IM 3900 THIRD PARTY LIABILITY (TPL)

A. Definitions.--

Third Party is defined in 42 CFR 433.136 and includes a group health plan, as defined in §607(1) of the Employee Retirement Income Security Act (ERISA) of 1974, a service benefit plan, and a health maintenance organization (HMO). This is effective October 1, 1993.

Private Insurer is defined in 42 CFR 433.136 and includes a group health plan, as defined in §607(1) of the Employee Retirement Income Security Act (ERISA) of 1974, a service benefit plan, and a health maintenance organization (HMO). This is effective October 1, 1993.

Health Insurer includes a group health plan, as defined in §607(1) of the Employee Retirement Income Security Act (ERISA) of 1974, a service benefit plan, and a health maintenance organization (HMO). This is effective October 1, 1993.

Insurer, for purposes of medical child support (see §1908 of the Act), includes a group health plan, as defined in §607(1) of the Employee Retirement Income Security Act (ERISA) of 1974, a health maintenance organization (HMO), and an entity offering a service benefit plan. This is effective April 1, 1994.

For health insurer and insurer, the inclusions are explanatory and not mutually exclusive.

B. Third Parties.--Effective October 1, 1993, your State plan must provide that your State prohibits any health insurer from taking into account a person's Medicaid eligibility or the payment by Medicaid for services in the State, or in any other State, when enrolling the person or when making payments for benefits under its health insurance plan. (See §1902(a)(25)(H) of the Act.)

This is a State plan requirement and a State law is not required to be in effect. However, you or the State Insurance Commissioner may recommend that it be included with the required State laws below.

FFP will be withheld under §1903(o) of the Act and 42 CFR 433.140 for covered services that you pay for, but that could have been paid by a private insurer (under the revised definition), but were not because the insurer has an exclusionary clause in its contract pertaining to Medicaid.

Your State plan also requires that your State has laws in effect under which, to the extent that Medicaid payment has been made under the State plan for health care items or services furnished to an individual in any case where a third party has a legal liability to make payment, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services. (See §1902(a)(25)(I) of the Act.)

Your State should amend any existing laws, including any subrogation laws, which conflict with Federal statutes and regulations. Sections 1912(a)(1) and (b) of the Act and the implementing regulations in 42 CFR 433.145, 433.146, and 433.154 give you the right to payment from any liable third party under mandatory assignment of rights as a condition of eligibility for Medicaid. They also provide you with the right to identify and collect full

recovery amounts in both tort and non-tort situations and the distribution priority of the amounts collected.

C. Medical Child Support.--Effective April 1, 1994, your State plan requires that you provide assurances, satisfactory to the Secretary, that your State has in effect laws relating to medical child support required under §1908 of the Act. (See §1902(a)(60) of the Act.)

Your State must have in effect or enact laws that specifically:

1. Prohibit an insurer from denying enrollment of a child under the health coverage of the child's parent because the child was born out of wedlock, the child is not claimed as a dependent on the parent's Federal tax return, or the child does not reside with the parent or in the insurer's service area;

2. Require an insurer, in any case where a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an insurer:

a. To permit the parent to enroll the eligible child under the family coverage without enrollment restrictions,

b. To enroll the child upon application by the child's other parent or by the State Medicaid or child support enforcement agency, if that parent is enrolled but fails to make application for the child, and

c. Not to disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health coverage through another insurer without loss of coverage;

3. Require an employer, in any case where a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an employer doing business in the State:

a. To permit the parent to enroll the eligible child under the family coverage without enrollment restrictions,

b. To enroll the child upon application by the child's other parent or by the State Medicaid or child support enforcement agency, if that parent is enrolled but fails to make application for the child,

c. Not to disenroll or eliminate coverage of the child unless the employer is provided satisfactory written evidence that the court or administrative order is no longer in effect or the child is or will be enrolled in comparable health coverage without loss of coverage or the employer has eliminated family health coverage for all of its employees, and

d. To withhold from the employee's compensation the employee's share, if any, of premiums for health coverage, not to exceed the maximum amount permitted to be withheld under §303(b) of the Consumer Credit Protection Act, and to pay the employee's share of the premiums to the insurer. (Federal regulations may provide for appropriate circumstances under which an employer may withhold less than the employee's share of the premiums.);

4. Prohibit an insurer from imposing requirements on a Medicaid agency, which has been assigned the rights of a Medicaid recipient covered by the insurer, that are different from requirements applicable to an agent or assignee of any other persons covered by the insurer;

5. Require an insurer, in any case in which a child has health coverage through the insurer of a noncustodial parent:

a. To provide necessary information to the custodial parent about how to obtain benefits,

b. To permit the custodial parent or provider, with the custodial parent§s approval, to submit claims for covered services without the approval of the noncustodial parent, and

c. To make payment on claims submitted under item b. directly to the custodial parent, provider, or the Medicaid agency; and

6. Permit the Medicaid agency to garnish employment income and withhold State tax refunds, for the recoupment of Medicaid expenditures on a child§s behalf, to any person who:

a. Is required by court or administrative order to provide medical support to a child eligible for Medicaid,

b. Has received payment from a third party for medical care, but

c. Has not used the payment to reimburse, as appropriate, either the child's other parent or guardian or the service provider.

Claims for current or past due child support, however, take priority over any claim for the costs of medical services.

D. General Applicability.--Your laws implementing the requirements referenced in items 1 and 5 and the court or administrative orders in items 2 and 3 may be enacted to apply to all children and not limited to children eligible for Medicaid.

E. Coordination.--Work with the child support enforcement (CSE) agency and with the State Insurance Commissioner in developing the language for State legislators.

Be aware that related amendments have also been made to laws governing ERISA plans. (See §4301 of OBRA 1993.)

In order for medical child support orders to be enforceable against ERISA plans, the orders may have to meet certain Federal requirements as set forth in §609 of ERISA. For instance, ERISA plans are required to honor medical child support orders which are defined as any judgment, decree, or order issued by a court of competent jurisdiction. States often use an administrative process for obtaining and enforcing orders. This means that ERISA plans may choose not to honor orders obtained through an administrative process.

In addition, ERISA plans are only required to honor "qualified medical support orders". Qualified medical support orders must include specific information such as a description of the type of coverage to be provided by the plan, each plan, and the period to which such order applies. Most orders currently do not include this level of specificity. Therefore, ERISA plans may not honor or enforce such orders.