TO: Local District Commissioners; Medicaid Directors

FROM: Betty Rice, Director, Division of Consumer and Local District Relations

SUBJECT: Medicare Part D and Retiree Health Insurance Benefits, Updates to the DOH Intranet Site

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Liaison
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Medicaid recipients are required to enroll in Medicare as a condition of eligibility for Medicaid. This includes the new Medicare Part D Prescription Drug Benefit.

Employer and union plans may take different approaches to coverage. If an employer/union retiree health plan includes prescription drug coverage that is as good as the Medicare Part D benefit, the employer can receive payments from the federal government to reimburse a portion of their costs for maintaining drug coverage for retirees who **do not** join a Medicare drug plan. These federal tax-free payments are known as the "Retiree Drug Subsidy." If the retiree joins a Medicare Drug plan, the employer/union cannot collect the Retiree Drug subsidy. It is these plans that will discontinue recipient health care benefits if the recipient joins a Medicare Prescription Drug plan. A person with employer/union group health coverage may not be able to drop drug coverage without also dropping health coverage.

Because CMS is auto-enrolling all dual eligibles into a Medicare Prescription Drug Plan, some dual eligibles and their dependents who have retiree health coverage in certain employer/union plans are at risk of losing their health insurance. If they lose their health care coverage, they and any family members covered by the plan may not be able to get the coverage back.

In order to allow such dual eligibles to maintain their private health insurance, an exception to the requirement to enroll in Medicare Part D as a condition of Medicaid eligibility has been established. A finding of good cause not to enroll in Medicare Part D may be found to exist, but **only** in situations where it is determined that the Medicaid applicant/recipient has cost effective health insurance **and** will lose that insurance if the recipient enrolls in Part D.

This good cause exception will not be allowed in instances where Medicaid has been furnished to an individual whose legally responsible relative has failed or refused to provide medical support.

A determination of cost effectiveness is determined solely by the local department of social services and should take into consideration the impact on the recipient's Medicaid and/or non-Medicaid dependents that may also lose health care coverage. Be aware that some plans may allow spouses and dependents to continue to receive coverage from the employer/union plan even when the retiree loses such coverage as a result of enrolling in Medicare Part D. Also, take into consideration whether the health benefit they are losing is for drug coverage only. In this instance, enrolling in Medicare Part D and losing their private drug coverage may be more cost effective. Proof of pending termination of benefits must be presented to the local Medicaid office. Such documentation should be kept in the case record.

If a person has already been disenrolled from their cost effective employer/union plan, they should contact their employer/union to determine whether they can reenroll. Medicare is working with employers and unions that are participating in the retiree drug subsidy program to provide a flexible transition for their retirees who have been auto-enrolled in a Medicare drug plan.

Should the local district receive inquiries from dual eligibles who are faced with losing private health insurance if they enroll in a Part D plan, the local district should advise them to disenroll from Medicare Part D by calling 1-800-MEDICARE or by calling the plan directly. The recipient in turn must provide proof of pending termination of employer/union benefits to the local district. Information regarding this exception policy will be added to the CNS opening notice.

The Department is evaluating the incidence of dual eligibles who disenroll from Medicare Part D and the possible systems modifications needed to ensure recipient compliance with policy.

Districts are instructed not to manually close cases at this time for failure to enroll in Medicare Part D. However, documentation regarding the potential loss of health insurance should be maintained in the case record for future reference.

Since the release of Administrative Directive 05 OMM/ADM-5, Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Medicare Part D), a number of questions have been directed to this department. As a result, a list of frequently asked questions has been compiled. This list can be found on the New York State Department of Health intranet web site at *http://sdssnet5/*. Click DOH on the New York State map, under "Site Contents", choose "Programs", select "Third Party" from the list and then select the "Medicare Prescription Drug Program" link to view the list of frequently asked questions.

In addition to the frequently asked questions, other resources also posted under the Medicare Prescription Drug Program link include: GIS 05 MA/024 Medicare Prescription Drug Coverage, 05 OMM/ADM-5 Medicare Prescription Drug Improvement and Modernization Act of 2003 (Medicare Part D), A list of New York State Medicare Prescription Drug Benchmark Plans, and the Medicaid Update Special Edition on Medicare Part D.