

DOUBLE COVERAGE

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I. ISSUE

Double Coverage.

II. POLICY

A. **Existence of Other Coverage.** Prior to payment of any claim for services or supplies rendered to any TRICARE beneficiary, regardless of eligibility status, it must be determined whether other coverage exists under any other insurance plan, medical service or health plan. If other coverage exists, TRICARE coverage is available only as secondary payer, and only after a claim has been filed with the other plan and a payment determination issued. This must be done regardless of any provisions contained in the other coverage. For example, a dependent child who is eligible for TRICARE through his/her natural parent may also be eligible for some other coverage through a step-parent. The step-parent's coverage is primary payer, regardless of any provision in that coverage which provides that the natural parent's coverage is primary.

B. **Lack of Payment by Other Health Insurer.** TRICARE will not pay amounts which have been denied by the other coverage simply because the claim was not filed timely with the other coverage or because the beneficiary failed to meet some other requirement of coverage. When such a claim is received, the contractor is to develop the claim for a statement from the other coverage as to how much would have been paid had the claim met the other coverage's requirements. If such a statement is provided to the contractor, the claim is to be processed as if the other coverage actually paid the amount shown on the statement. If no such statement is received, the claim is to be denied.

C. **Definitions.** For purposes of TRICARE, the following definitions apply:

1. **Insurance plan.** An insurance plan is any plan or program which is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services and supplies. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled by law or as a result of employment or membership in, or association with, an organization or group. An insurance plan provided to a beneficiary as a result of his or her status as a student (student insurance) is also included.

a. Not included are:

(1) So-called TRICARE supplemental insurance plans which, for all categories of beneficiaries, provide solely for cash payment of deductibles, cost-shares, and amounts for non-covered services due to program limitations or for which the enrollee is liable (see [Chapter 13, Section 23.1](#) for additional information); or

(2) Income maintenance programs which provide cash payments for periods of hospitalization or disability, regardless of the amount or type of services required or the expenses incurred. These plans are not intended to actually pay for medical services, but are intended only to supplement the beneficiary's income during a time of increased expenses, and perhaps lowered income. On the other hand, a plan which varies its benefits depending on the care received or the patient's diagnosis would be considered health insurance coverage as opposed to an income supplement and would be primary payer to TRICARE. Any payment made directly to the provider of care as opposed to the beneficiary can be assumed to be an insurance plan and not an income supplement.

2. Medical service or health plan - A medical service or health plan is any plan or program of an organized health care group, corporation or other entity for the provision of health care to an individual from plan providers, both professional and institutional. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled by law or as a result of employment or membership in, or association with, an organization or group.

a. Not included are:

(1) Certain federal government programs which are designed to provide benefits to a distinct beneficiary population and for which entitlement does not derive from either premium payment or monetary contribution.

(2) Health care delivery systems not considered within the definition of either an insurance plan, medical service or health plan including the Veterans Administration, the Maternal and Child Health Program, the Indian Health Services, and entitlement to receive care from Uniformed Services Medical Treatment Facility. These programs are designed to provide benefits to a distinct beneficiary population, and they require no premium payment or monetary contribution prior to obtaining care. (See the [OPM Part Two, Chapter 3](#) for procedural instructions.)

D. No Waiver of Benefit From Other Insurer. Beneficiaries may not waive benefits due from any plan which meets the above definitions. Benefits are considered to be the services available. For example, if the other plan includes psychotherapy as a benefit, but only by a psychiatrist, the beneficiary cannot elect to waive this benefit in order to receive services from a psychologist. (See [OPM Part Two, Chapter 3](#) for procedural instructions.)

E. Double Coverage Procedures. These revised procedures will result in the following specific changes. The double coverage procedures are now identical for all classes of beneficiaries. The three tests for determining primary payer for active duty dependents have been eliminated, and contractors may no longer make payment before developing for double coverage on claims for active duty dependents. Moreover, the exclusionary clause provisions previously relating to retirees, etc. are no longer applicable. Lastly, TRICARE is secondary

payer to all other plans including privately-purchased nongroup coverage and student health plans.

III. CONSIDERATIONS

A. The following special considerations apply to TRICARE double coverage procedures.

1. Claims processed under the TRICARE/CHAMPUS DRG-based payment system.

a. Claims with a date of admission prior to July 1, 1990. When double coverage exists on a claim processed under the TRICARE/CHAMPUS DRG-based payment system, the DRG-based amount is to be used as the billed charge. Thus, where the DRG-based amount is greater than the hospital's actual billed charge, and the primary payer has paid the full billed charge, TRICARE will pay the difference up to the DRG-based amount. On the other hand, if the other health insurance (OHI) payment equals or is greater than the TRICARE/CHAMPUS DRG-based amount, no additional payment can be made. Nor can the hospital bill the beneficiary for any amounts because of the participation limitations. (See the [OPM Part Two, Chapter 3](#), for further details.)

b. Claims with a date of admission on or after July 1, 1990. When double coverage exists on a claim processed under the TRICARE/CHAMPUS DRG-based payment system, the TRICARE payment cannot exceed an amount that, when combined with the primary payment, equals the lesser of the TRICARE/CHAMPUS DRG-based amount or the hospital's charges for the services (or the amount the hospital is obligated to accept as full payment). Thus, when the DRG-based amount is greater than the hospital's actual billed charge, and the primary payer has paid the full billed charge, TRICARE will make no additional payment. When the DRG-based amount is less than the hospital's actual billed charge, and the primary payer has paid the full DRG-based amount, no additional payment can be made. Nor can the hospital bill the beneficiary for any amounts, except for unpaid cost-sharing amounts, because of the participation limitations. (See the [OPM Part Two, Chapter 3](#), for further details.)

2. Claims processed under the TRICARE/CHAMPUS inpatient mental health per diem payment system.

a. When double coverage exists on a claim processed under the TRICARE/CHAMPUS inpatient mental health per diem payment system, the TRICARE payment cannot exceed an amount that, when combined with the primary payment, equals the lesser of the TRICARE/CHAMPUS per diem based amount or the hospital's charges for the services (or the amount the hospital is obligated to accept as full payment). Thus, when the per diem based amount is greater than the hospital's actual billed charge, and the primary payer has paid the full billed charge, TRICARE will make no additional payment. When the per diem based amount is less than the hospital's actual billed charge, and the primary payer has paid the full per diem based amount, no additional payment can be made. Nor can the hospital bill the beneficiary for any amounts because of the participation limitations. (See the [OPM Part Two, Chapter 3](#), for further details.)

b. **Claims with a date of admission on or after October 1, 1998. When double coverage exists on a claim processed under the TRICARE/CHAMPUS inpatient mental health per diem payment system, the TRICARE/CHAMPUS payment cannot exceed an**

amount that, when combined with the primary payment, equals the lesser of the TRICARE/CHAMPUS per diem amount or the hospital's charges for the services (or the amount the hospital is obligated to accept as full payment). Thus, when the per diem amount is greater than the hospital's actual billed charge, and the primary payer has paid the full billed charge TRICARE/CHAMPUS will make no additional payment. When the per diem amount is less than the hospital's actual billed charge and the primary payer has paid the full per diem amount, no additional payment can be made. Nor can the hospital bill the beneficiary for any amounts, except for unpaid cost-sharing amounts, because of the participation limitations. (See the [OPM Part Two, Chapter 3](#), for further details.)

3. TRICARE and Medicare. Whenever a TRICARE beneficiary is also eligible for Medicare benefits (either under Part A, "Hospital Insurance", or Part B, "Supplementary Medical Insurance"), Medicare is always the primary payer.

4. TRICARE and Medicaid. Medicaid is essentially a welfare program, providing medical benefits for persons under various state welfare programs (such as Aid to Dependent Children) or who qualify by reason of being determined to be "medically indigent" based on a means test. In enacting P.L. 97-377, it was the intent of Congress that no class of TRICARE beneficiary should have to resort to welfare programs, and therefore, Medicaid was exempted from these double coverage provisions. Whenever a TRICARE beneficiary is also eligible for Medicaid, TRICARE is always the primary payer. In those instances where Medicaid extends benefits on behalf of a Medicaid eligible person who is subsequently determined to be a TRICARE beneficiary, TRICARE shall reimburse the appropriate Medicaid agency for the amount TRICARE would have paid in the absence of Medicaid benefits. (See the [OPM Part Two, Chapter 3, Section IV.B](#), for further information.)

5. Worker's compensation. All TRICARE benefits are specifically excluded for any medical service and supply provided to a TRICARE beneficiary to treat a work-related illness or injury for which benefits are available under a worker's compensation program. The TRICARE beneficiary may not elect to waive worker's compensation benefits in favor of using TRICARE, and it is the beneficiary's responsibility to apply for worker's compensation benefits.

a. Extending TRICARE Benefit.

(1) The agency having authority to do so (as designated under the applicable worker's compensation law) shall have final authority in the determination of whether or not an illness or injury is work-related. If a TRICARE beneficiary exhausts available worker's compensation benefits, TRICARE will assume the case and benefits for otherwise covered services and supplies may be extended.

(2) In worker's compensation cases which involve a lengthy investigation by the applicable worker's compensation agency before a decision can be made as to whether a case is work-related, or which involve an unusual delay because the TRICARE beneficiary elects to appeal an adverse decision by the worker's compensation agency, TRICARE benefits may be extended for otherwise covered services and supplies when authorized by the Executive Director, TMA (or a designee).

6. Program for Persons with Disabilities-PFPWD (formerly known as Program for the Handicapped). All double coverage rules and procedures which apply to claims under

the basic program are also to be applied to PFPWD claims. All local resources must be considered and utilized before TRICARE benefits under the PFPWD may be extended. If a TRICARE beneficiary who is otherwise eligible for benefits under the PFPWD is eligible for other federal, state, and/or local assistance to the same extent as any other resident or citizen, TRICARE benefits are payable only on a secondary payer basis. The sponsor does not have the option of waiving available federal, state, and/or local assistance in favor of using TRICARE benefits.

7. Partnership providers and Public Law 99-272 2001 (10 USC 1095). Section 1095 of Title 10 United States Code requires the uniformed services treatment facilities to bill third party payers the established government rate for those beneficiaries who have other health insurance. Thus, when a uniformed services treatment facility bills a third party payer, that bill should not include the charges for the services rendered by the Partnership provider. In those cases in which the uniformed services treatment facility bills an all-inclusive rate, the charges for the Partnership provider should be deducted from the all-inclusive rate. Because 10 USC 1079(j)(1) makes TRICARE second payer to all third party payers except for Medicaid beneficiaries, the Partnership provider must bill the third party payer for services rendered by the Partnership provider. Once the third party payer has satisfied its liability, then the Partnership provider may bill TRICARE for the difference between the amount to be paid the Partnership provider under the Partnership agreement and the amount paid by the third party payer in accordance with the established TRICARE rules regarding other health insurance.

8. Double coverage and multi-program claims. If there has been a double coverage payment on a multi-program claim, the following procedures are to be followed.

a. If the amount of the double coverage payment applicable to each program (professional services, drugs, etc.) is known without development, the appropriate double coverage amounts are to be applied to each program. Any deductible amounts are to be applied to the program which results in the greatest payment to the beneficiary unless multiprogramming for fiscal years dictates the program to which the deductible must be applied.

EXAMPLE: (Effective April 1, 1991). Active duty sponsor whose rank is E-5 or above (also applicable to all non-active duty family members and retirees), with all services from the same fiscal year and the OHI payments for each program are known. The deductible amount is \$150.00 (For care rendered to all eligible TRICARE beneficiaries prior to April 1, 1991, or when the active duty sponsor's military rank is E-4 or below, regardless of the date of care the base deductible is \$50.00).

Professional Services

Billed charge	\$536.54
Allowed amount	515.40
OHI payment	21.14

Drugs

Billed charge		\$267.67
Allowed amount		\$267.67
OHI payment		254.14
Step 1:	\$515.40	\$267.67
	<u>-103.08</u> cost-share	<u>-150.00</u> deductible
	\$412.32	\$117.67
		<u>- 23.53</u> cost-share
		\$ 94.14
Step 2:	\$536.54	\$267.67
	<u>- 21.14</u> cost-share	<u>-254.14</u> OHI payment
	\$515.40	\$ 13.53
Step 3:	Amount paid = \$425.85 (\$412.32 + \$13.53)	

b. If the amount of the double coverage payment applicable to each program is unknown (i.e., only the total amount of the payment is known), the double coverage amount is to be prorated among the programs in relative proportion to the billed charges for each program. Any deductible amounts are to be prorated based on the allowed amounts for each program unless multiprogramming for fiscal years dictates the program to which the deductible must be applied.

EXAMPLE: (Same criteria as in above example but only the total OHI payment is known):

Professional Services

Billed charge	\$536.54
Allowed amount	515.40

Drugs

Billed charge	\$267.67
Allowed amount	\$267.67
OHI payment	\$275.28

Step 1:	Professional services equal 65.8% of total allowed amounts 65.8% of \$150 = \$98.70
	Drugs equal 34.2% of total allowed amounts 34.2% of \$150 = \$51.30
	\$515.40
	<u>- 98.70</u> deductible
	\$416.70
	<u>- 83.34</u> cost-share
	\$333.36
Step 2:	Professional services equal 66.7% of total billed charges 66.7% of \$275.28 = \$183.61

Drugs equal 33.3% of total billed charges 33.3% of 275.28
= \$91.67

\$536.54	\$267.67
- <u>183.61</u> OHI deductible	- <u>91.67</u> OHI payment
\$352.93	\$176.00

Step 3: Amount paid = \$506.46 (\$333.36 + \$173.10)

See the [OPM Part Two, Chapter 3, Section IV](#) for additional information.

9. Claims with discounted rate agreements. Under special programs approved by the Executive Director, TMA (e.g., the Health Care Finder and Participating Provider Program), where there is a negotiated (discounted) rate agreed to by the provider, benefits should be coordinated in accordance with the steps found in the [OPM Part Two, Chapter 3, Section III](#).

10. Effective September 13, 1994, State Victims of Crime Compensation Programs are not considered double coverage. When a TRICARE beneficiary is also eligible for benefits under a State Victims of Crime Compensation Program, TRICARE is always the primary payer over the State Victims of Crime Compensation Programs.

IV. EXCEPTIONS

A. Medicaid. An exception to this policy is entitlement under any plan administered under Title XIX of the Social Security Amendments of 1965 (79Stat.286), Medicaid. TRICARE remains first pay to Medicaid.

B. No Legal Obligation to Pay. Payment should not be extended for services and supplies for which the beneficiary or sponsor has no legal obligation to pay; or for which no charge would be made if the beneficiary was not an eligible TRICARE beneficiary. Whenever possible, all double coverage claims should be accompanied by an explanation of benefits (EOB) from the primary insurer. If the existence of a participating agreement limiting liability of a beneficiary is evident on the EOB, payment is to be limited to that liability; however, if it is not clearly evident, the claim is to be processed as if no such agreement exists.

V. EFFECTIVE DATE

This change is effective for all claims processed on or after December 21, 1982, regardless of the actual date of service.

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