Version History Table			
Date:	**Document:**	**Changes Made:**	**Impacted Pages:**
5/2025	TPL Guide	- Language updated with instructions that BCBS of Nebraska coverage must be manually entered into C1.	Pg. 5
10/2025	TPL Guide	- Examples of plan cards added - Clarification about NEDSNP added - Carrier code information updated	Pgs, 7-8

TPL GUIDE

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Definitions:

CHAMPUS: Civilian Health and Medical Program of the Uniformed Services. CHAMPUS is a US federally funded health program that provides beneficiaries with medical care, supplemental to that available in US military and Public Health Service facilities.

CHAMPVA: The Civilian Health and Medical Program of the Department of Veterans Affairs: A comprehensive health care program in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries. The program is administered by the Veterans Health Administration Office of Community Care (VHA OCC) in Denver, Colorado.

TRICARE: The worldwide health care program for uniformed service members and their eligible family members.

Third Party Liability (TPL): The legal obligation of a third party (including certain individuals, entities, insurers, and programs) to pay for or provide monies or benefits. Medicaid is the payer of last resort. A individual must cooperate with the Department to ensure this. Third-Party Resources include Casualty, Child Support, Medical Payment, Medical Support, and Spousal Support.

Purpose: The purpose of the TPL Guide is to provide guidance for staff when navigating cases with Third Party Liability, and to combine all information into a single, streamlined document.

The guide will be separated into five different sections:

- Third Party Liability – Best Practices
- TPL Non-MAGI Disregards
- Medical Expense
- UHC Dual Complete Plans
- TRICARE/CHAMPUS/CHAMPVA

Section 1: Third Party Liability – Best Practices (TPL Top Ten)

This section is comprised of MLTC best practices when working on cases where the individual may have TPL.

- Medicaid is always the payer of last resort. It is important that the Agency obtains this information to ensure that TPL is billed first for services.

- Per information received from the COB Help Desk, TPL policies must not be entered into C1 for a individual that is Medicare Buy-In only. If the individual becomes Medicaid eligible later the information must be verified and entered into NFOCUS and C1, respectively.

- If the TPL questions are not answered on the application, ask the individual.

- At Initial Application:
    - If the pending children are enrolled in creditable health insurance, they are ineligible for CHIP. The case needs to be processed and staff must mark the "Insured" option on the TPL popup in order to have the children be denied by the system.
        - If children are determined eligible for CHIP, and have current *Federally Facilitated Marketplace (FFM)* coverage, eligibility may be determined and coverage overlap while the individual's FFM insurance is terminated. If the household indicates they have insurance and no further information is provided follow-up is needed to determine the type of insurance coverage (e.g. employer-sponsored coverage or FFM coverage) and if this is still a current policy.
    - If the children are approved, and are enrolled in creditable health insurance but ***are not*** approved for CHIP, policy information must be requested as needed and added to C1.

- Change Management (e.g., report of TPL on active case):
    - If TPL is reported and the children in the case are in the CHIP category, the children are continuously eligible until the time of their annual renewal and must not be closed outside of that period. See the Continuous Eligibility Guide and NFOCUS Workarounds for Continuous Eligibility and 12 Month Postpartum for further information.

- At Renewal:
    - If the individual is eligible for Medicare Buy-In only and at renewal or change report the individual then becomes eligible for Medicaid the worker must get verification of the individual's TPL policy and the expense. Once the TPL information is received, it must be entered into C1.
    - If the CHIP-approved children have been enrolled in creditable health insurance, they are no longer eligible for CHIP at renewal time as the child is no longer continuously eligible. The case needs to be processed and staff must mark the "Insured" option on the TPL popup screen in order to have the children be denied by the system. See the Continuous Eligibility Guide for further information.

- Cooperation with TPL is a requirement for all programs, MAGI and NON-MAGI. This includes participants who are current pay SSI.

- Always check C1 and upload the insurance information if needed. See the C1 TPL Quick Reference Guide for further information.

- Individuals with medical insurance that covers prenatal and maternity services are ***not*** eligible for 599 CHIP.

- C1 no longer electronically interfaces with Blue Cross Blue Shield (BCBS) of NEBRASKA. **BCBS coverage *must* be manually entered into C1.**

- A individual may claim good cause for not cooperating with TPL. However, establishing good cause is the individual's responsibility.

- Only adults, not children, can be closed or denied if TPL information is not provided.

- If there is questionable information, ask the individual for clarification.

- Verification of the TPL policy is required, per Section 2 of this document below, to determine if the policy meets the criteria and can be allowed as an expense in the budget. On Medicare Buy-In only cases TPL policies are not entered into C1. **NOTE:** verification of a TPL expense is not a mandatory verification.

- TPL policies must not be added to C1 if a individual is eligible for Medicare Buy-In only.

Section 2: TPL NON-MAGI Disregards

Medical insurance premiums are an allowable disregard if the individual, or financially responsible relative, is responsible for the payment(s) (477 NAC 22-005.03).

The health insurance policy must provide or require specific medical or health service(s) before benefits can be obtained (477 000-026). If the policy pays strictly for a claim that does not require medical or health service, then the policy is ***not*** allowed as a disregard.

1. Examples of ***allowable*** health insurance:
   a. Hospital daily indemnity policy pays $50 each day the individual is hospitalized. The policy is considered health insurance because the individual must be hospitalized before s/he can receive benefits. Hospitalization is considered a medical service.
   b. Cancer treatment insurance pays $50 for each chemotherapy and radiation treatment. The policy is considered health insurance because the individual must receive chemotherapy or radiation treatment before benefits from the policy can be obtained.
   c. Long-term care insurance pays $100 a day for each day an individual is in a nursing home. This policy would be allowed because nursing home care is considered a medical service.

      NOTE: Long-term care email: DHHS.MedicaidLTCinsurance@nebraska.gov

2. Examples ***not*** considered to be health insurance:
   a. Accident insurance pays $50 a day for each day an individual misses work; there are no other benefits. This policy is not considered health insurance because it is considered an income replacement policy.
   b. Cancer policy pays a $5,000 lump payment if the individual's diagnosed with cancer; there are no other benefits. The policy is not allowed because it is strictly based on a diagnosis and does not require a specific medical or health service to claim a payment.

NOTE: If the above accident or cancer policies include medical service benefits as part of the policy and verification of these benefits was provided, then the premium may be allowed as a medical disregard. For example, if the accident insurance includes benefits for emergency room or surgery then it would be allowed, or if the cancer plan includes additional medical benefits, such as $100 for each chemotherapy or radiation treatment received, then it would be allowed.

Section 3: Medical Expenses

The cost of medical insurance premiums is deducted if the individual or responsible relative is responsible for payment. (477 NAC 22-005.03)

NOTE: The cost of premiums for income-producing policies is not allowed as a medical deduction. See Appendix (477-000-026) for more information.

In order to deduct a medical insurance premium in the budget, the worker must have verification that the medical expense is incurred by an individual, a person included in the household size of the individual, or a financially responsible relative. See: Policy Memo 18-05 Medical Expense.
For the purpose of this deduction, incurred means to become liable for, whether the expense is paid or unpaid. The Agency needs only to verify that the expense has been incurred in order to include the expense as a deduction in budgeting.

1. ***Acceptable*** **verifications include:**
   a. A billing statement from the insurance company.
   b. A statement from the insurance agent noting the policy coverage and premium.
   c. Call made by the worker to the insurance company or agent, and documenting in the file.
   d. A bank account statement showing the premium as a deduction from the account.
   e. A receipt from the insurance company verifying that the premium has been paid.
2. **Do *not* accept:**
   a. An application for insurance
   b. Individual declaration or attestation
   c. Employers benefit package
3. **If verification is *not* provided confirming that the medical insurance premium is incurred or paid:**
   a. Do ***not*** close or deny the case due to Failed to Provide Information.
   b. Continue with the Medicaid eligibility determination without the medical deduction included in the budget.

Section 4: Medicare Advantage Plans (such as United HealthCare (UHC) Dual Complete)

1. A United HealthCare (UHC) Dual Complete Plan is a Medicare Advantage HMO plan, sometimes referred to as Medicare Part C. It combines an individual's Medicare Part A and B into one plan.

2. Eligible individuals must reside within the plan's service area which includes the following counties: **Cass, Douglas, Lancaster, Sarpy, Adams, Buffalo, Burt, Dodge, Gage, Hall, Madison, Otoe, Saline, Saunders, Seward,** and **Washington**. Members are offered a variety of value-added services at no cost.

3. There is no premium for individuals who qualify for ***both*** Medicare and Medicaid.

4. How to identify these plans:
    a. Review the CMS Interface, Part D Enrollment.
    b. Compare the information with the current Medicare Part D Chart.
        i. If the plan is not listed on the chart:
            1. Attempt to contact the individual and determine if it should be explored as a Medicare Part C/Medicare Advantage Plan.
            2. If determined as a Medicare Part C/Medicare Advantage Plan, see: (Understanding the Parts of Medicare).
            3. UHC AARP Medicare Advantage: Carrier code 87726 009 contains the mailing address (PO Box 31362, Salt Lake City, UT)
            4. If unable to contact the individual, send a Verification Request for this information.

    NOTE: The UHC Medicare Advantage is separate from the Medicaid and Heritage Health cards. If the individual provides copies of their UnitedHealthcare Community Plan cards, the SSW should **not** put these plans in C1 as these are the plans administered by Nebraska Medicaid.

NOTE: A copy of the actual card is not needed if the policy information can be obtained (e.g. phone call) or is already on file.

5. UHC Dual Complete plans must be added to C1 (C1 Quick Reference Guide for Eligibility Workers):
    a. Obtain a copy of the UHC Dual Complete Card **or** policy information.

b. Enter the plan on C1 using **Carrier Code: 88889-184** and **Coverage Type: 130.**
   i. Nebraska UHC Dual Complete: Carrier code 88889 184 contains the mailing address (PO Box 5240, Kingston, NY).
   ii. Group number is NEDSNP for all Nebraska UHC Dual Complete plans.

c. Send an email to DHHS.MedicaidCOBHelpDesk@nebraska.gov with the Master Case number and Medicaid ID number asking the code **130** be changed to **375**. If this plan is from another state, include that information in the email.

d. Document all case actions.

Section Five: TRICARE/CHAMPUS/CHAMPVA

TRICARE/CHAMPUS/CHAMPVA: The Department of Defense (DOD) is in the process of converting all individuals with Tricare/CHAMPUS/CHAMPVA to a Benefit Number rather than using the person's SSN. Individuals would have a DOD ID Card. If the individual has been issued a Benefit Number that is different from their SSN, the Benefit Number would need to be entered into C1.

NOTE: DOD cards cannot be copied. Individual attestation to their Benefit Number is acceptable**.**

When the individual attests to TPL provided by TRICARE/CHAMPUS/CHAMPVA:

1. Attempt a call-out to the individual to determine if they have a Benefit Number that is different than their SSN.
   a. If able to reach the individual:
      i. If the Benefit Number is different than their SSN, input this number into C1 as the participant Policy Number.
      ii. If the Benefit Number is the same as their SSN, input this number into C1 as the participant Policy Number.
   b. If unable to reach the individual:
      i. Send a Verification request asking the individual to verify their benefit number as listed on their DOD ID card number.
      ii. Once received:
         1. *If the Benefit Number is different than their SSN, input this number into C1 as the participant Policy Number.*
         2. *If the Benefit Number is the same as their SSN, input this number into C1 as the participant Policy Number.*
      iii. If the Verification Request has not been received:
         1. *If there is no reply/response to the VR by the due date, close the non-CE/PW participant using the reason of Failed to Provide Information*.

NOTE: Once the individual is issued their Benefit Number, their SSN can no longer be used in C1.