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**Medicaid Premium Assistance in the Employer Sponsored Insurance Market**  
**Frequently Asked Questions**  
*MONTH 2015*

**Overview**

Medicaid Premium Assistance in the employer sponsored insurance (ESI) market (“ESI premium assistance”) enables states to pay employee premiums on behalf of Medicaid beneficiaries. By using ESI premium assistance, states can purchase a product that covers some of the cost of services for beneficiaries, although states remain responsible for ensuring that coverage is provided in accordance with all Medicaid requirements, including benefit and cost-sharing protections. With the expansion of Medicaid to new adults under the Affordable Care Act, a number of states have expressed renewed interest in using ESI premium assistance as a tool for delivering care to some Medicaid beneficiaries. This set of FAQs clarifies and updates guidance on establishing and complying with requirements regarding ESI premium assistance programs. It addresses the statutory bases for premium assistance; eligibility for ESI premium assistance; the conditions under which states can mandate enrollment into ESI premium assistance; obligations to meet Medicaid benefit and cost-sharing requirements (by providing what is referred to as a benefit or cost-sharing “wrap”); and options for evaluating the cost-effectiveness of ESI premium assistance.

Under ESI premium assistance, an employer offers and contributes to the cost of a group health plan on behalf of a Medicaid-eligible individual. Medicaid pays the employee share of the coverage, ensures the enrollee does not incur the cost of premiums or cost-sharing above Medicaid limits, and remains responsible for providing any medical assistance covered by Medicaid and not available through the ESI. In some instances and if determined cost-effective, Medicaid will pay ESI premiums for a plan that also covers an individual’s family members even if they are not themselves eligible for Medicaid; however, states cannot receive any federal Medicaid matching funds for the costs associated with paying the deductible or other cost-sharing charges for services on the family members’ behalf.

Employer-sponsored coverage is considered cost-effective if the cost of premiums, the cost of the benefit and cost-sharing wraps, and administrative costs are less than the cost of providing comparable coverage directly. In some instances, states can mandate that beneficiaries participate in ESI premium assistance and, in this context, they can require beneficiaries to cooperate in providing the information needed to assess the cost-effectiveness of coverage as a condition of remaining eligible for Medicaid.

Once enrolled in ESI premium assistance, Medicaid beneficiaries are expected to use the ESI network to access Medicaid-covered services if they are available through the ESI. In addition, Medicaid beneficiaries can take advantage of any other services covered by their ESI, although they will need to pay any cost-sharing charges required by the ESI for non-Medicaid services. If beneficiaries require Medicaid services not covered by the ESI, the state must ensure they are covered through a wrap.

**Statutory Authority**

**Q1: What are the statutory bases for ESI premium assistance, and what are the key differences among them?**

A1: The authority to establish a Medicaid ESI premium assistance program has existed since 1990 through Social Security Act §1906, “Enrollment of Individuals under Group Health Plans.” Additional authority under Social Security Act §1906A, “Premium Assistance Option,” was first established in 2009 to allow states to offer children and their parents voluntary enrollment into ESI premium assistance under certain conditions. In 2014, the Affordable Care Act modified §1906A, such that there is now significant alignment between these two statutory authorities and now both can be used to enroll adults, as well as children. For a comparison, see Chart below.

	<b>SSA 1906 “Enrollment of Individuals under Group Health Plans”</b>	<b>SSA 1906A “Premium Assistance Option”</b>
<b>Eligibility</b>	All Medicaid eligibles	All Medicaid eligibles
<b>Voluntary or Mandatory</b>	Voluntary or Mandatory	Voluntary
<b>Employer contribution</b>	Not applicable	Employer must contribute at least 40% of total premium
<b>Benefit Wrap</b>	Must cover all Medicaid benefits not covered by the ESI benefit package	Must cover all Medicaid benefits not covered by the ESI benefit package
<b>Cost-Sharing Wrap</b>	Must ensure beneficiaries do not incur cost-sharing above Medicaid permissible limits	Must ensure beneficiaries do not incur cost-sharing above Medicaid permissible limits
<b>Cost-Effective</b>	Must be determined cost-effective	Must be determined cost-effective

States have also used 1115 waivers as a vehicle for establishing ESI premium assistance programs and additional authorities, not discussed in this set of FAQs, create state flexibility to establish ESI premium assistance programs specifically for children. In addition, § 1905(a) provides some flexibility for states to use Medicaid funds to help individuals purchase individual coverage through a Marketplace or other means; see 42 C.F.R. § 435.1015 for more details.

**Q2: Are ESI premium assistance enrollees permitted to enroll in ESI outside of the employer’s annual open enrollment period?**

A2: In recognition that employers typically limit the points in time at which an employee can sign up for coverage to an annual open enrollment period (or, for a new employee, to a specified number of days after the date of hire), federal law requires group health plans to allow beneficiaries found eligible for Medicaid or CHIP ESI premium assistance to enroll outside of these limited periods. According to section 701(f)(3) of the Employee Retirement Income Security Act of 1974 (“ERISA”), 29 U.S.C. § 1181(f)(3), a group health plan must permit an employee (or dependent) who is: (1) eligible for but not enrolled in the ESI, and (2) determined eligible for an ESI premium assistance program under Medicaid or CHIP, to enroll in ESI coverage no later than 60 days after the date the employee (or dependent) is determined eligible for the premium assistance program.

**Eligibility**

**Q3: Which Medicaid eligibility groups can be eligible for ESI premium assistance? To what extent can states limit eligibility for ESI premium assistance to only certain Medicaid-eligible individuals?**

A3: If a state implements ESI premium assistance, it must extend it to all eligibility groups. ESI premium assistance is subject to the comparability requirement of Social Security Act §1902(a)(17), and states cannot limit ESI premium assistance to specific eligibility groups. This means that any Medicaid beneficiary who asks to be evaluated for ESI premium assistance can request an evaluation as to whether the beneficiary has cost-effective coverage available to him or her.

At the same time, while states must ensure that any Medicaid-eligible individual with an ESI offer can request an ESI premium assistance determination, states have latitude to focus their resources on conducting evaluations for individuals who are likely to have cost-effective coverage. For example, a state might decide to routinely evaluate cost-effectiveness for beneficiaries with offers of coverage who are likely to incur high costs due to, for example, being pregnant or having a specific diagnosis, such as diabetes or cancer, but, otherwise only do so if asked by a beneficiary. Similarly, a state may “automatically” treat as eligible for ESI premium assistance those individuals who work for employers with coverage that the state already has

evaluated and found to be cost-effective (even if the state otherwise uses a case-by-case approach to assessing cost-effectiveness).

**Q4: Who can participate in an ESI premium assistance program on a voluntary basis? Who can be required to participate in an ESI premium assistance program?**

A4: A voluntary ESI premium assistance program permits individuals to decide whether or not they want to enroll in ESI premium assistance (if deemed cost-effective). A mandatory program requires adults with access to cost-effective ESI to enroll in order to maintain eligibility for Medicaid. As noted above, states have the option to establish a mandatory ESI premium assistance program without a waiver under Social Security Act §1906. A mandatory program conditions an individual's eligibility on his/her cooperation with the ESI premium assistance eligibility and enrollment requirements. For example, a Medicaid agency may require a beneficiary to submit documentation needed to determine cost-effectiveness and, if the ESI coverage is deemed cost-effective, to enroll in the plan. If an individual does not cooperate with these requirements, he/she may be determined ineligible for Medicaid.

Even in a mandatory program, children and spouses of ESI policyholders may not be terminated from Medicaid due to the policyholder not cooperating with the ESI premium assistance program requirements.

**Standards for Mandatory Programs**

**Q5: What can states require of beneficiaries who are being evaluated for mandatory ESI premium assistance?**

A5: After beneficiaries are found eligible for Medicaid and enrolled in coverage, a state can require them to provide information needed to evaluate the cost-effectiveness of ESI, such as an ESI summary of benefits. States, however, cannot require beneficiaries to provide information that the state already has on hand or should be able to access electronically. Once a state has determined that coverage is cost-effective, it can require the beneficiary to enroll in the ESI plan within the 60-day special enrollment period established to accommodate ESI premium assistance. If a beneficiary does not cooperate with the requirements to gather information needed to evaluate cost-effectiveness or to enroll in the ESI plan, the State may terminate the person's eligibility for Medicaid.

**Q6: What constitutes "cooperation" by Medicaid beneficiaries during an ESI premium assistance eligibility determination?**

A6: States have discretion to establish standards for what constitutes cooperation by beneficiaries who are expected to provide the information needed to evaluate cost-effectiveness and to enroll in a plan if it is deemed cost-effective. For example, states may establish how many days

an individual has to comply with requirements to provide information about their ESI, as well as identify “good cause” reasons why a beneficiary can receive an extension. Similarly, states may establish “good cause” reasons for allowing individuals to remain enrolled in Medicaid even if they fail to sign up for ESI that has been determined cost-effective, such as natural disasters, domestic violence concerns, or family crisis.

**Q7: If an individual is terminated from Medicaid for failure to cooperate with a mandatory ESI premium assistance program, when can the person reapply?**

A7: An individual terminated from Medicaid due to failure to cooperate with a mandatory ESI premium assistance program cannot be subject to a “lock out period.” Under 42 C.F.R. § 435.906, states must allow anyone wishing to apply to Medicaid to do so “without delay.”

**Provision of Medicaid Benefits**

**Q8: What services are available to ESI premium assistance enrollees?**

A8: States must ensure that beneficiaries enrolled in ESI premium assistance are able to access all Medicaid-covered benefits, including those that are not covered in the ESI package. States must make these services available via a “wrap” that is specific to the enrollee’s Medicaid benefit package. For example, a 16-year old enrolled in ESI premium assistance must be provided with any EPSDT benefits that are not covered by the ESI. Many states address this requirement by providing a separate Medicaid card to enrollees to cover “wrap” services, such as non-emergency medical transportation. In Indiana, the state has established an ESI premium assistance program for newly-eligible adults in the context of a Medicaid 1115 waiver that eliminates the need for a wrap by limiting premium assistance to those employer-sponsored plans that meet the standards for the State’s alternative benefit plan. The State also limits ESI premium assistance to those ages 21 and older and has a time-limited waiver of non-emergency Medicaid transportation, eliminating the need for a wrap of these services.

States must also provide Medicaid coverage to individuals during the ESI premium assistance eligibility determination process. Most states do so using Medicaid fee-for-service.

ESI premium assistance enrollees may also access ESI-covered services that are not covered in Medicaid through the ESI network of providers. States, however, cannot receive any federal Medicaid matching funds for the costs associated with paying the deductible or other cost-sharing charges associated with an ESI service not covered by Medicaid.

**Premiums & Cost-Sharing**

**Q9: How do Medicaid premium and cost-sharing rules apply in ESI premium assistance?**

A9: All Medicaid premium and cost-sharing rules apply to beneficiaries enrolled in ESI premium assistance programs. Enrollees may not incur the costs of premiums or cost-sharing above

Medicaid allowable limits for Medicaid-covered services, regardless of whether the provider of the services is in the Medicaid network. As is the case for all Medicaid beneficiaries, if there is a risk that aggregate cost-sharing may exceed the 5% of income cost-sharing cap, the state must track cost-sharing against this cap.

States continue to develop strategies to comply with the requirement that beneficiaries not incur premiums or cost-sharing in excess of Medicaid allowable limits. For example, New York sends ESI enrollees a check to cover the cost of their premiums in advance of when the obligation is due, ensuring that they have the resources with which to pay ESI premiums when their employers take the ESI deduction from their paycheck. Indiana has addressed the issue in the context of a Medicaid 1115 waiver by making a \$4,000 contribution to “POWER” accounts, which are Medicaid Health Savings Accounts that can be used to pay a beneficiary’s cost-sharing charges and premium charges in excess of the levels required by Indiana Medicaid.

### **Provider Network & Reimbursement**

**Q10: May states require ESI premium assistance enrollees to access Medicaid-covered services through the ESI network of providers?**

A10: States may require ESI premium assistance enrollees to access services through the ESI network of providers when reasonably available without a waiver.

**Q11: If an ESI premium assistance enrollee accesses Medicaid-covered services through a provider who participates in ESI and Medicaid, may states reimburse the provider at Medicaid allowable limits or ESI negotiated rates?**

A11: States have the option to reimburse providers either at Medicaid allowable limits or ESI negotiated rates when an ESI premium assistance enrollee accesses a Medicaid-covered service from a provider who participates in both ESI and Medicaid. If a state wants to reimburse such providers at Medicaid levels, it should include language in its contracts with providers that requires them to accept the Medicaid allowable limit for any Medicaid enrollee, regardless of other sources of coverage.

For example, assume a hypothetical state Medicaid program reimburses a primary care provider \$30 per visit (and does not charge the beneficiary a co-payment for such a visit). If the state requires its Medicaid providers to accept Medicaid allowable limits, regardless of other sources of coverage, the state would not owe the provider as long as he/she receives at least \$30 from the ESI. If, however, the state has elected to reimburse Medicaid providers at ESI levels for ESI premium assistance enrollees, the state could end up making payments that allow the provider to receive more than \$30 per visit. For example, if ESI reimburses the provider a total of \$60 per visit with \$40 paid by the ESI and \$20 by the enrollee, Medicaid would pay \$20 to ensure that the provider receives the full ESI reimbursement rate (even though the \$40 that the provider received from ESI already exceeds the Medicaid allowable limit of \$30). Federal

Medicaid matching funds are available for these payments even if they are above the state's Medicaid fee schedule.

**Q12: If an ESI premium assistance enrollee accesses Medicaid-covered services through a provider who participates only in ESI (i.e., does not participate in Medicaid), what obligations does the state have to ensure the beneficiary does not incur cost-sharing? What if the cost-sharing obligations are in excess of Medicaid allowable limits?**

A12: State Medicaid agencies must ensure that ESI premium assistance program enrollees do not incur cost-sharing obligations in excess of Medicaid allowable limits. If an ESI premium assistance enrollee accesses Medicaid-covered services through a provider who participates in the ESI network but not in Medicaid, the state is responsible for covering any cost-sharing incurred by the enrollee, including above Medicaid allowable limits. Complying with this requirement may necessitate both devising a method for paying providers directly who do not have a relationship with the Medicaid agency and paying above Medicaid allowable limits.

CMS recognizes that, under this scenario, states may have to pay providers that have not undergone Medicaid certification and for whom the state will not have the authority to require documentation. If the state is explicit in state law, code or guidelines that the Medicaid agency must pay non-Medicaid-participating providers in order to assure Medicaid protections for ESI premium assistance enrollees, the state will not be penalized in an audit for these payments.

### **Cost-Effectiveness**

**Q13: What is the definition of cost-effectiveness for ESI premium assistance?**

A13: To purchase ESI using premium assistance, a state must determine that ESI is “cost-effective,” or, that the cost to Medicaid of providing comparable coverage directly is less than or equal to the cost to Medicaid of providing ESI premium assistance, taking into account the cost of premiums, the cost of the benefit and cost-sharing wraps, and administrative costs.

**Q14: What is the “Secretary’s methodology” for cost-effectiveness?**

A14: States have the option to determine cost-effectiveness using the Secretary’s methodology, as laid out in Chapter 39, Section 3910 of the [CMS State Medicaid Manual](#). The purpose of the Secretary’s multi-step process is to determine whether the cost to Medicaid of providing direct Medicaid coverage is more or less than the cost to Medicaid of providing ESI premium assistance. The basic purpose of the methodology is to allow states to compare the cost of providing the Medicaid services covered by the ESI through Medicaid versus through the payment of premiums, cost-sharing charges, and administrative expenses.

As a first step, the state must determine what share of Medicaid services are covered by the ESI (e.g., a state might estimate that an ESI plan covers 75 percent of Medicaid services, reflecting that it excludes long-term care and other specialized Medicaid services not commonly found in ESI). It then compares the cost of providing these services through the Medicaid program versus

through the ESI, taking into account premium costs associated with the ESI and the cost-sharing charges that the Medicaid agency will need to pay (e.g., a state might assume that it will have to pay 20 percent on average of the cost of the Medicaid-covered services in an ESI plan, reflecting a deductible and cost-sharing charges). The Secretary's methodology also includes an adjustment to the cost of the ESI option that reflects, as appropriate in the state's assessment, the higher rates paid by ESI. Finally, when evaluating the cost effectiveness of purchasing the ESI, the state must add in administrative expenses using an average cost per person (e.g., \$50 or \$100 per person).

**Q15: What other options do states have for developing a cost-effectiveness methodology?**

A15: States have the option to use the Secretary's methodology as described above or to receive approval from CMS for a state-developed cost-effectiveness methodology. As described at 42 U.S. Code § 1397ee(c)(3), states have flexibility to design a methodology that evaluates cost-effectiveness at either an individual or aggregate level. A state could, for example, demonstrate that enrolling all Medicaid-eligible individuals with an offer of ESI is cost-effective for the program at an aggregate level by conducting a comprehensive survey of ESI offers in the state for all Medicaid categories. Or, a state could design an individualized methodology that takes into account the specifics of an individual's past and projected health costs and ESI benefits, premium, deductible and co-payment structure. To balance these two approaches, many states currently conduct evaluations for each individual but use average Medicaid costs and certain assumptions about the ESI offer to determine cost-effectiveness.

Some states that have chosen to develop a state methodology use a similar approach to the Secretary's methodology as a first step, but if the first methodology indicates a plan is not cost-effective, the State will take into consideration the individual's health status and run a second cost-effectiveness test based on projected costs for a specific diagnosis.

**Q16: To what extent can states mandate enrollment into the "most cost-effective" ESI plan in the event a beneficiary is offered more than one cost-effective ESI plan?**

Q16: States are encouraged to permit enrollees to choose among cost-effective ESI plans should a beneficiary have the option to enroll in more than one cost-effective ESI plan; however, acknowledging that many employers offer a large number of plans to employees, it may not be realistic for states to determine the cost-effectiveness of every ESI plan an individual is offered. States may use discretion in developing an approach that permits as much enrollee choice as possible but does not pose an excessive administrative burden on the state.

**Q17: How often must a state redetermine cost-effectiveness?**

A17: When conducting regularly-scheduled renewals for Medicaid beneficiaries, states must re-evaluate the cost-effectiveness of an ESI offer if they have reason to believe that the terms of the offer have changed or that its cost relative to the state's Medicaid program has increased. Moreover, if a state is aware of an upcoming ESI open enrollment period, it may require the

beneficiary to provide updated ESI information at that time to allow the state to redetermine cost-effectiveness and eligibility for ESI premium assistance. If the state has sufficient information at that time to start a new period of Medicaid eligibility, it may do so and, in the process, align the annual renewal date with the beneficiary's ESI open enrollment period.

### **Appeals**

**Q18: How do Medicaid appeal requirements apply in the context of an ESI premium assistance program?**

A18: []