State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
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ALAN J. GIBBS
Commissioner

SAUL M. KILSTEIN
Director

MEDICAID COMMUNICATION NO. 93-2 **DATE: 1/11/93**

TO: County Welfare Agency Directors
ISS Area Supervisors

SUBJECT: Indemnity Benefit Plans

The Division has received clarification from the Health Care Financing Administration (HCFA) regarding the eligibility and Third Party Liability (TPL) implications of indemnity benefit plans. These plans pay a fixed per diem rate to the insured individual when he or she becomes an inpatient of a governmental psychiatric hospital, psychiatric extended stay hospital, or a nursing facility. The purpose of this Medicaid Communication is to provide you with additional guidance regarding appropriate treatment of such benefit plans. Attached to this communication is a copy of Medicaid State Operations Letter #92-20.

In order to determine the treatment of payments from a specific indemnity plan, the plan itself must be examined to determine who receives payment, what benefits are provided, and the purpose of the payments. These factors become the basis for distinguishing between payments which are considered "income" in eligibility and post-eligibility determinations, and payments which are not considered income, but are considered as a "third party resource" in Medicaid payment determinations.

Eligibility Determination

If the indemnity benefit is paid to the individual and could be used to meet his/her needs, it is considered to be income, unless the payment is restricted to the purchase or reimbursement of medical services covered by the policy. In situations where the indemnity benefit is considered income, but the payment is received other than monthly, eligibility should be determined in accordance with N.J.A.C. 10:71-5.2 (b) 2.ii. or 3.i., as appropriate.

If the indemnity benefit is paid directly to a nursing/psychiatric facility, the benefit is not considered income nor would the medical care received be considered in-kind income. However, amounts paid to a nursing/psychiatric facility for purposes other than medical care may be considered income if the facility would make it available to the individual so that he or she could use it for his/her personal needs.

Post Eligibility Treatment of Indemnity Plans for Governmental Psychiatric Hospitals, Psychiatric Extended Stay Hospitals or Nursing Facilities

Once an individual has been determined eligible for Medicaid, consideration must be given to establishing total income available for: (1) contribution to the cost of care; or (2) potential third party resource. As with other insurance plans, the amount of the monthly premiums for these indemnity benefit plans are exempt from consideration as available income and should be listed on the PA-3L under "Health Premium".

Indemnity benefits paid to an individual, whether or not they are counted as income in determining financial eligibility, must be included in the post-eligibility determinations of the income available to offset the cost of care. Accordingly, the PA-3L should indicate the monthly amount of the indemnity benefit under "Other Income" and should annotate the source of the income under "Remarks". For this purpose, source includes the name of the insurance carrier and the code "I" to denote that these funds are from an indemnity benefit plan.

For income received monthly or for which an amount has been projected, the amount anticipated should be entered on the PA-3L. For months in which the receipt of the benefit makes the individual ineligible, the amount should be entered on the PA-3L, effective for the month of receipt and eligibility would be redetermined.

If the indemnity benefit is paid directly to the governmental psychiatric hospital, psychiatric extended stay hospital or nursing facility, no indication of this benefit is to be shown on the PA-3L. Instead, form TPL-1 is to be completed and forwarded to Bruce Fritzges of the Bureau of Third Party Liability, Division of Medical Assistance and Health Services, CN 720, Trenton, New Jersey 08625. As a result, the TPL segment on the Medicaid Eligibility File will be updated and the facilities will be required to enter the payment on their billing document. Confirmation of the systems input will be mailed to facilities and a copy of the notice forwarded to the County Welfare Agency or the Institutional Services Section (ISS) area office, as appropriate. Facilities were advised of their responsibility by New Jersey Medicaid Program Newsletter Volume 3 No. 2 (issued January 1993).

The County Welfare Agency or ISS area offices must inform recipients that they are responsible for making timely and accurate reports of any change in circumstances that may affect their eligibility. This includes reporting any additional income or resources obtained from indemnity plans and any change in the premiums. In addition, as a condition of eligibility or continued eligibility, the recipient must cooperate in identifying and providing information to assist in pursuing liable third parties.

Questions regarding this communication should be referred to the Medicaid field service staff assigned to your county. Questions concerning the completion of form TPL-1 or interpretation of the indemnity benefit plan should be addressed to Bruce Fritzges, Bureau of Third Party Liability, at 609-588-3040.

Sincerely,

Saul M. Kilstein
Director

SMK:Gg
Attachment

c: Marion E. Reitz, Director
Division of Family Development

Nicholas R. Scalara, Director
Division of Youth and Family Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to DMD-MOB-9

MAR 18 1992

Region II
Federal Building
26 Federal Plaza
New York NY 10278

MEDICAID STATE OPERATIONS LETTER #92-20

FROM: Associate Regional Administrator
Division of Medicaid

TO: State Agencies Administering the Medicaid Program

SUBJECT: Indemnity Benefit Plans

Recently, one of the States in Region II raised questions about the third party liability (TPL) and eligibility implications of indemnity benefit plans. Such plans pay a fixed amount of money per day to the insured party when he or she becomes an inpatient of a hospital or a long term care facility. We wish to share the following information with you, since it may help you to resolve questions that arise about these types of insurance plans.

In order to determine the treatment of payments from a specific indemnity plan, the plan itself must be examined to determine who receives payment, what benefits are provided, and for what purposes the payments may be used. These factors may be the basis for distinguishing between payments which are considered "income" in eligibility and posteligibility determinations, and payments which are not treated as income at all, but are considered to be a "third party resource" in Medicaid payment determinations.

In determining whether payments by an insurance policy are counted as income for eligibility purposes, the policies under the State's approved Medicaid plan govern. In the cases of aged, blind, and disabled individuals, the baseline approach is dictated by Supplemental Security Income (SSI) rules. Under these rules, income includes anything received by the individual, in cash or in-kind, that can be used to meet needs for food, clothing, or shelter. If the benefit payments are made directly to a nursing facility, the payments would not be income under SSI rules, since they were not received by the individual. Furthermore, medical care received would not be in-kind income because it would not meet needs for food, clothing or shelter. Amounts paid to a facility for purposes other than medical care may be considered income if the facility would make the money available to the individual so that he or she could use it for food, clothing, or shelter. Although SSI does not consider institutional medical care to be income for eligibility purposes, SSI reduces benefit levels for institutionalized individuals when Medicaid pays more than 50 percent of the cost of the institutional care.

Under SSI rules, insurance payments made directly to an individual are considered income, unless restricted so as to be unavailable for food, clothing, or shelter. Payments restricted to the purchase or reimbursement of medical services covered by that policy would not be income. An individualized review of the policy terms would be necessary to determine if the payments are dependent on specific medical expenditures. Of course, treatment of these payments for Medicaid purposes may be more or less liberal than these baseline rules if a State exercises options under sections 1902(f) or 1902(r)(2) of the Social Security Act.

Once an individual has been determined eligible for Medicaid, potential third party resources must be considered. Indemnity plans which are restricted for the purchase or reimbursement of medical services covered under the policy, which would not have been counted as income, are a potential third party resource which is assignable to the State. Under the cost avoidance payment system that is generally applicable, Medicaid payments must be reduced by the amount of the third party liability (TPL) for the cost of Medicaid services. In some circumstances, the Medicaid agency pays the full amount and subsequently seeks reimbursement from the liable third party, who, in this case, is the recipient.

Indemnity plans which are not restricted for purchase or reimbursement of medical services and are considered income must be included in posteligibility determinations of the individual's total income in determining the required contribution to the cost of care (see State Medicaid Manual section 3701.2). In addition to those benefits considered as income, amounts which were not included in income, but are nonetheless available to pay for medical care, are included in the posteligibility determination. Thus, benefits which were excluded from income because they were restricted for payment of medical care, but were not so tied to specific items or services in a way that gave rise to TPL considerations, should nonetheless be included in posteligibility determinations of the total income available for a contribution to the cost of care.

In any case, the Medicaid agency must have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility. This includes reporting any additional income or resources obtained from indemnity plans. In addition, as a condition of eligibility or continued eligibility, the recipient must cooperate in identifying

and providing information to assist in pursuing liable third parties. This requirement includes furnishing information about any indemnity plans that may be a potential source of third party payment to the recipient for medical care.

Any questions may be referred to your State representative on (212) 264-2775.

Arthur J. O'Leary