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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

| Citation | Condition or Requirement |
|-----------------|---|
| 1906 of the Act | State Method on Cost Effectiveness of Employer-Based Group Health Plans |

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 or Department of Health staff obtain information about the insurance policy and the individual applying for the premium payment. If the average Medicaid payment is known for certain demographics (e.g., sex, age, location), cost effectiveness for paying the premium can be easily determined by comparing that cost to the cost of a premium for the same demographics.

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 judgement of local district or Department of Health staff.

The following points should be considered at the time of determination and redetermination for coverage provided through employer-based group health plans.

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 notice for the past year. Determine the total amount paid by all parties for the medical services.

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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.

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?

- Have the maximum benefit levels been met, rendering the A/R ineligible for benefits?
- If so, is the maximum benefit recurring? Will it be reinstated on an annual basis, at the end of a specific benefit period, or does it apply separately to unrelated injuries, sicknesses, and/or conditions?
- 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 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 maintain the policy. That is, does the cost of the premium payment and cost-sharing amounts appear likely to be less than Medicaid expenditures for an equivalent set of services?

NOTE: For those districts that use the [Health Insurance Automated Decision Tree] "Health Insurance Cost Appraisal Program (HICAP)" make sure that the premium payment used in the calculation is the Medicaid portion of the premium payment.

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