Upstream Reporting of Copay Assistance Issues Brief

Version 1.0

June 2018

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The existence of a link or organizational reference in any of the following materials should not be assumed as an endorsement by NCPDP.

The writers of this issues brief will review and possibly update their recommendations should any significant changes occur.

This document is for Education and Awareness Use Only.

1. Background

Commercial health insurance plans typically include a deductible and/or coinsurance provision as part of their benefit. Plans can be structured where the member pays an up-front and/or ongoing out-of-pocket (OOP) amount to share the costs of their coverage. For instance, a health plan may require a member first pay $500 in deductible before program benefits begin, and then a 15% coinsurance until some maximum OOP amount has been reached.

With increasingly expensive medications and the increase in commercial plans that include higher deductibles, ensuring patients can afford their prescribed treatment is a growing challenge for the industry. Programs, which may or may not be needs-based, have been developed to assist patients with their out-of-pocket costs. These supplemental programs are commonly referred to as "copay assist", "voucher", "manufacturer coupons" and "patient assistance", among other names. Examples include, but are not limited to, brand drug programs funded by pharmaceutical manufacturers/suppliers and not-for-profit organizations who offer assistance for specific disease states or medications.

NCPDP formed the WG1 Upstream Reporting of Copay Assistance Task Group to explore options for reporting these supplemental programs' contributions toward a patient's liability to a prior payer, such as a commercial health plan. This might enable the prior payer to calculate a patient's actual OOP expenses after all programs have been billed and apply those expenses to commercial plan accumulators.

Based on the task group's research, the complexities related to the stated issue became more apparent. As a result, the scope of the task group was limited to examining scenarios that involve a commercial payer, a supplemental prescription assistance program and the potential for reporting the information utilizing an NCPDP transaction.

The task group is aware of proprietary methods for reporting or collecting copay assistance information; these were not reviewed as part of the research. Only existing NCPDP standard transactions were reviewed as potential solutions.

2. Purpose

The purpose of this issues brief is to document the results of the task group research and not to provide recommendations or solutions. The research includes:

- Program types
- Possible use cases
- Viability of using the NCPDP Telecommunication Standard Information Reporting (Nx) Transaction
- Other Obstacles to solutions

For questions related to this issues brief contact info@ncpdp.org.

3. Types of Prescription Assistance

There are many different types of programs available to patients to reduce their out-of-pocket pharmacy costs. The two main classes of programs include but are not limited to:

- Copay Assistance or Manufacturer Coupon Programs:
  These programs are generally funded by the drug manufacturer for the specific product being dispensed and are considered non-needs-based, where there are usually no income requirements for the patient to qualify for the program. These programs may or may not require the patient have a specific diagnosis to be eligible. These programs may have per use, monthly or annual limits on the amount they will contribute and are offered at the sole discretion of the manufacturer.

- Patient Assistance Programs:
  These programs are generally funded by foundations, charitable organizations, or drug manufacturers. If these programs are administered by a non-profit entity, they will have filed the appropriate tax documents. These programs have qualification requirements (such as financial need, clinical, geographic or socio-economic status) patients must meet to be eligible for assistance.

For the purposes of this document, the terms “copay assistance” or “manufacturer coupon” shall refer to all non-needs-based programs, while the term “patient assistance” will refer to needs-based types of programs. The general term “prescription assistance” will be used broadly to refer to both types of programs.

4. Use Case

Commercial plans track member qualified spending in order to determine when deductibles and other financial accumulators are met. Prescription assistance programs are not linked with commercial health insurance plans, therefore the monetary assistance provided by the former are not considered when the commercial plan is tracking the member's financial accumulators.

There is currently no standard mechanism to share transaction data between prescription assistance programs and commercial health insurance programs. There are two separate transactions processed by the same processor or different processors – the primary (commercial) claim and the claim for the prescription assistance program. The commercial plan may not have knowledge of the prescription assistance program. Ultimately, the primary payer wants to differentiate the amount the patient paid versus any amounts paid on their behalf by specific payer types.

Example Scenario 1:
Jane Doe has a prescription for Drug A. Drug A is estimated to cost $24,000 per year. Jane's health plan has a $5,000 deductible and once that is met she pays 20%. Drug A's manufacturer offers a coupon program that Jane can use, limiting her out of pocket cost to $250/month. At year end, although Jane's plan has recorded that she met her $5,000 deductible, the manufacturer coupon actually reduced her out-of- pocket to $3,000.

Example Scenario 2:
There is a charitable foundation where Jane can apply for financial assistance. Jane meets the income requirements for the disease state grant fund and is awarded $5,000 over the next 12 months. She uses these funds for doctors' visits, home therapy and prescriptions. Her medical insurance does not count these funds towards those expenses and her prescription coverage would likely follow suit.

5. Research

5.1 Prescription Assistance Billing Methods

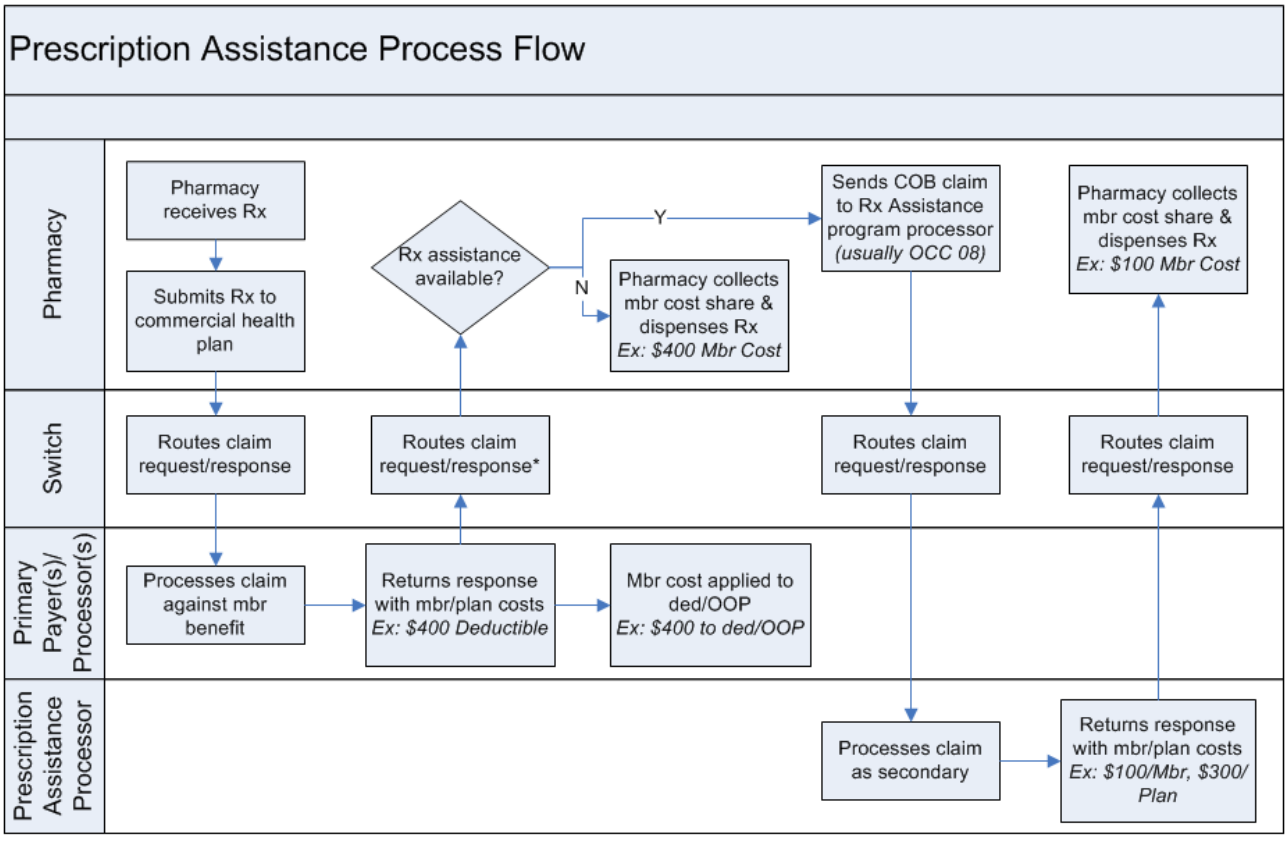
Prescription assistance programs are typically billed as coordination of benefit (COB) claim transactions. The primary payer is billed and provides a response with the patient's cost share information and then the prescription assistance program is billed. These COB claims are normally billed via NCPDP Telecommunication Standard version D.0 with the following Other Coverage Codes (308-C8):

- 03: Other Coverage Billed – claim rejected - Code used in coordination of benefits transactions to convey that all payers billed have returned rejected responses indicating the claim is not covered. This is typically used when the patient has valid insurance coverage, but the plan does not cover the submitted transaction.

- 08: Claim is billing for patient financial responsibility only - Code used in coordination of benefits transactions to convey that at least one payer has been billed and returned an approved response; and the current claim is a billing for other payer patient financial responsibility amounts only.

In the case of Other Coverage Code 08, it allows the prescription assistance program to pay for some portion of the cost that would normally be part of the patient's cost share.

See diagram below:



**where eCoupon may be applied (described below)*

Since the prescription assistance is processed after all commercial claim billing and is typically submitted to a different payer/processor, the commercial plan is not aware of the prescription assistance program or the

amount it may have covered. In the process flow above, the commercial plan has assessed a patient cost share of $400, which could have applied to the patient's deductible and/or maximum out-of-pocket. However, a prescription assistance program has covered $300 of that cost, reducing the patient's total cost share to $100, which is not reflected in the patient's commercial accumulators.

Copay assistance and other prescription assistance programs may have other billing mechanisms in place, including but not limited to:

- Universal Claim Form (UCF): Pharmacy submits a paper claim or other request to the prescription assistance program for reimbursement.
- "eCoupons": These types of programs can be applied at the switch, where the prescription assistance is applied and the member's cost share is reduced in the claim response to the pharmacy.
- Direct Member Reimbursement: Patients may submit a request for reimbursement of some portion of their cost share directly to the prescription assistance program outside of the pharmacy workflow.

5.2 Reporting of Final Patient Costs

Since the application of the prescription assistance happens after the original claim transaction, a reporting mechanism would be required for the commercial plan to account for the prescription assistance and be able to calculate the patient's final out-of-pocket expenses as they apply to commercial plan accumulators. Any reporting developed will also need to consider the ramifications of multiple downstream payers in determining which amounts to report and how they will be reported.

The following NCPDP Telecommunication Standard transaction and Batch Standard file format were researched to determine whether they would be viable methods for communicating this information:

- **Information Reporting (Nx) Transaction**
- **Batch Standard File**

5.3 The Nx Transaction as a Reporting Option

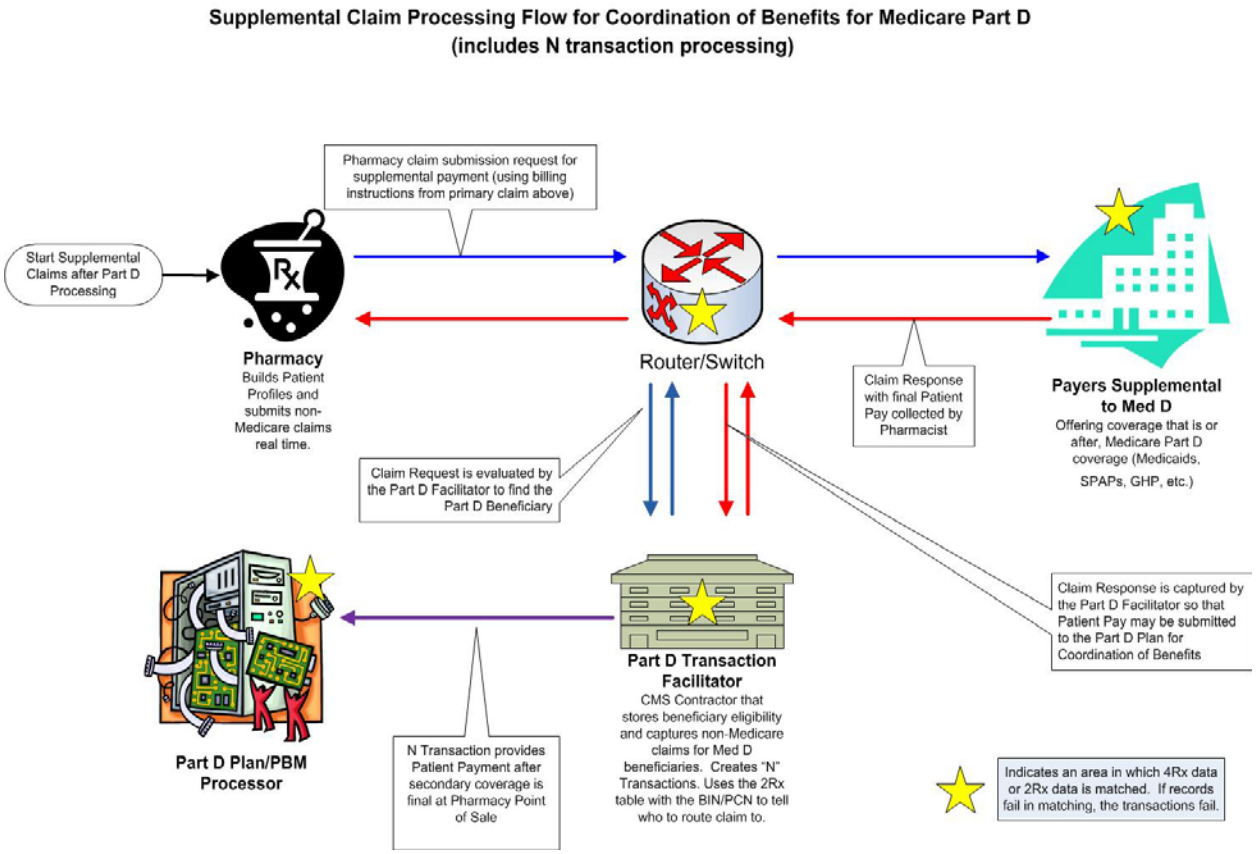
Today, the Information Reporting Transaction (Nx) is used to report financial transactions for the purpose of tracking Medicare Part D payments. This transaction can be submitted in real time or via a batch file. At a high level, the Centers for Medicare & Medicaid Services' (CMS) Benefits Coordination & Recovery Center (BCRC) compiles data on a Medicare Part D beneficiary's other coverage, which is provided to CMS. In turn, CMS provides that data to the Part D Sponsor and the Part D Transaction Facilitator.

As shown in the diagram[1] below, the Part D Transaction Facilitator process is triggered by the submission of a pharmacy transaction to a payer supplemental to Part D. If the supplemental payer returns a paid response, the Part D Transaction Facilitator captures pertinent claim information to create and transmit the Nx to the Part D Plan Sponsor/Processor. The Part D Plan Sponsor/Processor matches the Nx received to their claim by cross-referencing the submitted member information on the Nx to the known Other Health Information (OHI) on file for the member.

For more information on the process by which Nx transactions are sent for Medicare Part D, see the NCPDP white paper, *Overview of the Medicare Part D Prescription Drug Coordination of Benefits (COB) Process* on

[1] Source: July 2013 NCPDP *Overview of the Medicare Part D Prescription Drug Coordination of Benefits (COB) Process* document.

the NCPDP website.



The N transaction contains the following field for supplemental payment information, which could be sent to the primary payer/processor to reconcile the patient's commercial accumulators, if they are able to accept and match an N transaction to a commercial claim:

- **433-DX: PATIENT PAID AMOUNT SUBMITTED**: This data is copied from field 505-F5, PATIENT PAY AMOUNT in the response transaction from the Supplemental Payer to the pharmacy.

  In the earlier example for the prescription assistance process flow, the primary payer assessed a patient pay amount of $400. A COB claim billed to the prescription assistance payer was assessed a patient pay amount of $100. In this case, field 433-DX in the Nx would be populated with a value of $100.

With this information, the primary commercial processor would have access to the patient's final out-of-pocket expense and could calculate the copay assistance received.

6. Obstacles to use of the N Transaction

While the Nx, either real-time or batch, could technically be used for the purpose of reporting supplemental payments from prescription assistance programs back to commercial plans, there are several obstacles to its use described below.

6.1 Creation of the Nx

Under Medicare Part D, the Part D Transaction Facilitator creates and sends the N transaction when a COB claim is processed for a Medicare Part D beneficiary, as identified in the CMS Eligibility File. In the absence of a transaction facilitator or a centralized membership database, the process to use the N transaction outside of Part D would require some entity to appropriately create and send the Nx (in real time or batch) to the commercial plan.

Under a commercial model, the only two entities that are known to be aware of both the primary and secondary or supplemental payer(s) of a claim are the pharmacy and the switch. Since the coupon processor does not receive the BIN, PCN, Cardholder ID, and Group ID (4Rx) in the COB segment of the claim transaction, they would be unable to generate an Nx or know where to send it.

6.2 Applying the Nx

Upon receipt of the N transaction, the payer/processor would need to be able to complete three key functions: accepting, matching and applying the N transaction.

1. Accept the N transaction
   A payer/processor would need the ability to accept an N transaction from a source reporting data for a copay assistance program.

2. Match the N transaction
   A payer/processor would need to match the Nx to the original claim billing.

The payer/processor would need to be able to match the Nx to the original claim billing. This would be challenging without a member's other health information (OHI). Under Part D, plan sponsors are provided the OHI for their beneficiaries, including the 4Rx data. The N transaction is populated with the 4Rx data used to process the supplemental payment, not the primary or prior payer's 4Rx data. The commercial plan must then crosswalk the Nx against the OHI for their membership to identify a claim to match to the Nx. Prescription Assistance programs often employ "on the fly" eligibility, which complicates the matching process. Typical "on the fly" programs create a member ID by combing unique patient data elements, such as name, date of birth, ZIP code, etc.

In the absence of a centralized member database and eligibility sharing process, a commercial plan and prescription assistance programs may need to agree to, and create a process to share, eligibility information to match the Nx to a claim. If the commercial plan does not have this crosswalk from their membership data to the other health information of prescription assistance programs, they may be unable to match the Nx.

For example, the original claim could have been submitted and processed with the 4Rx data shown on the left in the grid (below), while the supplemental prescription assistance COB claim could have been processed with the 4Rx data on the right. The N transaction would be populated with the values from the prescription assistance claim, so the commercial plan would need to be able to crosswalk those values to their member and the specific claim.

Txn Field	Field Name	Commercial Plan Submitted Value	Rx Assistance Program Submitted Value
101-A1	BIN NUMBER	123456	789456
104-A4	PROCESSOR CONTROL NUMBER	RXPLAN	VALUE
302-C2	CARDHOLDER ID	867530900	123456789
301-C1	GROUP ID	PLAN2	COUPON2

3. Apply the N transaction
   A commercial plan would apply the information in a manner they deem appropriate. One possible application of this data is to adjust patient accumulators.

7. Other Considerations

7.1 Distinguishing Copay Assistance vs. Patient Assistance Programs

Commercial plans may want or need to distinguish between patient assistance programs and copay assistance programs when updating their patients' accumulators.

Although not available in NCPDP's Telecommunication Standard version D.0, version F2 does support the Adjudicated Program Type field that can be used in the claim response to the pharmacy to communicate the type of program that adjudicated the claim. As of the publication of this document, the Telecommunication Standard version F2 has not been implemented by the industry.

- **ADJUDICATED PROGRAM TYPE (A28-ZR)**: The type of prescription benefit plan/program under which the claim was adjudicated. One of the following values in this field in the claim response from the subsequent processor may help to identify claims where the member cost was reduced and the type of prescription assistance program.

  6 = *Manufacturer Sponsored Patient Pay Reduction Program – pharmaceutical manufacturer sponsored program used to reduce patient pay amount (such as copayment/coinsurance or self-pay/cash payment).*
  24 = *Independent Charity Patient Assistance Program - Patient assistance program funded by a 501(c) charitable organization in which assistance is awarded in an independent manner based upon a reasonable, verifiable, and uniform measure of financial need that is applied in a consistent manner.*
  25 = *Manufacturer Patient Assistance Program - Pharmaceutical manufacturer sponsored program that provides product to low income patients for free or nominal cost. Income qualifications are typically at or below 200 percent of the federal poverty level (FPL) and patients have insufficient or no prescription drug coverage. Funding for this program cannot be paid from a 501(c).*

7.2 Patient Consent

Federal and state privacy laws and regulations must be considered when sharing patient information. Nothing in this document should be construed as legal advice; entities are encouraged to seek the input of legal counsel.

Right to the Information

In the absence of guidance governing the sharing of prescription assistance payment information to commercial plans for the specific purposes of managing member accumulators, it is unknown whether a commercial plan has a right to this information. Payers, pharmacies, and switches may wish to conduct their own legal review as to the appropriateness of sharing the prescription assistance payment information and whether patient consent is necessary to send or receive it.

It is possible that every entity may need to obtain and store its own patient consent in order to adhere to state or federal privacy requirements or contractual obligations (e.g. audits).

Patient Education

It is entirely possible that patients do not understand the scope and implications of data sharing that occurs in pharmacy-related transactions. Each participant in the process of upstream reporting of prescription assistance (commercial plan/prescription assistance program/pharmacy) should provide information to the patient regarding how their information may be used to avoid confusion or dissatisfaction. The language

included in a Notice of Privacy Practices, a certificate of coverage or as part of a program enrollment most likely does not address the details of data sharing specific to the use case addressed in this issues brief. In addition, those documents may not address the nuances of agreements signed by pharmacies with payers (reporting requirements, etc.). A patient should be aware that information related to prescription assistance programs could be reported to their commercial plan and that it may impact how their accumulators (deductible, out-of-pocket) are calculated.

As an example, if a patient has a $5,000 deductible and the initial claim processed by the commercial plan reflects a $2,500 OOP (the patient's responsibility for the current fill) which is also applied to the patient's deductible accumulator. Yet if copay assistance is applied, in the amount of $1,000, then the patient's actual OOP expense is $1,500. If the $1,000 is reported to the commercial plan, the deductible may be adjusted to reflect $1,500, not $2,500. It will take the patient longer to meet their deductible obligation if the prescription assistance information is reported, and they may not realize they have consented to the data being shared for that purpose.

Scope of Patient Consent

Currently, there is no industry standard to capture patient consent for this purpose. Some considerations related to the scope of consent include the following:

- What constitutes proof of patient consent?
- What information is covered?
- Does proof of patient consent vary according to the entity collecting it?
- For prescription assistance programs, patient consent must be at the program or offer level.
- With whom may the information be shared?
- For what purposes may the information be used?
- Effective period of the patient consent.
- Patient acknowledgement/authorization.

Obtaining and Storing Patient Consent

The following entities may need to obtain and store patient consent as well as verify if they have the right to delegate the consent to another entity.

Commercial Plan / Primary Payer

- Existing plan documentation may have language about privacy, data sharing and member rights; modifications may be needed to support data sharing related to copay assistance.
- The commercial plan may want to validate their authority to use data received from a supplemental plan.

Prescription Assistance Program

Prescription assistance programs will need to determine if they will accept the patient consent obtained by the commercial plan before sharing information, or if they will obtain their own patient consent directly from the patient. If the prescription assistance program is sharing the data and has determined patient consent is required, obtaining patient consent could be accomplished during the enrollment/activation process or via verbiage on the program collateral (card, brochure or website) if allowed under applicable law or regulation. (If it is deemed a signed consent form is the necessary vehicle, the latter would not apply.)

Challenges to obtaining patient consent include but are not limited to:

- Some programs may not have patient initiated activation or enrollment prior to the claim submission therefore there may be no opportunity to obtain patient consent. (Program collateral may have verbiage which implies consent).
- Electronic coupons (eCoupons) offer no mechanism for obtaining patient consent as they are applied automatically at the switch without prior patient knowledge.

Pharmacy

- Pharmacy is the only business entity (aside from the switch) that sees both transactions.
- The process involved with storage and access of patient consent would be burdensome to existing workflow at pharmacies.
- Pharmacies will need to review and consider all contractual terms that may apply to patient consent for data sharing.

Communicating Patient Consent

Mechanism

The mechanism used for communicating patient consent will depend on the entity that collects it and the entity to which it is being transmitted.

Based on a review of the Telecommunication Standard, no existing data elements were identified as viable solutions for communicating patient consent. The following data elements were considered for communication of patient consent and deemed unacceptable:

- **SUBMISSION CLARIFICATION CODE(420-DK)**: This field is available in the B1/B3 claim billing transactions today; most commonly used in situations where the claim would otherwise reject without the submission of the code. The code transmitted is indicating the pharmacist is clarifying the submission. *Currently there are no values associated for patient consent for information sharing. In addition, the business case of communicating consent doesn't conform to the defined use of this data element.*
- **MESSAGE (504-F4)**: This field is used to return free-text messaging from the payer to the pharmacy. Pharmacy systems would need to search for key words related to patient consent. *This field is not available in pharmacy-to-payer or payer-to-payer transactions.*
- **ADDITIONAL MESSAGE INFORMATION (526-FQ)**: Similar to the Message field, this field transmits free text messaging to the pharmacy and *is not available in pharmacy-to-payer or payer-to-payer transactions.*
- **APPROVED MESSAGE CODE (548-6F)**: There are many different approved message codes available, although none refer to patient consent for releasing supplemental payment information back to a primary payer. *In addition, the business case of communicating consent doesn't conform to the defined use of this data element.*

Additional Consideration: Use of Flags

Another consideration for communication of patient consent to the pharmacy is the concept of a consent flag on the billing response transaction. Currently such a flag or indicator does not exist in the applicable NCPDP transactions and a new data element would have to be requested for a future version. Agreement would be needed that the indicator represents the existence of documented patient consent and is deemed acceptable as proof of patient consent. Multiple indicators may be needed to support situations such as a prescription assistance program may want its consent flag to indicate the patient has agreed to the sharing of their data, whereas a commercial health plan's flag may indicate consent to receive data

from prescription assistance programs.

7.3 Pharmacy Participation

It may be difficult to engage pharmacies for the purpose of providing downstream claim detail information to an upstream payer. Pharmacies may not be contractually obligated to provide this data and there is no reimbursement for this activity. Additionally, there may be concerns about violating patient confidentiality.

Because of the current lack of distinct identifiers for program type, pharmacies could have trouble distinguishing patient assistance programs from other supplemental programs that are not needs-based. This could be problematic for accurate reporting in the event that the reporting is required, for instance, only for programs that are not needs-based. The Adjudicated Program Type, as described in Section 4.3, should partially or fully remedy the program type identification problem.

7.4 Patient Resistance

Patients may be unwilling to provide their consent for data sharing if prescription assistance payments no longer apply towards their out-of-pocket expenses. From the patient's perspective, it will appear they have to wait longer and incur additional expenses to meet deductibles and other out-of-pocket limits.

7.5 Manufacturer Resistance

Since the goal of the manufacturer is increased uptake and adherence to their drug, any negative impact to the patient is likely to also have a negative effect on their program. As a result, manufacturers may opt to discontinue point-of-sale patient assistance programs and look for alternative methods to assist patients.

7.6 Reversal Process/Correction of a Claim

Additional research would be needed to identify and develop the processes needed to ensure proper accounting of claim reversals and corrections.

7.7 Cost of Reporting Mechanism

There will be costs to develop and implement new processes to support the reporting of the data which will impact commercial plans, pharmacies, and prescription assistance programs. Stakeholders are encouraged to consider the financial impact to their workflows and data storage requirements.

8. Summary

The purpose of this issues brief was to review and analyze the issue of reporting prescription assistance to upstream payer(s). This document provides the results of research into potential solutions using NCPDP standards/transactions, many of which are only partial solutions, and identifies known obstacles to these solutions. Due to the complexities and challenges associated with this issue, recommendations and solutions are not included.

Commercial plans track member qualified spending in order to determine when deductibles and other financial accumulators are met. Prescription assistance programs are not linked with commercial health insurance plans, therefore the monetary assistance provided by the former are not considered when the commercial plan is tracking the member's financial accumulators.

Given the lack of a standard mechanism to share transaction data between prescription assistance programs and commercial health insurance plans, the WG1 Upstream Reporting of Copay Assistance Task Group researched potential solutions leveraging NCPDP standards. Areas reviewed included the types of prescription assistance programs (copay vs. patient assistance), billing methods and reporting of final costs.

Reporting options that can be systematically implemented are limited, including those using existing standard transactions, due to the complexity of the information involved. Among the key challenges is the ability to "match" the patient between programs. The prescription assistance program may or may not have sufficient patient identifying information for the commercial plan to match and apply the supplemental amounts accurately. Without a systematic, automated mechanism to support patient matching, any solutions would pose a significant burden on stakeholders to accurately link a patient among programs.

Another key challenge is the issue of patient consent. Given the myriad laws and regulations that apply, determining the validity of patient consent to obtain, share, and store information related to supplemental claims is viewed as a significant burden to the implementation of a systematic solution.

If this is a problem the industry wants to solve holistically, all impacted stakeholders will need to come together to address the issues identified within this document, as well as the other issues that are likely to arise when more discussion occurs.

9. Appendix A. Stakeholders

Commercial Health Insurance

Any healthcare policy that is not administered or provided by a government program.

Commercial Plan Sponsor

An employer or similar group benefit health plan, an insurer, or other financially responsible entity.

Coupon Vendor (non-claim activity)

Marketing services companies that manage prescription medicine coupon programs on behalf of pharmaceutical manufacturers.

Intermediary

An entity performing services on behalf of the pharmaceutical manufacturer, such as patient enrollment verification, data aggregation, etc.

Patient

An individual who has received, is receiving, or intends to receive health care services. (Health care services as defined by federal and state regulations.) Can be a cardholder, subscriber, member, beneficiary, or dependent.

Pharmacy

An entity responsible for dispensing and distributing medicine under applicable legal and ethical guidelines to ensure the correct and safe supply of medical products to the general public.

Pharmaceutical Manufacturer

A company that makes and sells pharmaceuticals. Some manufacturers fund prescription assistance programs for one or more of their drugs.

Prescriber

A licensed entity that prescribes prescription drugs and provides professional medical services, such as clinical services respective to the prescribing function. The entity may be a clinic or independent prescriber, hospital, or care facility.

Prescription Assistance Program Processor

An entity or third party administrator (TPA) responsible for processing claims and administering prescription drug programs on behalf of a pharmaceutical manufacturer or other sponsor.

Processor/Pharmacy Benefit Manager (PBM)/Adjudicator

Administers prescription drug programs, as well as manages costs for a plan sponsor to achieve the most effective utilization of prescription drug expenditures, such as benefit design, formulary management, rebate contracting, retrospective Drug Use Review (DUR), prospective DUR, network administration, disease state management, and so forth.

Supplemental Program

Offers benefits or coverage after primary coverage has been applied. These benefits may reduce the patient's financial responsibility determined by prior payers.

Switch

An entity that accepts an electronic transaction from another organization and electronically routes the transaction to a receiving entity. A switch/intermediary may perform value added services including detailed editing/messaging of input/output data for validity and accuracy and translating data from one format to another.

10. Appendix B. Glossary

Accumulators

A running total of qualified expenses that apply to a member's deductible and Out of Pocket (OOP) maximum for a specific time period.

Benefits Coordination & Recovery Center (BCRC)

A federal contractor which consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The BCRC does not process claims, nor does it handle any mistaken payment recoveries or claims specific inquiries. The Medicare intermediaries and carriers are responsible for processing claims submitted for primary or secondary payment.

BIN/PCN/Group Number

The BIN (Bank Identification Number), PCN (Processor Control Number), and Group Number combinations are used by pharmacies, switches, and processors to electronically route and adjudicate pharmacy claims for prescriptions and typically identify pharmacy insurance programs.

Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services (CMS) is part of the Department of Health and Human Services (HHS). Some programs administered by CMS include: Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace.

Coordination of Benefits (COB)

Allows entities involved in claims processing to determine respective payment responsibilities including determination of primary payer and the extent to which other entities will contribute when an individual has more than one payer option. Payers may be mutually exclusive or supplemental.

Coordination of Benefits (COB) Claim

The mechanism for the pharmacy to bill multiple entities when there is more than one entity involved in the claims process. A COB claim allows payers supplemental to a primary payer to receive pertinent information about prior payer(s) coverage.

Copay Assistance or Manufacturer Coupon Programs:

These programs are generally funded by the drug manufacturer for the specific product being dispensed and are considered non-needs-based, where there are usually no income requirements for the patient to qualify for the program. These programs may or may not require the patient have a specific diagnosis to be eligible for the program. These programs may have per use, monthly or annual limits on the amount they will contribute/cover and are offered at the sole discretion of the manufacturer.

Information Reporting (N) Transactions

The Part D Transaction Facilitator transmits supplemental coverage information from payer-to-payer. The Part D Transaction Facilitator process is triggered by the submission of a transaction by a

pharmacy to a payer supplemental to a Part D Sponsor. The Information Reporting transactions Information Reporting (N1), Information Reporting Reversal (N2), and Information Reporting Rebill (N3) are used in this process and defined further in this document. These transactions are in the NCPDP ***Telecommunication Standard Implementation Guide***.

- **N1 - Information Reporting**
  This transaction is used to transmit a record of supplemental coverage information related to a Part D beneficiary's liability. Information Reporting (N1) is a transaction request and a response.

- **N2 - Information Reporting Reversal**
  This transaction is used to reverse a previously submitted N1 (Information Reporting) transaction. Information Reporting Reversal (N2) is a transaction request and a response.

- **N3 - Information Reporting Rebill**
  This transaction is an Information Reporting submission with an implied reversal. It is used by the Originator to cancel an Information Reporting transaction submitted that had been processed previously, and submit a new Information Reporting transaction in the same transaction. Information Reporting Rebill (N3) is a transaction request and a response.

Medicare Part D Sponsor

An entity that administers the Medicare Part D benefit through prescription claims processing, makes a decision regarding the level of reimbursement and sends the appropriate message or reject code back to the pharmacy/provider for action.

National Council for Prescription Drug Programs (NCPDP)

NCPDP is a not-for-profit, multi-stakeholder forum for developing and promoting industry standards and business solutions that improve patient safety and health outcomes, while also decreasing costs. The work of the organization is accomplished through its members who bring high-level expertise and diverse perspectives to the forum.

NCPDP Telecommunication Standard

The NCPDP Telecommunication Standard is used for the electronic submission of eligibility verification, claim and service billing, predetermination of benefits, prior authorization, information reporting, and controlled substance (general and regulated) transaction exchanges. The Telecommunication Standard is named in HIPAA and the Medicare Modernization Act.

Part D Transaction Facilitator

The Part D Transaction Facilitator is a federal contractor which is responsible, in conjunction with CMS, for establishing procedures for facilitating eligibility queries (E1 transactions) at point of sale (POS), identifying costs reimbursed by other payers (Information Reporting (Nx) transactions) and alerting Part D sponsors about such transactions, and facilitating the transfer of TrOOP-related data (financial information reporting (FIR) transactions) when a beneficiary changes plan enrollment during the coverage year.

Patient Assistance Programs

These programs are generally funded by foundations, charitable organizations, or drug manufacturers. If these programs are administered by a non-profit entity, they will have filed the

appropriate tax documents. These programs have qualification requirements (such as financial need, clinical, geographic or socio-economic status) patients must meet to be eligible for assistance.

11. Appendix C. History of Changes