STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: FLORIDA

Requirements for Enrollment in
Employer Based Group Health Insurance

Enrollment in employer-sponsored health care coverage, if available and cost effective is a condition of eligibility for the recipient.

A. Cost Effectiveness

1. Enrollment in employer-sponsored health care coverage shall be considered cost effective when the amount of financial assistance provided for the recipient to pay the employee share of the employer-sponsored health care coverage does not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for the recipient.

2. When determining cost effectiveness of employer-sponsored health care coverage, the Agency shall consider the following:

   a. The cost of the Medicaid premium that would have been paid to a managed care plan for the recipient.

   b. The employee share of the employer-sponsored health care coverage, including copayments and deductibles that the State may reimburse.

3. The employer-sponsored health care coverage shall be treated as a third party resource in accordance with federal third party liability requirements. When recipients are enrolled in employer-sponsored health care coverage, this coverage shall become the first source of health care benefits up to the limits of such coverage, prior to the availability of Title XIX benefits.

4. If Medicaid services covered under the State plan are not part of the services covered by a recipient's employer sponsored health care coverage, the recipient may obtain those services from participating Medicaid providers. These services are reimbursed at the State Medicaid rate.

5. The Agency shall pay all premiums, deductibles, coinsurance and other cost sharing obligations for items and Medicaid services covered under the State plan up to Medicaid's rate for recipients in employer-sponsored health care coverage, except for the cost sharing amounts permitted under the State plan which are the recipient's responsibility.

B. Cost Effectiveness Review

1. The Agency shall complete a cost effectiveness review at least once every six (6) months.

2. The Agency shall perform a cost effectiveness redetermination if:

   a. The employee share of the employer-sponsored health care coverage changes;

   b. Any of the individuals covered under the employer-sponsored health care coverage lose Medicaid eligibility; or

   c. There is loss of employment.

C. Coverage of Non-Medicaid Family Members

The Agency shall pay the employee share of the employer-sponsored health care coverage when cost-effective regardless of whether all family members are Medicaid eligible. The Agency shall not pay a deductible, coinsurance, or other cost-sharing obligation, or provide for payment of services covered under the State Plan but not covered by the plan on behalf of a participating family member who is not Medicaid eligible.