RESOURCES

THIRD PARTY RESOURCES

Description: Third party resources include health, hospital, assignable income protection, and/or accident insurance policies. Benefits under these policies partially or fully pay or reimburse the cost of medical care and services. Third party benefits are available through employers, unions, colleges, fraternal organizations, liability carriers, court actions, trust funds, private insurers, the federal and state government, etc.

Policy: Health, hospital, assignable income protection, and/or accident insurance benefits are applied to the fullest extent to insure that Medicaid is the payer of last resort.

The exceptions to this policy occur when individuals are covered by the Children with Physical Disabilities Program or the Crime Victims' Compensation Program. In cases where individuals are covered by either of the above programs, Medicaid becomes the payer of first resort after any other available third party resources have been applied.

With the exception of income protection policies, individuals with third party health insurance (TPHI) are not eligible for Family Health Plus.

References:

SSL Sect.	104(b) 366.2(f) and (g) 367. a
Dept. Reg.	360-3.2(a)-(**f**) 360-7.2 360-7.3 360-7.4 360-7.7
ADMs	**99 ADM-5** 94 ADM-14 89 ADM-23 87 ADM-40
INFs	88 INF-56
GIS	***01 MA/019***

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Interpretation:

Benefits which pay for the cost of medical care and/or services are used to pay for or reimburse the cost of all inpatient and outpatient medical care and services. Some plans pay for the complete cost of all care and services. However, most plans are limited in the amount of payment, length of care, and type of services. Some plans require the recipient to pay a deductible and/or **co-insurance**.

Generally, the owner of a policy pays any deductibles and/or **co-insurance** directly to the medical providers. If the owner of the policy is eligible for Medicaid, medical providers may only request Medicaid co-payments from the recipient. No other cash payment may be requested from the eligible Medicaid recipient. The insurance company pays the balance directly to the provider.

However, when an A/R has a "Wrap Around" policy, the insurance company pays the medical provider in full, then bills the policy owner for any deductibles and/or **co-insurance**. The deductibles and **co-insurance may be** billed directly to the policyholder via a retail installment credit agreement (credit card) or are deducted from the policy owner's wages.

WRAP AROUND POLICIES are treated like any other health insurance in determining eligibility.

The local district will determine if an arrangement can be made with the insurer to eliminate the need for the policy owner to pay the **co-insurances** and/or deductibles. If the **local district** cannot or does not make this arrangement, the local district reimburses the policy owner directly for any wage deductions or credit card bills incurred by the Medicaid recipient for medical care and services.

Health insurance may be available through an absent parent's employer, union, etc. Generally, a Medicaid household that includes a child with an absent parent is referred to the Child Support Enforcement Unit (IV-D) for pursuit of support. [89 ADM-23 explains the Third Party Resource Unit's (TPRU) responsibility to obtain third party health insurance for Medicaid A/Rs.] (See page 434 for IV-D requirements).

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Generally, insurance plans allow parents to cover students and disabled children, after they have reached adulthood. Adult disabled children are persons who become disabled prior to the age of 19. Disability is defined by Title II of the Social Security Act.

When an A/R owns an income protection policy, the **local district** determines if the policyholder **can** assign payment to a hospital or nursing home. The **local district** enters the appropriate codes into **eMedNY**, indicating that the A/R has an assignable income protection policy. If the A/R is admitted to a medical facility, the facility takes an assignment from the A/R. Payments from the income protection policy are made directly to the medical facility. The income is not available to the A/R. In the event that the income protection policy payments are greater than the A/R's bill, it is the responsibility of the facility to return the excess to the A/R. **If the income protection policy is not assignable, any income received by the recipient would be counted as income in the month received and a resource thereafter.**

MEDICARE is a federal health insurance program administered by the Social Security Administration. Medicare consists of two parts, A (hospital insurance) and B (outpatient care). Part A provides hospital insurance to the elderly (age 65 and over) who are eligible for Social Security or Railroad Retirement benefits and persons who have been in receipt of Social Security disability benefits for twenty-four consecutive months**, or suffers from chronic renal (kidney) disease or has Amyotrophic Lateral Sclerosis (ALS)**. Persons entitled to Part A are automatically enrolled in Part B, unless they decline coverage. In addition, all citizens and lawfully admitted aliens having resided in the U.S. for 5 years who are age 65 or older are eligible for Part B. A person age 65 or older is eligible for Part B, whether or not s/he is eligible for Social Security or Railroad Retirement benefits. Not all persons eligible for Part B are in receipt of Part B. Because there is a premium charge for Part B, individuals may decline Medicare Part B coverage. (See page 118 for information about the Medicare Savings Program.)

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TRICARE (formerly known as CHAMPUS) is the Department of Defense health care program for members of the uniformed services and their families and survivors, and retired members and their families. All active duty members in the Army, Navy, Air Force, Marines, Coast Guard, National Oceanic and Atmospheric Administration (NOAA) and Public Health Service (PHS), their family members and survivors, retirees and their family members who are under 65, Medicare eligible because of a disability, and enrolled in Medicare Part B are eligible to participate in TRICARE.
The TRICARE program offers the following three options:

- ***TRICARE Prime is the managed care option offered by the Department of Defense.***

- ***TRICARE Standard is a fee-for-service option that is the same as the former CHAMPUS benefit. The beneficiary is responsible for deductibles and co-payments.***

- ***TRICARE Extra is similar to TRICARE Standard but offers discounts to patients when they use TRICARE network providers. After paying the deductible, the beneficiary would pay a reduced co-payment.***

For additional information regarding TRICARE eligibility and benefits, refer to http://www.tricare.osd.mil/.

When injuries are the result of an accident, medical payments may be available from Workers' Compensation, auto, homeowners' liability insurance, or a civil court action.

When a court action is pending, Medicaid may be authorized, provided the A/R is otherwise eligible and a lien is placed against the court settlement. (See page 476.) When the action is settled, the A/R's financial eligibility is re-evaluated, considering any assets gained from the settlement.

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Individuals involved in an automobile accident in New York State are covered under the No-Fault Insurance Law. Benefits include all reasonable and necessary medical and rehabilitation expenses incurred as the result of an automobile accident. Benefits are also available to compensate the victim for non-medical losses resulting from the accident.

When No-Fault, Workers' Compensation, or a liability insurance company is responsible for medical expenses, no payment is made by Medicaid for treatment of the injuries or illness covered.

When No-Fault Insurance is available or potentially available, the **local district** considers the type of benefit payment. The **local district** determines if payments are specifically for incurred medical expenses or for a loss. Losses include loss of wages and services (such as the need to hire a baby-sitter, because the accident victim cannot care for his/her children). An injured A/R may also sue the person negligently causing the accident, when the medical expenses and other losses exceed No-Fault benefits.

When No-Fault payments are made to the A/R for other than medical care and service expenditures, the payments are considered a windfall (see page 263 for the treatment of windfalls depending on the category of the A/R).

An A/R may have more than one insurance plan or liability claim in existence at one time; for example, an automobile accident suffered while driving on the job. In this instance, the A/R may have hospitalization coverage through his/her employer, a Workers' Compensation claim and a liability claim against another motorist.

When to Verify: Third Party health insurance benefits are verified when:

The A/R indicates that s/he has health insurance coverage;

The A/R is employed;

The A/R is enrolled in college (health insurance is often a mandatory college fee);

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A member of the household, absent parent or absent spouse is a member of a union, fraternal organization, or armed forces;

The A/R indicates that s/he was involved in an accident;

The A/R indicates that s/he has a work related illness/disability;

The A/R is over age 65 or has been disabled for at least 24 months, suffers from chronic renal (kidney) disease, **has Amytrophic Lateral Sclerosis (ALS)** or is a disabled widow; or

The A/R is a disabled dependent widower between 50 and 65.

Verification/ Documentation: Sufficient to establish an audit trail.

Copies of both sides of benefit cards;

Name of insurance carrier, persons covered, dates of coverage, name of the policy holder, kinds of coverage, address to which claims are sent;

Employer or Union name and address; or

If an accident claim, name of the party who is liable for claim, copy of the police report, date of claim, names of attorneys, status of any tort action and a copy of lien.

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Disposition:

Third party benefits are fully used in order to reduce the amount of Medicaid paid. As a condition of eligibility an A/R assigns his/her third party benefits. In addition, s/he assigns the rights of any other applying household members for whom s/he has the legal right to make an assignment. The A/R automatically assigns these rights, when s/he signs the application.

The following three sections discuss additional eligibility requirements related to third party resources:

Good cause not to bill third party health insurance;

Assignment and subrogation;

Enrollment in employer group health insurance; and

New York State Partnership for Long Term Care.

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GOOD CAUSE NOT TO BILL THIRD PARTY HEALTH INSURANCE

Description: **Medicaid providers are instructed to bill any available health insurance prior to submitting a bill to the Medicaid program. However, in situations where the billing could jeopardize the health, safety and/or confidentiality of the recipient, the State Department of Health (SDOH) or the local district may determine that there is "good cause" not to bill third party health insurance.**

Policy: **When appropriate, individuals or providers may request a determination of "good cause" and authorization not to bill third party health insurance. Examples of circumstances in which the recipient's health, safety or confidentiality could be compromised by third party billing include domestic violence situations, or instances when individuals do not want their families to know they are receiving pregnancy/family planning services.**

The eMedNY Third Party Subsystem includes a "good cause" indicator; users can inquire about, add or change information in this field. In situations where available third party insurance should not be billed, the local district can set the good cause indicator on eMedNY for either the date that a service will be provided (if known), a specific period of time, or an open-ended time period. Setting the good cause indicator will also prevent the third party contractor from making a post-payment recovery. Districts should periodically check the eMedNY Mobius reports of individuals for whom the indicator is set, to be certain "good cause" is still appropriate.

In the case of a minor applying for the Family Planning Benefit Program (FPBP), third party health insurance should not be billed unless the local district has an affirmative statement that the insurance can be billed. To prevent billing third party coverage for FPBP, the district may either:

- **Not enter the third party insurance information in eMedNY, or**
- **Enter the third party information and set the good cause indicator.**

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If third party coverage is already on eMedNY, the district may either end-date the insurance or set the good cause indicator.

In situations where a provider is requesting good cause not to bill a patient's third party insurance for reproductive health services, the provider may contact the State Department of Health (SDOH) for a determination of good cause. If granted, the provider must document the call and determination in the client's billing record.

For more information about setting the "good cause" indicator, districts should refer to the "eMedNY Implementation, Third Party Training Manual."

References:

Dept Reg. 360-3.2(a)-(f)
360-7.4(a)(3)

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