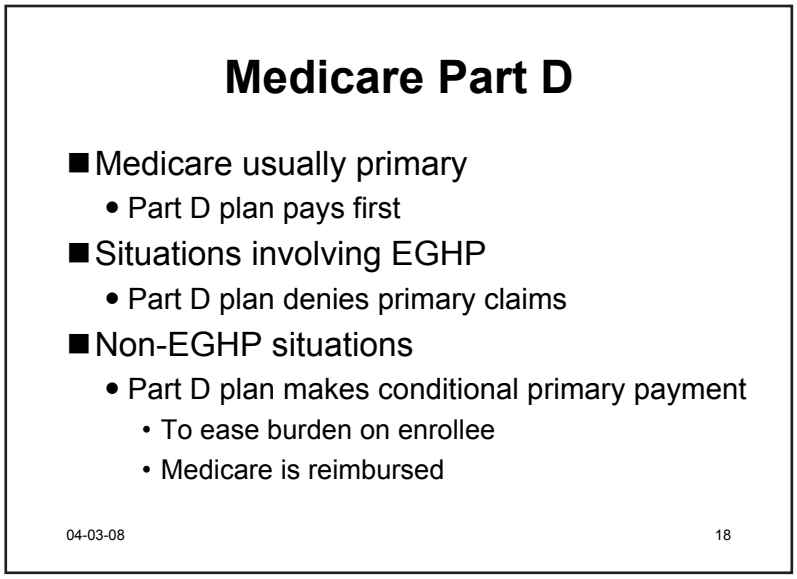

Generally, Medicare provides primary coverage for prescription drugs. Whenever Medicare is primary, the Part D plan is billed and will pay first.

In situations involving an EGHP when Medicare is the secondary payer, Part D plans will always deny primary claims. Again that would apply for:

- Working Aged with EGHP with 20 or more employees
- Disability with large EGHP with 100 or more employees
- ESRD with EGHP of any size during the 30-month coordination period

In situations NOT involving an EGHP when Medicare is the secondary payer, or when a plan does not know whether a covered drug is related to an injury, Part D plans will always make conditional primary payment to ease the burden on the policyholder, unless certain situations apply. 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.

The Part D plan will not pay if it is already 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 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.

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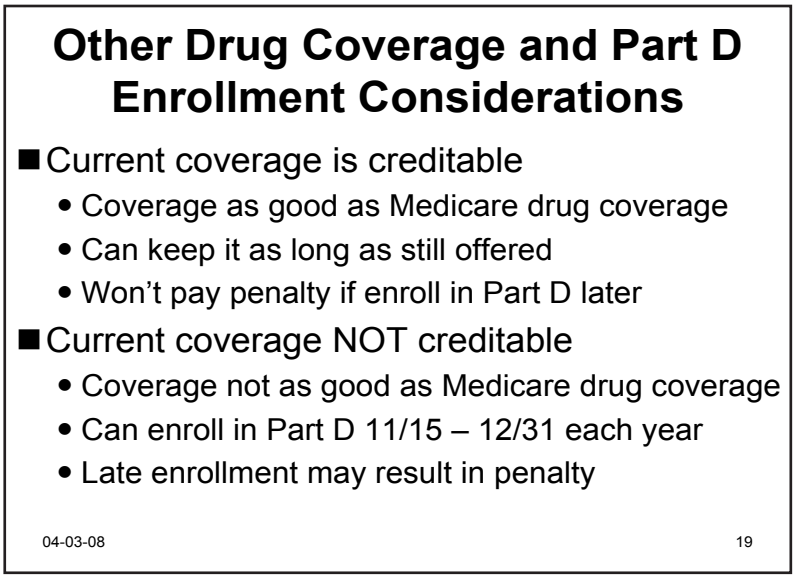

The Part D late enrollment penalty is an important consideration for people with other drug coverage. People who wait to enroll in Medicare drug coverage may have to pay a higher premium if their current coverage is not creditable. People should watch for the annual notice from the plan or talk to their 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 November 15 – December 31 each year but may have to pay a higher monthly premium.

NOTE: People who qualify for the extra help from Medicare may enroll in a Part D plan or switch plans at any time, with the new plan effective the first day of the following month.

(**NOTE:** Before June 20, 2007, only people who had Medicaid or were in a Medicare Savings Program qualified for this continuous SEP.)

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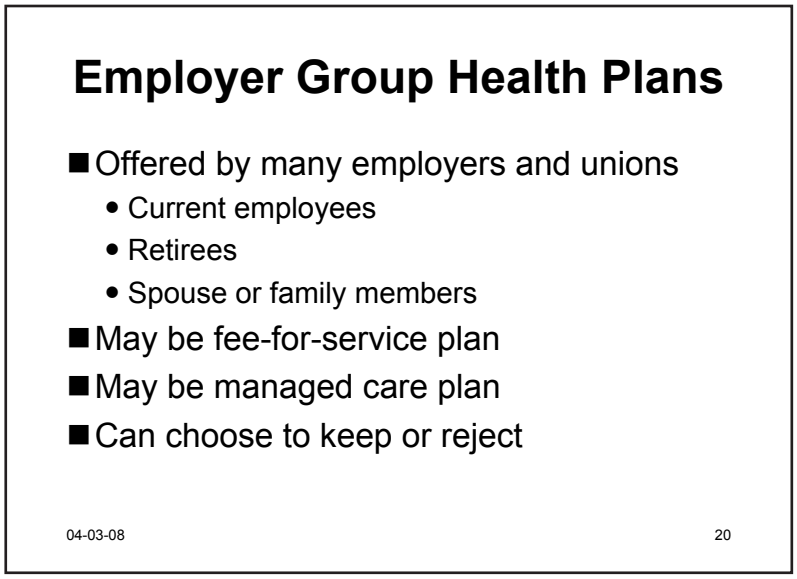

Let's look more closely at both EGHP and non-EGHP situations.

First 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 size of the company he or she works for.

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.

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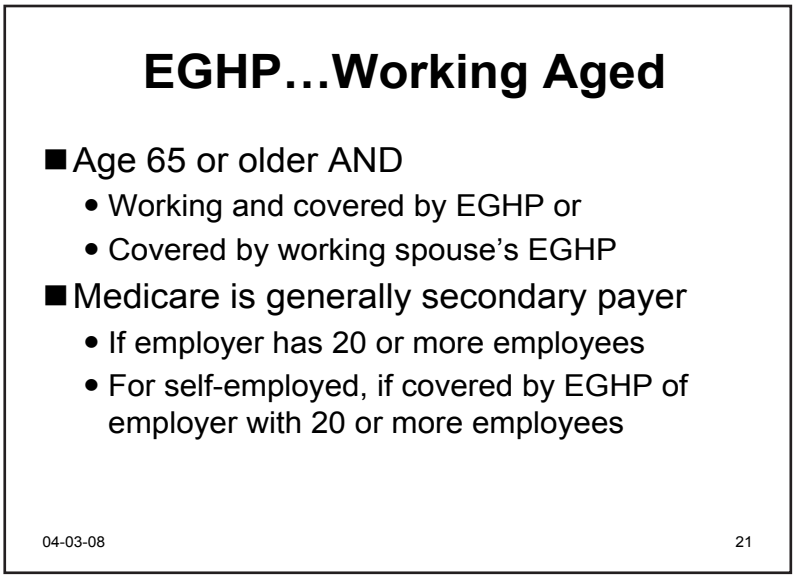

Next, let's define the term "working aged." Working aged means that a person is at least age 65 and

- 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
- If 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.

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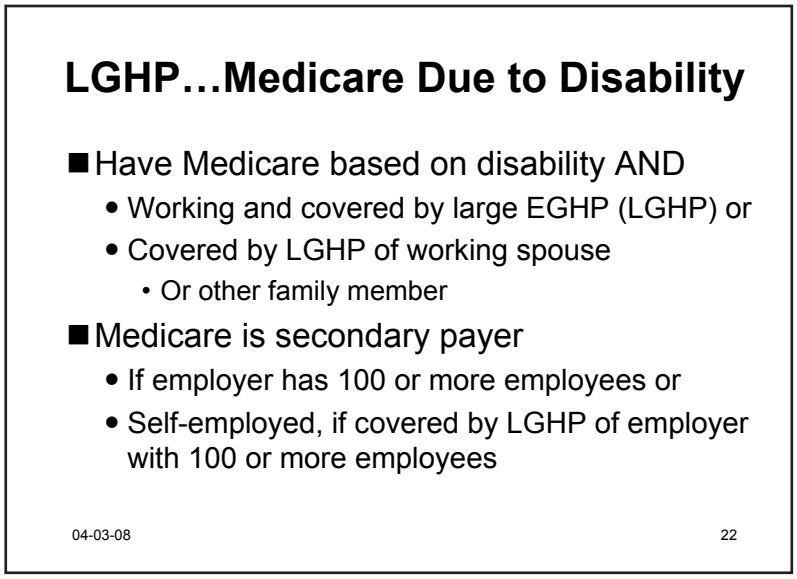

Medicare is the secondary payer for people who are under age 65 and entitled to Medicare because of a disability, if they are covered by a large EGHP (LGHP) through current employment, either their own or that of a family member. In this instance, the employer must have 100 or more employees.

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, including individuals associated with employers within the group that have less than 100 employees.

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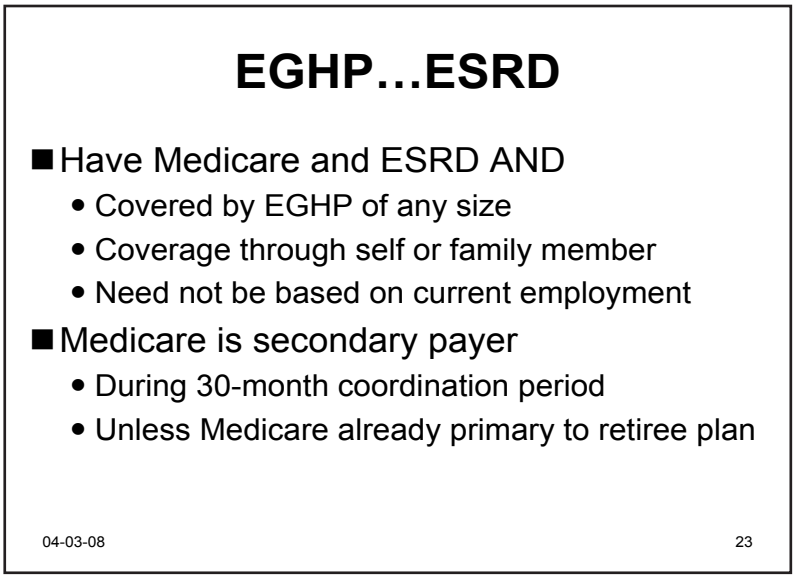

People with Medicare based on ESRD who have EGHP coverage on any basis may also have Medicare as a secondary payer, regardless of the number of employees and regardless of whether or not they are currently employed. This applies both to people who have their own coverage and to those covered as family members.

Medicare is secondary payer for a 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 pays first.

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 primary.

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).

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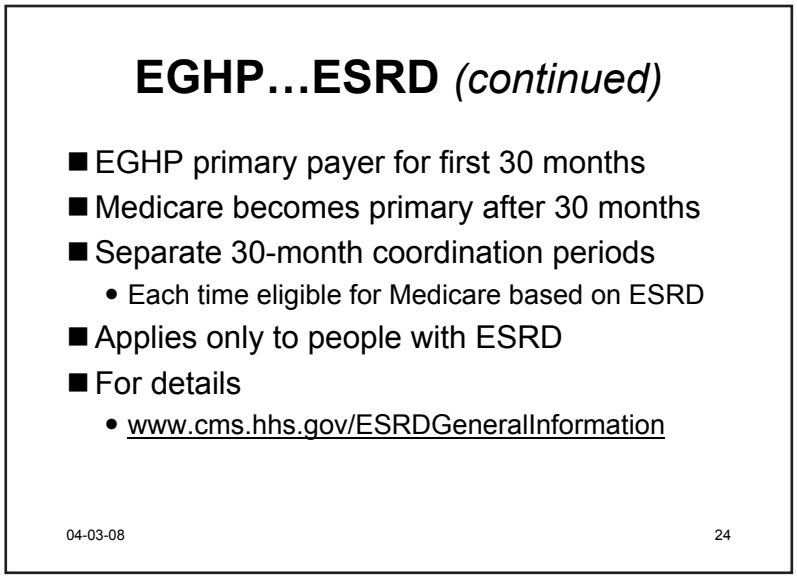

Let's look at this third group a little more closely.

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 enrolled in Medicare yet. The EGHP is the primary payer during this period. 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.

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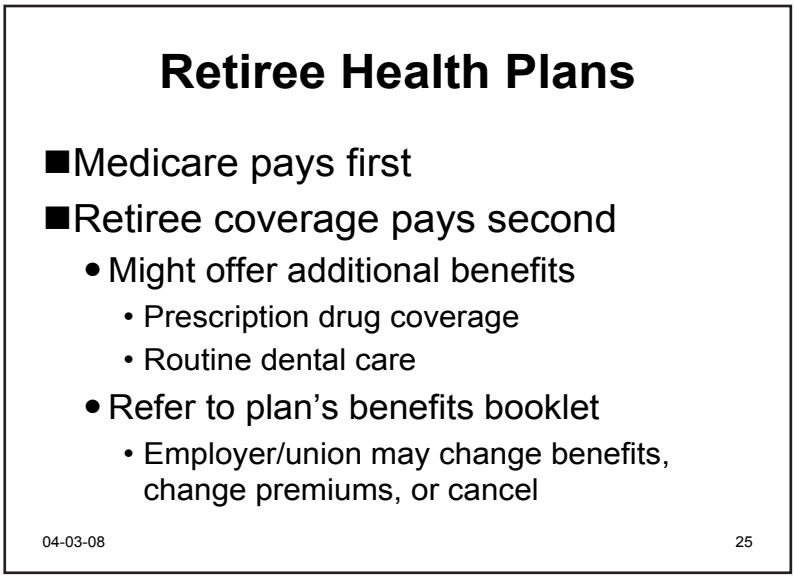

And now let's discuss people who are covered by an EGHP and are retired. Who pays first? Generally, Medicare will pay first for health insurance claims, and the retiree coverage will be the secondary payer. Retiree coverage might fill some of the gaps in Medicare coverage and might offer additional benefits such as routine dental care. Workers approaching retirement should find out if employer coverage can be continued after they retire and should check the price and the benefits, including benefits for a spouse. They should know what effect continuing coverage as a retiree will have on both their 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," or a limit on out-of-pocket costs. 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. 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 cancel the insurance if it chooses.

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

The Federal Employee Health Benefit Program (FEHBP) will be discussed separately later.

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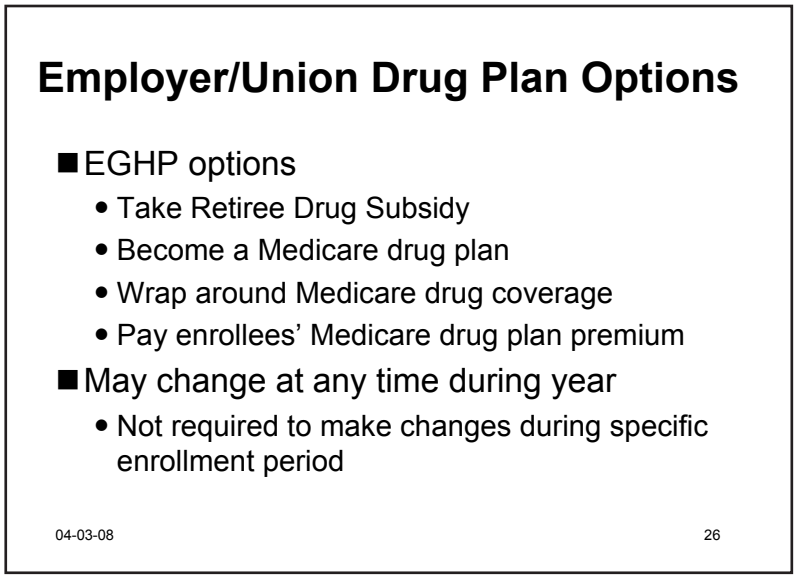

Now let's talk about how retiree plans can work with Medicare prescription drug coverage. The MMA allows employers and unions flexibility in designing their benefit packages and is intended to encourage them to keep, or even improve, the coverage they offer.

Plans can choose from different options. The option the employer group health plan 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.

Employer group health plan options include:

- Opting for the Retiree Drug Subsidy
  - These plans may require enrollees to choose between Medicare drug coverage or the EGHP
- Becoming a Medicare drug plan
- Wrapping around Medicare drug coverage
- Paying the Medicare drug coverage premium for their enrollees

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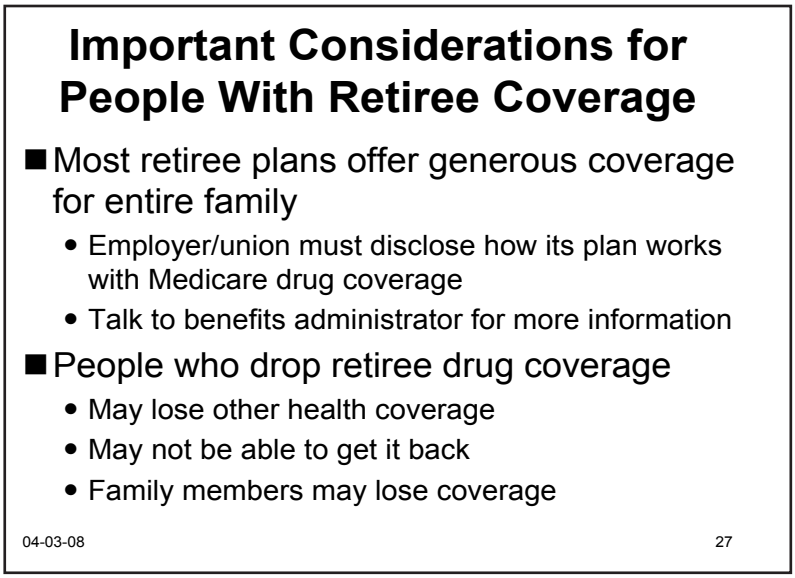

People with Medicare who have coverage provided by employer or union retirement plans must carefully consider their options.

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 from year to year. Each plan is required by law to disclose to its members how it works with Medicare prescription drug coverage at least once a year. If a person with Medicare loses "creditable" coverage, he/she has 63 days to find comparable coverage without incurring a penalty for late enrollment. The benefits administrator for the EGHP can provide specific information about the plan, including how it works with Medicare prescription drug coverage.

When making a decision on whether to keep or drop coverage through an employer or union retirement plan, there are some important points to consider.

- Most employer/union retirement plans offer excellent prescription coverage comparable to Medicare drug coverage, and often offer generous hospitalization and medical insurance for the entire family, which is particularly important for those who are chronically ill or have frequent hospitalizations.
- People who drop retiree group health coverage may not be able to get it back.
- People 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 it is critical that any decision about prescription drug coverage be made in the context of the entire family's health status and coverage needs.

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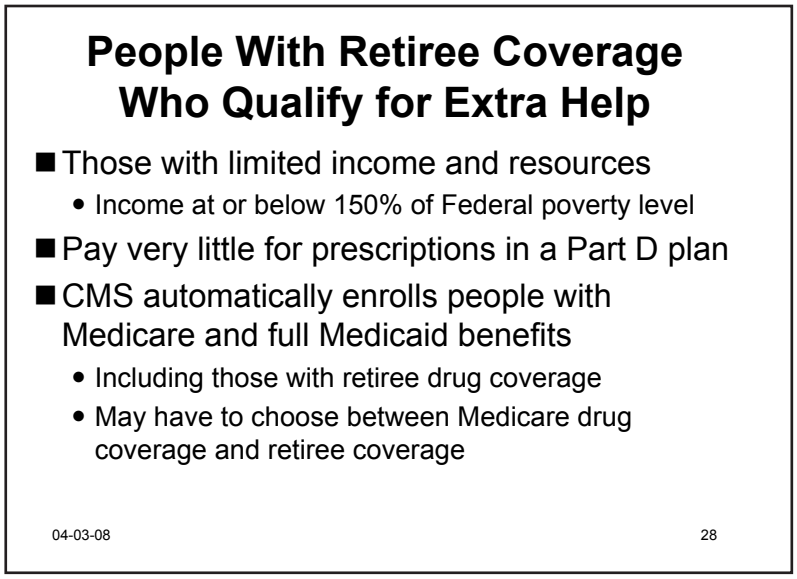

People with limited resources and income at or below 150% of the Federal poverty level may qualify for extra help with Medicare drug plan costs. The choice of plans for people in this category who also have employer/union coverage can be more involved than for other individuals. That's because:

- 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 the extra help, but not those whose employers or unions are claiming the Retiree Drug Subsidy.
- Many employer/union plans are claiming the Retiree Drug Subsidy and have informed all 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.

As a result, these individuals may have to choose between being enrolled 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 the 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.

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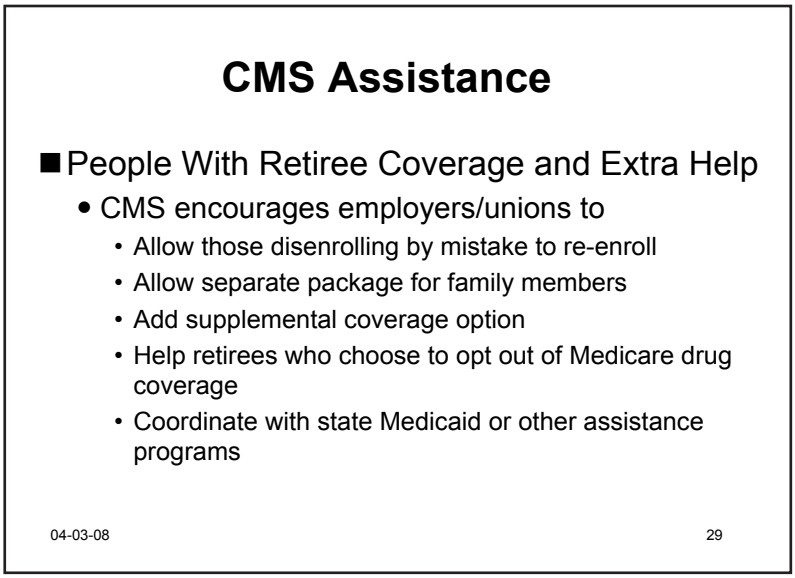

To assist people with Medicare and limited income in their decision-making and minimize undesirable consequences, CMS encourages employers and unions to design their retiree benefits to be more flexible in certain areas, including:

1. Providing a flexible transition/correction period;
2. Allowing spouses and dependents to continue receiving retiree coverage when the retiree enrolls in Medicare drug coverage;
3. Adding a supplemental coverage option;
4. Providing information to help retirees opt out of Medicare drug coverage, when that is what they choose; and
5. Coordinating with State Medicaid or other assistance programs.

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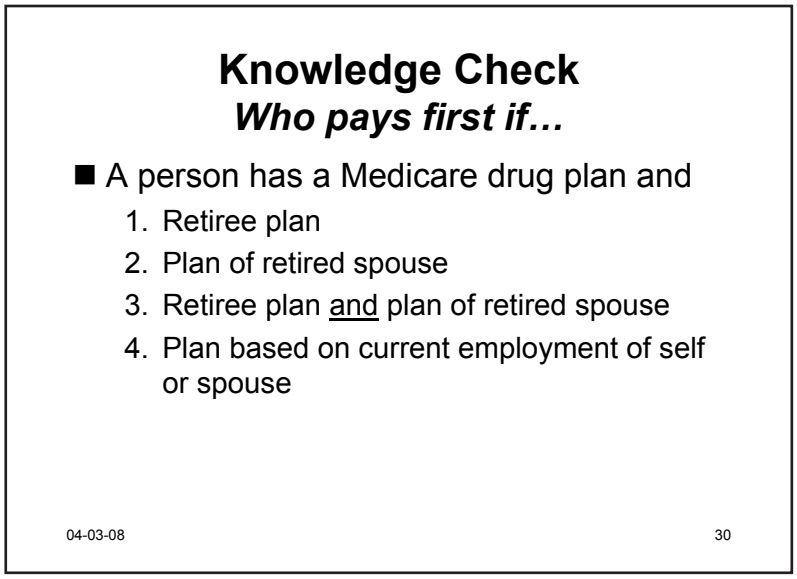

Let's review how Part D, Medicare drug coverage, works with employer/union coverage by looking at a few scenarios.

Question: Who pays first if a person has Part D and is retired and is covered through the former employer's retiree group health plan?
Answer: When a person with Medicare is covered through a retiree group health plan, the plan is secondary to Part D. The person's Part D plan will pay first.

Question: Who pays first if a person with Medicare has Part D and is also covered under the health plan of a retired spouse?
Answer: When the person is covered through the plan of a retired spouse, the plan is secondary to Part D. The Part D plan will pay first.

Question: Who pays first if a person has Part D and retiree health coverage AND is covered under a spouse's retiree plan?
Answer: Because the person and spouse are both retired, the two retiree plans are secondary to Part D. The Part D plan will pay first, and then the person's own retiree plan will be billed second, followed by the spouse's plan if there is any remaining balance.

Question: Who pays first if a person has Part D and is currently working with coverage through the employer's group health plan? What about someone with Part D who is not working but is covered under the EGHP of a working spouse?
Answer: When people with Medicare are covered through their employer's group health plan because they are currently working, generally Part D is secondary to the EGHP. The EGHP will normally pay first, although it depends on the size of the employer.

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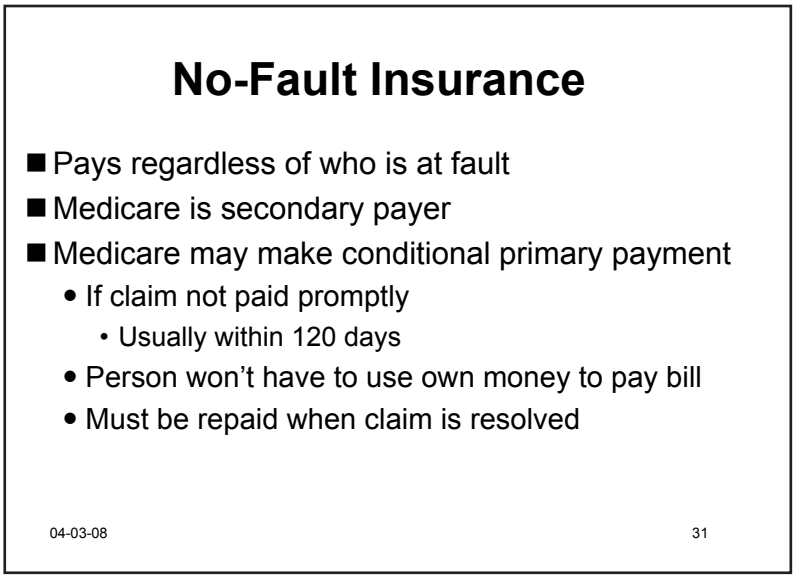

Let's take a look at no-fault insurance.

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

What is no-fault insurance? 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:

- Automobile insurance
- Homeowners' insurance
- Commercial insurance plans

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 seeks 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.

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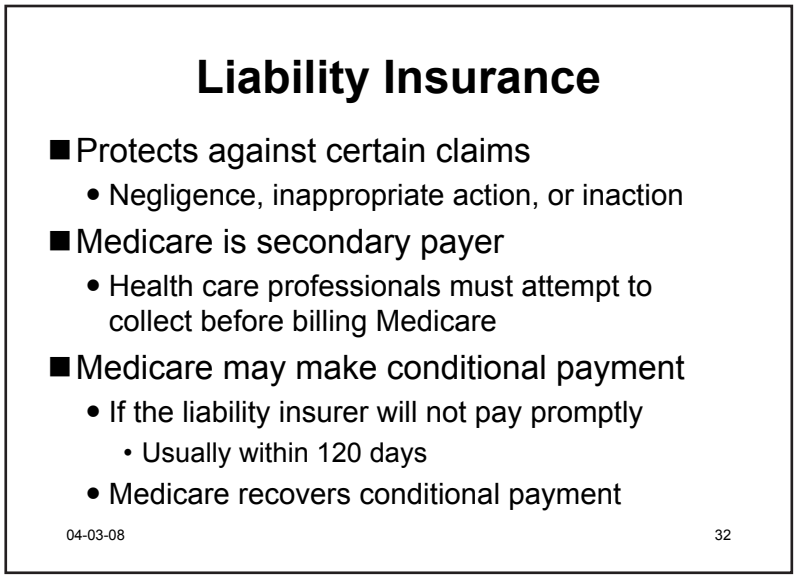

What is liability insurance? Liability insurance is coverage that protects a party who allegedly commits a tort (civil wrong) against claims based on negligence, inappropriate action, or inaction that results in injury to someone or damage to property. Liability insurance includes, but is not limited 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.

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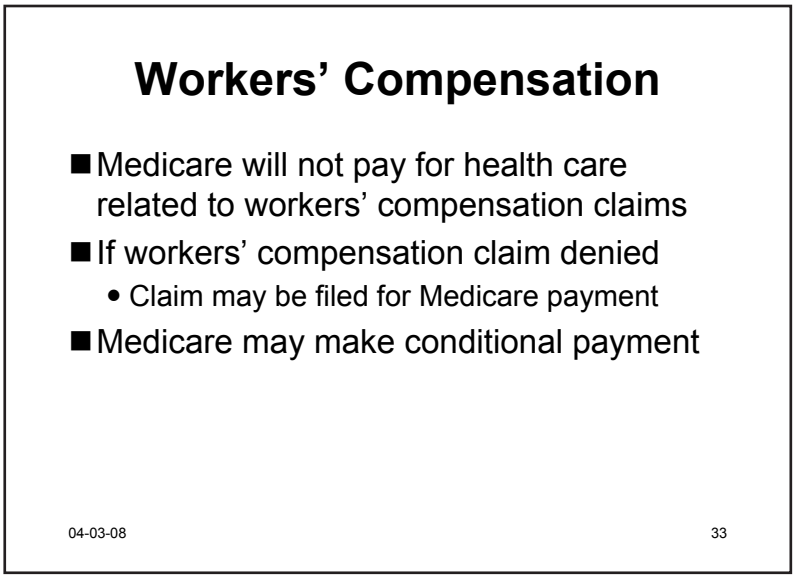

Medicare will not pay for an injury or illness/disease covered by a workers' compensation plan. If all or part of a claim is denied by workers' compensation on the grounds that it is not covered by workers' compensation, a claim may be filed with Medicare. Medicare may pay a claim that relates to a medical 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.hhs.gov/WorkersCompAgency Services/04_wcsetaside.asp#TopOfPage*

Reference:
Section 1862(b)(2) of the Social Security Act (42 USC 1395y(b)(2))

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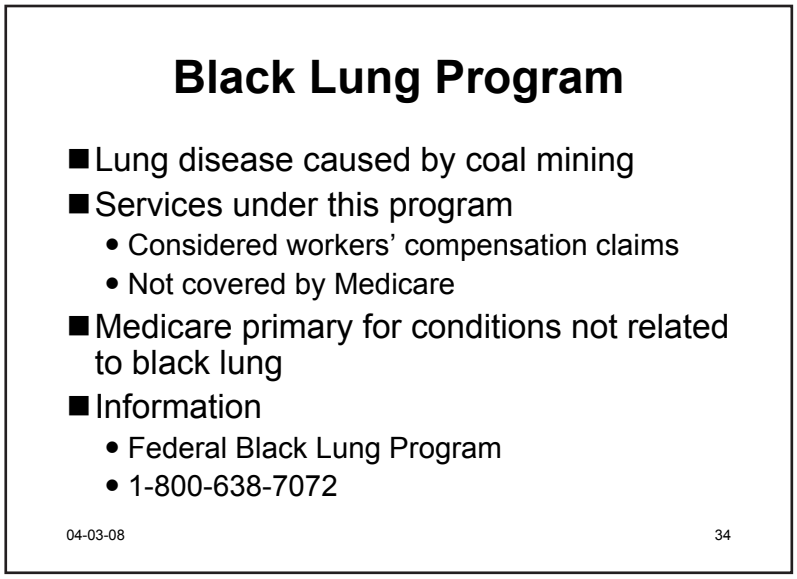

Some people with Medicare can get medical benefits under the Federal Black Lung Program for services related to lung disease and other conditions caused by coal mining. The Medicare program does not pay for health services covered under this program.

Black lung claims are considered workers' compensation claims. Doctors or other providers should send all claims for services that relate to a diagnosis of black lung disease 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

- There is no other primary insurance
- The individual is eligible for Medicare
- The services are covered by the Medicare program

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, (800) 638-7072, also has been designated for the office that is responsible for the Black Lung Program's medical diagnostic and treatment services.

Over 102,000 beneficiaries and 18,000 dependents received black lung benefits in 2004. 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.

Reference:
www.dol.gov/esa/regs/compliance/owcp/bltable.htm

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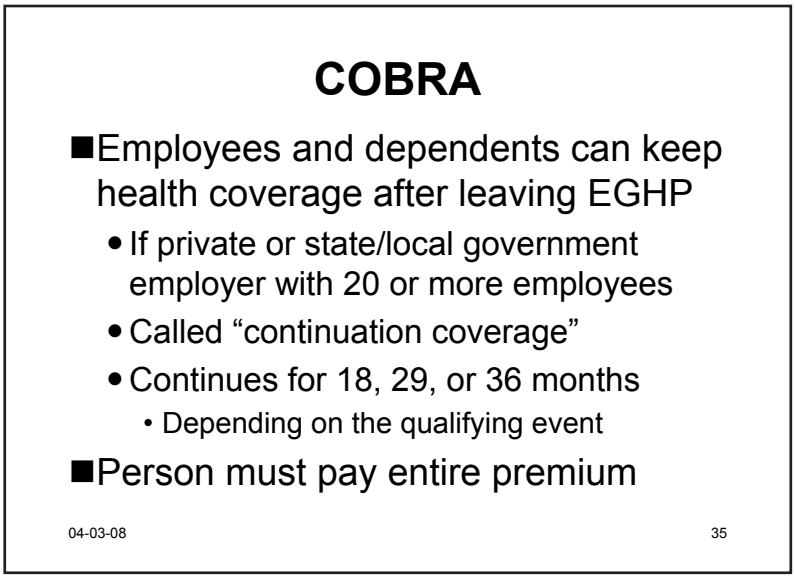

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to let employees and their dependents keep their health coverage for a time after they leave their EGHP, under certain conditions. This is called continuation coverage.

The law applies to plans in the private sector and those sponsored by state and local governments. The law does not apply to plans sponsored by the Federal government, the governments of the District of Columbia or any territory or possession of the United States, or to certain church-related organizations. (The Federal Employee Health Benefits Program is subject to similar temporary continuation of coverage provisions under the Federal Employees Health Benefits Amendments Act of 1988).

People may have this right when coverage is lost due to certain specific 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 employer usually pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. However, it is ordinarily less expensive than individual health coverage.

Reference:
www.cms.hhs.gov/COBRAContinuationofCov and *www.cms.hhs.gov/HealthInsReformforConsume*

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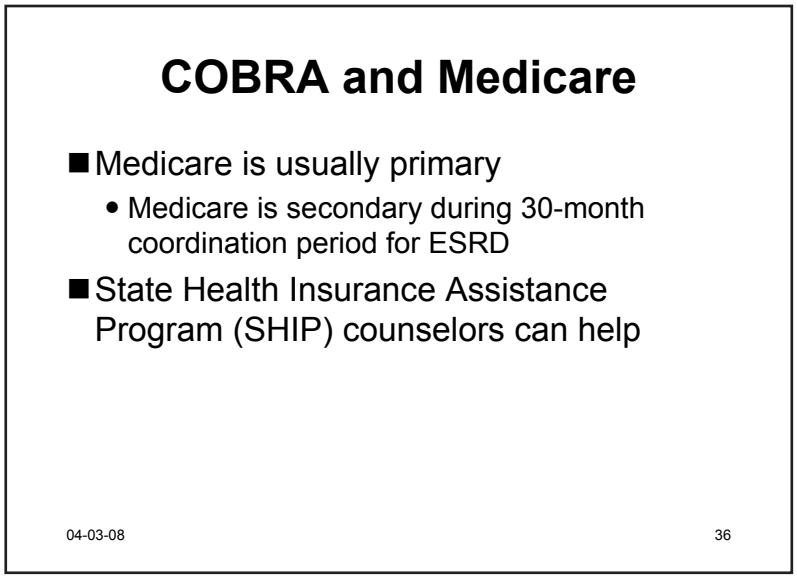

Medicare is primary to COBRA continuation coverage for aged and disabled individuals.

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.

Reference:
"Medicare and Other Health Benefits: Your Guide to Who Pays First," CMS Pub. 02179

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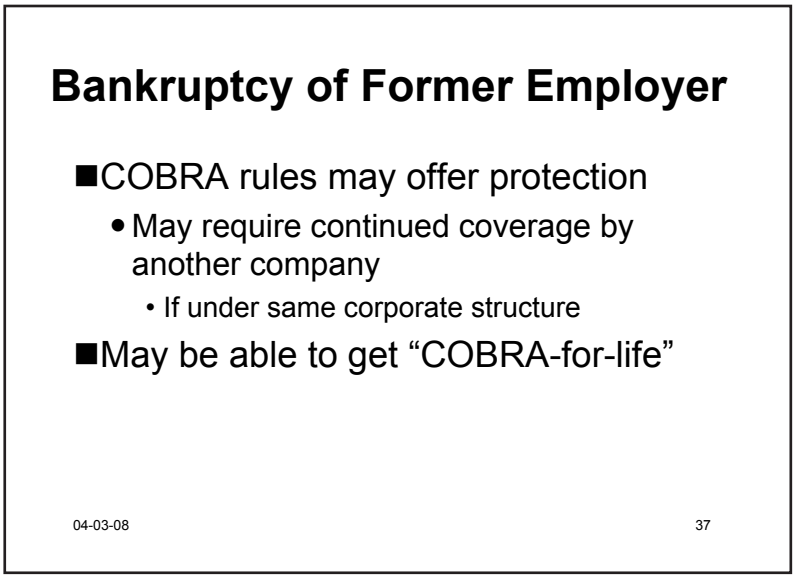

Many people wonder what happens if they have retiree health coverage after they retire and the former employer goes bankrupt or out of business.

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.

Reference:
Medicare and Other Health Benefits: Your Guide to Who Pays First, CMS Pub.02179

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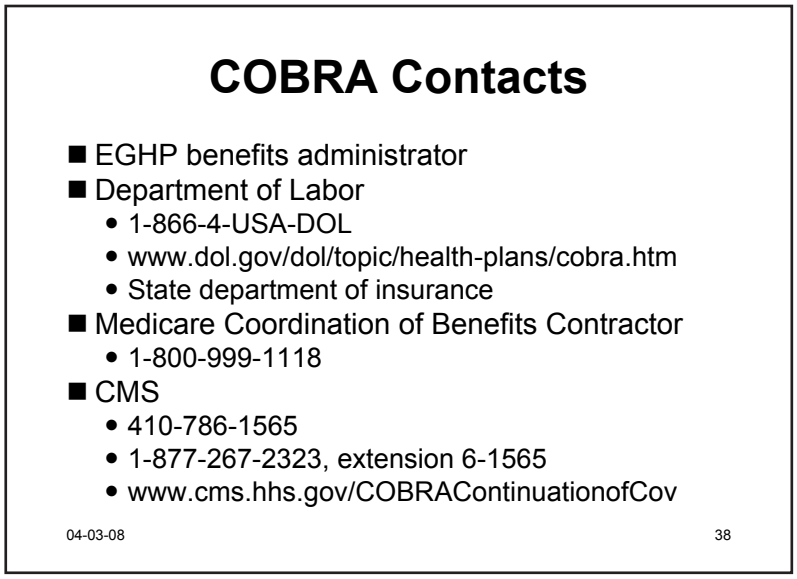

In most situations when COBRA rights apply, other than divorce or a child ceasing to be a dependent, people should get a notice from their benefits administrator. People who don't get a notice or who get divorced should call their benefits administrator as soon as possible. People should call their benefits administrator for questions about COBRA coverage and payments. People with Medicare secondary payer questions should call the Coordination of Benefits Contractor at 1-800-999-1118.

People can get help with COBRA questions from the Department of Labor Health and Benefits Section.

People who work for a state or local governmental employer can get their questions addressed by CMS. The numbers to call at CMS are:

- 410-786-1565
- 1-877-267-2323, extension 6-1565

People who work for the Federal Government can get their questions answered by their agency's Human Resources Department or by the Office of Personnel Management (OPM). OPM's number is (202) 606-0745.

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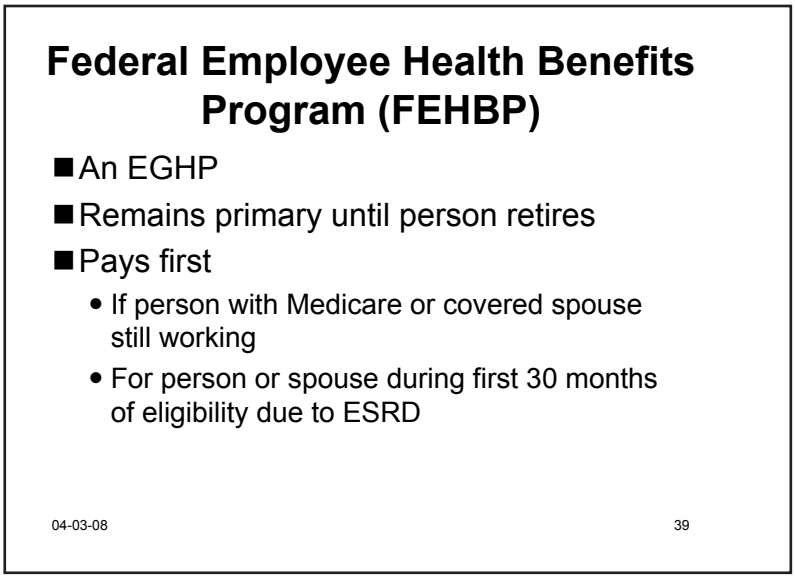

The Federal Employee Health Benefits Program (FEHBP) offers health coverage for current and retired Federal employees and covered family members. Generally, FEHBP plans help pay for the same kind of expenses as Medicare. FEHBP plans also cover prescription drugs, routine physicals, emergency care outside 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 or his/her covered spouse when the person has Medicare, unless the reemployment position is excluded from FEHBP coverage, or the person is enrolled in Medicare Part B only. Likewise, 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.

Retired people with an FEHB plan can choose whether or not to enroll in Medicare. However, those who choose to enroll in Medicare after their initial enrollment period must wait for a general enrollment period (January 1 to March 31 each year) to enroll, and coverage will begin the following July 1. If they take Part B, their premium will go up 10% for each 12-month period they could have had Part B but didn't take it.

Reference:
www.opm.gov/insure/health/medicare/medicare04.asp and *www.cms.hhs.gov/partnerships/downloads/FEHBP.pdf*

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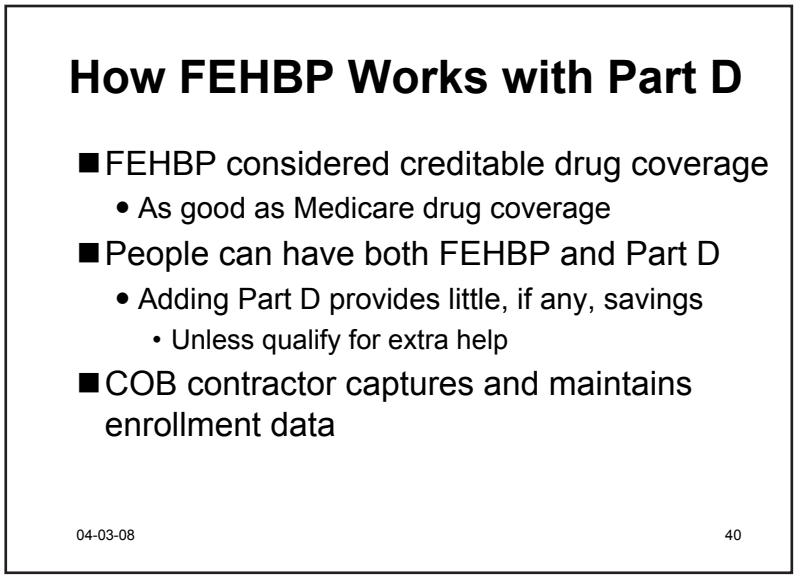

OPM has determined that the prescription drug coverage offered by plans participating in the FEHBP is, on average, comparable to Medicare Part D coverage. Therefore, it is not necessary for people with an FEHB plan to enroll in Medicare Part D. However, people covered by FEHBP can choose to enroll in 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.

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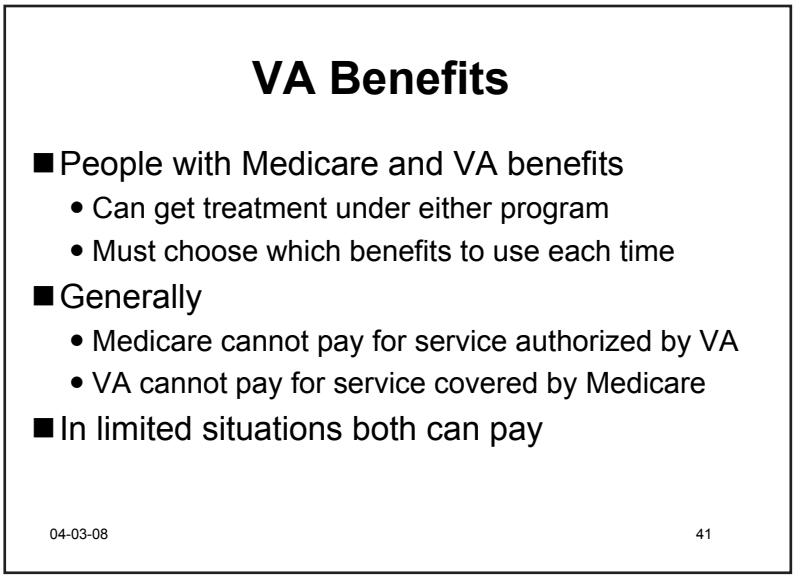
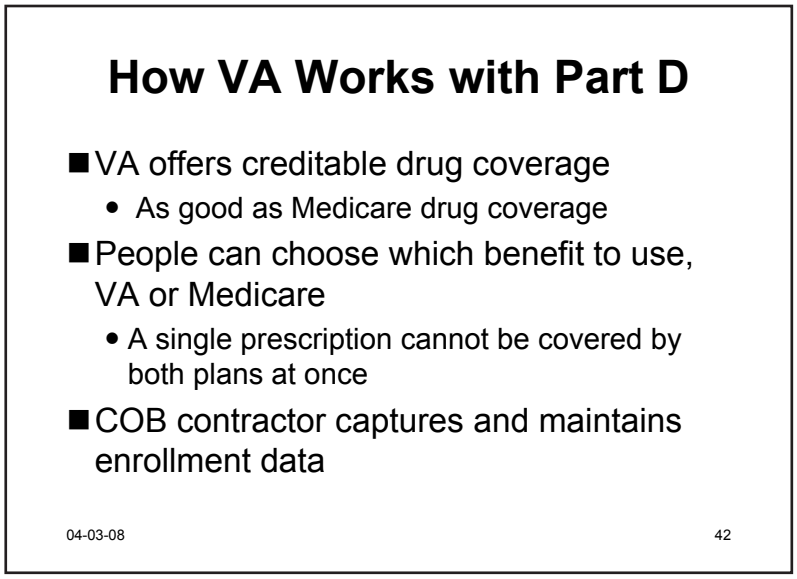


People with both Medicare and veterans' benefits can receive coverage under either program. When a person with VA benefits and Medicare receives health care, he or she must choose which benefits to use. This choice must be made each time the person sees a doctor or receives health care, e.g., in a hospital. Medicare cannot pay for the same service that was authorized by the Department of Veterans Affairs, and veterans' benefits cannot make primary payment for the same service that was covered by Medicare. To get services under VA, people must go to a VA facility or have the VA authorize services in a non-VA facility. There are some limited situations where both Medicare and the VA can pay. If a person with Medicare receives VA authorized services in a non-VA facility that doesn't cover all services rendered, Medicare can pay for the Medicare-covered part of the services that the VA doesn't cover.



Because VA drug coverage is so comprehensive, most people with Medicare and VA coverage do not need to enroll in Medicare Part D. VA drug coverage is as good as Medicare coverage, and people who wait to enroll in Part D will not have to pay a late enrollment penalty, however they will have to wait for a valid enrollment period to apply (i.e. the annual enrollment period November 15 – December 31 each year with coverage beginning on January 1 of the next year.

People with VA coverage may want to consider joining a Medicare drug plan if they qualify for the extra help, if they live in a nursing home, or if their VA facility or pharmacy is not nearby or if they have prescriptions that are not covered under the VA formulary.

However, people can't have a single prescription covered by both programs. If people want to have both VA and Medicare drug coverage, they can choose on a prescription-byprescription basis whether to get it 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 should be captured and maintained by the COB contractor and be made available to Part D plans as part of the COB process.

For more information, see *www.cms.hhs.gov/partnerships/downloads/VA.pdf*

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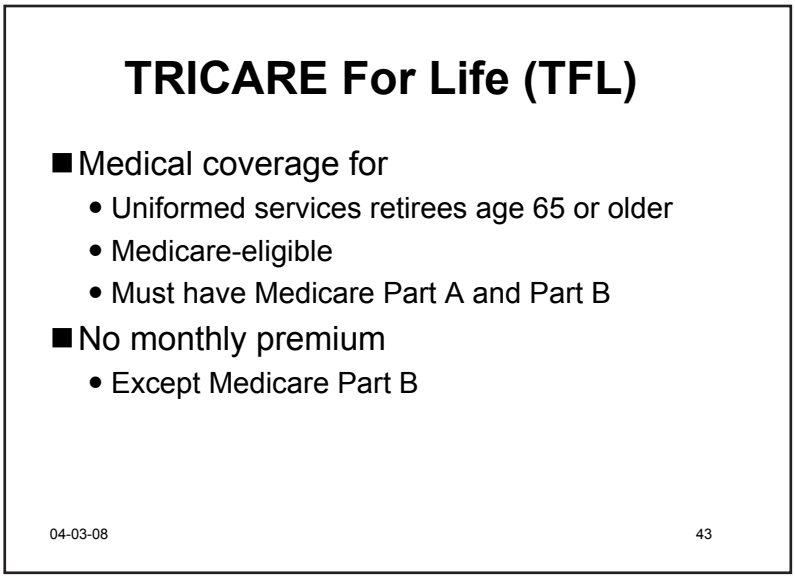
Module 5: Coordination of Benefits



The FY 2001 National Defense Authorization Act modified the TRICARE program (the Department of Defense, or DOD, health care program) to provide expanded medical coverage to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses. This program, known as TRICARE for Life (TFL), began October 1, 2001.

DOD automatically notifies those eligible, 90 days prior to attaining age 65, that their medical benefits are about to change, and they are asked to contact the nearest Social Security office about enrolling in Medicare.

To get TFL benefits, people must have both Medicare Part A and Part B.

- TRICARE For Life is generally a secondary payer to Medicare.
- Medicare-paid claims are crossed automatically to TFL based on an eligibility file provided by TFL. A signed COB agreement enables TFL to receive automatic crossovers.
- There are no monthly premiums (except Medicare Part B).
- Eligibles have generous coverage under both Medicare and TFL, including a generous pharmacy benefit under the TRICARE Pharmacy program.

NOTE: A coordination of benefits cost matrix is available at *www.tricare.mil/tfl/tflcostmatrix_b.html* on the web.

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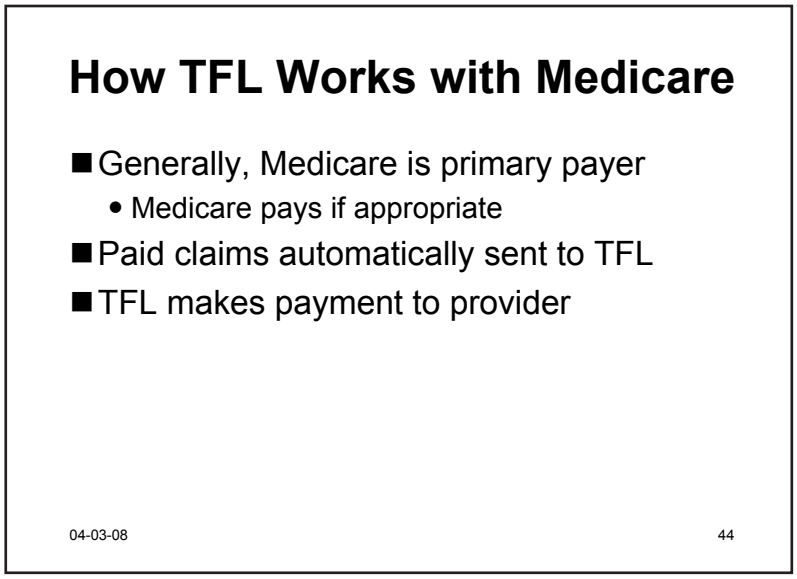
My Health. My Medicare.



When Medicare receives a claim, it will determine if the services received are payable by Medicare and, if so, pay the doctor and/or hospital. Medicare will then automatically send the claim to TRICARE for payment of the remaining amount, assuming that TFL has a signed COB agreement in place with Medicare through the Medicare COB Contractor . The TRICARE payment will be sent automatically to the doctor or hospital.

If an individual 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.

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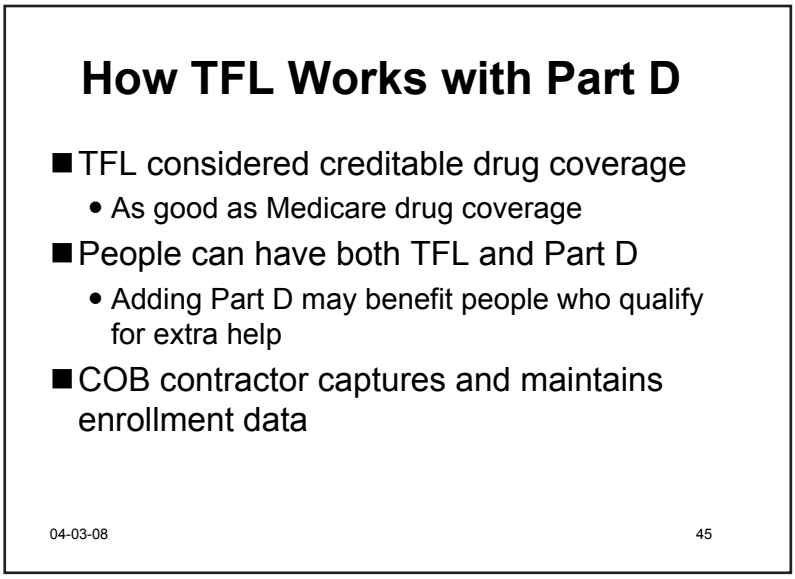

Like VA coverage, TRICARE has a more generous pharmacy benefit than Part D, so it is not in the interest of most TRICARE enrollees to join Part D unless they are eligible for the extra help (low-income subsidy).

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.

Those eligible for the extra help 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.

The COB contractor captures and maintains enrollment data for those choosing both TRICARE and Part D coverage.

For more information see *www.cms.hhs.gov/partnerships/downloads/tricare.pdf*

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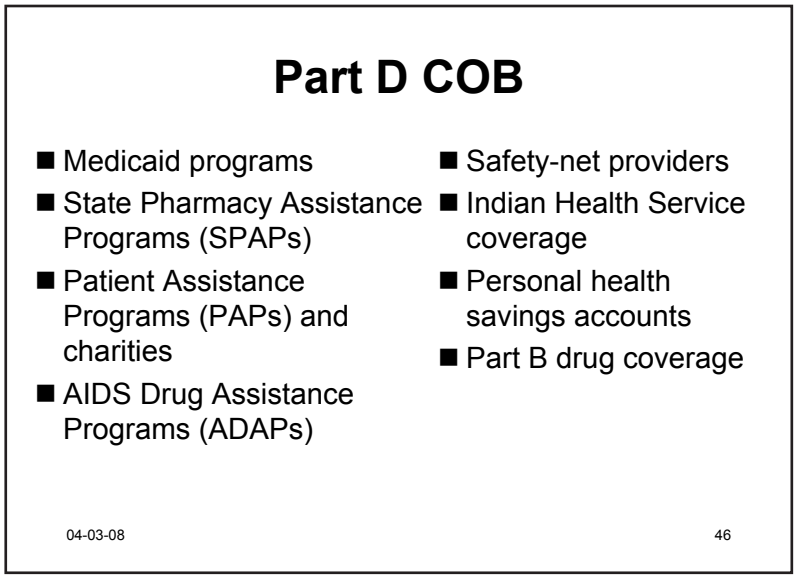

Let's look again at the additional COB stakeholders introduced by the MMA. Again, for purposes of coordination of benefits (COB), MMA specifically requires data sharing by Part D plans with certain entities like EGHPs, and Part D plans must permit other entities providing prescription drug coverage (like SPAPs) to also coordinate benefits with them. While Part D plans must coordinate with other payers, other payers are not obligated to exchange eligibility files.

We will now look at these payers individually and how each of them works with Medicare prescription drug coverage.

Reference:
www.cms.hhs.gov/PrescriptionDrugCovContra/02_RxContracting_COB.asp

For details on low income cost-sharing in Part D plans see *www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/LISLevelIIIDeductiblesLessThan50.pdf*

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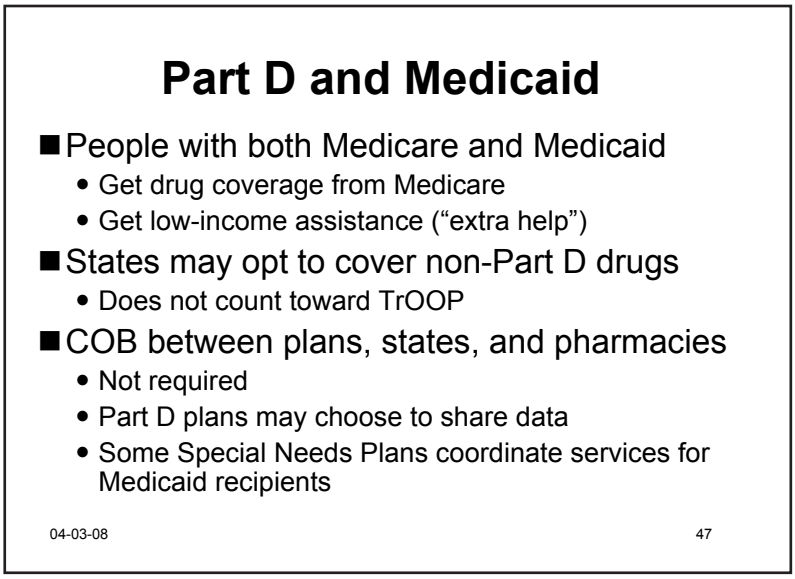

Under the MMA, state Medicaid programs no longer receive Federal funds for drugs covered under Medicare Part D. Consequently people with both Medicare and full Medicaid benefits (called "full-benefit dual eligibles") now receive drug coverage from Medicare instead of Medicaid. States still have the option of providing Medicaid coverage of drugs the MMA excludes from Part D coverage. [**Reference:** *section 1927(d)(2) of the Social Security Act.*] 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 True Out of packet (TrOOP) costs toward meeting 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 Rule.

Some Medicare Advantage Special Needs Plans coordinate Medicare-covered services, including prescription drug coverage, for people with both Medicare and Medicaid.

Reference:
www.cms.hhs.gov/States

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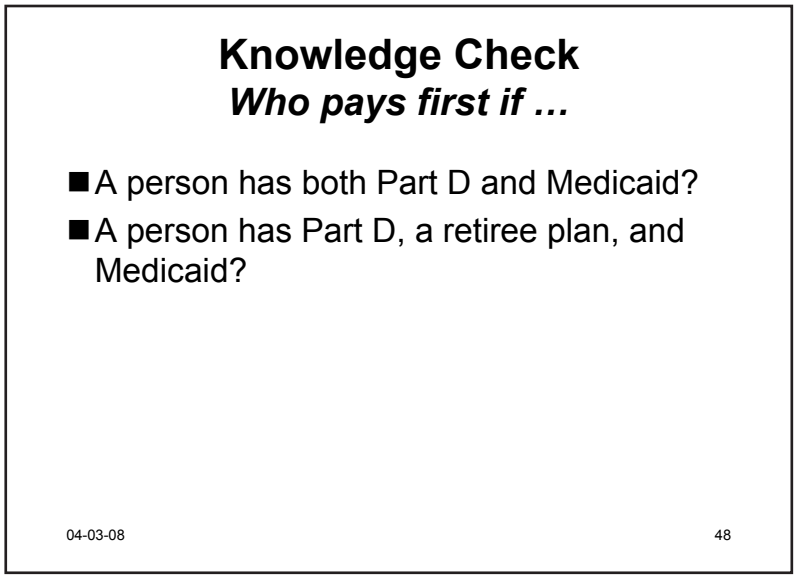

Let's now look at a "what if" scenario.

Question: Who pays first if a person has Part D and is also covered under Medicaid?
Answer: Medicaid only pays for drugs for people with Part D when those drugs are not allowed to be covered by Part D. Medicaid coverage of excluded drugs varies from state to state. People covered under both Part D and Medicaid will never have one drug paid for by both types of coverage. Either the Part D plan will pay or Medicaid will pay.

Question: Who pays first if a person has Part D and is covered under both a retiree health plan and Medicaid?
Answer: The retiree plan is secondary to Part D. Medicaid is a "payer of last resort," so it is secondary to the retiree plan. If the drug is covered by the Part D plan, the Part D plan pays first and then the retiree plan will be billed. Medicaid will not be billed because it cannot pay for Part D-covered drugs. If the drug is not a Part D-covered drug, the retiree plan will be billed first and then Medicaid.

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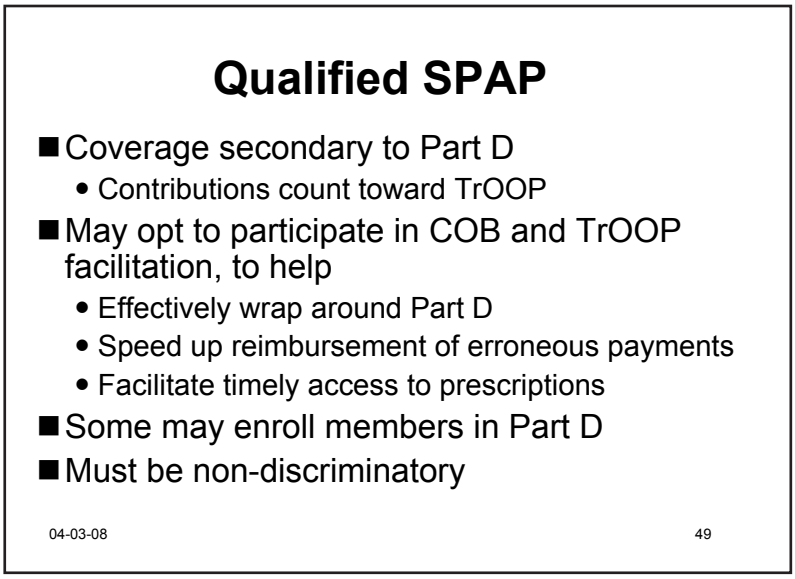

Qualified State Pharmacy Assistance Programs SPAPs are unique among other payers because any payments they make on behalf of enrollees to supplement benefits available under Part D coverage before enrollees reach the annual out-of-pocket limit will count toward TrOOP. SPAP coverage is secondary to Part D.

SPAPs are not required, but are encouraged, to participate in coordination of benefits 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 all their 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.hhs.gov/States/07_SPAPs.asp*

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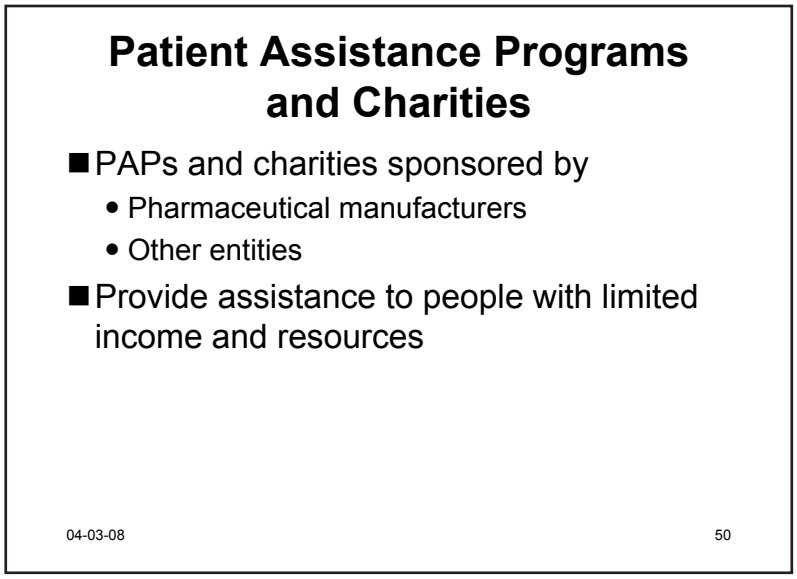

Pharmaceutical manufacturers and other entities sponsor a number of patient assistance programs (PAPs) and charities to provide financial assistance (with costsharing or premiums) or free products (through in-kind product donations) to low-income patients, particularly those with incomes below 200% of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

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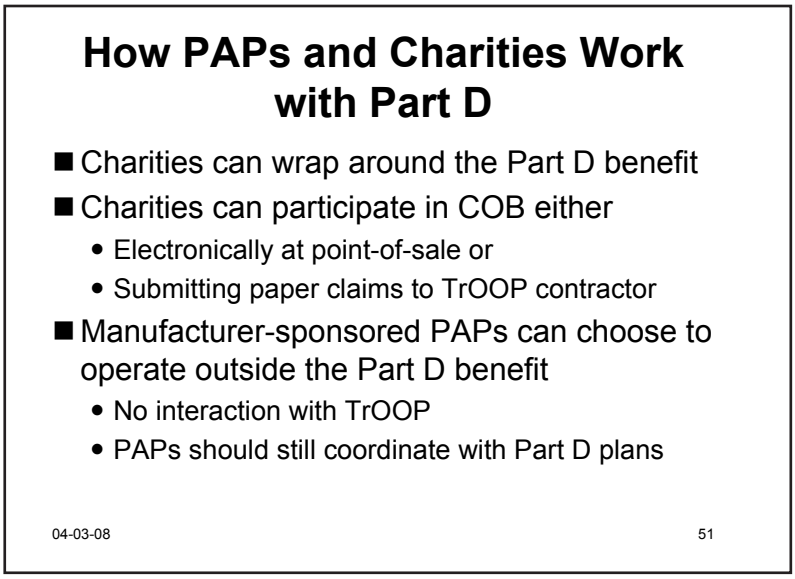

Unless a charity is a group health plan, insurance, a government-funded health program, or other third-party payment arrangement, any financial assistance it provides on behalf of Part D enrollees will count toward the TrOOP catastrophic threshold.

Charitable program members may present a retail identification card at the point of sale to obtain financial assistance. Charities that choose to participate in electronic data exchange can expedite adjudication of claims at the point of sale. Alternately, charities may require enrollees to submit a paper claim after the transaction and then may submit 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 prescription drug plan, along with documentation of the copayment.)

For more information see *www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PAPInfo_01.24.06.pdf* and *www.cms.hhs.gov/apps/files/factsheets/Tauzin%20PAP.pdf*

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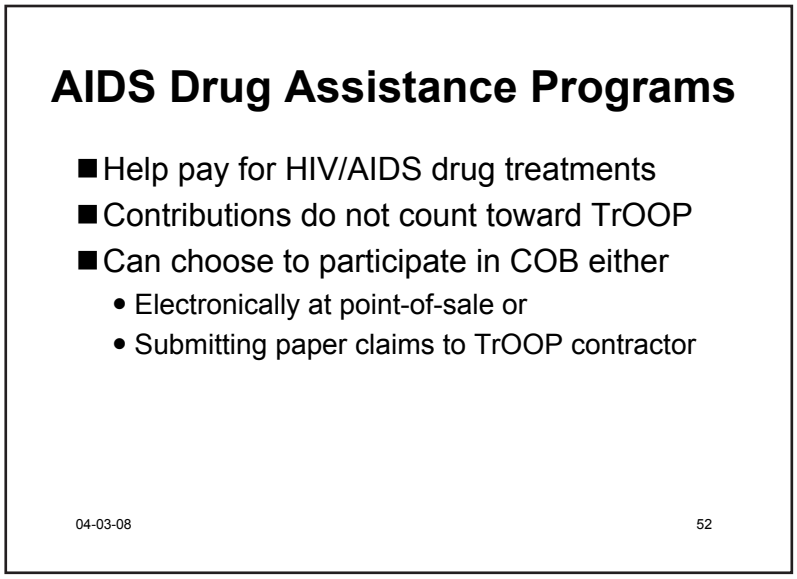

AIDS Drug Assistance Programs (ADAPs) are funded under the Ryan White CARE Act and are an integral component of the safety-net for HIV/AIDS patients because they fill coverage gaps in public and private insurance for critical HIV/AIDS drug treatments.

Although ADAP assistance with Part D cost-sharing may not count as incurred (TrOOP) costs toward meeting the out-of-pocket threshold at which catastrophic coverage begins, MMA does not prohibit ADAPs from assisting with cost sharing or subsidizing premiums.

When ADAPs voluntarily choose to participate in coordination of benefits, 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.

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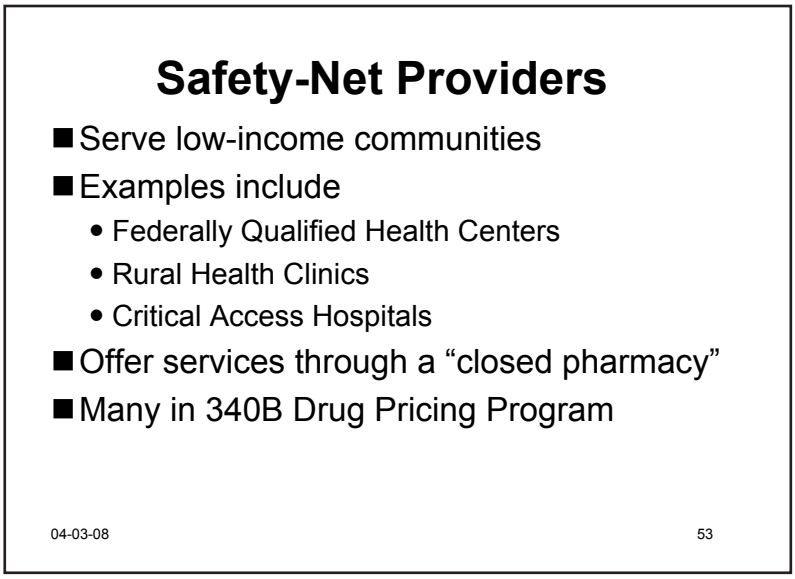

Safety-net provider organizations serve people who have limited income. These organizations typically include Federal, state, and local community health centers or clinics, many of which are deemed Federally Qualified Health Centers; public hospital systems; and local health departments. In some communities 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.

Reference:
www.cms.hhs.gov/Pharmacy/05_340b.asp

For more information on Part D and the Ryan White CARE Act, see *ftp://ftp.hrsa.gov/hab/partdmed.pdf*

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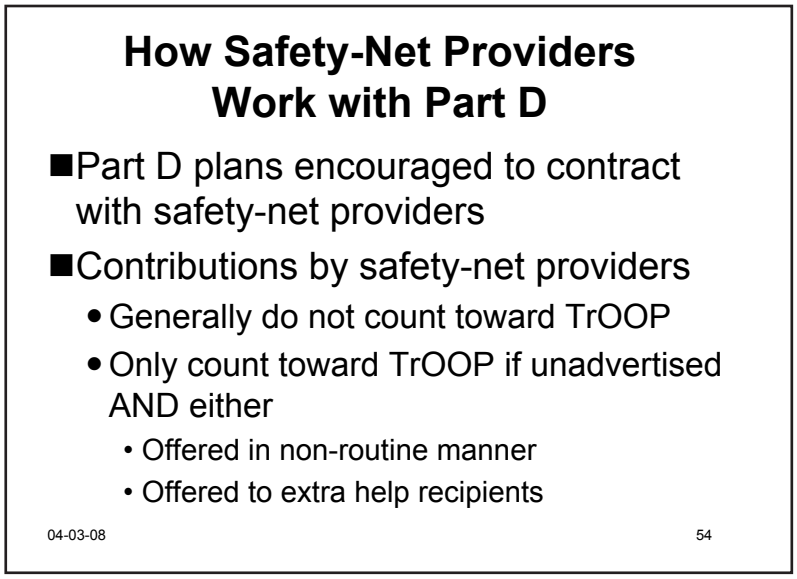
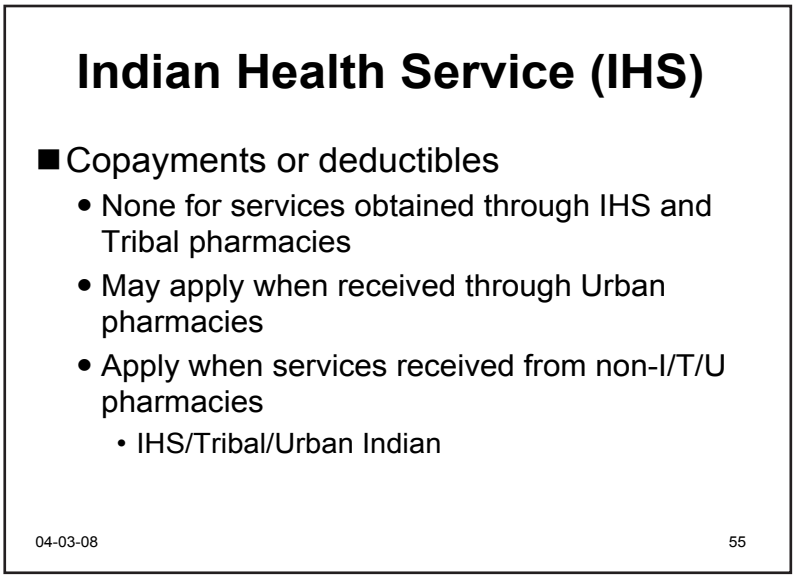


Part D sponsors are not required to contract with safety-net providers. However, CMS created an incentive for plans to do so by allowing them to count Federally Qualified Health Centers and rural health clinic pharmacies toward their retail pharmacy networks.

The MMA added an exception to the anti-kick-back 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 wraparound coverage will not count toward TrOOP. That's because most safety-net pharmacies are government-funded health programs, and 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*



By custom and regulation, American Indian/ Alaska Native (AI/AN) people with Medicare cannot be charged any cost-sharing, meaning that 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.

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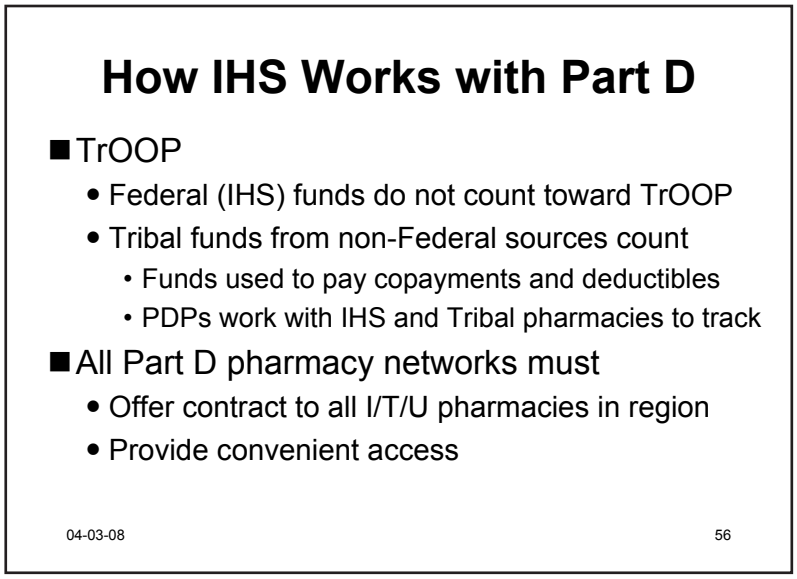

Although not prohibited by the MMA, assistance with Part D cost-sharing by I/T/U pharmacies does not count as TrOOP costs toward meeting the catastrophic coverage threshold.

Coordination of benefits with IHS and tribes is tied to pharmacy network contracting. Regulations require all Part D sponsors to offer network contracts to all I/T/U pharmacies operating in their service area. Plans also must demonstrate to CMS that they provide convenient access to I/T/U pharmacies for AI/AN enrollees.

For more information, see *www.cms.hhs.gov/AIAN/* and *www.cms.hhs.gov/Pharmacy/06_itu.asp*

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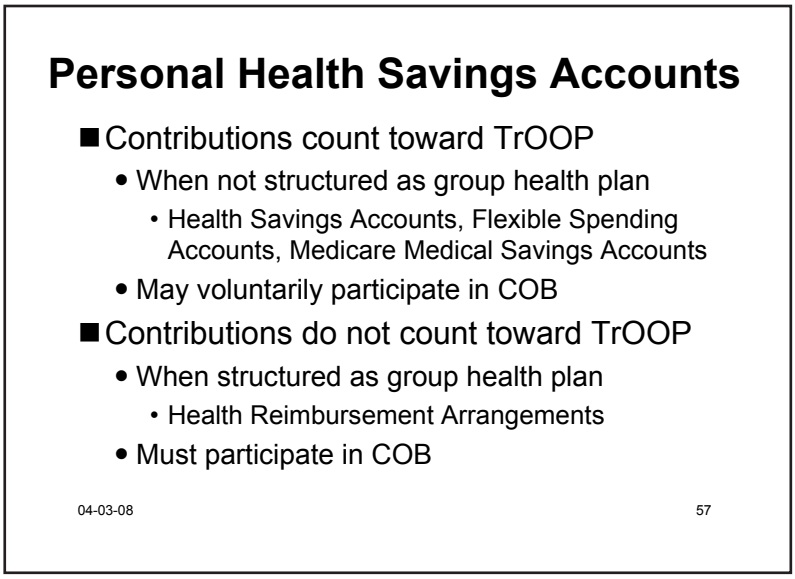

Personal health savings vehicles may or may not be structured as group health plans. Those structured as group health plans cannot count toward TrOOP, while those not structured as group health plans can count toward TrOOP.

CMS regulations indicate that Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs) and Archer Medical Savings Accounts (MSAs)* are not group health plans and that distributions from these vehicles will count as incurred costs.

In a Medicare MSA, Medicare pays for a high-deductible health insurance plan for people who enroll, and puts money in an account established for the person, generally at the beginning of the year. This money and any earnings on this money are tax free as long as the person uses it to purchase allowable health care. After the deductible is met in a given year, Medicare-covered services are covered by the health insurance plan. Amounts not used in one year remain in the account for use in a future year for payment of qualified medical expenses even if the person is no longer in a high deductible health plan.

By contrast, Health Reimbursement Arrangements (HRAs) are considered group health plans subject to all requirements that apply to payers providing prescription drug coverage, and 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.

*Archer MSAs help self-employed individuals and employees of certain small employers meet the medical care costs of the account holder, the account holder's spouse, or the account holder's dependent(s).

For more information see *www.cms.hhs.gov/apps/media/press/release.asp?Counter=1894*

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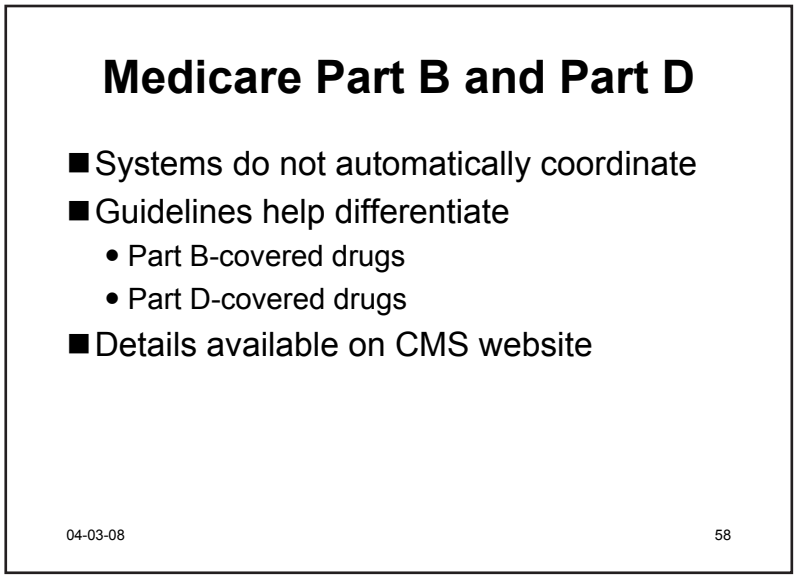

CMS did not establish automatic cross-over procedures for situations in which a Part B carrier denies a claim under Part B and then submits the claim to the appropriate Part D plan (or its claims processing agent) via the TrOOP facilitation contractor. Future implementation would require changes in HIPAA 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 publication number 11315P *Information Partners Can Use on: Medicare Drug Coverage under Medicare Part A, Part B, and Part D.*

For more information, see *www.cms.hhs.gov/Pharmacy/08_Parts%20B%20&%20D%20Information.asp* and *www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBMChap6FormularyReqrmts_03.09.07.pdf* (appendix C)

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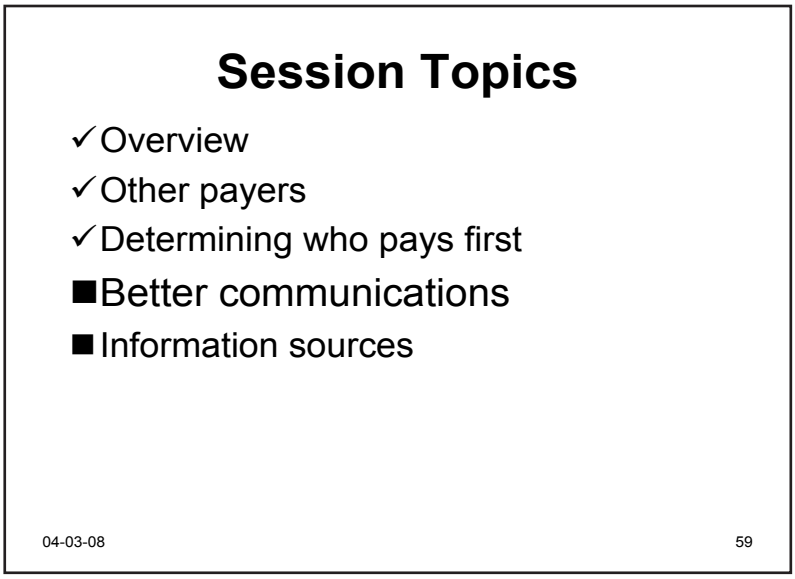

Now let's look at issues related to better communications.

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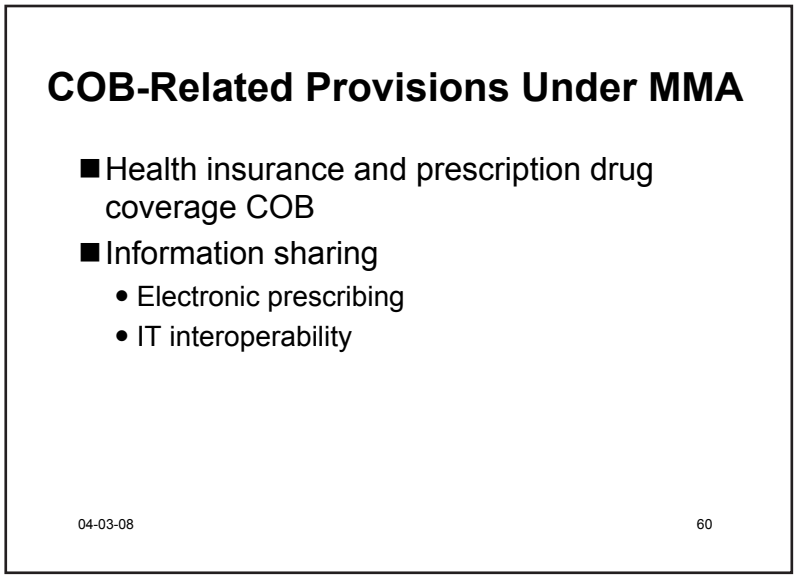

Several provisions in the MMA legislation aim to improve coordination of benefits efforts:

- A system of data sharing has been established between Medicare, PDPs, SPAPs, group health plans, insurers, and other third-party arrangements. As we discussed earlier, CMS has developed and implemented COB systems including the facilitation of tracking out-of-pocket threshold costs that will enable pharmacies to obtain information about secondary insurers, as well as the correct billing order.
- The MMA also contains an electronic prescribing section which will sharply reduce medication errors due to bad handwriting. It encourages adoption of a first set of national electronic prescribing standards starting January 2006 to include: (1) information about all medications the patient is currently taking, so that the doctor and the pharmacist can be on the alert for potential adverse drug interactions; and (2) formulary information pertaining to the patient's drug plan, including whether the plan has tiered co-payments or a specific drug is preferred or non-preferred. That way, the doctor will know in the examining room whether a therapeutically appropriate switch to a different drug might save the patient money. This provision particularly impacts people in rural areas and the chronically ill. Providing this information directly to doctors is expected to cut down on the need for follow-up phone calls between pharmacists and doctors once the patient has reached the pharmacy counter.

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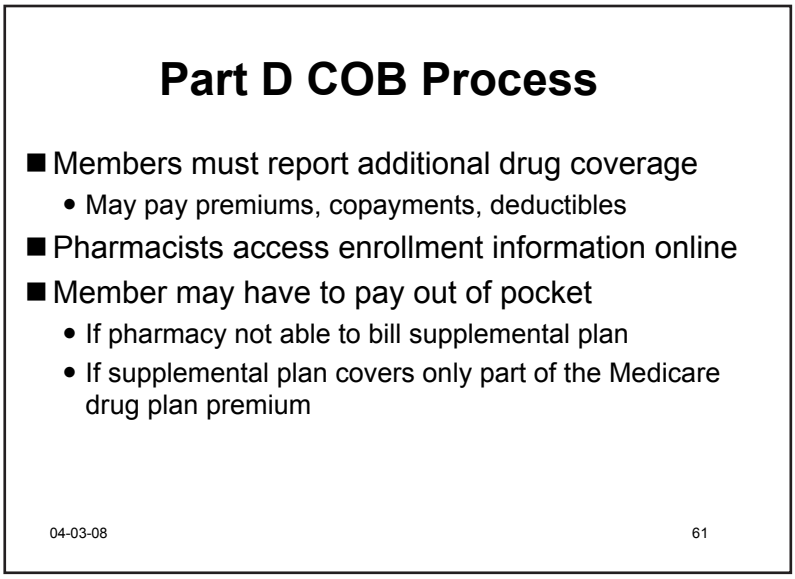

Some people with Medicare have drug coverage that supplements Medicare prescription drug coverage. To ensure that bills are paid correctly, Medicare established a process to coordinate prescription drug benefits:

- When people with Medicare join a Medicare drug plan, they must report to the plan if they have other prescription drug coverage. The plan collects this information by mail, telephone, or face-to-face survey within 30 days of enrollment and annually thereafter. CMS also gets this information from some employers and payers directly. People with Medicare must also report if they are reimbursed for out-of-pocket drug costs.
- When a person with Medicare fills a prescription, local pharmacies can use an online billing system to find out if the Medicare drug plan or a supplemental drug plan should be billed. The system tells the pharmacist how much the person should pay for the prescription and whether a third party can be billed. After the pharmacist bills Medicare and any supplemental drug coverage, the person with Medicare will be billed at the pharmacy counter for the remaining amount.

Supplemental drug plans may also help pay Medicare prescription drug coverage out-of-pocket costs like premiums, copayments, and deductibles. But in some cases the person with Medicare may have to pay as well. This may happen:

- If the pharmacy can't submit the claim electronically. The person may have to pay out of pocket and can later submit a claim to his or her supplemental drug coverage for reimbursement.
- If the supplemental plan doesn't cover the entire premium, the Medicare drug plan will bill the person with Medicare for any remaining portion of the premium.

Reference: *www.cms.hhs.gov/partnerships/downloads/COB.pdf*

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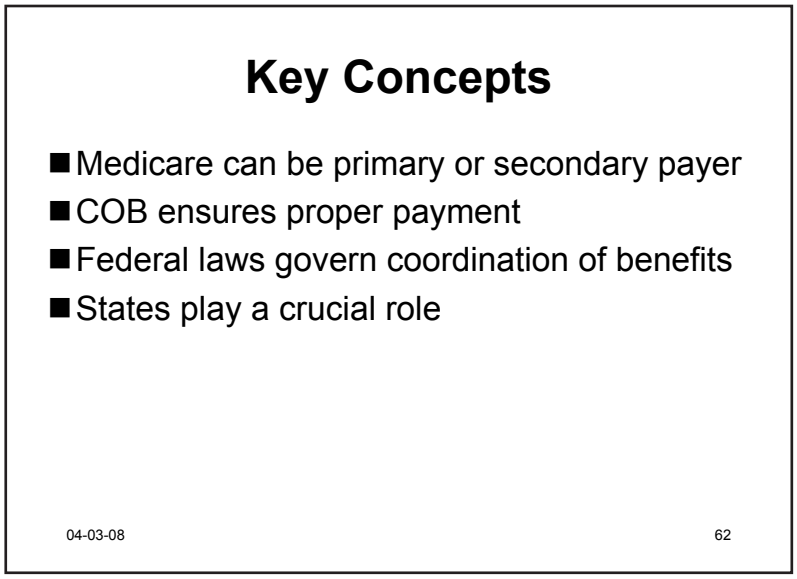
Module 5: Coordination of Benefits



We have just covered a great deal of detailed information about how Medicare benefits are coordinated with other sources of health care coverage. We have learned that Medicare can be the primary or the secondary payer, and that coordination of benefits helps to ensure that claims are paid right the first time, every time.

All other available coverage must be considered, and individual circumstances can be complicated.

Although it is each provider's responsibility to bill the Medicare program correctly, it is also important for people with Medicare and those who counsel them to be able to determine when and why the Medicare program is primary or secondary payer.

We have also learned of several Federal laws that govern how coordination of benefits is administered, such as COBRA, HIPAA, and MMA, and that statespecific rules also play an important role in the process.

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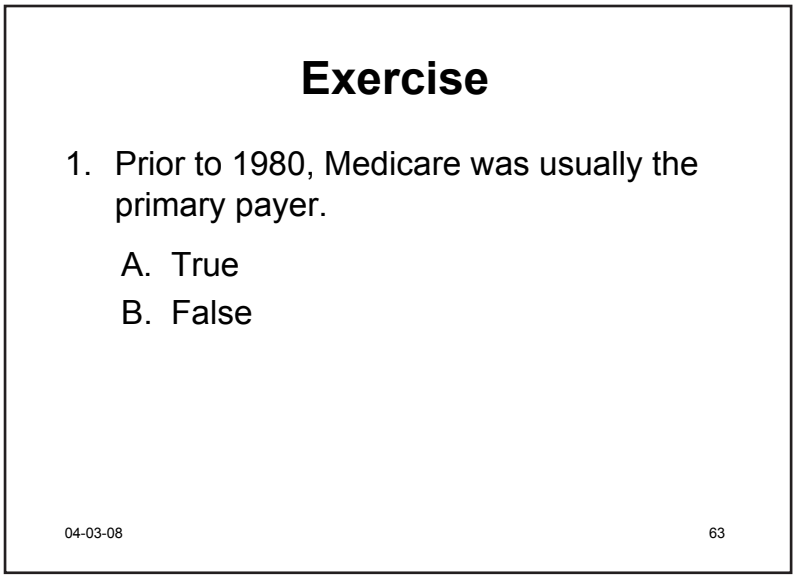
Exercise



1. Prior to 1980, Medicare was usually the primary payer.
   A. True
   B. False

NOTES:

Answer: A. True

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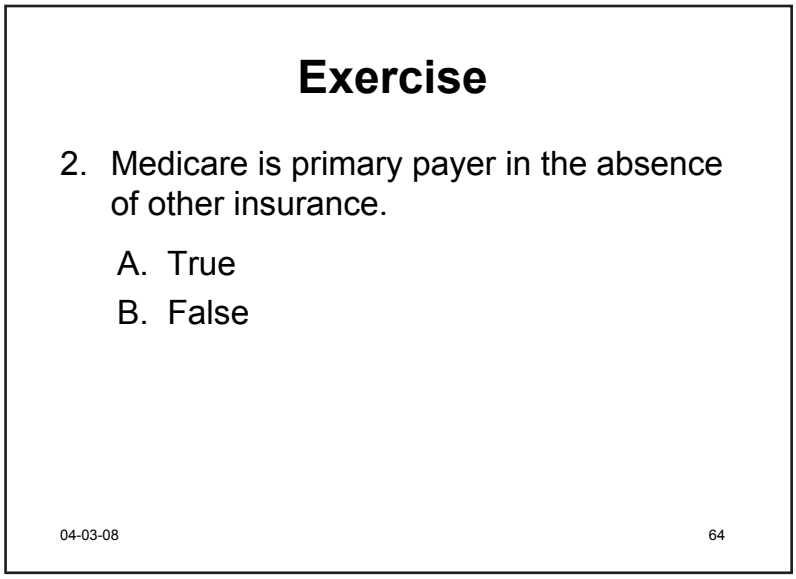
Exercise



2. Medicare is primary payer in the absence of other insurance.
   A. True
   B. False

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ANSWER: A. True

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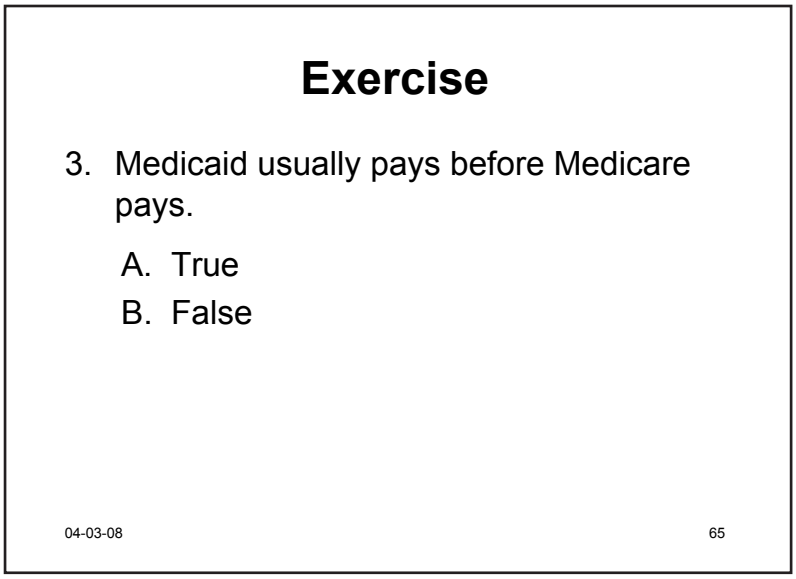

3. Medicaid usually pays before Medicare pays.
   A. True
   B. False

NOTES:

Answer: B. False

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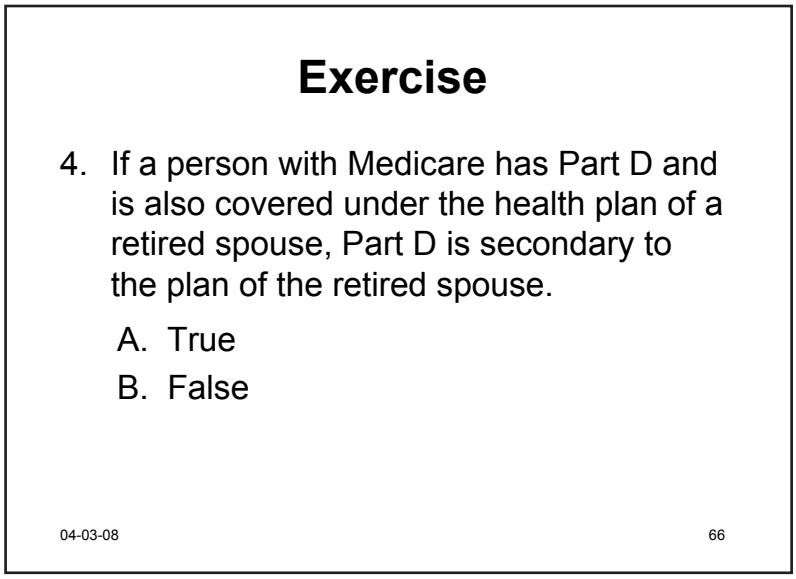

4. If a person with Medicare has Part D and is also covered under the health plan of a retired spouse, Part D is secondary to the plan of the retired spouse.

   A. True

   B. False

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ANSWER: B. False

My Health.
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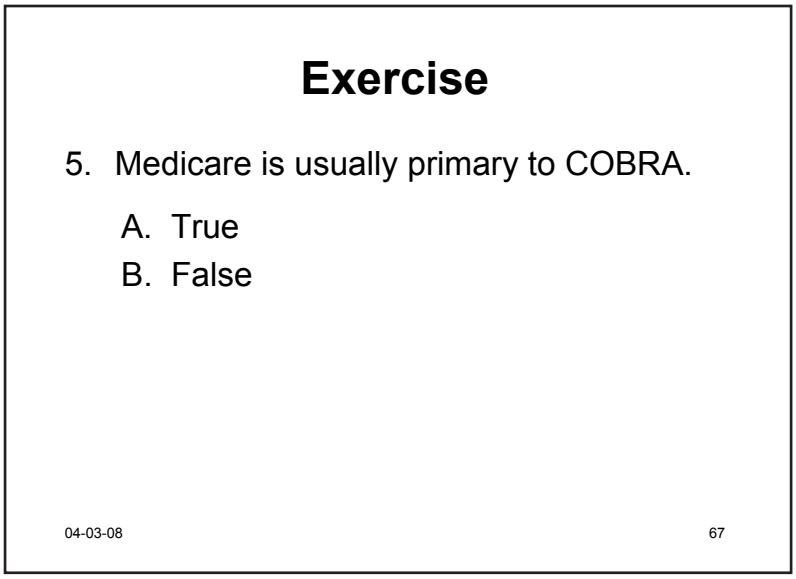
Exercise



5. Medicare is usually primary to COBRA.
   A. True
   B. False

NOTES:

Answer: A. True

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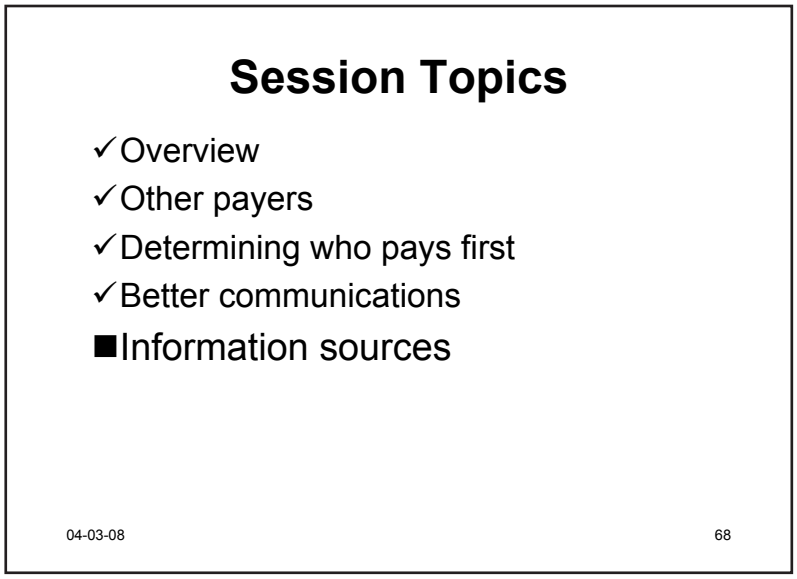

Finally, let's look at sources of additional information on coordination of benefits.

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Information Sources

- Medicare Coordination of Benefits
  - www.cms.hhs.gov/COBGeneralInformation/
  - www.cms.hhs.gov/COBAgreement/
  - www.cms.hhs.gov/PrescriptionDrugCovContra/02_RxContracting_COB.asp#TopOfPage
- *Medicare and Other Health Benefits: Your Guide to Who Pays First*
  - www.medicare.gov/Publications/Pubs/pdf/02179.pdf

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This slide lists some key references used in creating this training module, plus some sources of additional information.

- Medicare Coordination of Benefits, available at *www.cms.hhs.gov/COBGeneralInformation* and *www.cms.hhs.gov/COBAgreement*
- COB Guidance to Part D sponsors available at *www.cms.hhs.gov/PrescriptionDrugCovContra/02_RxContracting_COB.asp#TopOfPage*
- CMS Publication 02179 *"Medicare and Other Health Benefits: Your Guide to Who Pays First,"* September 2005, at *www.medicare.gov/Publications/Pubs/pdf/02179.pdf*
- You can also refer to "COB Fact Sheets: MSP Claims Investigation Fact Sheet for Providers" at *www.cms.hhs.gov/ProviderServices/Downloads/claimsinvestigation.pdf*

(continued on next slide)

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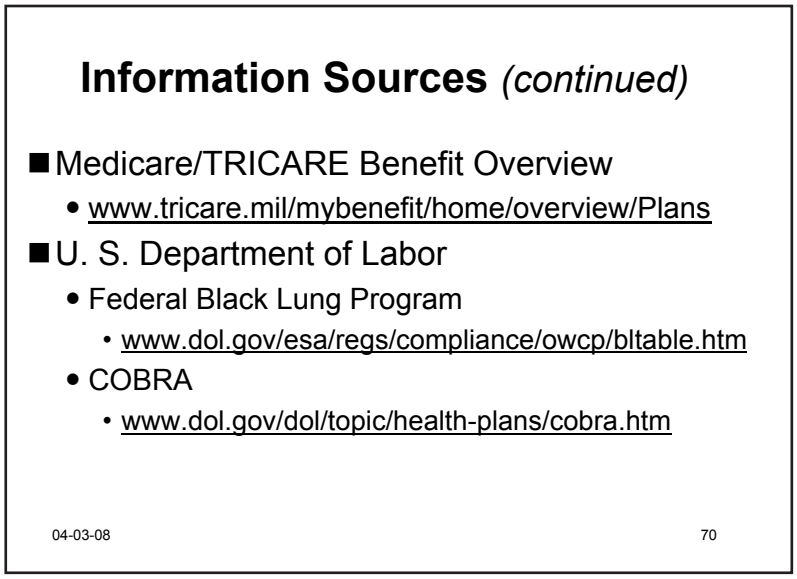

This slide lists additional resources:

- Medicare/TRICARE Benefit Overview, available at *www.tricare.mil/ndaa/medicare.htm*
- "TRICARE Improvements in the National Defense Authorization Act," November 22, 2000, available at *http://www.tricare.mil/mybenefit/home/overview/Plans*
- U.S. Department of Labor Division of Coal Mine Workers' Compensation Home Page at *www.dol.gov/esa/regs/compliance/owcp/bltable.htm*
- You can also find COBRA information on the DOL website at *www.dol.gov/dol/topic/health-plans/cobra.htm*
- For those who are interested, an additional resource not shown on this slide is the CMS publication 10128 *"Medicare Coverage of Kidney Dialysis and Kidney Transplant Services,"* April 2007, at w*ww.medicare.gov/Publications/Pubs/pdf/10128.pdf*

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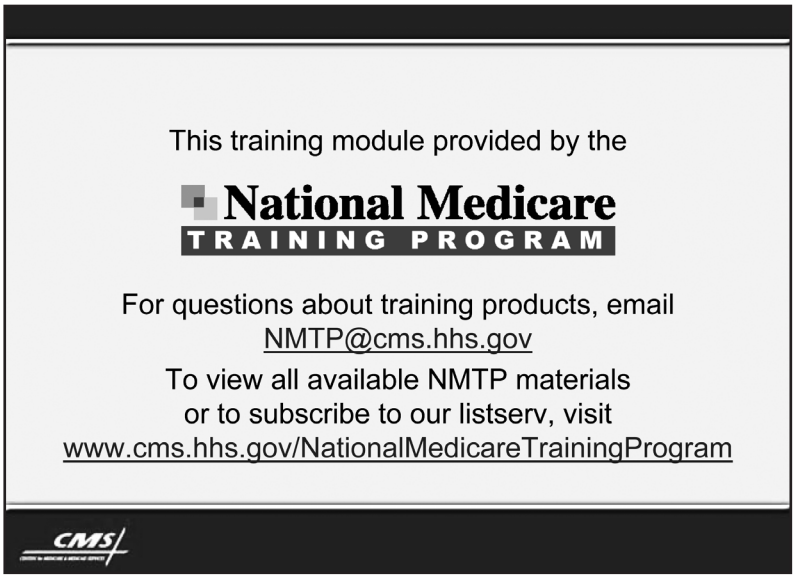
Module 5: Coordination of Benefits



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