ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 94 ADM-14

DIVISION: Health & Long Term Care

TO: Commissioners of Social Services

DATE: August 25, 1994

SUBJECT: Wrap Around Policy Payment Responsibilities

SUGGESTED DISTRIBUTION:
Third Party Workers
MA Supervisors
PA Supervisors
Accounting Supervisors
Staff Development Coordinators

CONTACT PERSON:
Fred Perkins, Bureau of Eligibility and Resources
1 (800) 342-3009 extension 6-5870
For claiming questions contact: Roland Levie for Regions I-IV at (518) 474-7549, User ID# FMS001 and Marvin Gold for Region V at (212) 373-1733, User ID# OFM270.

ATTACHMENTS:
Attachment 1 - Notice (not available on-line)
Attachment 2 - Vendor Payment Notice (available on-line)
Attachment 3 - Reimbursement Detail Form (not available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
			367-a(1)(c)		

I. PURPOSE

This release advises social services districts of their payment responsibilities for recipients covered by "Wrap Around" health insurance policies.

II. BACKGROUND

A WRAP AROUND POLICY is a health insurance policy in which the insurance company pays the billing provider's charges in full. The coinsurance and deductibles affiliated with these policies are either billed to the policyholder via a retail installment credit agreement or they are deducted directly from the policyholder's salary by his or her employer.

The Department first encountered "Wrap Around" policies in 1985 in Monroe County. At that time, Blue Cross and Blue Shield of Rochester paid participating providers in full and Lincoln First Bank billed the coinsurance and deductible charges to the policyholder. Our next encounter arose in Cortland County in October, 1992 where employed, fully-eligible Medical Assistance (MA) recipients participated in these plans. These fully-eligible recipients were responsible for payment of the coinsurance and deductible charges which they incurred. There was no standard mechanism permitting recipients to submit these bills to their fiscally responsible social services district or to the Medicaid Management Information System (MMIS). Due to their MA eligibility, the recipients were not responsible for payment of these charges.

A recent Department survey concluded that nine of the fifty-eight social services districts have encountered Wrap Around plans and five of these districts consider the policies to be a significant problem. It is conceivable that more employers will offer these plans because they encourage low utilization by placing an increased financial burden on the policyholder.

Some social services districts have notified the Department that they are resolving the deductible and coinsurance billing problems by contacting the insurance carriers, advising them of the recipient's situation and requesting that they not remit the deductible and coinsurance payments to providers. Some insurance carriers are cooperating with these requests. In so doing, the carrier pays the providers charges less coinsurance and deductibles. The providers would be advised to bill MA for the remaining amounts. Please note that the insurance carriers are not required by any law or regulation to cooperate with these requests.

III. PROGRAM IMPLICATIONS

This ADM provides social services districts with the option of either:

(1) resolving the recipient billing problems directly with the insurance carrier as explained previously or,
(2) reimbursing policyholders directly for coinsurance and deductible amounts deducted from their salary for MA-eligible family members.

In addition, social services districts will be required to issue payments to insurance companies and other billers (i.e., banks) for coinsurance and deductibles incurred by MA-eligible policyholders/dependents when the amounts are not withdrawn from the policyholders' salaries.

IV. REQUIRED ACTION

Wrap Around policies must be treated like any other health insurance policy when determining MA eligibility. If the policyholder is applying for MA, the premium for the Wrap Around policy must be treated as an earned income deduction.

If the applicant is eligible for MA without including the premium payment as a deduction, the district must determine the cost effectiveness of paying the premium. The instructions for determining cost effectiveness are found in 87-ADM 40. Third Party Resources Detection and Utilization and additional assistance is available through the Health Insurance Automated Decision Tree (HIADT) disc distributed to local district Third Party Resources Units (TPRU's) by the Bureau of Eligibility and Resources.

The district may require the applicant/recipient (a/r) to maintain the Wrap Around policy if it is determined to be cost effective and the district allows for the employee contribution.

Examiners must refer all cases with health insurance identified through the application/recertification interview to the TPRU for verification and entry onto WMS. A copy of the front and back of the health insurance card should be attached to this referral.

Each district has established procedures for making third party resources (TPR) referrals. Examiners who are unaware of the TPR referral procedure in their district should contact their immediate supervisor or the TPRU for advice.

I. Instructions Regarding A/Rs Who Are Fully Eligible for MA

The procedure described below must be followed for MA-eligible recipients who are covered by Wrap Around health insurance policies.

A. Examiners must determine through the interview how coinsurance and deductible amounts for the insurance coverage are billed. They should seek advice from the TPRU if they are uncertain about the policy. If the bills are deducted from the a/r's salary or a bank, or some other creditor issues the bill, the examiner must advise the a/r to remit the bills to the social services district for payment.

1. The MA-eligible policyholder may submit bills for himself or herself and any of his or her MA-eligible dependents to the social services district for reimbursement.

2. The non MA-eligible policyholder must be reimbursed for any bills incurred by his or her MA-eligible spouse or dependents. This also applies to absent parents who are court-ordered to cover their dependents with health insurance. Two exceptions to this policy for absent parents follow:

- If the absent parent is court-ordered or agrees to cover all of his or her dependents' medical bills, MA will not reimburse the coinsurance and deductible billings for the MA-eligible dependents; and

- If the absent parent is court-ordered or agrees to provide health insurance coverage and also is ordered or agrees to pay for coinsurance and deductibles, MA will not reimburse the dependents' coinsurance and deductibles.

3. When bills are submitted to the social services district, the examiner must contact the TPRU for assistance. The TPRU will determine whether an arrangement can be made with the insurer to eliminate the need for the social services district to reimburse the coinsurance and deductible. Under any such arrangement, the insurer would be required to pay the contracted fee less the amount of the coinsurance or deductible. The provider would bill MA for the balance.

4. If the TPRU chooses not to or cannot obtain the insurer's cooperation to eliminate billing for coinsurance and deductibles, then the social services district must pay these amounts through reimbursement for wage deductions or direct payment for other billing arrangements.

5. See Section III, page 5 for payment instructions.

II. Instructions Regarding A/Rs Who Must Reduce Excess Income Prior To Attaining MA Eligibility.

Excess Income: available net income in excess of the exemption standard for Federal Participation (FP) persons and which is considered available to meet the cost of medical care and services. (Excess income is also referred to as surplus income or as the spenddown.)

1. In cases when an A/R must reduce excess income for MA eligibility, bills for coinsurance and deductibles must be applied to spend down excess income. Therefore, the examiner should not ask the TPRU to eliminate the applicant's coinsurance and deductible responsibilities.
2. The examiner must refer the Wrap Around policy to the TPRU for verification and data entry onto WMS when the A/R becomes MA eligible.

3. The Wrap Around bill must be treated like any other medical bill when used to reduce excess income. The following guidelines apply:

   a. Medical expenses must be incurred only to establish eligibility for federally related A/Rs. When a combination of different types of bills for medical expenses are provided by an A/R, the social services district selects the appropriate bills to apply against the excess income. The selection should generally be based upon the following hierarchy:
   - paid bills;
   - non-covered services (e.g. chiropractic care);
   - conditional bills including medically necessary over-the-counter medical goods, transportation, etc.;
   - non-participating providers;
   - older unpaid bills; or
   - medical expenses payable by the MA Program.

   b. The medical expenses of a legally dependent relative or a legally responsible relative whose income is considered available to the applicant may be used to meet the applicant's excess income requirements. When medical expenses sufficient to spend down have been incurred to meet the excess income for the eligibility period under consideration, all FP individuals in the household become eligible.

III. Instructions for Payment of Wrap Around Policy Coinsurance and Deductible Billings.

- Obtain the creditor's bill and explanation of benefits (EOB) from the recipient/policyholder. If the medical payment is deducted from the recipient/policyholders' salary, a paystub indicating the deduction and either an EOB or the medical bill itself must be obtained.

- Reimbursement will be only issued for MA-eligibles.

- Forward the billing information obtained from the recipient/policyholder to the unit in your social services district which is responsible for preparing payment for recipient medical bills. In most cases this will be the accounting unit.

- Maintain copies of the bills submitted to the accounting unit in the recipient's case record.

- The unit or person responsible for issuing the MA reimbusement must complete the required notice as explained in Section IV of this directive.

- Any MA reimbusement of Wrap Around coinsurance and deductibles must be claimed on Schedule E, line 24 (Health Insurance Premiums).

IV. Notice Requirements

The Notice: DSS-4452 (Attachment 1) and a DSS 3870: Medical Assistance Reimbursement Detail Form (Attachment 3) must be sent to each recipient or nonrecipient policyholder indicating whether or not the coinsurance and deductibles incurred or paid will be reimbursed by the fiscally responsible social services district.

There are five boxes on Attachment 1: DSS-4452. Each box indicates a potential action available to the social services district. Check only those boxes applicable to your district's action on the coinsurance and/or deductible submissions. The possible actions are explained below:

i) If after reviewing the coinsurance and deductible billings, it is decided to reimburse the vendor, check the first box on Attachment 1. Then, if necessary, check boxes three and/or four. You will also need to complete the vendor information on Attachment 2: Vendor Payment Notice and complete Attachment 3: DSS-3870. A copy of each attachment should then be sent to the recipient/policyholder.

ii If after reviewing the coinsurance and deductible billings, reimbursement will be issued directly to the recipient/policyholder, check the second box on Attachment 1. Then if necessary, check boxes three and/or four. A copy of Attachment 1 and Attachment 3 should then be sent to the recipient/policyholder.

iii If the coinsurance and/or deductible payments are being made as the result of a Fair Hearing, check the third box and box one, two and four as applicable.

- If the payment is made to the vendor, follow the actions in i above.

- If the payment is made directly to the recipient/policyholder, follow the actions in ii above.

iv Box four should be checked if any of the coinsurance and/or deductible charges presented for reimbursement by the recipient/policyholder are denied for payment. These charges should be listed on Attachment 3: DSS-3870 with an explanation for the denial. A copy of Attachments 1 and 3 should then be sent to the recipient/policyholder.

v Box five should be checked when the social services district decides not to reimburse any of the submissions for coinsurance and/or deductibles. The denied charges should be listed on Attachment 3 with the reasons for denial. A copy of Attachments 1 and 3 should then be sent to the recipient/policyholder.

Please note that the recipient/policyholder may request a fair hearing for a decision with which he or she disagrees. The fair hearing notice is listed on the reverse side of Attachment 1.

All three attachments must be reproduced locally. Attachment 2 is available on-line.

V. SYSTEMS IMPLICATIONS:

None

VI. EFFECTIVE DATE:

This Administrative Directive is effective August 1, 1994.

_____

Sue Kelly
Deputy Commissioner
Division of Health & Long Term Care

ATTACHMENT 2
VENDOR PAYMENT NOTICE

The vendor which is checked below will be paid for the copayment and/or deductible amounts incurred/paid by a Medicaid eligible family member(s). The bills submitted to the Department for payment are listed on the enclosed DSS-3870.

+---+ Employer
+---+ Name:_____

Address:_____

_____

City_____State_____Zip_____

Contact Name:_____Phone #_____

+--+ Insurance Company
+--+ Name:_____

Address:_____

_____

City_____State_____Zip_____

Contact Name:_____Phone #_____

+--+ Bank, Other
+--+ Name:_____

Address:_____

_____

City_____State_____Zip_____

Contact Name:_____Phone #_____