

New York

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**COST EFFECTIVENESS METHODOLOGY FOR
COBRA CONTINUATION BENEFICIARIES**

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Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guideline used in determining cost-effectiveness by selecting one of the following methods:

☐ The methodology as described in SMM section 3598.

☒ Another cost-effective methodology as described below. *

*See [Supplement 11 to Attachment 2.6\(A\)](#), pages 2 and 3

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**COST EFFECTIVENESS DETERMINATION FOR
PREMIUM PAYMENTS UNDER THE
COBRA CONTINUATION COVERAGE PROGRAM**

The determination of cost benefit for any health insurance policy is an evaluation of many varied but interrelated criteria. It is difficult to establish exact guidelines for cost benefit determinations that can be applied uniformly in all cases. Unless a person is already in poor health, whenever insurance is purchased a risk is taken as to whether or not health expenses will be incurred. Therefore, cost benefit determinations must be made on an individual basis after the local district staff obtain insurance policy and the individual applying for the premium payment.

Please note that for some cases, even after reviewing these criteria, the determination to pay for a health insurance policy may still be unclear. In these cases, the final decision will rest solely on the judgment of local district staff.

The following points should be considered in making a determination whether or not to pay insurance premiums within the framework of the COBRA Continuation Coverage Program.

1. Assess the types of medical services covered by the health insurance policies.
2. Has there been a high utilization of medical services by the applicant/recipient (A/R)?

Request the applicant/recipient to bring to the interview all medical bills (paid and unpaid), statements of insurance benefit payments and premium notices for the past year. Determine the total amount paid by all parties for the medical services.

3. Can the past utilization of medical expenses be expected to continue or increase?

During the interview inquire if any acute or chronic medical conditions exist. If so, does the condition require or could it potentially require extensive medical services? Will these potential expenses be covered by the policy?

4. Does a situation exist which warrants maintaining the policy even though there is no history of high medical utilization?

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Due to the client's age or a pre-existing condition, is it reasonable to assume that the client may not be able to obtain another policy in the future or that a pre-existing condition would not be covered by a new policy for a period where medical utilization may be expected.

5. For policies in force, what are the maximum benefit levels of the policy?
 - a) Have the maximum benefit levels been met, rendering the A/R?
 - b) If so, is the maximum benefit recurring? Will it be reinstituted on an annual basis, at the end of a specific benefit period, or does it apply separately to unrelated injuries, sicknesses, and/or conditions?
 - c) If there will be benefits or recurring benefits that will pertain to the A/R's potential medical expenses, how do these benefits compare to the cost of the premium?
6. Review the number of dependents in a family. In general, the larger the family, the more cost beneficial it is to purchase family coverage.
7. Compare the cost of the COBRA premium to the cost of all medical services received by the applicant/recipient in the previous year (see #2). Using this comparison and the other factors related to anticipated future utilization (3 through 6) decide whether or not it is cost beneficial to pay the premium. That is, does the cost of the COBRA premium payment appear likely to be less than the Medicaid expenditures for an equivalent set of services.

NOTE: For those districts that use the "Health Insurance Automated Decision Tree" (HIADT), make sure that the premium payment used in the calculation is the total premium. Under COBRA continuation coverage, the individual (or Medicaid) is generally responsible for both the employer's and employee's share of the insurance premium not to exceed 102% of the applicable premium (or 150% of the premium for disabled individuals beginning in the nineteenth month of coverage). In addition, only use the Medicaid payments for the equivalent set of services that would otherwise be paid for by the insurance policy.

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