Make Medicare Work Coalition Topical Brief

Medicare, VA and TRICARE Health Benefits: What You Need to Know to Make Informed Decisions about Your Medicare Coverage

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The U.S. Department of Veterans Affairs (VA) Health Administration branch is one of the nation’s largest coordinated health care systems and provides health care benefits to more than 8.5 million veterans nationwide. The VA uses innovative health care methods, such as electronic health records, primary care teams and care coordination to improve quality and access to care for the veterans they serve. The most recent survey conducted in 2013 by the Veterans Health Administration reported that more than half of the veterans enrolled in VA health benefits are also enrolled in Medicare.

As more and more veterans approach Medicare eligibility, they must make the important decision of whether to enroll in Medicare or not. For some Medicare eligible veterans, Medicare premiums may deter them from enrolling in Medicare. Some may think Medicare coverage is not necessary because they have access to VA health benefits. Other veterans may encounter barriers to accessing health care at the VA (e.g., services that are not covered, wait times for appointments, etc.) and as a result, look into using other coverage such as Medicare. Veterans who choose to delay enrolling in Medicare because they have VA coverage may not realize that there are limited time frames to enroll. If an individual does not enroll in Medicare when they are first eligible, penalties usually apply for enrolling later.

This Brief examines what veterans eligible for VA health care need to know as they approach their Medicare eligibility and how these benefits do and don’t work with Medicare. It also provides helpful information to assist them to explore their options and make informed decisions that best suit their health needs.

The Brief also provides information about the TRICARE program and how it works for active and retired military members who become eligible for Medicare, as well as how TRICARE for Life (TFL) works for more than the 2 million retired military members on the program. It reviews what TRICARE members need to know when they become eligible for Medicare, how TRICARE works with Medicare and which members can delay enrolling in Medicare Part B.
What is Medicare?

Medicare is a federal health insurance program for individuals 65 and older and certain people with disabilities. The Centers for Medicare and Medicaid Services (CMS) administer the Medicare program, and the Social Security Administration handles eligibility and enrollment.

“Original” or “traditional” Medicare provides beneficiaries with hospital insurance through Part A and medical insurance through Part B. Prescription drug coverage, called Medicare Part D, can be purchased through private insurance companies that contract with Medicare. Medicare beneficiaries also have the option of receiving their Part A and B benefits through a Medicare Advantage plan, a private health plan that contracts with Medicare. Many Medicare Advantage plans also offer drug coverage.

Who is eligible for Medicare?
Eligibility for Medicare is based on a beneficiary’s age and work history. To qualify for Medicare, individuals must be age 65 and older and have 40 credits of Social Security or Railroad Retirement covered employment, meaning they paid into the system through payroll taxes, through their own work or spouse’s work history.

Individuals with disabilities may also qualify for Medicare if they are receiving disability benefits under Social Security Disability Insurance (SSDI) or Railroad Retirement for 24 months or more. Individuals with End-Stage Renal Disease (ESRD) or Amyotrophic Later Sclerosis (ALS) may qualify for Medicare at any age even if they have not received SSDI for 24 months as long as they have acquired the required Medicare covered work credits with Social Security or Railroad Retirement.

Individuals who have earned enough work credits with Social Security or Railroad Retirement receive Medicare Part A coverage without paying a premium, but they must pay a monthly premium to enroll into Medicare Part B. Individuals who do not qualify for Social Security or Railroad Retirement benefits because they do not have enough of a qualified work history (enough work credits) may purchase Medicare if they are 65 or older and a U.S citizen or qualified non-citizen. (Legal permanent residents who have lived in the U.S. for at least 5 years are qualified non-citizens, as are several other special immigrant groups, such as refugees and asylees.)

How do you apply for Medicare?
Individuals who receive Social Security retirement benefits will automatically be enrolled in Medicare Part A and Part B when they turn 65 years of age. Individuals with disabilities under age 65 and who receive Social Security Disability Insurance (SSDI) benefits will automatically be enrolled into Medicare Parts A and B after receiving SSDI benefits for 24 months (also referred to as the two-year waiting period).

Individuals need to contact the Social Security Administration to actively apply for Medicare when they turn 65 if they do not yet collect Social Security benefits or decide to delay applying for retirement benefits. SSA will not automatically enroll anyone into Medicare who is not already receiving benefits when they turn 65.

What benefits are included under Original Medicare?
Original Medicare has two parts: Part A covers inpatient care (inpatient hospital care, skilled nursing facility care, home health care and hospice) and Part B provides coverage for medical care (doctors, durable medical equipment and other outpatient health services). Medicare does not provide coverage for most dental and vision care, hearing aids or exams, custodial care or long-term care such as in a nursing home.

What is Medicare Advantage?
Medicare Advantage (MA) health plans are a way to receive your Medicare benefits and an alternative to original Medicare. MA plans are also commonly referred to as Medicare Part C or Medicare health plans and include managed care plans specifically for people with Medicare.
Medicare pays MA plans a fixed amount each month to provide beneficiaries their Medicare Part A and B services. Some MA plans also include prescription drug coverage (called MA-PD plans).

There are different types of MA plans (HMOs, PPOs, PFFS). MA plans may require a member to use doctors, hospitals and other providers that work with the plan, called a network, for services to be covered or to see the most cost savings. Many MA plans also provide extra benefits that are usually not covered by Medicare, such as dental, hearing and transportation services.

**Does Medicare include prescription drug coverage?**
Medicare contracts with private companies to provide the prescription drug coverage benefit called Medicare Part D. Beneficiaries have the option of choosing a stand-alone Part D plan that provides coverage for only prescription drugs or a Medicare Advantage health plan that covers drugs and other health benefits. Whether a veteran who is enrolled in VA coverage needs to also enroll in Medicare Part D will be reviewed later in this brief.

**Where can I use my Medicare card?**
Individuals can use their Medicare benefits at any provider that accepts Medicare. Beneficiaries should always make sure to ask their doctors and medical providers if they accept Medicare assignment, meaning they agree to accept the Medicare approved amount as payment in full. Providers that accept Medicare but do not take assignment can charge beneficiaries up to 15% more than the Medicare approved rate of payment. Doctors who do not accept Medicare cannot bill Medicare for services and patients may be required to sign a private contract requiring the individual to pay for services in full.

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**VA Benefits and Medicare: A Closer Look**

**Introduction to VA Benefits**
VA health benefits are health care benefits provided by the U.S. Department of Veterans Affairs (called the VA). Healthcare is provided through the VA health care system, one of the largest healthcare systems in America serving nearly 9 million veterans. A common misconception is that all veterans are eligible for VA health care. Veterans do not automatically qualify for VA health coverage and must apply to determine eligibility and be enrolled to receive services. Eligibility for services is based on a veteran’s active military service, discharge status other than dishonorable, length of service, if they have a service connected disability, and income.

The number of veterans accessing VA health care benefits is dependent on the amount of funding Congress allocates to the VA each year. To ensure that veterans with the highest need for services are being served, the VA has created a system of priority groups from 1-8 in order to prioritize enrollment into the program, with priority group 1 being the highest and priority group 8 the lowest. For example, priority group 1 veterans are those in the highest need of services and includes veterans with service connected disabilities of 50% or more. Priority group 5 includes veterans without a service connected disability but have incomes below the set VA income threshold. Priority groups 7 and 8 includes veterans who do not have a service connected disabilities and have incomes...
that are at the higher end of the income threshold set by the VA. The [VA web site](http://www.va.gov) has a complete list and description of the current eight Priority Groups.

Once a veteran is enrolled, s/he is assigned to a priority group and mailed a Veterans Health Benefits Handbook that is tailored for that veteran and lists the benefits s/he is eligible to receive based on the assigned priority group. At their first appointment, veterans are assigned a primary care provider and issued a Veteran Health ID card that can be used at VA facilities for medical care, prescriptions and other services. Veterans do not have to pay a monthly premium for VA health care. Medical care for service connected conditions costs $0 regardless of the veteran’s priority group but cost sharing amounts for non-connected conditions are dependent on the individual's assigned priority group.

Certain veterans who do not have a service connected disability or do not receive a pension payment may be required to submit their household income information. This income information is used to determine whether these veterans will be required to pay a co-pay for their health care services and prescription drugs that are not connected to a service condition. Income thresholds for VA health benefits vary by geographic area and can be found [here](http://www.va.gov). The co-pay amounts for veterans with higher incomes who receive care for non-service connected conditions can be found [here](http://www.va.gov). These costs include out of pocket costs for inpatient care, primary care, and specialty care visits. Visits that include multiple primary care and/or specialty visits will only be charged one outpatient co-pay amount regardless of the number of VA providers you see in one day. There are no co-pays for immunizations or preventive care screenings.

**What types of health services are available at the VA?**

All veterans, regardless of which priority group they are assigned to, are eligible to receive the VA comprehensive medical benefits package. These services include inpatient hospital care, outpatient services, preventive care, specialty care, mental health and prescription drug coverage for eligible veterans. *To access a comprehensive list of services included in the VA medical benefit package click [here](http://www.va.gov).*

VA health coverage also provides [dental, vision and audiology services](http://www.va.gov), but may not be available to all enrolled veterans and only available to veterans who meet certain eligibility and medical criteria. Access to these benefits depends on whether the veteran meets certain eligibility and medical necessity guidelines (use links above to see eligibility information for each of these services). Veterans who are homebound or require long term care and meet eligibility guidelines may receive assistance to pay for care through the [Veterans Aid and Attendance program](http://www.va.gov).

The VA’s use of electronic medical records allow a veteran to receive services at any VA medical center or outpatient clinic in the country including situations when veterans are traveling or temporarily living somewhere other than their primary address. [Vet centers](http://www.va.gov) have limited sharing of records with the VA. A list of VA medical facilities by state can found [here](http://www.va.gov).

In order for the VA to cover health services, the veteran must receive care at a VA facility. Special and limited circumstances allow the VA to pay for care at a non-VA facility or community-based provider in emergency situations or if the veteran has received advanced prior authorization by the VA for a specific service. Veterans who receive care at a non-VA hospital in emergency situations
should contact the VA within 72 hours of being admitted to the emergency room so the VA can determine what the VA is authorized to pay for and how to proceed if the veteran requires further inpatient hospital care.

At times and depending which VA facility a veteran has access to, the VA may have waiting lists to see a VA doctor for specialty care or specific services. To address this concern the VA created the Veterans Choice Program. The Veterans Choice Program allows veterans already enrolled in the VA to access medical care at non-VA facilities and to receive care from a medical provider in their community. Veterans must enroll in the program, be found eligible, and meet certain criteria (e.g., having to wait more than 30 days for an appointment to receive care at a VA facility, live more than 40 miles driving distance from the closest VA facility or encounter excessive travel burdens (such as traveling by boat or air) to visit their closest VA facility). Veterans who use the Veterans Choice program and also have Medicare, Medicaid or TRICARE will not be required to pay the applicable Medicare, Medicaid or TRICARE cost sharing amounts for services received through the Veterans Choice program.

**How to Apply for Veterans Health Benefits**
Veterans can apply for health care benefits in person at a local VA facility or by completing and submitting an application. Paper applications can also be downloaded online, obtained by visiting a local VA facility or completed over the phone by calling (877) 222-8387. Phone applications are mailed back to the veteran to review, sign and return to the VA. Help is available to veterans who need assistance completing an application. Visit [http://www.va.gov/healthbenefits/apply/](http://www.va.gov/healthbenefits/apply/) for additional information.

**Veterans Approaching Medicare Eligibility: What Do they Need to Know?**
As veterans approach their Medicare eligibility date, they are faced with the important decision of whether they should enroll in Medicare or not. With a limited time frame to enroll and potential penalties for not enrolling at the right time, many veterans are often unsure of what they need to do. There is no right or wrong answer as to whether a veteran who is enrolled in VA health benefits should also enroll in Medicare. The VA strongly encourages veterans to enroll in Medicare, however, because each veteran’s circumstance may vary (limited financial resources to pay for Medicare premiums, lack of information, or a decision to rely solely on VA health care), some veterans may decide to delay or unknowingly miss the limited time frame they have to enroll in Medicare.

Enrolling in Medicare may have advantages for veterans who also have VA health benefits. Primarily, being eligible for Medicare and VA coverage provides veterans with a wider choice of health care providers and choices. Medicare and VA usually do not coordinate benefits. This means that veterans who have Medicare and VA coverage cannot use both to pay and cover the same service. Medicare does not make payments for services received at a VA health facility and the VA usually does not pay for medical care outside of the VA except in very limited circumstances such as in emergency situations or if the individual has VA prior authorization. VA health coverage can generally only be used at VA facilities and federal law prohibits federal agencies like the VA from billing Medicare for services (see section 50 of [Chapter 16 on General Exclusions from Coverage](https://www.cms.gov/medicare/medicare-fee-for-service-payment/physician-chase-fraud-prevention/16general-exclusions-from-coverage.html) of the Medicare Benefit policy Manual for more information).
This means that veterans who choose to receive health care outside of the VA will be responsible for any costs incurred unless they have other health coverage such as Medicare or other private insurance to pay for care. Veterans who have both Medicare and VA benefits will need to decide which type of coverage to use before they receive a service. Deciding factors may include whether the veteran will have cost sharing for the service or whether there are wait times at the VA for an appointment. Additionally, some veterans like having the flexibility of having Medicare to see a non-VA provider, such as a specific specialist, or pursue a course of treatment that VA has not authorized.

Whether a veteran enrolls in Medicare will depend on each veteran’s individualized needs. However, it is important to highlight that VA health care does not provide veterans with the option of delaying enrollment into Part B coverage because they have VA benefits. (Note that the rules are different for Medicare Part D drug coverage. VA and Part D benefits will be covered later in this brief.) Medicare only provides a special enrollment period into Part B at a later time if the beneficiary had group health insurance based on current employment, the employer coverage was the primary payer and that coverage ends. Veterans who delay enrolling in Medicare and who do not have other private insurance (such as an employer group health plan) will be responsible for paying any late enrollment penalties if they decide to enroll in Part B at a later time. This includes veterans who only have VA coverage and choose to delay enrollment into Part B.

VA and Medicare Coverage: Managing Your Care

Many veterans who use VA health care also see non-VA health care providers in the community. An annual VA survey revealed that 57% of VA enrollees also have a non-VA provider they visit. The VA has some useful resources to assist veterans who visit both VA and non-VA providers in coordinating and facilitating their care. These resources can help both types of health providers to access medical information about the patient from each other. Below is a list of resources veterans may want to consider and review if they are using a combination of VA health care and Medicare or other private insurance.

- **My HealtheVet** at [www.myhealth.va.gov](http://www.myhealth.va.gov) is a secure online web portal administered by the U.S. Department of Veterans Affairs that allows veterans and their families to maintain their health information online. Registration is required and based on which account level they choose. Veterans who are VA patients can create an online personal health record that provides access to VA health information, medical history, lists of doctors and to refill VA prescriptions. The site provides tools to help veterans connect their VA and non-VA health providers to important information regarding their health.

- **Virtual Lifetime Electronic Record (VLER)** allows VA and non-VA medical providers to exchange medical information through protected networks and is useful tool for veterans to co-manage their care if they receive some of their care outside of the VA. Although it is the veteran’s responsibility to keep VA and non-VA provides informed about the care they receive at each doctor, this limits the amount of information and paperwork veterans must bring along
The Release of Information Office at the local VA medical center allows veterans to sign a release form to access and obtain medical records that can be sent to their private non-VA providers. Click here to find a local VA medical facility and submit a form.

**Medicare Enrollment and Premiums**

Once a veteran becomes eligible for Medicare, either because they turn 65 or become eligible based on disability status through Social Security, they have a 7-month time frame known as the Initial Enrollment Period to enroll into Medicare (it begins three months before the Medicare eligibility date, the month of, and up to three months after). Most people choose to enroll in Part A because they do not have to pay a monthly premium for it. However, there is a monthly premium for Part B which the VA will not pay for veterans. The veteran is responsible for paying the Medicare Part B premium out of his/her own pocket unless s/he qualifies for and enrolls in a Medicare Savings Program.

Veterans who miss their IEP and decide to enroll at a later time will have to use the Medicare General Enrollment Period to enroll in Part B. Veterans who qualify for premium free Part A can sign up for Part A at any time without a late enrollment penalty, even if it is after their IEP. However, enrollment into Part B can only be done during the Medicare General Enrollment Period, which takes place January 1 through March 31 of each year (with coverage taking effect July 1st of the same year). In addition, penalties usually apply for late enrollment into Part B, which amount to 10% of the Part B premium for every full 12 months an individual was eligible but did not enroll. The Part B penalty is in addition to the monthly Part B premium and is not capped, which means the longer a veteran goes without Part B (if eligible), the higher the penalty will be if s/he decides to enroll at a later time.

**Do Veterans need Medicare Part B?**

The following are important considerations for veterans debating whether to enroll in Medicare Part B or not:

**Wait Times**

In recent years, national media coverage has reported long waiting times for appointments at some VA medical facilities. Depending on the VA facility, there may be a wait to access specialty care and providers. Even though the Veterans Choice program was created in August 2014 to address this issue, enrolling in Medicare may also provide veterans with an additional option. Medicare may provide quicker access to medical care for some veterans and help pay a portion of that care.

**Provider Access**

Access to providers also plays an important role when deciding of whether to enroll in Medicare. The most recent VA Survey of Enrollees (2013) revealed that more than 50% of veterans who responded to the survey have a provider outside of the VA that they like and trust. However, veterans who would like to continue seeing non-VA medical providers are responsible for the costs. Enrolling in Medicare can help provide coverage for these non-VA provider visits. In addition, veterans who enroll in
Medicare have the amenity of choosing from a wider selection of medical providers and specialists (e.g., cardiologists, oncologists, etc.) and do not have to solely rely on VA providers.

Where a veteran lives may also come into play when deciding whether s/he should enroll in Medicare. Veterans who live more than 40 miles away from the nearest VA medical facility have the option of enrolling in the Veterans Choice Program, but veterans who live less than 40 miles away and still have difficulty traveling to their local VA facility may want to consider enrolling in Medicare for convenience and for more provider options. While the VA does provide transportation services to facilities, availability of services vary by program and geographic area.

Priority Group and Continued Access to Coverage

Another factor to keep in mind is funding appropriated to the VA. Veterans who are enrolled in lower Priority Groups (Groups 7 and 8) should take into consideration that future funding allocated by Congress to the VA could decrease, meaning that veterans in lower groups or potential new enrollees may have to find alternative means of health care if their access to VA coverage is eliminated or suspended in the future. Priority Groups were created to guarantee that veterans are enrolled to receive care in order of medical need. If inadequate funding is provided to meet the growing number of veterans enrolling in VA health care, the VA may exclude veterans in higher priority groups (like 7 or 8) to guarantee services to other veterans. For example, in 2003, the VA temporarily suspended new enrollments into Priority Group 8 in order to meet the health care costs for veterans in higher level priority groups.

Questions to Ask Veterans

Below is a list of considerations that can be reviewed with veterans when making Medicare enrollment decisions.

- Do you have extensive health needs?
- Would you like the flexibility of choosing from a larger list of providers (non-VA providers)?
- Do you visit medical providers that are not part of the VA that you like and would like to continue seeing?
- Does your local VA facility have a waiting list to access certain health services or are there long wait times to see specific VA providers?
- Are there waiting lists at the VA to get an appointment for services like a specialty care?
- How close or far away do you live from a VA health facility? Is it easy for you to travel to your local VA outpatient facility?
- Does your local VA facility provide all the health care services you need?
- Are you on a low-priority group (like group 7 or 8)? Do you want secondary coverage to “fall back on” in case these groups do not receive funding in the future?
- Do you have co-pays for care related to non-service connected conditions?
Can you afford to pay the monthly Medicare Part B premium?

Have you been screened for benefit programs to determine if you qualify for help in paying the Part B premium?

Veterans with Medicare: Supplementing Medicare Coverage
Veterans who are enrolled in Medicare and receive medical care from a non-VA Medicare provider will be responsible for Medicare out-of-pocket costs, such as Part A and Part B deductibles and co-insurance amounts. The VA will not pay these costs and beneficiaries are responsible for paying these costs under original Medicare. It is important to consider the different options that can help manage and reduce these out-of-pocket costs.

The first step should always be to screen the veteran for benefits assistance programs that may help pay some of the Medicare premiums and cost sharing. Programs like Medicaid, Medicare Savings Programs, and Extra Help can help alleviate some of the financial costs associated with using Medicare benefits. Although these programs cannot be used at the VA for VA services, they do make Medicare more affordable and encourage veterans to enroll. Veterans who do not qualify for benefits assistance programs may want to consider exploring other ways to cover Medicare’s out of pocket costs, such as Medigap plans or Medicare Advantage plans.

Medigap plans (also referred to as Medicare Supplement plans) are one way veterans who enroll in Medicare can supplement their coverage. Medigap plans are health insurance policies sold by private companies to supplement Medicare Parts A and B and can only be used with original Medicare. Medigap policies currently sold do not include drug coverage. The policies help pay some of the costs Medicare does not cover and can usually be used at any provider that accepts Medicare. Beneficiaries who buy a Medigap policy pay a premium for the policy (in addition to the Part premium).

The best time for a beneficiary to buy a policy is during his/her Medigap open enrollment period - a six month period that begins once you enroll in Part B. During this time, individuals have guaranteed issue and can buy any policy they want, cannot be denied a policy or charged more because of a pre-existing health condition. There are other times beneficiaries have guaranteed rights to purchase a policy outside of their Medigap OEP, but being enrolled in VA health coverage is not one of them. Veterans with Medicare who are interested in buying a Medigap policy should also consider a Medicare Select policy, a type of Medigap plan that requires you to use a network of hospitals (usually not physicians) and in return offers lower premiums. For more information about Medigap plans, see our MMW resources on Medigap insurance.

Medicare Advantage plans are another coverage option to help limit and better manage out-of-pocket costs when seeking health care outside of the VA. It is important that Medicare eligible veterans understand how these type of plans work prior to enrolling in a MA plan. MA plans usually require their members to use a network of providers to see the best costs savings and some types of MA plans, like HMOs, pay nothing if a member visits a provider that is not part of the network (except in cases of an emergency). It also important to be aware of how much services with a MA plan cost because the costs can vary from what beneficiaries pay under original Medicare.
Keeping this in mind, if a veteran is content with using the MA plan’s list of providers and is familiar with the costs, an MA plan may be worth considering. MA plans may be a good way of providing a veteran with “backup” coverage to access to providers outside of the VA if needed. MA plans usually offer set co-pay or co-insurance amounts for using services (e.g., $10 for a primary care visit or $45 for a specialist visit) so it allows members to gauge what it would cost if they see a non-VA provider. In addition, MA plans are required by CMS to have an annual maximum out-of-pocket limit for Part A and Part B services, which means that once the member pays the limit out of his or her own pocket, the MA plan covers the costs of Part A and Part B services for the remainder of the calendar year and the member pays nothing. Many MA plans offer a $0 monthly premium, meaning there is no additional premium (beyond the Part B premium) to enrolling in that plan. (Note that regardless of how a veteran with Medicare decides to supplement his Medicare coverage, s/he will still have to pay the monthly Part B premium unless s/he qualifies for a Medicare Savings Program.)

Many MA plans include Part D drug coverage, as well, which allows veterans who choose an MA plan to have the option of using the MA plan or VA coverage to fill their drugs. (Whether to use Part D or VA coverage will be covered in the next sections of this brief.) Click here to learn more about MA plans.

**Medicare Part D and VA prescription drug coverage**

Like Medicare Parts A and B, Part D plans cannot be used at the VA. The VA offers its own drug coverage as part of a veteran’s medical benefit package. However, unlike Part B, veterans can delay enrolling into a Part D plan without penalty if they decide to purchase a plan at a later time. This is because VA coverage is seen as “creditable” coverage for Medicare Part D. Many veterans do not see the need to enroll in a Part D plan if their prescriptions are covered by the VA. Using VA coverage only (and foregoing Part D coverage) saves veterans from paying monthly Part D premiums, deductibles and co-pays., Veterans who do enroll in Part D plans can have a bit more flexibility in accessing their drugs and reassurance that Medicare Part D can be an alternate option to rely on if the VA formulary does not meet their drug needs in the future.

**VA Drug Coverage: How it Works**

VA health benefits include prescription drug coverage. Medications must be prescribed by a VA doctor, on the VA National Formulary and filled at a VA pharmacy or through the VA’s mail order program in order to be covered. Veterans who are prescribed a medication by a non-VA doctor should talk to their VA physician about whether the VA will cover that drug. The VA uses its own mail order program, the Consolidated Mail Outpatient Pharmacy (CMOP), for most routine refills to reduce waiting times at pick-up windows at local VA medical facilities. Newly prescribed or special prescriptions can be filled and picked up at a local VA pharmacy where a pharmacist can review the safety precautions of taking a new drug with the veteran.

The VA usually prescribes generic equivalent medications when they are available. Brand name drugs are prescribed when there is no generic alternative available or the available generics do not work as well as the brand name does. The VA drug benefit also includes coverage for over-the-counter (OTC) medications if they are listed on the VA formulary (Note: depending on the OTC medication, it may less expensive to purchase it out-of-pocket).
Outpatient medications prescribed for a service connected disability do not have a co-pay regardless of the veteran’s Priority Group. Drug co-pays for all other non-connected disabilities depend on the veteran’s Priority Group and are listed below for 2015:

- Veterans in Priority group 1 do not pay a copay for prescribed medications
- Veterans in Priority groups 2-6 have a co-pay amount of $8 for each 30-day supply and are limited to a $960 annual cap in co-pay charges they pay for medications each year.
- Veterans in Priority groups 7-8 have a $9 co-pay for each 30-day supply. There is no annual drug cap for these groups.

Note that certain veterans are exempt from paying co-pays. Click here to view the 2015 VA formulary. Click here to view a fact sheet that lists the 2015 VA co-pay amounts by Priority group for prescription drugs.

**Medicare Part D: How it Works**

Medicare Part D is prescription drug coverage that is offered by private insurance companies that contract with Medicare. Individuals who are enrolled in Medicare Part A and/or Part B are eligible to enroll in a Part D plan. Each plan offers a list of covered drugs (called a formulary) and a network of pharmacies that members may use. All Part D plans are required to include at least two drugs from each drug category, as well as nearly all drugs from six protected categories that include HIV/AIDS drugs, antidepressants, antipsychotics, anticonvulsives, immunosuppressants, and anticancer drugs. Costs of a Part D plan include a monthly premium, annual deductible (some plans do not have one), and co-payment or co-insurance amounts for drugs. All Part D plans organize their formularies into tiers; co-payment or co-insurance amounts for specific drugs vary based on the tier the plan places that specific drug in.

Individuals can receive Part D in one of two ways: a stand-alone Part D plan that provides only coverage for prescription drugs or a Medicare Advantage plan that includes hospital, medical and prescription drug coverage through one plan. All Part D plans follow a benefit structure that is based on how much the plan and individual spend on drugs annually. Once the individual and plan spend a certain amount in prescriptions each year, the beneficiary enters the “donut hole” (also referred to as the coverage gap). Medications filled with a plan during the donut hole may cost the individual more because beneficiaries pay a portion of the full cost of the drug during the donut hole instead of the co-pay amount they had been paying prior to entering the donut hole. The Affordable Care Act changed how the donut hole works and provides individuals with discounts that gradually increase through 2020. At that time, the donut hole will be eliminated. Beginning in 2020, beneficiaries will pay the standard cost sharing set by the plan (set co-pay or co-insurance amount) throughout the entire year. (It is important to note that not all individuals with a Part D plan will enter the donut hole and depends on the medications they fill and how much those drugs cost with the plan. To view their specific Part D plan options and cost sharing for specific drugs, Medicare beneficiaries and benefits counselors can use the Medicare Part D Plan Finder tool here. For information on conducting plan searches using the Medicare Part D Plan Finder, please visit our MMW webpage.
Do Veterans Need Medicare Part D and VA Drug Coverage?
VA drug coverage is considered creditable coverage for Medicare Part D. This means that a veteran may delay enrolling in a Part D plan if they choose and will not have a late enrollment penalty if they decide to enroll in Part D plan at a later time. However, veterans who wish to enroll in a Part D after their initial Medicare eligibility may only do so during the fall Medicare open enrollment period, which runs from October 15 - December 7 of each year (with coverage becoming effective January 1st of the new calendar year).

Whether an individual needs to enroll in Part D depends on their prescription drug needs and whether their needs are being met by VA drug coverage. Veterans may choose to rely strictly on the VA to obtain their medications if they choose. In many instances, this may be the most affordable and best option if the individual’s drug needs are being met and since enrolling in a Part D plan incurs additional costs. Some questions to consider include:

- Are all your prescription drug needs being met at the VA? Are they affordable?
- Do you take prescriptions that you cannot obtain through the VA National Formulary or have prescriptions from a non-VA doctor that the VA won’t cover?
- Is there a VA facility close to you for when you need to pick up your prescriptions that are newly prescribed or prescribed for short term use?
- Do you live in a long-term care facility or other institution that does not allow you to access a VA pharmacy?
- Can you afford the costs associated with enrolling in a Medicare Part D plan, such as the monthly premium, any deductible and co-pay amounts?
- Are you using multiple generic medications that costs $8-$9 each for a one-month supply at the VA but may have a less expensive co-pay if you use a Part D plan?
- Are you eligible for Medicare’s Extra Help program? (If so, a veteran may want to think about enrolling in a Part D plan and review his costs with that Part D plan. Many veterans who qualify for Extra Help pay less than the $8 or $9 VA co-pay for a one-month supply of drugs.)

If a veteran decides to enroll in Medicare Part D and has VA coverage, they cannot use both benefits to cover the same prescription. Medications filled at a VA pharmacy do not count toward a Part D plan’s benefit and vice versa. Each benefit is kept separate and individuals will need to decide which benefit to use each time they fill a drug. Note that the VA does not usually fill medications that are prescribed by a non-VA provider but can take a civilian provider’s recommendation for a medication and write a prescription to fill at the VA if they agree that the medication is needed.

Veterans who decide to use the VA and Part D plan should review their medications and decide which benefit to use for each drug. Typically, the VA is more affordable for costlier medications, as the co-pays generally range from $8-$9 for a 30-day supply. Unlike the Part D donut hole, the VA
does not have a set spending limit in which a veteran’s costs increase when they reach a certain dollar amount.

However, veterans who take a number of less expensive generics may want to review their monthly drug costs with each benefit to find out if there are cost savings to enrolling in Medicare Part D. (Prescriptions at the VA have a co-pay of $8 - $9 regardless of the drug or price.) Many Part D companies now offer plans with affordable monthly premiums in which commonly preferred generic drugs are placed on low cost tiers. For example, many Part D plans offer preferred generic drugs at $0 for a one-month supply if the member uses retail pharmacies that are part of the plan’s preferred network. For a veteran taking multiple generics not related to his or her service condition, it may be less expensive to use a Part D plan, depending on the drugs s/he is taking and the plan s/he chooses. Senior Health Insurance Program (SHIP) counselors or 1-800-MEDICARE can assist individuals to compare Part D plans and find out how much drug costs with a Part D plan.

**Veterans who are eligible for Medicare Part D’s Extra Help Program**

Extra Help only works with a Medicare Part D plan; it does not work with VA prescription coverage. Individuals in Extra Help receive a subsidy to help pay for Part D plan costs, including the monthly premium, any annual deductible, and drug co-payment amounts. Individuals eligible for Extra Help pay reduced co-pays for their prescriptions if they use a Part D plan to fill their drugs, which may be less than VA co-pay amounts (currently $8 - $9 for each 30-day supply). Veterans who are eligible for Extra Help should consider enrolling in a Part D plan. With Extra Help, a Part D will most likely not cost the veteran very much, and they will have the choice of using either Part D or VA drug coverage for each drug they take, choosing the option that offers the less expensive co-pay or easier access.

**VA and Medicare Resources**

- **VA and Other Health Benefits**, U.S. Department of Veterans Affairs
- **Who Is a “Veteran”?—Basic Eligibility for Veterans’ Benefits**, Congressional Research Service Report
- **Medicare and VA Health Benefits**, Medicare Rights Center
- **Basics Eligibility for VA Health Benefits**, U.S. Department of Veterans Affairs
- **Medicare and Other Health Benefits: Your Guide to Who Pays First**, Medicare
- **2013 Survey of Veteran Enrollees’ Health and Reliance Upon VA**, VA Office of the ADUSH for Policy and Planning website
- **Veteran Q&A**, Inquiry Routing & Information System (IRIS) on VA website
- **Healthcare Options for Veterans**, Virginia Commonwealth University

**TRICARE and Medicare**

**What is TRICARE? An Overview**
TRICARE is health insurance from the U.S. military that provides health benefits to active and retired military members (including National Guard and Reserve members), their spouses and dependents. The program is operated by the Department of Defense and provides coverage for 9.5 million individuals. TRICARE, formerly known as CHAMPUS or the Civilian Health and Medical Program of the Uniformed Services, offers health services to military members and their families that are provided by military facilities and civilian physicians and providers.

TRICARE benefits are available to members of the military who are on active duty or retire with at least 20 years of service. Individuals can also qualify if they are “medically retired,” meaning they are temporarily or permanently disabled. Eligibility for TRICARE benefits is maintained by information reported to the Defense Enrollment Eligibility Reporting System (DEERS). Once military members become eligible for Medicare they should contact DEERS to report it. Other information that should be reported to DEERS includes changes related to the status of the service member’s military career and family or contact and address information.

There are different types of TRICARE programs available depending on the member’s eligibility category (on active duty, retired, eligible for Medicare, survivor, etc.) and each works in a different way. This Brief only contains information about how TRICARE health benefits works for military members who become eligible for Medicare. Information about TRICARE benefits for all other eligible categories can be found at [http://www.TRICARE.mil/](http://www.TRICARE.mil/). It is also important to note that TRICARE benefits may not be permanent and a service member may lose benefits if they:

- Separate from active duty (leaves the military before retiring)
- Become eligible for Medicare and do not enroll in Part B (if required)
- Do not keep DEERS information up-to-date

Family members may lose TRICARE benefits if:

- A widow, former spouse or surviving spouse remarries
- A dependent child “ages out”

**Medicare and TRICARE: Who Needs to Enroll in Medicare**

Once an individual becomes eligible for Medicare, the type of TRICARE program they are eligible for may change depending on whether they are on active duty, retired or enrolled in one of three specific TRICARE health programs (TRICARE Reserve Select, TRICARE Retired Reserve, or the US Family Health plan). Their eligibility status will play an important part in whether they need to enroll in Medicare Part B or not. Note that service members who are age 65 or older and who are not eligible for Medicare and would otherwise need to “buy” Part A, may qualify for benefits under one for the other TRICARE programs depending on their circumstances.

Retired military members who become eligible for premium free Part A must enroll in Part B during their Medicare initial enrollment period (IEP) to remain eligible for TRICARE. Failure to enroll in Part B may not only result in a lapse in TRICARE coverage, but an individual will also incur Medicare Part B late enrollment penalties if s/he does not sign up during their initial enrollment period when they are first eligible. In addition, members who miss their IEP will only be able to enroll in Medicare using the General Enrollment Period (January 1 – March 31 of each year) with Medicare coverage going into effect July 1st of the same year. TRICARE does not pay the monthly Medicare Part B premium for members or any late enrollment penalties.
Once retired military members are enrolled in Parts A and B, they are eligible to receive TRICARE benefits under TRICARE for Life (TFL). TFL begins the same day Part B becomes effective.

Which Medicare eligible TRICARE members can delay enrolling in Part B?
Some members who become eligible for Medicare may be able to delay enrolling in Part B and continue their eligibility for benefits through one of the other TRICARE programs. Groups who are allowed to delay Part B enrollment and exceptions to delaying enrollment into Part B are listed below.

Active duty service members or their family members who become eligible for Medicare can enroll in premium free Medicare Part A but delay enrolling in Medicare Part B if they choose. Members who delay enrolling in Medicare Part B can use one of TRICARE’s other health programs until they retire (TRICARE Prime, Extra or Standard), depending on the member’s circumstances.

Once the member’s active duty status ends (s/he becomes a military retiree), the member or family member will need to enroll in Part B to maintain eligibility for TRICARE. Members who transition from active duty to retiree status receive a special enrollment period (SEP) to enroll in Part B without a late enrollment penalty. This SEP can be used by the member or family member at any time during the member’s active duty and up to eight months after the member’s active duty comes to an end. However, it is recommended that the individual enroll in Part B before the sponsor’s active duty ends to ensure there is not a break in coverage. (Note that TRICARE does not pay the monthly Part B premium and it is the member’s responsibility to pay the premium once s/he enrolls.)

Active duty members who have Medicare because of End-Stage Renal Disease are an exception - they should enroll in Part B when they first become eligible since these individuals do not receive an eight month SEP to pick up Part B when they retire.

Other exceptions include members who are enrolled in a US Family Health Plan, TRICARE Reserve Select or TRICARE Retired Reserve. Although TRICARE does not require members in these plans to enroll in Part B to maintain TRICARE eligibility, TRICARE recommends they do so because Medicare does not provide a SEP for these individuals to enroll into Part B at a later time. Individuals in these plans who choose to enroll in Part B after they first become eligible will have to use the Part B General Enrollment Period and may have to pay a late enrollment penalty.

Retired service members who have a private group health plan through current employment may be able to delay enrolling in Medicare Part B without paying a penalty if the employer plan will be the primary payer. Who is primary can be determined by calling the employer plan’s benefit administrator. It is important to note that even if the member is able to delay enrolling in Part B without Medicare penalties, TRICARE does not become a secondary payer to the employer plan unless the member is enrolled in Part A and Part B and as a result becomes eligible for TFL. Therefore, members with employer plans that are primary must decide whether they want to rely exclusively on their employer plan for health coverage or enroll in Medicare Part B, become eligible for TFL, and use TFL as secondary coverage.

Members with employer plans who decide to enroll in Part A and Part B and use TFL as secondary coverage will need to have their doctor submit claims to TRICARE (or submit the claims themselves) since TFL is always the last payer.

Members who use only their employer plan and delay enrolling in Part B will receive an eight month SEP to enroll in Part B without penalty once the member stops working or coverage ends, whichever
happens first. Once they are enrolled in Part A and Part B, they become eligible for TFL. Members should remember to enroll before their employer plan ends to avoid a lapse in coverage.

**TRICARE for Life - TRICARE coverage for military retirees with Medicare**

TRICARE for Life (TFL) is TRICARE’s health coverage for TRICARE beneficiaries who have Medicare Part A and Part B. Retired service members who qualify for TRICARE do not need to enroll in TFL - they are automatically covered once they enroll in Medicare Part A and Part B. However, these members should report their Medicare effective date to DEERS to make certain it is on file.

TFL works like a “wrap around” program with Medicare - it reduces the retired service member’s out-of-pocket costs by covering the full Medicare deductible and co-insurance/co-payment amounts for services that are covered both by Medicare and TRICARE. Essentially, TFL acts very similar to a Medicare Supplement policy, where Medicare is primary and TFL pays secondary. TFL never is the primary payer for Medicare covered services unless the TFL retiree lives overseas where Medicare is not available.

**Where can TFL members receive care?**

Members can receive care at “civilian” medical providers (non-military providers) and pay very little or nothing if the provider accepts Medicare. TFL will also pay the extra 15% non-participating charge if a member chooses to see a Medicare provider that does not accept Medicare assignment. TFL members only need to show their Medicare card when visiting civilian providers. Once Medicare makes a payment on the claim, it is then forwarded to TRICARE for any remaining payment.

TFL members who see a provider who opts-out of Medicare will be responsible for paying a portion of the service. In these instances, the member’s cost sharing will be more (usually 20% of the allowable TRICARE rate) because Medicare will not make any payment and TFL will only pay as a secondary payer.

TFL members can also receive prioritized care at no cost at military facilities if space is available. In addition, the TRICARE Plus program is another option TFL members can use if available at their local military facility. TRICARE Plus is a health care program that provides primary care at certain military medical facilities. Availability of the program varies by military hospital or clinic and enrollment is required. If eligible, TFL members pay nothing for primary care received through TRICARE Plus. In addition, TRICARE Plus will only pay for care received at the facility the member is enrolled at and cannot be transferred to pay for care at other military facilities or civilian providers. TRICARE Plus does not offer specialty care; therefore, it is recommended that it be used alongside TFL coverage to complement care. Medicare does not pay for care received at a military facility or through the TRICARE Plus program even if the member is enrolled in TFL.

**TFL and Medicare: Covered Services**

Retired service members do not have to pay a monthly premium for TFL. For most services, TFL wraps around Medicare and both work together to pay nearly all of the costs for military retirees and eligible family members if the service is covered by both programs. Like Medicare, TFL provides coverage for inpatient outpatient care, specialty care, emergency care, preventive and mental health services, and medical equipment. For a more comprehensive list of TRICARE covered and excluded services click here.

There may be instances when a particular service is covered by either TFL or Medicare alone. For services that are covered by TFL but not Medicare, retired service members will be responsible for

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some cost sharing because TFL is the primary and only payer (unless the member has other insurance). When TFL is the only payer, the member pays the applicable TFL deductibles and co-pays. In addition, TFL may also become the primary payer for services that have been exhausted under Medicare such as skilled nursing facility or inpatient hospital days.

Although many health services are covered for members by Medicare and TFL, there may be some services that are covered by Medicare but not TFL. For such services, Medicare is the primary payer and the member is responsible for any Medicare cost sharing. TFL does not pay anything.

**TFL and VA health benefits**
Veterans who are eligible for TFL and VA health benefits should be aware that using the VA to receive care for non-service connected conditions may be costly for them. TFL members have Medicare and TRICARE work together to pay for their care. Because the VA cannot bill Medicare, TRICARE is the only payer in these instances and only pays up to 20% of the TRICARE allowable amount even if the VA provider used is in the TRICARE network. To pay the least out-of-pocket, veterans who are eligible for both TFL and VA should use the VA for service connected conditions and providers who accept Medicare for non-service connected conditions. TRICARE recommends “contacting Wisconsin Physicians Service (WPS), which administers the TFL benefit, to confirm coverage details and to determine what will be covered by TRICARE.”

**TFL Drug Coverage and Medicare Part D**
TFL members can delay enrolling in a Part D plan and use TFL drug coverage if they choose because TFL coverage is considered creditable coverage for Medicare Part D. Because there is no monthly premium for using TFL coverage, many TFL members delay enrolling in a Part D plan to avoid extra costs and because TFL coverage is as usually as good as Part D.

TFL members who lose TRICARE eligibility will have 63 days from the date their coverage ends to enroll in a Part D plan without penalty. TFL members who would like to enroll in a Part D plan while they are still eligible for TFL can do so during the Medicare annual enrollment period (October 15 – December 7 of each year) without paying a late enrollment penalty.

TFL drug coverage consists of a formulary that is separated into three tiers: generic drugs, brand names drugs and non-formulary drugs. Co-pays range from $0 - $20 for formulary drugs that are filled using TFL’s home delivery mail program or a network pharmacy. Network pharmacies include civilian pharmacies in the community, including many of the retail pharmacies. Drug co-pays for non-formulary drugs or for using an out-of-network pharmacy usually cost more. TFL has a formulary search tool members can use to find out if a drug is on the formulary, if it has restrictions, how much is costs and whether a generic equivalent is available.

TFL members who use select maintenance medications are required to use the TRICARE’s Pharmacy Home Delivery or a military pharmacy to fill those medications as part of the TFL Pharmacy Pilot program. For more information about the program and a list of included maintenance medications visit the TFL website and watch a YouTube video created by TRICARE.

TFL members who decide to enroll in a Part D plan will be responsible for paying the Part D plan’s monthly premium. For these members, the Medicare Part D plan becomes the primary payer and TFL pays for drug costs as a secondary payer, meaning the member will pays very little in drug co-pays until drug costs reach the donut hole limit (also referred to as the Part D coverage gap). Once drug costs reach the donut hole, the member is responsible for paying the standard TFL drug co-pays.
In many cases and unless the member is eligible for Extra Help, there may be more cost savings to using TFL drug coverage exclusively. TFL members who may benefit from enrolling in a Part D plan are members with limited incomes who would qualify for Medicare’s Extra Help program and as a result receive assistance paying for their Part D plan premium and drug co-pays. In these cases, it may be less expensive for TFL members to use a Part D plan to obtain medications that may cost more under the TFL pharmacy benefit.

**TFL and Medicare Resources**

TRICARE website: [http://www.TRICARE.mil/](http://www.TRICARE.mil/)

TRICARE and Medicare: [http://www.TRICARE.mil/medicare](http://www.TRICARE.mil/medicare)

TRICARE and Medicare Part D: [http://www.TRICARE.mil/medicarepartd](http://www.TRICARE.mil/medicarepartd)

TRICARE Pharmacy costs: [http://TRICARE.mil/pharmacycosts](http://TRICARE.mil/pharmacycosts)

Wisconsin Physician Services (TFL customer service and processes TFL claims): [www.TRICARE4u.com](http://www.TRICARE4u.com)

TRICARE PowerPoint: [Medicare and TRICARE](http://www.TRICARE.mil/)

TRICARE for Life Handbook

TFL and Medicare fact sheet

**TRICARE and Medicare -- Turning 65**

Transitioning from Active Duty to Retirement: Health Care Options

**TRICARE and Medicare: Under Age 65**

TFL and VA benefits

**CHAMPVA**

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a medical program for the spouses, survivors and children of certain veterans. The program is administered by the Department of Veterans Affairs (VA) Chief Business Office and helps to cover some of members’ health expenses by reimbursing non-VA providers for providing medical care.

To qualify for CHAMPVA, the individual must be a spouse, widow(er), or child of a veteran who:

- is rated permanently and totally disabled due to a service connected disability, or
- was rated permanently and totally disabled due to a service connected condition at the time of death, or
- died of a service connected disability, or...
• died on active duty and the dependents are not otherwise eligible for Department of Defense TRICARE benefits

CHAMPVA requires members who turned age 65 after 2001 and are eligible for premium free Medicare Part A to enroll in Medicare Part B in order to maintain their CHAMPVA eligibility. CHAMPVA does not pay the monthly Medicare Part B premium for members.

If a CHAMPVA member is not eligible for premium free Part A, they are not required to enroll in Part B to maintain CHAMPVA benefits.

Individuals who qualify for Medicare and CHAMPVA usually have very low out-of-pocket costs because Medicare is always the first payer and CHAMPVA “wraps around” and pays the Medicare out-of-pocket costs (deductibles, copays).

Services covered by CHAMPVA and Medicare usually cost little or nothing for members who visit providers that accept Medicare assignment. For services that are covered only by Medicare and not CHAMPVA, the beneficiary will be responsible for the Medicare co-insurance/co-pay or any unmet Medicare deductible. Services that are only covered by CHAMPVA will be subject to the applicable CHAMPVA cost sharing, which is usually 25%. CHAMPVA also has an annual out-of-pocket limit of $3,000, which means a beneficiary’s out-of-pocket costs will never exceed this amount for covered services in a calendar year.

CHAMPVA provides creditable prescription drug coverage, so CHAMPVA members may delay enrolling in Part D if they choose. They will not pay a late enrollment penalty if they decide to enroll in a Part D plan after their Medicare initial enrollment period. CHAMPVA members who enroll in Part D are responsible for paying any Part D premiums. The Part D plan is then the primary payer for prescriptions, with CHAMPVA reimbursing the member’s out-of-pocket costs (co-pays) up to the approved amounts. For additional details about CHAMPVA and information on how to apply visit the VA’s Chief Business Office website or call 1--800-733-8387.

CHAMPVA Resources

CHAMPVA website

CHAMPVA Policy Manual, CHAMPVA website

FAQs about CHAMPVA, VA website

Medicare and CHAMPVA fact sheet