# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

## STATE METHOD ON COST EFFECTIVENESS OF EMPLOYER-BASED GROUP HEALTH PLANS

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
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<tbody>
<tr>
<td>1906 of the Act</td>
<td>1. The cost of the premium is determined and annualized.</td>
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<td>2. The services covered by the group plan and the Medicaid program are determined by contacting the employer by telephone and confirming coverage and deductible amounts.</td>
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<td>3. The projected annual cost of individuals covered under Medicaid is based on a cost per eligible month for individuals with specific demographic characteristics. This calculation is figured annually. The resulting data are formulated into lookup tables in a PC-based program adapted from the State of New York. These tables are used for evaluations during the subsequent year. The characteristics evaluated are as follows:</td>
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<tr>
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<td>a. Rural vs. Urban location within the State.</td>
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<td>b. Five categories of eligibility, which include:</td>
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<td>i. AFDC-related</td>
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<td></td>
<td>ii. Aged</td>
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<td>iii. Blind</td>
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<td>iv. Disabled</td>
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<td>v. Pregnant women</td>
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<td>c. Age (under 1, 1-5, 6-20, 21-64, 65+)</td>
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<td>d. Sex</td>
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<td>e. Medicare status</td>
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<td>4. A factor for administrative expense is added to the Medicaid cost. The projected cost for co-insurance and deductible charges is also added to the cost of the premium.</td>
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<td>5. The total projected annual Medicaid expenditures for services under the plan are compared to the annual projected premium plus the projected administrative costs and the projected co-insurance and deductible costs identified in item 4 above. The most cost-effective option for Medicaid is selected.</td>
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T.N. # 91-025  
Approval Date 7-10-92  
Supersedes T.N. # New  
Effective Date 12-1-91
### STATE METHOD ON COST EFFECTIVENESS OF EMPLOYER-BASED GROUP HEALTH PLANS (Continued)

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<td>6. Staff determining cost effectiveness can override a system-recommended decision based on the above calculations when a covered individual has significant medical problems that would not be fairly represented by the average medical expenditures determined in item 3 above. In this case, the justification for the override must be compelling.</td>
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