STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
.O. BOX 942732
ACRAMENTO, CA 94234-7320

October 24, 1991

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

Letter No. 91-94

SUBJECT: OMNIBUS BUDGET RECONCILIATION ACT OF 1990
PREMIUM PAYMENT PROGRAM

REFERENCE: All County Welfare Directors Letter 90-23

Background

Section 4402, Omnibus Budget Reconciliation Act of 1990 (OBRA 90) mandated, effective January 1, 1991, that all states, when it is cost effective, pay the health insurance premiums, deductibles, co-payment and other cost-sharing obligations for Medi-Cal recipients who are eligible for enrollment in an employer group health plan. The State may also pay only the premiums for a non-Medi-Cal eligible, if the Medi-Cal eligible's enrollment in the health plan is dependent on the non-Medi-Cal eligible's enrollment. In addition, OBRA 90 mandates that enrollment in an employer or group health plan, when cost effective, is a "condition" of Medicaid eligibility except for an individual (such as a child) who is unable to enroll on his/her own behalf.

In order to identify Medi-Cal applicants or beneficiaries who are potentially eligible for the program, we are requiring that county workers, effective December 1, 1991, notify the Department of employed applicants/beneficiaries or family members who are eligible for, but have not applied for, employer health coverage. In addition, if the applicant/beneficiary indicates that he/she is now enrolled in a group health plan but plans to drop the coverage, the county is required to notify the Department.

County Responsibilities

a. Issue a Health Insurance Questionnaire form (DHS 6155) to the beneficiary to complete during the application and redetermination process, when the applicant/beneficiary indicates: 1) that he/she or a family member is employed, and that group or employer related health insurance is available, but has not been applied for. 2) that he/she or a family member has group or employer related health insurance, but is going to drop the coverage.

b. Assure that critical segments of the Health Insurance Questionnaire (DHS 6155) (applicant/beneficiary name, Medi-Cal identification number, applicant/beneficiary telephone number; Section I), union/employer name and telephone number (Section II.4) are complete, accurate and readable.

c. Advise the applicant/beneficiary that providing the health insurance information will not interfere with Medi-Cal eligibility, but that if payment for the group or employer related health insurance plan is approved by the Department, enrollment in the health plan is mandatory. Disenrollment from the plan by the applicant/beneficiary, after approval, is cause for discontinuance of Medi-Cal eligibility.

d. Advise the applicant/beneficiary that if health insurance coverage is available from any source, (i.e., employer, union), at no cost to the beneficiary, the applicant/beneficiary must enroll. If the applicant/beneficiary fails to cooperate by not enrolling in the plan, the county worker must deny or discontinue Medi-Cal eligibility.

e. Retain a copy of the Health Insurance Questionnaire (DHS 6155) in the case file.

f. Mail the completed Health Insurance Questionnaire (DHS 6155) within five (5) days to the Department of Health Services. In the upper right hand corner of the DHS 6155 form, write the notation OBRA 90. Send the OBRA DHS 6155 forms in a separate envelope from all other DHS 6155 forms to:

Department of Health Services
Recovery Branch
HIPP
P. O. Box 1287
Sacramento, CA 95812-1287

g. Notify the Department immediately by calling the toll free number (1-800-952-5294) if the CWD learns that a beneficiary has withdrawn from enrollment in the State-paid health plan. The Department will direct the CWD by letter to discontinue Medi-Cal eligibility upon verification of the beneficiary's disenrollment from the health plan. The county must notify the beneficiary that eligibility has been withdrawn in accordance with Section 50179(c) (7), Title 22, CCR, when instructed by the Department to discontinue Medi-Cal eligibility.

Department of Health Services Responsibilities

a. Review, process, and approve the Health Insurance Questionnaire (DHS 6155) if it is determined cost effective for the State to purchase the health insurance coverage.

b. Notify the CWD and the beneficiary of State's intent to approve or deny payment of the health insurance coverage.

c. Initiate premium payments to insurance carrier, employer or beneficiary as appropriate.

d. Update MEDS with the appropriate OHC indicator and the Health Insurance System (HIS) with health insurance information.

e. Re-evaluate premium payment cases annually and notify the CWD and beneficiary in the event State premium payment is discontinued.

f. Notify the CWD when it is verified that the beneficiary discontinued enrollment in an approved health care coverage plan and request the CWD to give notice and discontinue Medi-Cal eligibility.

If you have any questions regarding this letter or the OBRA program, please contact Robert Kimball at (916) 739-3258.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch