Chapter 4 Section 1

Double Coverage

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1.0 POLICY

1.1 Existence of Other Coverage

Double coverage consists of medical benefits coverage by both TRICARE and another medical/hospital insurance, medical service, or health plan (with the exception of Medicaid and certain other programs identified by the Director, TRICARE Management Activity (TMA), e.g., the Indian Health Service (IHS) and State Victims Assistance Plans). 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. 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. A contractor must coordinate benefits and obtain the information regarding the other insurance payment to determine what the TRICARE liability is to assure that:

1.1.1 TRICARE beneficiaries receive maximum benefits from their health coverage, but no more than they are entitled to receive, and

1.1.2 The combined payments under TRICARE and the double coverage plan do not exceed the total charges.

1.2 Last Pay Limitation

Except for certain situations in which Medicare is the primary payer (see Section 4, paragraph 1.0), no more can be paid as secondary payer than would have been paid in the absence of other coverage. TRICARE, as secondary payor, cannot reimburse charges for any services or supplies which are not otherwise covered under the program. TRICARE benefits cannot be paid for services received prior to TRICARE eligibility. The application of double coverage provisions does not extend or add to the usual TRICARE payment amounts.

1.3 Lack of Payment by Other Health Insurer

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 cannot be paid. If a statement from the other coverage as to how much would have been paid had the claim met the other coverage's requirements is provided to the contractor, the claim can 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.

1.4 Definitions

1.4.1 Insurance Plan

1.4.1.1 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.

1.4.1.2 Not included are:

- So-called 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 1, Section 26); or

- 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; or

- State Victims of Crime Compensation Programs.

- Automobile liability/no fault insurance which provide compensation for health and medical expenses relating to a personal injury arising from the operation of a motor vehicle.

1.4.2 Medical Service Or Health Plan

1.4.2.1 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.

1.4.2.2 Not included are:

- 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 (e.g., Medicaid and Worker's Compensation).

- Health care delivery systems not considered within the definition of either an insurance plan, medical service or health plan including the Department of Veterans Affairs (DVA), the Maternal and Child Health Program, the Indian Health Services (IHS), and entitlement to receive care from the designated provider. 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.

1.5 No Waiver of Benefit From Other Insurer

Beneficiaries may not waive benefits due from any plan which meets the above definitions. If a double coverage plan provides, or may provide, benefits for the services, a claim must be filed with the double coverage plan. Refusal by the beneficiary to claim benefits from the other coverages must result in a denial of TRICARE benefits. 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. For TRICARE for Life (TFL) claims, an exception exists for mental health counselors and pastoral counselors as well as for services received under a private contract (see Section 4, paragraph 1.3.1.5).

1.6 Beneficiary Liability

In all double coverage situations, a beneficiary's liability is limited by all TRICARE provisions. As a result, a provider cannot collect from a TRICARE beneficiary any amount that would result in total payment to the provider that exceeds TRICARE limitations. For example, a beneficiary is not liable for any cost-sharing or deductible amounts required by the primary payer, if the sum of the primary payer's and TRICARE's payments are at least equal to 115% of the TRICARE allowable amount for a nonparticipating provider. This is true whether TRICARE actually makes any payment or not. This also applies to claims from participating non-network providers and from network providers. Because of the payment calculations, the provider usually will receive payments from the primary payer and from TRICARE that equal the billed charges. In those rare cases where this does not occur, the provider cannot collect any amount from the beneficiary that would result in payment that exceeds the TRICARE allowable amount.

Note: It is important to note that this paragraph addresses beneficiary liability and does not change in any way the amounts TRICARE will pay based on provisions elsewhere in this chapter.

1.7 Claims Processed Under the TRICARE Diagnosis Related Group (DRG)-Based Payment System or the Inpatient Mental Health Per Diem Payment System

When double coverage exists on a claim processed under the TRICARE DRG-based payment system or the 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 DRG-based amount, the inpatient mental health per diem based amount, or the hospital's charges for the services (including any discount arrangements). Thus, when the DRG-based amount or the inpatient mental health 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. Similarly, when the DRG-based amount or the inpatient mental health per diem based amount is less than the hospital's actual billed charge, and the primary payer has paid the full DRG-based amount or inpatient mental health per diem based amount, no additional payment can be made. Nor can the hospital bill the beneficiary for **any** additional amounts in these cases.

1.8 Claims Processed Under The Reasonable Cost Method For Critical Access Hospitals (CAHs)

When double coverage exists on a claim processed under the reasonable cost method for CAHs, the TRICARE payment cannot exceed an amount that when combined with the primary payment equals the lesser of the established cap amount multiplied by the billed charges or 101% of reasonable cost. The reasonable cost method for CAHs is the lesser of the established/ determined Cost-to-Charge Ratio (CCR) cap (reference Chapter 15, Section 1 for Fiscal Year (FY) inpatient and outpatient CCR cap) multiplied by billed charges or 101% of reasonable costs [1.01 x (hospital-specific CCR x billed charges)].

1.9 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.

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