ADMINISTRATIVE DIRECTIVE

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
40 North Pearl Street
Albany, New York 12243
Cesar A. Perales, Commissioner

TRANSMITTAL NO:	87 ADM-40
DATE:	October 28, 1987
DIVISION:	Operations
TO:	Commissioner of Social Services
SUBJECT:	Third Party Resources (TPR) Detection and Utilization
SUGGESTED DISTRIBUTION:	Income Maintenance Staff Medical Assistance Staff Third Party Resources Staff Child Support Enforcement Staff Children's Services Staff Staff Development Coordinators
CONTACT PERSON:	John Brunelle, Bureau of Third Party Resources by calling 1-800 342-3715, extension 4-0345.

I. Purpose

The purpose of this administrative directive is to implement new Federal requirements and to emphasize changes to the TPR program that have occurred during the past two years. 85 ADM-47, "Responsibility For the Detection, Utilization and Recovery of Third Party Resources" is superceded by this release.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Department Regs.	Social Services Law and Other Legal References	Manual References	Miscellaneous Reference
81 ADM-49	82 ADM-20	360.9	367-a	84 MB-11	SSA 1902-a(25)
82 ADM-17	84 ADM-19	360.22	363-a		42 CFR 433.135-154
82 ADM-48	85 ADM-47	360.17	104-B		Ins. Law 3216 and 3221
82 ADM-79		360.10	143		Fed. Discrimination Act, Sec. 701K
84 ADM-17		351.1(b)(2)(iii)	366		DOD Reg. 6010.8R
		540.6(e)			PA Source Book

II. Background

A. Historical

1. Prior to 1976, the detection, utilization and recovery of third party resources was primarily the responsibility of the local districts with periodic assistance from the Department through various bureaus including Audit and Quality Control and the Division of Medical Assistance.

2. The enactment of the Medicaid Management Information System (MMIS) implementing legislation, Section 367-b, 7 of the Social Services Law established a shared responsibility by the Department and districts for utilizing third party resources and recovering Medicaid expenditures when appropriate.

3. With the implementation of MMIS, the Department began using insurance and Medicare indicators on its MMIS file to avoid paying Medicaid to providers prior to their billing the third party. This is commonly referred to as a cost avoidance system. The TPR indicators are entered on MMIS centrally when the resources are identified through automated file matches. When the resources are identified locally as a result of detection through eligibility interviews, they are data entered onto WMS in all upstate districts and in some pilot Income Maintenance centers in NYC. In addition, NYC can enter data onto MEF or staff can complete Health Insurance Data Sheets (DSS 3077) and mail them to the Department for data entry.

4. On April 8, 1986, the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) was passed. Unless the recipient claims and is determined to have good cause, COBRA made the recipient's cooperation in pursuing available third party resources a condition of eligibility for **both Public and Medical Assistance.** This requirement has been mandated in the corresponding Federal Regulations effective May 28, 1987.

B. Terms and Definitions

1. **Third Party Resources (TPR):** A "third party" is any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. Examples of liable third parties include commercial insurance companies through employment-related or privately purchased health insurance or through casualty coverage resulting from an accidental injury; an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more Medicaid recipients; fraternal groups; unions; or State Worker's Compensation Commissions. Other examples of a third party would include an absent parent or other entities providing medical support or services.

2. **Medicaid Management Information System (MMIS):** The New York State Department of Social Service's automated system for processing data for claims payment and management information.

3. **Welfare Management System (WMS):** The New York State Department of Social Services' automated eligibility system through which third party information is data entered at the local level.

4. **Medicaid Eligibility File (MEF):** New York City's automated Medicaid eligibility system through which limited third party information can be entered and passed to MMIS.

5. **Third Party Form:**

   Third Party Resources Form (DSS 3281): Used for all upstate recipients for data entry onto WMS to pass data to MMIS.

   Health Insurance Data Sheet (DSS 3077): Used for PA, MA, and SSI recipients in New York City when entry through MEF is too limiting and used upstate when entering third party information on cases that have been closed more than two months or to protect insurance entered by the district from future direct updates. These forms are also used when it is necessary to change Prepaid Capitation Plan (PCP) coverage for the "guarantee" period or to change PCP coverage in the past.

   Authorization for Medical Assistance (W-663B): Used for MA and SSI recipients in New York City.

6. **Third Party Verification Procedures:** These vary from district to district but in general involve the referral of potential or actual resources via a Third Party form to a Third Party specialist or unit for final investigation and verification prior to data entry.

7. **MMIS Policyholder Screen (MMPLHR):** This screen is the most accurate source for inquiry about current and historical TPR data on a recipient.

8 **Cost Avoidance:** In relation to MMIS, it is that process whereby claims submitted by providers are automatically reviewed and matched with the recipients' third party record to make sure that, if there is a third party resource available to pay for the medical service, that resource is appropriately billed and reflected on the claim. This ensures that the cost to the Medicaid program is avoided until all other available resources are billed correctly.

III. Program Implications

All third party resources which are detected and correctly data entered as part of the Public Assistance (PA) and Medical Assistance (MA) eligibility interview process ensure that Medicaid payments are not made for those services for which a liable third party exists. To the maximum extent possible, cost avoidance will be employed in the management of client resources through early and accurate detection and recording. In certain instances, the Department or the local district supplement their cost avoidance activities with recovery procedures to insure the appropriateness of Medicaid payments. In order to assure that the TPR program is effective on a statewide basis, the efforts of the Department and the local districts is coordinated so that Medicaid claims are cost avoided as federally mandated and recoveries are pursued when cost avoidance is inappropriate. This occurs in certain instances when responsibility for payment by a third party can not be clearly established in a timely manner (for example accident/liability cases) or when coverage by a third party is not identified until after the claim has been paid by Medicaid.

IV. Required Action

A. TPR Detection Responsibility

1. Primary

The responsibility for the initial detection of third party resources lies with the local district PA and MA eligibility worker. However, the process for verifying and data entering the coverage varies from district to district. As part of the steps required by this ADM, eligibility workers and supervisors should become familiar with their district's procedures and workflow for verifying and data entering third party resources. The end result should be the entry of the most complete information possible to use in MMIS claims processing which identifies third party payments and rejects claims when providers do not bill appropriately.

2. Secondary

Workers in several program areas, in addition to PA and MA eligibility workers, have responsibilities related to this task. Children's Services staff who are responsible for recipients who receive Medicaid cards or are on Medicaid rosters must investigate the availability of third party resources and make sure that those resources are data entered through the district's established procedures. Child Support Enforcement (CSE) workers shall continue to request that health insurance be provided by the absent parent in all support petitions and notify referring units in accordance with 82 ADM-79, Pursuit of Medical Support and Collection of Third Party Resources. If medical support is ordered, the CSE worker should notify the Third Party Resources Worker directly. All other Public Assistance and Medical Assistance examiners and staff from the Office of Mental Health (OMH) and the Office of Mental Retardation and Development Disability (OMRDD) are required to incorporate the following steps into their eligibility interviews.

a. New Applications

1) Employed Applicants: A denial of health insurance coverage through the employer must be verified through your district's established TPR verification procedures and documented in the case record. If the applicant states that the employer provides insurance coverage, follow the procedures required in Section IV A, 2,f..

2) Unemployed Applicants: During the interview process determine the availability of insurance coverage for each member of the case. Indications of potential or actual insurance coverage are listed on **Attachment I.** If a third party resource is identified, complete a Third Party form and data enter the verified information.

b. Reapplications and Changes to the Category of Assistance.

1) When an examiner opens a case that has previously been opened in their own or another district, or changes the category of a case, the examiner must determine if the recipient has an active third party resource. To do this, the MMIS policyholder (MMPLHR) screen must be accessed in upstate districts, and in NYC you must question the recipient.

2) If there is an active TPR, the examiner should determine through the interview process or through outside verification, if the resource continues to be available or if there have been any changes to the coverage.

3) If it is determined that the third party resource should be changed or terminated, a Third Party form should be completed and the district's TPR verification and data entry procedures followed.

4) If there is no resource indicated, question the applicant about potential or actual third party coverage from the sources listed in **Attachment I.** If such a resource is identified through this process, complete a Third Party form and follow the district's established TPR verification procedure.

c. Recertifications

1) Prior to a scheduled face-to-face recertification as a part of the case preparation, the examiner should determine if a third party resource is currently active on MMIS. If insurance is indicated, verify the current availability and accuracy of the coverage during the interview.

2) If no insurance appears on MMIS, review the existing case record for indications of available TPR that have not been previously data entered. Some of these indicators include but are not limited to:

- copies of insurance or Medicare cards,
- payroll deductions for insurance,
- employment with a large employer that may provide insurance,
- copies of court orders for medical support, or
- a fee for health insurance as part of college tuition.

3) If potential or actual coverage is identified through this case review process, the worker should complete a Third Party form with the information and follow established TPR verification procedures.

4) If there is no evidence of a third party resource in MMIS or the case record, follow the same procedures as with new applications outlined in section IV,A,1,a.

d. Verification of Insurance Coverage Indicated As Potentially Available During a Tape File Match

On a regular basis, the Department conducts automated tape file matches between files containing the names of applicants/recipients and absent parents and files of selected insurance carriers and other agencies that provide health coverage. The results of these matches are sent to local districts on Insurance Update or Absent Parent match reports. There are times when the

-3808 (2/87)

coverage cannot be directly entered on MMIS because additional investigation is necessary. Two such instances are the identification of an absent parent with an individual insurance policy or an absent parent or recipient with a family policy.

1) Investigative Process

a) Resources for Investigation

The Insurance Direct Update/Family Contract report only lists information for the policyholder for each policy. Each policyholder has family insurance coverage available to dependents. It is necessary to investigate each case to determine which dependents are covered under the policy. Resources for investigation include but are not limited to the following:

i) The case record - This may be used to determine the recipients in the case and the relationship of the policyholder to those recipients.

ii) Direct employer contact - Employer contacts may be utilized to obtain beneficiary and coverage information directly.

iii) Recipient information - Recipients may be able to supply information regarding coverage for family members as well as employment information. You should attempt to verify any information given by a recipient.

b) Data Entry of Coverage

Once coverage information has been obtained, a third party form (DSS 3077 for NYC and DSS 3281 upstate) should be completed to include each additional covered individual. Coverage codes may be added at this time if additional coverage has been identified. If the case is closed, a DSS 3077 should be completed for each recipient and sent to the Department's Bureau of Third Party Resources for data entry.

c) Return of Results to Department

The Insurance Update/Family Contract report is printed on two-part paper. Part I should be completed as follows, and returned to the Bureau of Third Party Resources within 60 days from the date of the cover letter accompanying the report.

i) If additional coverage is added, circle the coverage indicator for that recipient.

ii) If additional recipients are found to be covered under the policy, write the number of additional recipients on the far right side of the report (after the policy number).

d) Part I should be sent to:

Third Party Resources
New York State Department of Social Services
P.O. Box 1935
Albany, New York 12201
ATTN: Direct Update Reports

Part II may be kept for local district files.

2. Investigation of Coverage Identified During An Absent Parent Match.

a. Family Contracts

i) Instructions for Open Cases -

Regardless of whether or not there is a court order, determine which recipients should be covered by the insurance and enter the information on WMS/MMIS. The IV-D Unit should be able to provide you with the names of the individuals in the case for whom the absent parent is responsible.

ii) Instructions for Closed Cases -

Verification: Determine which line numbers (recipients) are covered by the identified health insurance. Review the MMIS/MMPLHR screen to determine if the health insurance has already been added to MMIS.

Action:
- o If the insurance has been added for each dependent, take no further action.
- o If the insurance has not been added to MMIS for each dependent or if it has been added inaccurately, complete a DSS 3077 for each covered individual and submit them to the Department's Bureau of Third Party Resources.

b. Individual Contracts

i) Instructions for Open Cases -

Verification: As previous investigations failed to identify the existence of the insurance coverage contact the absent parent's employer and/or insurance company to determine if family coverage is available. If so, determine the cost of converting the individual coverage to family coverage.

Action:

- o If family coverage is not available, take no further action.
- o If the cost of converting from an individual contract to a family contract appears to be unreasonable, take no further action.
- o If the cost is reasonable, attempt to obtain voluntary compliance from the absent parent by asking him to convert his individual contract to a family contract. If the cost is high but you make a determination that the coverage would be beneficial to the Medicaid program, you may want to offer to pay for the additional coverage. Since IV-D will not ordinarily prepare a petition just to include claims for medical support, notify IV-D of this resource and ask that they pursue the health insurance if a change to the original/modified petition is sought.

ii) Instructions for Closed Cases

Take no Action.

NOTE: In all situations where a court order is amended to include health insurance for an absent parent's dependents, contact the absent parent's insurance company and notify them that under Court Order number "NNNN" they are now primary payor.

c. Data Entry and Reporting

1) In accordance with federal regulations, 42 CFR 433.138 (b) and (g) (2)(i), information obtained during initial application and redetermination, must be followed up on and data entered onto WMS/MMIS so that it can be used for claims processing and/or recoveries within 60 days of the agency first becoming aware of it.

2) In all instances where the Department provides reports of the potential availability of a third party resource, the local district must verify the coverage and data enter it within the time frames specified with the release of each report.

3) In some instances, districts will be required to complete reports for submission to the department indicating actions taken. These reports are to be completed within the specified time period.

e. Local District TPR Recovery Responsibility - Accidents

1) Until the centralized systems are implemented, pursuit of TPR recoveries in those areas remains the responsibility of local districts. In addition to pursuing those recoveries, any recoveries not specifically addressed within this ADM remain the responsibility of the local districts. This includes the requirement to investigate each potential accident/liability referred by the Department to the local district.

2) The Department is responsible for identifying recipient accidents on a Statewide basis and for reviewing each accident for potential third party resources. This is accomplished through two centralized processes. The first develops leads through attorneys requests for claim detail reports (CDR's) and the second involves potential accident codes on claim forms. In the first process, the Department frequently receives requests from attorneys for records of Medicaid payments made for services furnished to recipients being represented by them. These are screened by the Bureau of Third Party Resources and the local districts are notified that an attorney is seeking information concerning one of the district's recipients. The local district is required to investigate and determine if the attorney's request is the result of a lawsuit or accident. If there is a potential liability for which Medicaid funds might be able to be recovered, the local district must file a lien.

3) The second process involves the centralized mailing of questionnaires to recipients and hospitals if a Medicaid claim contains a specific code indicating that the medical service was provided as the result of an accident for which there is a potential or actual liability. If it appears that a potential third party resource exists, the Department refers the recipient and/or provider questionnaire to the responsible district. The district must conduct

3808 (2/87)

a further investigation into the accident to determine whether or not the third party resource actually exists and must notify the Department of the action it has taken on each accident within forty-five days of the referral. Specifically, the local district should determine;

- Where and how the accident occurred,
- Who is the negligent party?
- Were there witnesses to the accident?
- Was a police report filed?
- Is insurance coverage available? Some potential sources of liability insurance are Home Owners, Motorcycle No-Fault (for motorcycle passenger), Worker's Compensation, Automobile No-Fault, Motor Vehicle Accident Indemnification Corporation (for passengers in uninsured motor vehicles), School Liability Insurance (for injuries) and Nursing Home Liability Insurance (for visitors to a nursing home).

Additional actions that should be taken are:

a) If a liable third party resource is identified, review your district's adjudicated claims microfiche to ensure that all accident related payments made by the Medicaid fiscal agent are accounted for in the district's claim against the liable party.

b) Enter the third party resource onto WMS/MMIS using the date of the accident as the "Begin Date" of coverage and check the medical insurance coverage codes that apply to the injuries received by the recipient as a result of the accident.

c) According to local district procedure, when any suit has been initiated by either the client or the district, a lien should be placed to recover Medicaid Payment.

f. Client Cooperation As A Condition of Eligibility

As a condition of eligibility for public and medical assistance, recipients must cooperate in assigning existing third party benefits to the Department and local district. This is accomplished through their signature on their application form for assistance. In addition, the applicants/recipients must cooperate in applying for and utilizing potential available benefits as follows:

1. Employer Group Health Plans

a) Within 30 days of the local district's request for the information, the applicant/recipient (a/r) shall provide information on the policy's premium, coverage and claiming data. If there is no cost for the insurance coverage, the a/r must enroll in the employer plan.

b) If there is a cost for the coverage, the local district shall make a cost benefit determination to pay for the premiums. In most districts this determination will be made by the Third Party Resources Worker. Attachment II can be used to help make this determination but is not mandated.

c) If the policy is determined not to be cost effective, the a/r is then under no obligation to enroll or maintain enrollment in that plan.

d) If the policy is cost effective, the local district shall require the a/r to apply for and utilize such benefits. Cost to a/r required to enroll shall be paid as a medical expenditure in accordance with 360.17(g) except for the spenddown cases, where the expense of the coverage can be deducted to reach the Medicaid level of eligibility.

2. Non-Employer Third Party Resources Including Medicare Coverage

For these types of resources, the same steps should be followed as with Employer Group Health Plans that require premium payments.

3. Failure to Comply

When an a/r fails to comply with a request to enroll for insurance or Medicare within 30 days of the beginning of the first available open enrollment period, he or she shall be notified through timely and adequate notice procedures of an intent to deny or discontinue Medicaid coverage until compliance occurs.

NOTE: If an MA only parent of an applying minor child fails to comply with this requirement only the parent or caretaker relative is ineligible.

V. Systems Implications

None.

VI. Additional Information

A. TPR Detection and Updating by the State Department of Social Services

The Department will continue to conduct automated tape file matches to identify available or potentially available insurance and Medicare coverage. In order to use the identified resources as soon as possible to reduce Medicaid expenditures through cost avoidance, verified coverage for recipients who are policyholders will be directly entered onto MMIS by the Department.

B. TPR Recoveries by the State Department of Social Services

The Department will pursue TPR recoveries centrally through the use of MMIS whenever it is cost beneficial to do so. This will be accomplished by periodically matching the adjudicated claims file with a file of recipients having retroactive insurance/Medicare coverage.

1. The following centralized automated billing systems have already been implemented by the Department:

   - Medicare Part A (Inpatient)
   - Medicare Part B (Clinic: Hospital Based and Freestanding)
   - Medicare Part B (Physician, Lab, etc.)
   - Insurance Inpatient (Blue Cross and Commercial Carriers)

2. The feasibility of establishing the following automated systems for the future are being investigated. You will be officially notified of the effective date prior to their implementation.

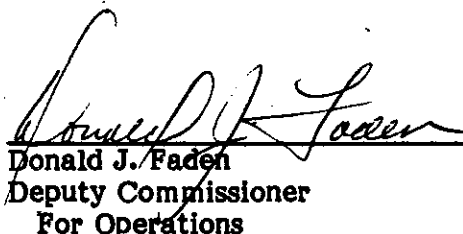
   - Blue Cross/Blue Shield and Commercial Insurance Hospital Based and Freestanding Clinics. (This will be piloted in September 1987).
   - Blue Cross/Blue Shield and Commercial Insurance Outpatient (for example: physician, lab, pharmacy)

C. Monitoring Third Party Performance

The Department maintains the responsibility for monitoring the performance of local district TPR programs through management reports, on-site monitoring visits, case reviews and audits. Failure to detect and data enter third party resource information or pursue appropriate recoveries may result in a withholding of a part of State reimbursement or other administrative sanction.

Attachment I contains sources of TPR that should be considered during the eligibility interview. Attachment II contains criteria to be considered in the cost benefit determination for health insurance/Medicare. Attachment III contains sources for obtaining absent parents' social security numbers.

VII. Effective Date: December 1, 1987



Donald J. Faden
Deputy Commissioner
For Operations

DSS-3808 (2/87)

ATTACHMENT I

In all application or recertification interviews for Public Assistance and Medical Assistance, the existence or non-existence of a Third Party Resource **must be explored and documented** in the case record. If a third party resource is found that can be used to reduce Medicaid expenditures, follow your district's established procedures for verifying and data entering the information. During the interview and case review process, the eligibility workers and their supervisors should investigate third party eligibility situations including, but not limited to, the following:

A) **Medicare Coverage**

1) The applicant/recipient is entitled to Medicare coverage when he/she:

   a) Is over 65 years of age, or
   b) Is in receipt of an SSA disability check and has received them for twenty-four months, or
   c) Has received renal dialysis for three months, or
   d) Received a kidney transplant.

2) The applicant/recipient can only be eligible for Medicare if he applies for benefits.

3) Have the applicant apply at SSA, and after proof of application make a referral to the Third Party Unit.

B) **Employer Related Insurance**

1) Investigate health insurance if the applicant/recipient or member of the household is:

   a) Currently employed
   b) Retired with a pension
   c) Recently laid off or fired - See Item 3 below and Section H on Conversion Coverage.

2) Union Sponsored

   Union benefit plans may supply all of an applicant's/recipient's coverage or be used to supplement the employer's. Union coverage should always be checked when the applicant/recipient,

   a) Is currently a member of a union,
   b) Has retired from a union with at least five years of work history with the union,
   c) Is receiving a pension from the union as a current or retired employee.

3) Continuation of Coverage

   Internal Revenue Service Code (Section 162) requires an employer or union with more than twenty employees to offer a continuation of existing group coverage to an employee who leaves employment under ordinary circumstances. The employee must be notified within 14 days of the end of employment and, if coverage is desired, must pay the group rate plus

DSS-3808 (2/87)

up to a two percent administrative handling charge. Churches and governmental agencies are excluded.

In all these situations make a referral to the Third Party Unit.

C) **Private Insurance Coverage**

Because medical costs are so expensive, people will generally try to retain health insurance coverage. Some groups, especially the disabled or critically ill (e.g., AIDS), realize that once they lose this coverage for a pre-existing condition it may never be available again. Therefore, available coverage from persons both within and outside the case should be investigated. If the coverage is available at additional cost to the a/r, refer to 82 ADM-48 for the payment of premiums.

D) **Absent Parent Referral For Medical Support (Refer to 82 ADM-79)**

If a legally responsible relative is not in the case, make an absent parent referral to IV-D as follows:

- PA cases must be referred to IV-D utilizing the DSS 2860, Child Support Enforcement Referral.
- MA cases must be referred utilizing the DSS 2521, Application for Child Support Services.

It is important that eligibility workers complete the referral forms with as much information as is available including: social security number of absent parent, address of absent parent, name and address of employer, and any information known about the availability of health insurance. Information such as availability of family coverage, name and address of insurance carrier, policy number, cost of insurance would be especially helpful to child support enforcement workers when petitioning the court to establish the legal liability for medical support.

Potential sources of the absent parent's social security number are contained in Attachment III. Attachment III may be photocopied and given to the applicant/recipient to assist them in searching for this essential piece of information. The IV-D and TPR Units should cooperate in identifying and data entering available health insurance coverage.

E) **Civilian Health and Military Personnel Uniformed Services (CHAMPUS)/Civilian Health and Military Personnel Veterans Administration (CHAMPVA)**

1. CHAMPUS is a health benefit program for all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service and National Oceanic and Atmospheric Administration. It covers:

    a. Husbands, wives, and unmarried children of active duty service members,

    b. Retirees from the armed services, their husbands or wives, and unmarried children,

    c. Unremarried husbands and wives and unmarried children of active duty or retired service members who have died,

d. Husbands, wives and unmarried children of reservists who are ordered to active duty for 30 days or longer (they are covered only during the reservist's tour), and

e. Unremarried divorcees, without other health insurance coverage, who were divorced after February 1, 1983, after at least 20 years of marriage to a service member who was on active duty during those 20 years.

2. CHAMPVA is coverage given to a spouse or child or a veteran who has a permanent total service connected disability. CHAMPVA is also available to a surviving spouse or child of military personnel who died as a result of a service connected disability or had a permanent, total service-connected disability when s/he died.

To obtain CHAMPUS/CHAMPVA coverage have the a/r apply in person or by writing to the nearest VA Medical Facility.

F) **Law Suit (Liability or Tort Case)**

Question the a/r as to why he/she is applying for assistance or if any accidents have occurred since the last recertification. If there was an accident and the injury was major (e.g., automobile accident, fall requiring hospitalization), take the information on the incident and any pending legal action. Transmit the information to the Third Party Worker for the potential initiation of a suit on the a/r's behalf or the initiation of a lien against existing legal action.

Even if no lawsuit is existing or pending, coverage for the a/r's medical bills still may be available through a "no fault casualty" coverage. This coverage, termed "voluntary medical benefits" to avoid confusion with no fault automobile benefits, is generally available with limits of $500-$2,000 for homeowners and $250-$1,000 for commercial establishments. The payments are available without an admission of liability and are designed to prevent lawsuits over nuisance cases. Transmit the information to the Third Party Worker.

G) **Worker's Compensation**

Inquire if any accident at work caused the a/r to receive medical attention. If so, obtain the information on the insurer and transmit it to the Third Party Worker for the appropriate action.

H) **Conversion/Extension Rights**

Although not always available, conversion/extension rights should be investigated under the following circumstances:

1) When an employee is laid off from his job, he may be eligible for conversion to another policy.

2) When divorce/annulment occurs, the non-policyholder may convert from a group to another policy.

3) If a minor child, prior to his nineteenth birthday, is judged to be incapable of functioning as an adult as defined by New York State's Mental Hygiene Law, he/she may have an application made on their behalf and receive continued coverage after they become 19 years of age under the existing family policy.

4) When a child under 23 is a full time student, they may be eligible to receive coverage under the family policy.

In all the above situations, additional premium costs, if any, may be paid by the district. The Third Party Unit should be contacted to make the appropriate arrangements.

I) Foster Parent in the Household

Because of the living arrangements, some insurance policies will cover children who are residing with a foster parent. Refer to the Third Party Unit for investigation and the potential payment of any additional premium.

J) Fraternal/Benefit Societies and Churches

Many organizations as part of their dues or as a benefit to their members, offer health insurance coverage. Please investigate these policies and make a referral to the Third Party Unit.

K) Student Health Insurance

Many students pay health premiums as a part of their college fee. If a recipient is attending college, be sure to check if this coverage exists. If found, make a referral to the Third Party Unit.

L) Health Maintenance Organization (HMO)

Investigate if the a/r has health insurance coverage available through an HMO or similar health plan. Many recipients have this type of coverage. For Medicaid to realize the full benefits of this program, the recipient should - except in cases of verifiable emergency - utilize the authorized HMO provider.

ATTACHMENT II

CRITERIA TO BE CONSIDERED IN THE COST BENEFIT DETERMINATION FOR PURCHASING TPR COVERAGE

The determination of cost benefit for any health insurance policy is an evaluation of many varied but interrelated criteria. It is difficult to establish exact guidelines for cost benefit determination that can be applied uniformly in all cases. Unless a person is already in poor health, whenever you purchase insurance a risk is taken as to whether or not a person will incur health expenses. Therefore, cost benefit determination must be made on an individual basis after the local district staff obtains information about the recipient(s) and the policy. In order to guide the local district in their decisions, this attachment lists criteria to consider in cost benefit determinations.

Please note that for some cases, even after reviewing these criteria, the determination to purchase a health insurance policy may still be unclear. In these cases, the final decision will rest solely on the judgement of local district staff. If the premium is paid, a tickler file should be established to reevaluate within a year the cost of the premiums as compared to the medical expenses paid by Medicaid and the insurance policy.

The following points should be considered in making a determination whether or not to pay insurance premiums on behalf of an applicant/recipient:

1. Has there been a high utilization of medical services? This determination can be made in one or more of the following ways.

   a) Request new a/r to bring to the interview all medical bills, insurance benefit statements, and premium notices for the past year. If no premium notices have been received, the recipient can obtain a letter from his/her employer indicating the cost of coverage. Separately total the amount paid by the recipient, the amount paid by the insurance company and the insurance premiums. Then follow the guidelines explained in #1c.

   b) For recipients who have been on Medical Assistance for at least one year, use the Adjudicated Claims Microfiche to determine actual Medicaid usage. Review the last twelve months of adjudicated claims. Separately total the amount paid by Medicaid and by insurance. Request the recipient to provide a statement from their employer/insurance company verifying the policy's premiums and insurance payments made during the last twelve months. Then follow the guidelines explained in #1c.

   c) Obtain information on past health care expenses as explained in #1a and #1b. If no insurance was available last year, are the a/r's payments or Medicaid payments in excess of the insurance premium plus deductibles and co-insurance? Would the policy have paid the bills which were incurred, if the policy had been in force?

. If insurance was available, did it pay more than the a/r or Medicaid paid in premiums, deductibles, and other medical fees? Will the insurance still pay for those types of medical services in the upcoming insurance period?

2. Can the past utilization of medical expenses be expected to continue or increase?

   During the client interview (or on a form letter to SSI recipients) inquire if any acute (e.g., cancer, pregnancy) or chronic (e.g., diabetes, childhood asthma) medical conditions exist. If so, does the condition require or could it potentially require extensive medical services? Will these potential expenses be covered by the policy?

3. Recipients over 65 or in receipt of Social Security disability benefits for at least 24 months are considered to be high users of medical services. For this population it is usually cost effective for a local district to pay premiums for Medicare Part B if the client is not already enrolled.

   After questioning the a/r about previous medical history and/or reviewing past Medicaid payments, if there is a high probability that the a/r may need periodic inpatient care you may consider paying premiums for insurance coverage to complement Medicare coverage. You should be aware however, that these policies are generally not cost-effective if the a/r is not likely to be in need of inpatient care. This is because, effective January 1, 1987, Medicaid will not pay coinsurance or deductible amounts for Medicare Part B services (non-inpatient) if the Medicare payment is the same or greater than what Medicaid would pay for that service. Since Medicare payments generally exceed Medicaid payments, there would be no benefit from a policy that is used primarily to complement Medicare Part B coverage.

4. Does a situation exist which warrants maintaining the policy even though there is no history of high medical utilization?

   Due to the client's advanced age or a pre-existing condition, is it reasonable to assume that the client may not be able to obtain another policy in the future or that a pre-existing condition would not be covered by a new policy for a period where medical utilization may be expected?

5. For policies in force, what are the maximum benefit levels of the policy?

   a) Have the maximum benefit levels been met, rendering the a/r ineligible for benefits?

   b) If so, is the maximum benefit recurring? Will it be reinstituted on an annual basis, at the end of a specific benefit period, or does it apply separately to unrelated injuries, sicknesses, conditions?

   c) If there will be benefits or recurring benefits that will pertain to the a/r's potential medical expenses, how do these benefits compare to the cost of the premium?

6. What does the policy's disclosure statement (usually found at the beginning of the policy) indicate?

   a) What is the "expected benefit ratio" ("anticipated loss ratio" on policies issued prior to January 1, 1983)? This percentage identifies the average amount the entire insured population receives in benefits as compared to

the amount of premiums paid to the company. The minimum ratio for basic hospital, medical, or major medical policies is approximately 50% - 60%. The higher the expected benefit ratio (anticipated loss ratio), the better the policy.

b) What are the policies labeled?

In most cases, avoid paying premiums for policies labeled:

- Limited Benefits Health Insurance
- Income Protection
- Hospital Indemnity
- Disability Income
- Accident Indemnity

Paying premiums for these policies would be indicated only in rare cases where an a/r has a particular medical condition which a policy in force will cover in excess of the premiums.

Limited Benefits Health Insurance provides less than the minimal coverage required for basic hospital, basic medical, or major medical coverage.

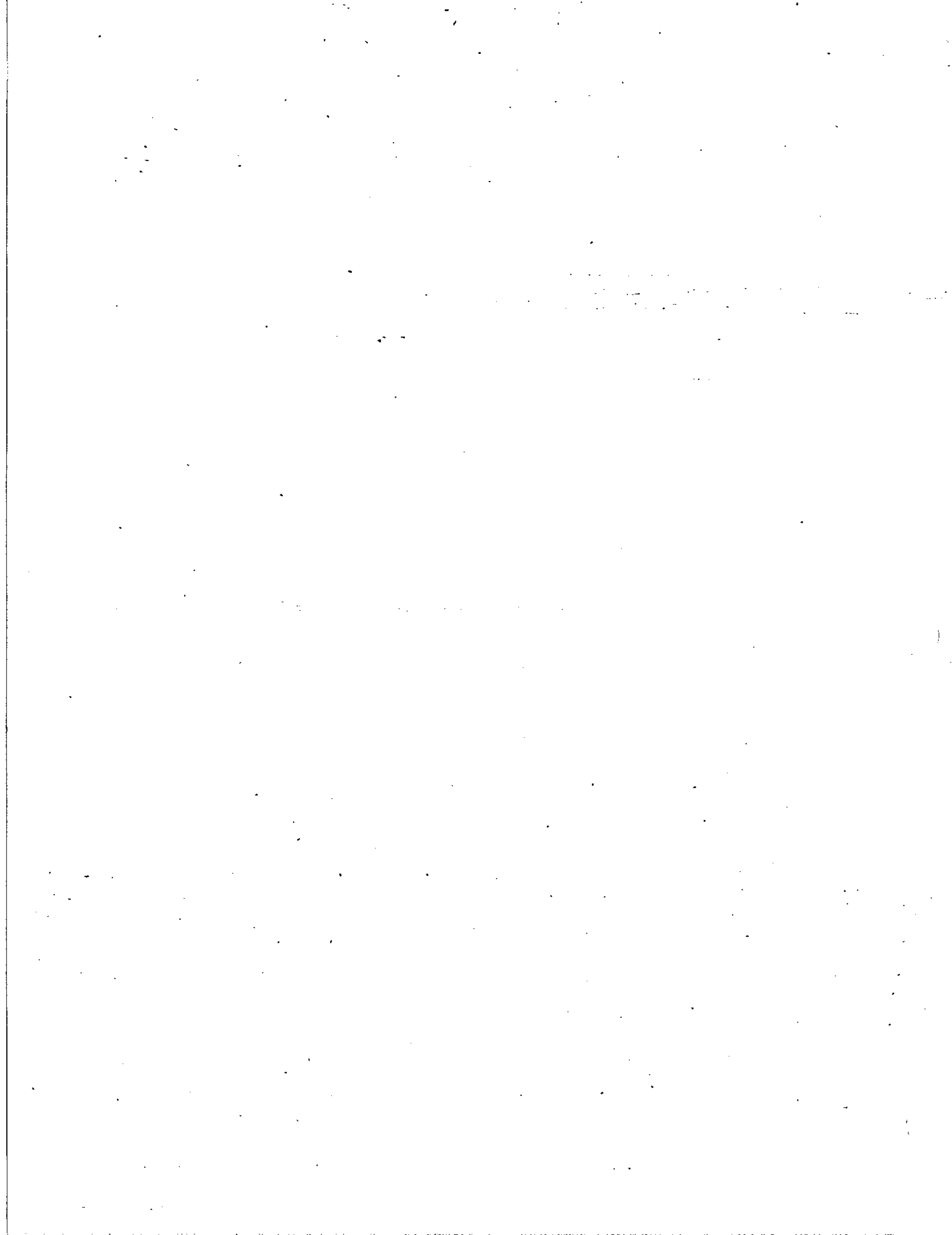
Hospital Indemnity, Disability Income and Accident Indemnity policies are not health insurance and should not be entered onto the MMIS file. Benefits from such policies should be counted as income.

7. Review the number of dependents in a family. In general, the larger the family, the more cost beneficial it is to purchase family coverage.

8. Using the minimum standards set by the State of New York Insurance Department, Regulation Number 62 (11 NYCRR 52) as a guide, assess the amount of medical services covered by the health insurance plan. To obtain a copy, write to:

State of New York Insurance Department
Empire State Plaza, Agency Bldg. #1
Rockefeller Plaza
Albany, New York 12257

DSS-3808 (2/87)



ATTACHMENT III

Sources for Locating An Absent Parent's Social Security Number

The absent parent's social security number is critical in this Department's effort to locate and utilize the absent parent's resources. To help find this information, please check the sources listed below:

- Payroll stubs; Forms W-2 or 1099;
- Unemployment Insurance Benefits Booklet;
- Statement of Benefits for Worker's Compensation;
- Tax Returns, particularly any joint returns filed during the past seven years*;
- Any of his/her correspondence with Tax Department;
- Military Documents (the military currently uses the social security number as the serial number);
- Life insurance policy;
- Credit applications;
- Automobile insurance policy;
- Credit Cards;
- Credit agreement for purchases (such as furniture, refrigerator, television);
- Old ID Cards (health insurance, school ID, alien registration card);
- Marriage license;
- Bank books (active or retired);
- Any personal documents from the Social Security Administration;
- Documents from the Veterans Administration;
- College or school records;
- Medical or dental records or bills.

* The absent parent's Social Security Number can be traced using the recipient's.