

WHO PAYS FIRST? MEDICARE OR YOUR EMPLOYER'S INSURANCE?

Medicare pays first for your health care bills, before the IHS. However, if you have a group health plan through an **employer**, and the **employer** has 20 or more employees, then generally the plan **pays first**, and **Medicare pays** second. If your **employer** has fewer than 20 employees, **Medicare** generally **pays first**.

How Medicare works with other insurance

If you have Medicare and other health insurance or coverage, each type of coverage is called a "payer." When there's more than one payer, "coordination of benefits" rules decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. In some cases, there may also be a third payer.

What it means to pay primary/secondary

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The one that pays second (secondary payer) only pays if there are costs the primary insurer didn't cover.
- The secondary payer (which may be Medicare) may not pay all the uncovered costs.
- If your employer insurance is the secondary payer, you may need to enroll in Medicare [Part B](#) before your insurance will pay.

If the insurance company doesn't pay the claim promptly (usually within 120 days), your doctor or other provider may bill Medicare. Medicare may make a conditional payment to pay the bill, and then later recover any payments the primary payer should've made.

How Medicare coordinates with other coverage

If your questions about who pays first, or if your coverage changes, call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627). Tell your doctor and other health care provider about any changes in your insurance or coverage when you get care.

I have Medicare and:

1. **I have Medicaid.** Medicaid never pays first for services covered by Medicare. It only pays after Medicare, employer group health plans, and/or Medicare Supplement (Medigap) Insurance have paid.
2. **I'm 65 or older and have group health plan coverage based on my current employment (or the current employment of a spouse of any age), and my employer has 20 or more employees.** If the employer has 20 or more employees, the group health plan generally pays first. If the group health plan didn't pay all of your bill, the doctor or health care provider should send the bill to Medicare for secondary payment. Medicare will pay based on what the group health plan paid, what the group health plan allowed, and what the doctor or health care provider charged on the claim. You'll have to pay any costs Medicare or the group health plan doesn't cover. Employers with 20 or more employees must offer current employees 65 and older the same health benefits, under the same conditions, that they offer employees under 65. If the employer offers coverage to spouses, they must offer the same coverage to spouses 65 and older that they offer to spouses under 65.
3. **I'm under 65, entitled to Medicare because I have a disability (other than ESRD), I'm covered by a large group health plan because I or a family member is still working.**

Generally, if your employer has fewer than 100 employees, Medicare pays first if you're under 65 or you have Medicare because of a disability (other than End-Stage Renal Disease).

Sometimes employers with fewer than 100 employees join with other employers to form a multi-employer plan or multiple employer plan. If at least one employer in the multi-employer plan or multiple employer plan has 20 employees or more, Medicare pays second.

If the employer has at least 100 employees, the health plan is called a large group health plan. If you're covered by a large group health plan because of your current employment or the current employment of a family member (like a spouse, domestic partner, parent, son, daughter, or grandchild), Medicare pays second. If you go outside your employer plan's network, it's possible that neither the plan nor Medicare will pay. Call your employer plan before you go outside the network to find out if the service will be covered.

4. **I work for a small company that has a group health plan.**

If your employer has fewer than 20 employees, Medicare generally pays first.

But, Medicare would generally pay second if both of these apply:

- Your employer joins with other employers or employee organizations (like unions) to sponsor a group health plan (called a multi-employer plan)
- Any of the other employers have 20 or more employees

Your plan might also ask for an exception. So, even if your employer has fewer than 20 employees, you'll need to find out from your employer whether Medicare pays first or second.

Generally, if your employer has fewer than 100 employees, Medicare pays first if you're under 65 or you have Medicare because of a disability (other than End-Stage Renal Disease).

Sometimes employers with fewer than 100 employees join with other employers to form a multi-employer plan or multiple employer plan. If at least one employer in the multi-employer plan or multiple employer plan has 20 employees or more, Medicare pays second.

If the employer has at least 100 employees, the health plan is called a large group health plan. If you're covered by a large group health plan because of your current employment or the current employment of a family member (like a spouse, domestic partner, parent, son, daughter, or grandchild), Medicare pays second.

If you go outside your employer plan's network, it's possible that neither the plan nor Medicare will pay. Call your employer plan before you go outside the network to find out if the service will be covered.

5. I have a domestic partner with group health insurance coverage.

Medicare pays first if both of these apply:

- A domestic partner is entitled to Medicare on the basis of age
- A domestic partner has group health plan coverage based on the current employment status of his/her partner.

Medicare generally pays second:

- When the domestic partner is entitled to Medicare on the basis of disability and is covered by a large group health plan on the basis of his/her own current employment status or the status of a family member (a domestic partner is considered a family member).
- For the 30-month coordination period when the domestic partner is eligible for Medicare on the basis of End-Stage Renal Disease (ESRD) and is covered by a group health plan on any basis.
- When the domestic partner is entitled to Medicare on the basis of age and has group health plan coverage on the basis of his/her own current employment status.

6. **I have declined or dropped employer-offered coverage.**

Medicare pays first for any Medicare-covered health care service you get if you don't take group health plan coverage from your employer, unless these apply:

- You have coverage through an employed spouse.
- Your spouse's employer has at least 20 employees.

If you don't take employer coverage when it's first offered to you, you might not get another chance to sign up. If you take the coverage but drop it later, you may not be able to get it back. Also, you might be denied coverage if both of these apply:

- Your employer or your spouse's employer generally offers [retiree coverage](#).
- You weren't enrolled in the plan while you or your spouse was still working.

Call your employer's benefits administrator for more information.

7. **I'm retired, 65 or older and have group health plan coverage from my former employer.**

Generally, if you get your group health plan coverage through your own former employer:

- Medicare pays first for your health care bills.
- Your [group health plan \(retiree\) coverage](#) pays second.

Your spouse's plan pays first and Medicare pays second if both of these apply:

- You retire but your spouse is still working.
- You're covered by your spouse's group health plan coverage. Your spouse's employer must have 20 or more employees, or the employer must be part of a multi-employer plan or multiple employer plan.

[If the employer has 20 or more employees, the group health plan generally pays first.](#)

If the group health plan didn't pay all of your bill, the doctor or health care provider should send the bill to Medicare for secondary payment. Medicare will pay based on what the group health plan paid, what the group health plan allowed, and what the doctor or health care provider charged on the claim. You'll have to pay any costs Medicare or the group health plan doesn't cover.

Employers with 20 or more employees must offer current employees 65 and older the same health benefits, under the same conditions, that they offer employees under 65. If the employer offers coverage to spouses, they must offer the same coverage to spouses 65 and older that they offer to spouses under 65.

8. [I'm retired, under 65 and disabled \(other than by ESRD\), and have group health plan coverage from my former employer.](#)

Generally, if you get your group health plan coverage through your own former employer:

- Medicare pays first for your health care bills.
- Your [group health plan \(retiree\) coverage](#) pays second.

Your spouse's plan pays first and Medicare pays second if both of these apply:

- You retire but your spouse is still working.
- You're covered by your spouse's group health plan coverage. Your spouse's employer must have 20 or more employees, or the employer must be part of a multi-employer plan or multiple employer plan.

If the employer has 20 or more employees, the group health plan generally pays first.

If the group health plan didn't pay all of your bill, the doctor or health care provider should send the bill to Medicare for secondary payment. Medicare will pay based on what the group health plan paid, what the group health plan allowed, and what the doctor or health care provider charged on the claim. You'll have to pay any costs Medicare or the group health plan doesn't cover.

Employers with 20 or more employees must offer current employees 65 and older the same health benefits, under the same conditions, that they offer employees under 65. If the employer offers coverage to spouses, they must offer the same coverage to spouses 65 and older that they offer to spouses under 65.

9. [I have COBRA continuation coverage.](#)

If you have Medicare because you're 65 or over or because you're under 65 and have a disability other than End-Stage Renal Disease (ESRD), Medicare pays first.

If you have Medicare based on ESRD, COBRA continuation coverage pays first. Medicare pays second to the extent COBRA coverage overlaps the first 30 months of Medicare eligibility or entitlement based on ESRD.

Find out more in [7 facts about COBRA.](#)

1. COBRA is a federal law that may let you keep your employer [group health plan](#) coverage for a limited time after your employment ends or you lose coverage as a dependent of the covered employee.

This is called "continuation coverage."

2. In general, COBRA only applies to employers with 20 or more employees. However, some states require insurers covering employers with fewer than 20 employees to let you keep your coverage for a limited time.
3. In most situations that give you COBRA rights (other than a divorce), you should get a notice from your employer's benefits administrator or the group health plan. The notice will tell you your coverage is ending and offer you the right to elect COBRA continuation coverage.
4. COBRA coverage generally is offered for 18 months (36 months in some cases). Ask the employer's benefits administrator or group health plan about your COBRA rights if you find out your coverage has ended and you don't get a notice, or if you get divorced.
5. The employer must tell the plan administrator if you qualify for COBRA because the covered employee died, lost their job, or became entitled to Medicare. Once the plan administrator is notified, the plan must let you know you have the right to choose COBRA coverage.
6. You or the covered employee needs to tell the plan administrator if you qualify for COBRA because you got divorced or legally separated (court-issued separation decree) from the covered employee, or you were a dependent child or dependent adult child who's no longer a dependent.

You'll need to tell the plan administrator about your change in situation within 60 days of the change.

7. Before you elect COBRA, talk with your [State Health Insurance Assistance Program \(SHIP\)](#) about [Part B](#) and [Medigap](#).

Get answers to COBRA questions

Call your employer's benefits administrator for questions about your specific COBRA options.

- If you have questions about Medicare and COBRA, call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627).
- If your group health plan coverage was from a private employer (not a government employer), contact the [Department of Labor](#).
- If your group health plan coverage was from a state or local government employer, call the Centers for Medicare & Medicaid Services (CMS) at 1-877-267-2323 extension 61565.
- If your coverage was with the federal government, visit the [Office of Personnel Management](#).

10. I'm in a Health Maintenance Organization (HMO) Plan or an employer Preferred Provider Organization (PPO) Plan that pays first. Who pays first if I go outside the employer plan's network?

If you go outside your employer plan's network, it's possible that neither the plan nor Medicare will pay. Call your employer plan before you go outside the network to find out if the service will be covered.

11. I get health care services from the Indian Health Service.

Medicare pays first for your health care bills, before the IHS. However, if you have a group health plan through an employer, and the employer has 20 or more employees, then generally the plan pays first and Medicare pays second. If your employer has fewer than 20 employees, Medicare generally pays first.

12. I have more than one other type of insurance or coverage.

If you have Medicare and more than one other type of insurance, check your policy or coverage. It may include the rules about who pays first. You can also call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627).

13. I have TRICARE.

For active-duty military enrolled in Medicare, TRICARE pays for Medicare-covered services or items. Also, TRICARE will pay the Medicare deductible and coinsurance amounts and for any service not covered by Medicare that TRICARE covers. You pay the costs of services Medicare or TRICARE doesn't cover. For inactive-duty military, Medicare pays first for Medicare-covered services.

If you get services from a military hospital or any other federal health care provider, TRICARE will pay the bills. Medicare usually doesn't pay for services you get from a federal health care provider or other federal agency. Get more information on [TRICARE](#).

14. I have Veterans' benefits

If you have or can get both Medicare and Veterans' benefits, you can get treatment under either program.

When you get health care, you must choose which benefits to use each time you see a doctor or get health care. Medicare can't pay for the same service that was covered by Veterans' benefits, and your Veterans' benefits can't pay for the same service that was covered by Medicare.

NOTE: To get the [U.S. Department of Veterans Affairs \(VA\)](#) to pay for services, you must go to a VA facility or have the VA authorize services in a non-VA facility.

Medicare may pay for the Medicare-covered part of the services the VA doesn't pay for if both of these apply:

- The VA authorizes services in a non-VA hospital.
- The VA doesn't pay for all of the services you get during your hospital stay.

Medicare may also be able to pay all or part of your Copayment if you're billed for VA-authorized care by a doctor or hospital who isn't part of the VA

15. I have ESRD and group health plan coverage.

If you're eligible for Medicare only because of permanent kidney failure, your coverage usually can't start until the fourth month of dialysis. This means your employer or union group health plan will be the only payer for the first 3 months of dialysis (unless you have other insurance).

Once you become eligible for Medicare because of permanent kidney failure (usually the fourth month of dialysis), there will still be a period of time called a "coordination period." During this time (30 months), your employer or union group health plan will continue to pay first on your health care bills, and Medicare will pay second. If you take a course in home-dialysis training or get a kidney transplant during the 3-month waiting period, the 30-month coordination period will start sooner.

The union group health plan pays first during this "coordination period" no matter how many employees work for your employer, or whether you or a family member are currently employed. At the end of the 30 months, Medicare pays first. This rule applies to most people with ESRD, whether you have your own union group health plan coverage, or you're covered as a family member.

16. I have coverage under the Federal Black Lung Program.

For all health care not related to black lung disease, Medicare pays first, and you should send your bills directly to Medicare.

The Federal Black Lung Program pays first for any health care for black lung disease covered under that program. Medicare won't pay for doctor or hospital services covered under the Federal Black Lung Program.

Your doctor or other health care provider should send all bills for the diagnosis or treatment of black lung disease to:

Federal Black Lung Program | PO Box 8302 | London, KY 40742-8302 | 1-800-638-7072

If the Federal Black Lung Program won't pay your bill, ask your doctor or other health care provider to send Medicare the bill. Ask them to include a copy of the letter from the Federal Black Lung Program that says why it won't pay your bill.

17. I have a claim for no-fault or liability insurance.

No-fault insurance or liability insurance pays first and Medicare pays second.

If the no-fault or liability insurance denies the medical bill or is found not liable for payment, Medicare pays the same as it would if it were the only payer. But, Medicare only pays for Medicare-covered services; you're responsible for your share of the bill—for example, coinsurance, a Copayment or a deductible—and for services Medicare doesn't cover.

If doctors or other providers are told you have a no-fault or liability insurance claim, they must try to get payments from the insurance company before billing Medicare. But, this may take a long time. If the insurance company doesn't pay the claim promptly (usually within 120 days), your doctor or other provider may bill Medicare. Medicare may make a conditional payment to pay the bill, and then later recover any payments the primary payer should have made.

If Medicare makes a conditional payment, and you get a settlement from an insurance company later, the conditional payment from your settlement needs to go to Medicare. You're responsible for making sure Medicare gets repaid for the conditional payment.

If you have an insurance claim for your medical expenses, you or your attorney should notify Medicare as soon as possible. If you have questions about a no-fault or liability insurance claim, call the insurance company.

If you file a no-fault insurance or liability insurance claim, you or your representative should call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627).

The BCRC will gather information about any conditional payments Medicare made related to your no-fault insurance or liability insurance claim. If you get a settlement, judgment, award or other payment, you or your representative should contact the BCRC. The BCRC will determine the final repayment amount (if any) on your recovery case and send you a letter asking for repayment.

18. [I filed a workers' compensation claim.](#)

If you have Medicare and get injured on the job, workers' compensation pays first on health care items or services you got because of your work-related illness or injury.

Find out more about [how settling your claim affects Medicare payments.](#)

Note

Tell your doctor and other health care providers if you have coverage in addition to Medicare. This will help them send your bills to the correct payer to avoid delays

What's a conditional payment?

A conditional payment is a payment Medicare makes for services another payer may be responsible for. Medicare makes this conditional payment so you won't have to use your own money to pay the bill. The payment is "conditional" because it must be repaid to Medicare if you get a settlement, judgment, award, or other payment later. You're responsible for making sure Medicare gets repaid from the settlement, judgment, award, or other payment.

How Medicare recovers conditional payments

If Medicare makes a conditional payment, and you or your lawyer haven't reported your settlement, judgment, award or other payment to Medicare, call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY: 1-855-797-2627).

The BCRC will gather information about any conditional payments Medicare made related to your settlement, judgment, award or other payment. If you get a payment, you or your lawyer should call the BCRC. The BCRC will calculate the repayment amount (if any) on your recovery case and send you a letter requesting repayment.