Corrected #17-21-01C: DHS Explains Policy and Procedures for MA Cost-Effective Health Insurance (CEHI) and Why HSAs, MSAs, and VEBAs Are Not CEHI

TOPIC
Medical Assistance (MA) policy and procedures for CEHI, why MA cannot reimburse MA members for any health savings account (HSA) or Archer medical savings account (MSA) contributions, and why voluntary employees’ benefit associations (VEBAs) are not evaluated for CEHI.

PURPOSE
To correct Bulletin #17-21-01

CONTACT
Local agencies should submit questions about CEHI via SIR Web Mail to dhs.cehi@state.mn.us.

SIGNED
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TERMINOLOGY NOTICE
The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.
I. Notes about This Bulletin

This bulletin uses the following definitions:

- Group health plan: Employer-sponsored health insurance (see III.A.1 for a more detailed definition)
- Individual health plan: Health insurance that a person purchases in the private market

This bulletin uses the following abbreviations:

- “CEHI” for “cost-effective health insurance”
- “DHS” for “Minnesota Department of Human Services”
- “HDHP” for “high-deductible health plan”
- “HSA” for “health savings account”
- “MA” for “Medical Assistance”
- “MHCP” for “Minnesota Health Care Programs”
- “MSA” for “Archer medical savings account”
- “VEBA” for “voluntary employees’ benefit association”

“We,” “us,” and “our” refer to DHS. “MA member” refers to an MA enrollee.

This bulletin is addressed to local agency workers, and “you” refers to a local agency worker.

II. Introduction

As a condition of MA eligibility, an MA member with access to a group health plan must enroll in the plan and maintain enrollment when the plan is determined to be cost effective. An MA member may have access to a cost-effective group health plan through his or her own employer, or through a spouse’s or parent’s employer. A group health plan is considered “cost effective” if the cost for MA to pay premiums and cost sharing for the plan and wraparound coverage is less than the cost to pay for an equivalent set of services through a contracted managed care organization (MCO). If a plan is cost effective, MA reimburses the premiums for the member’s group health plan and provides wraparound coverage—that is, coverage for all MA benefits not included in the group plan.

In addition, if an MA member is enrolled in an individual health plan and the plan is cost effective, the MA member may request that MA reimburse the member for premiums paid for the plan. The analysis of an individual health plan’s cost effectiveness is identical to the analysis of a group health plan’s cost effectiveness; however, an MA member with access to a cost-effective individual plan is not required to enroll in it or maintain enrollment as a condition of MA eligibility.

Through its MA CEHI program, Minnesota determines and provides premium reimbursements for people required to enroll in cost-effective group health plans and people who choose to enroll in cost-effective individual health plans. As a county or tribal worker, you are responsible for evaluating whether MA members’ other health insurance is cost effective after MA approval, at annual renewal, during annual health plan selection, and any time an MA member reports gaining access to other health insurance.
III. Correcting Bulletin #17-21-01: CEHI Cooperation and Evaluation Requirements for MA Members with Access to Other Health Insurance

This bulletin replaces Bulletin # 17-21-01, published in January 2017, and provides guidance on CEHI cooperation requirements by doing the following:

- clarifying the difference between an MA member’s required enrollment in a cost-effective group health plan and optional enrollment in a cost-effective individual health plan
- clarifying which health plan policies are always cost effective and which are never cost effective
- clarifying the circumstances under which MA must pay for the entire premium amount of a cost-effective group health plan even when the employee or other family members covered by the plan are ineligible for MA
- clarifying that an MA member participating in an HSA or MSA cannot receive MA reimbursement for any contributions he or she makes to the HSA or MSA
- clarifying that local agencies should evaluate an MA member’s HDHP associated with an HSA or MSA and, if the HDHP is cost effective, require enrollment in the HDHP if it is a group health plan and reimburse the MA member for his or her HDHP premiums and cost sharing
- reaffirming that local agencies should not evaluate VEBAs for CEHI because VEBAs’ complexity and plasticity makes determining whether any given VEBA is a group health plan under the Internal Revenue Code too administratively costly at the local agency and state levels, thereby undermining the purpose of the CEHI program
- directing you to ONEsource for updated CEHI procedures that implement the policy found in this bulletin and the MHCP Eligibility Policy Manual

This bulletin is not a complete source of CEHI policy. Refer to the MHCP Eligibility Policy Manual, Section 2.1.1.2.1.3.1, MA Cost Effective Insurance, for further guidance.

A. MA Requirement to Enroll in a Cost-Effective Group Health Plan and Optional Enrollment in a Cost-Effective Individual Health Plan

MA members who report access to, or enrollment in, a group health plan must cooperate in determining the cost effectiveness of the plan as a condition of continued MA eligibility. An MA member cooperates by doing all the following:

- providing information about his or her group health plan so that the local agency can determine whether the plan is cost effective
- reporting changes in access to his or her group health plan
- enrolling in or maintaining group health coverage that has been determined to be cost effective
1. Required Enrollment in Cost-Effective Group Health Plans

As a local agency worker, you determine whether a group health plan available to an MA member is cost effective. Health care coverage exists in many forms, and not all health care coverage meets the definition of “group health plan.” A group health plan is either of the following:

- a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families
- COBRA continuation coverage of a health plan described in the above bullet point

When a health plan available to an MA member meets this definition, or when the MA member is already enrolled in a health plan that meets this definition, you must evaluate the plan for cost effectiveness and require enrollment in the plan if it is cost effective. An MA member may have a group health plan available through his or her own employer, or through a spouse’s or parent’s employer.

MA members with access to a group health plan that is not determined to be cost effective are not required to enroll or maintain enrollment in the plan as a condition of eligibility for MA. MA will not reimburse for premiums if MA members choose to continue these plans.

MA members must provide information about their employer group health plan to the local agency within 10 days of a request for the information. Allow additional time if the time to provide the information has expired but the MA member is cooperating. MA members who do not provide enough information to determine whether a plan is cost effective or do not maintain enrollment in their group health plan are no longer eligible for MA. Their MA coverage must be closed with a 10-day advance notice.

2. Exceptions to Required Enrollment in Cost-Effective Group Health Plans

Even if an MA member has access to a group health plan that is determined cost effective, there are certain circumstances in which enrollment in the plan is not required:

- If an MA member is cooperating with CEHI requirements but the MA member’s employer or another person who controls access to the group health plan refuses to enroll the MA member in the health plan, do not deny or close the member’s eligibility for MA.
- Children and spouses of MA members with access to a cost-effective group health plan remain eligible for MA even if the policyholder fails to cooperate with CEHI requirements. Do not deny or close eligibility for children or spouses who cannot enroll or maintain enrollment in a cost-effective group health plan on their own behalf.
- Pregnant women who are eligible for Children’s Health Insurance Program (CHIP)-funded MA are not required to provide information about or pursue other health care coverage that may be available to them through an employer or other means.
- Safe at Home (SAH) address confidentiality program participants are not required to cooperate with CEHI requirements when the policyholder is their probable assailant.
• If an MA member qualifies for a waiver because having to pay group coverage premiums and then wait for reimbursement from MA would be a financial hardship, the member is not required to cooperate with CEHI requirements.

3. Optional Determination of Cost Effectiveness for MA Members with Individual Health Plans

MA members who are enrolled in an individual health plan, instead of a group health plan, are never required to maintain enrollment in the plan as a condition of MA eligibility. An MA member may, however, request a determination of cost effectiveness and receive premium reimbursement if you determine the individual health plan is cost effective.

B. CEHI Policy Clarifications

1. Health Plan Policies That Are Always Cost Effective and Those That Are Never Cost Effective

Some health plan policies are always considered cost effective, and others are never considered cost effective.

a. Plan Policies That Are Always Cost Effective

The following plan policies are always considered cost effective:

• policies for which the monthly premium (or prorated portion of a family premium) plus 1/12th of the annual average cost factor\(^1\) by age is less than the current MA managed care rate for people of the same age, as determined by completing the Cost-Effective Insurance Calculation (DHS-3767C) using procedures found in ONEsource

• policies for which annual covered medical expenses exceed annual premium costs plus the annual average cost factor by at least a 2:1 ratio and the MA member’s medical condition remains the same

b. Plan Policies That Are Never Cost Effective

The following plan policies are never considered cost effective:

• Medicare Supplement or Medicare Advantage (Medicare Part C) policies for MA members 65 years old or older
• hospital or long-term-care (LTC)^2 indemnity policies that provide cash payments for each day in a hospital or nursing facility if the client is not currently collecting benefits

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\(^1\) The “annual average cost factor” is the average paid costs of health insurance (deductibles, coinsurance, and copayments) plus the cost of MA wraparound benefits and administrative costs in the preceding calendar year, averaged by age group or pregnancy status for people with cost-effective coverage.

\(^2\) If an MA member has an LTC insurance policy and is receiving MA-LTC services, email the policy and the member’s case number to dhs.cehi@state.mn.us via SIR Web Mail, and the DHS Health Insurance Recovery Unit will respond with a determination of whether the policy is cost effective.
2. MA Premium Payment When the Employee or Other Family Member Covered by a Health Plan Is Ineligible for MA

Oftentimes a CEHI evaluation involves a health plan that covers both MA members and those ineligible for MA within the same family coverage. Subsections a and b below explain how MA reimburses when these plans are cost effective.

a. Payment When the Full Family Premium Amount of a Group Health Plan Is Cost Effective

MA will reimburse the full family premium for a group health plan on behalf of an MA member or members, even when the employee policyholder or other family members covered by the plan are ineligible for MA, if:

- coverage under the group health plan for the MA member or members is not possible unless the employee or other family members enroll and
- premium reimbursement is still cost effective, even after incorporating the full family premium amount.

No other cost sharing, such as deductibles or copayments, may be paid by MA for the family members who do not qualify for MA.

Note: You cannot require an MA-ineligible family member to enroll in a group health plan, even if enrolling would be cost effective. MA members remain eligible for MA even if the MA-ineligible person refuses to enroll in the group health plan.

b. Payment When the Full Family Premium Is Not Cost Effective but the MA Member’s Prorated Portion of the Premium is Cost Effective

If the full family premium of a group health plan is not cost effective and the plan policyholder is ineligible for MA, but at least one family member who is (or could be) covered by the plan is eligible for MA, then MA must reimburse the MA member’s prorated portion of the plan premium when:

- the MA member’s prorated portion of the premium is cost effective and
- the plan policyholder chooses to enroll (or maintains the enrollment of) the MA member in the plan.

In this situation, you cannot require the policyholder to enroll (or maintain the enrollment of) an MA member in the plan. If the policyholder chooses to do so, however, MA will pay the MA member’s prorated premium amount but not the policyholder’s (or any other MA-ineligible family member’s) portion of the premium.

Note: MA can also reimburse prorated premium amounts as described in this subsection for individual health plans.

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3 MA does not pay the portion of an individual health plan premium for a policyholder or family member who is ineligible for MA.

4 If more than one family member is eligible for MA, the Cost-Effective Insurance Calculation (DHS-3767C) allows you to determine whether the combined prorated premium amount for all MA members in the family is cost effective. If the combined prorated premium amount for all MA members is cost effective, then that amount is reimbursed. Procedures for this situation are found in ONEsource.
C. Cooperation Requirements for an HDHP and an Associated HSA or MSA

You must evaluate the cost effectiveness of any HDHP that an MA member has access to (or is enrolled in) if the HDHP is a group health plan. If the MA member’s HDHP is an individual health plan, you must evaluate the HDHP for cost effectiveness at the MA member’s request. Regardless of whether reimbursement for an MA member’s HDHP premiums is required or optional, MA cannot reimburse the MA member for any contributions he or she makes to an HSA or MSA paired with an HDHP.

1. Evaluating HDHPs for Cost Effectiveness

An HDHP is a health insurance plan that does not cover enrollees until they have paid a costly deductible. After HDHP enrollees have paid the full deductible, all costs above the deductible amount are covered by the plan. HDHPs can be offered by employers or on the private market.

If an MA member has access to or is enrolled in an HDHP that is a group health plan, evaluate the HDHP using the Determining Whether the Policy Is Cost Effective procedure in ONEsource. The HDHP may be paired with an HSA or MSA that the employer, MA member, or both contribute to. Do not factor in the HSA or MSA when determining whether the HDHP is cost effective. Evaluate the HDHP premium only. If the HDHP is cost effective, require the MA member to enroll in, or maintain enrollment in, the HDHP and receive reimbursement for premiums.

If the MA member’s HDHP is an individual health plan, evaluate the HDHP as you would evaluate a group health plan, excluding an associated HSA or MSA from the evaluation, but do not require the MA member to enroll in, or maintain enrollment in, the individual health plan.

2. Excluding HSAs and MSAs from the MA CEHI program

MA cannot reimburse an MA member for any contributions he or she makes to an HSA or MSA paired with an HDHP.

a. What Is an HSA?

An HSA is a savings account set up as a tax-exempt financial instrument for payment of qualified medical expenses of a person enrolled in an HDHP. Any funds that a person deposits in an HSA are not taxed, so long as they are used to pay for qualified medical expenses, such as doctor’s visits and prescription drugs. An employer, bank, credit union, or insurance company may oversee the HSA.

b. What Is an MSA?

An MSA is a savings account set up as a tax-exempt financial instrument for payment of qualified medical expenses for a small-business employee or self-employed person. Like an HSA, an MSA must be coupled with an HDHP.

c. Why Can’t MA Pay for an MA Member’s HSA or MSA Contributions?

MA pays for an MA member’s group or individual health insurance premiums, deductibles, coinsurance, and other cost-sharing obligations for items and services covered under MA. HSA and MSA funds, however, must be used to pay for medical care that is not compensated for by insurance or otherwise if the funds are to remain tax exempt. Because MA pays for costs a member incurs for receiving services that the HDHP and MA insures,
and HSAs and MSAs pay for medical care the beneficiary receives that is not otherwise insured, MA cannot reimburse a person’s contributions to an HSA or MSA, as such reimbursement would be applied to an account that pays for medical care that is not covered under the HDHP or MA.

In addition, MA cannot pay for HSA or MSA contributions because there is no requirement under law that HSA or MSA funds be used only for qualified medical expenses—funds not spent on medical expenses simply receive different tax treatment. MA can reimburse only for coverage that is limited to paying for health services.

**Note:** When an MA member must receive (or chooses to receive) reimbursement for a cost-effective HDHP under the MA CEHI program, it is the MA member’s choice whether to remain enrolled in an HSA or MSA.

**D. CEHI Evaluation Is Not Required for a VEBA**

Do not evaluate VEBAs for cost effectiveness or require an MA member to enroll in, or maintain enrollment in, a VEBA as a condition of MA eligibility.

**1. What Is a VEBA?**

A VEBA is a tax-exempt entity created under the Internal Revenue Code, section 501(c)(9), and may include health benefit plans, life insurance, disability insurance, accident insurance, vacation, or other employee benefits. A VEBA can be a trust, corporation, or association, and it may be funded by employees or their employer (or both).

A VEBA may directly provide sick and accident benefits to or on behalf of enrollees and their dependents. A VEBA may also indirectly provide sick and accident benefits through the payment of premiums or fees to an insurance company, medical clinic, or other program under which enrollees and their dependents are entitled to medical services or to other sick and accident benefits. Sick and accident benefits may also be provided in noncash form, such as benefits in the nature of clinical care services by visiting nurses, and transportation furnished for medical care.

**2. Why Are VEBAs Excluded from the MA CEHI Program?**

Minnesota’s formula for determining the cost effectiveness of other health insurance includes local agency and state administrative costs of evaluating that insurance. VEBAs are complex tax-exempt entities that can take on a variety of forms, at times tailored to an individual employer’s criteria, and evaluating VEBAs for cost effectiveness can take an inordinate amount of time and technical expertise. Because of this burden, the administrative cost of evaluating VEBAs’ cost effectiveness results in VEBAs never being cost effective under Minnesota’s formula for cost effectiveness.

**IV. Action Required**

Starting from the date of this bulletin’s publication, implement your agency’s CEHI program in accordance with the policy in this bulletin and the MHCP Eligibility Policy Manual, Section 2.1.1.2.1.3.1, [MA Cost Effective Insurance](#). Apply this policy prospectively, when an MA member’s other health insurance is up for review under
the normal timelines of the CEHI program, such as after MA approval, at annual renewal, during annual health plan selection, and any time an MA member reports gaining access to other health insurance.

Implement the CEHI policy in this bulletin and the MHCP Eligibility Policy Manual by following the recently published CEHI procedures in ONEsource.

V. Legal Authority

United States Code, title 26, section 220
United States Code, title 26, section 223
United States Code, title 26, section 501, paragraph (c), clause (9)
United States Code, title 26, section 5000, paragraph (b)
United States Code, title 42, section 1396e, paragraph (a), clause (2)
Code of Federal Regulations, title 26, section 1.501(c)(9)–3
Code of Federal Regulations, title 42, section 435.1015
Minnesota Statutes, section 256B.056, subdivision 8
Minnesota Rules, part 9505.0430

Americans with Disabilities Act (ADA) Advisory

For accessible formats of this publication or assistance with additional equal access to human services, write to DHS.info@state.mn.us, call 800-657-3739, or use your preferred relay service. (ADA1 [9-15])