RESOURCES
THIRD PARTY RESOURCES

ENROLLMENT IN GROUP HEALTH INSURANCE

Policy:

An employed A/R, eligible for Medicaid without having to reduce excess income and/or resources, must enroll in any group health insurance plan offered by the employer (including health insurance offered by an employer as a COBRA extension) when an employee contribution is not required. When an employee contribution is required, the local district determines if enrollment is cost effective. When enrollment is determined to be cost effective, the local district may require the A/R to enroll, if the local district allows or pays for the employee's contribution.

References:

SSL Sect.	366.2(g) 367-a
Dept. Reg.	360-3.2(a) (1)
ADMs	91 ADM-53 87 ADM-40 84 ADM-19 82 ADM-48 82 ADM-20
INFs	88 INF-56
GISs	06 MA/026 02 MA/19

Interpretation:

An A/R whose employer or union provides group health insurance at no cost to the A/R, must apply for and use such benefits as a condition of eligibility for Medicaid. When the employer or union provides group health insurance benefits, at a cost to the A/R, the local district determines if enrollment is cost effective. In most districts, this determination is done by the Third Party Resources Unit (See 87 ADM-40). If enrollment is cost effective, the A/R may be required to enroll. When more than one insurance plan is available, the district determines which plan is the most cost effective, before requiring the A/R to enroll. The A/R's contribution is an allowable deduction from income for all categories except S/CC. When the A/R is employed, and is required by the local district to enroll in an available non-contributory health insurance plan, s/he is allowed 30 days to join the plan. The A/R must also utilize benefits available to his/her spouse and/or child under such insurance plan. An A/R who fails to comply with the requirement

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to enroll in an available health insurance plan may be denied Medicaid. Only the employed A/R may be denied.

When an A/R has private health insurance coverage in force at the time of application, the local district determines if continuation of the coverage is cost effective. The local district offers to pay health insurance premiums on behalf of all Medicaid A/Rs whenever the health insurance is determined to be cost effective and the A/R's net income and resources are at or below the allowable income/resource levels. Premium Payments are only paid for prospective months as it is generally not cost effective to pay premiums in a retro period. The exception to this may be in the instance where an A/R is at risk for losing the cost-effective insurance if the past premiums are not paid.

Cost effectiveness is determined by including Medicaid and non-Medicaid eligible family members in the cost effective determination. If the group policy is cost effective, then the local district pays for the entire premium. If the group policy is not cost effective, then the district can opt to prorate the cost of the premium for the Medicaid eligible family member.

NOTE: With the implementation of Medicare Part D, a policy determined to be cost effective may no longer be cost effective if the policy was used primarily for prescription drug coverage. A review of the policy and the A/Rs circumstances should be made**.**

If a medically needy recipient pays health insurance premiums from income and such payment, together with other applicable income disregards, reduces the individual's net available income below the appropriate income eligibility standard, the local social services district must pay or reimburse the recipient for the health insurance premium if the premium is determined to be cost-effective. The payment/reimbursement of the health insurance premium cannot exceed the difference between the individual's net available income and the appropriate income eligibility standard. For example, if the individual has a monthly spenddown of $150.00 and the health insurance premium is $200.00, the local district would reimburse the individual $50.00.