

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

State Methodology on Cost Effectiveness of
Employer-Based Group Health Plans

The Nebraska Medical Assistance Program (NMAP) determines the cost effectiveness of employer-based group health plans using the following methodology:

1. Obtain information on the group health plan available to the client. This information must include the effective date of the policy, exclusions to enrollment, the covered services under the policy, riders and exclusions of covered services, and premiums paid by the employee.
2. Using the Medicaid Management Information System (MMIS), obtain the total six-month estimated average Medicaid costs of persons like the applicant (age, sex, and category data). Adjust this amount for inflation.
3. Determine the amount of the total six-month Medicaid expenditures that are spent on the services covered by the individual policy, using the following categories: drugs, practitioner services (this includes physician services, durable medical equipment, other practitioners, etc.), inpatient hospital services, outpatient hospital services, and home health services.
4. Estimate the cost of coinsurance and deductibles up to the allowable amounts under the Nebraska Medical Assistance Program.
5. Determine the administrative cost to Medicaid for processing the group health plan information by determining the average increase in cost per client for the six-month period.
6. Determine the cost to Medicaid with insurance by adding the following:
 - a. The administrative cost determined under item 5;
 - b. The coinsurance and deductible cost determined under item 4;
 - c. The premium cost (The premium cost is determined by applying a premium factor for the percentage of clients who would receive services compared to those eligible for Medicaid. This accounts for Nebraska's costs being based on "per client" data instead of "per eligible" data.); and
 - d. The cost of non-covered services (subtract item 3 from item 2);

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7. Compare the cost to Medicaid with insurance (item 6) to the estimated average Medicaid costs (item 2). If the cost to Medicaid with insurance is less than the estimated average Medicaid costs, the group health plan is cost effective. If the cost to Medicaid with insurance is equal to or greater than the estimated average Medicaid costs, the group health plan is not cost effective.

If the client provides documentation of on-going medical costs that exceed the estimated average Medicaid costs (item 2), NMAP may determine that the group health plan is cost effective.

NMAP has determined that payment of premiums for a group health plan is not cost effective when the premium is used to meet a spenddown obligation under the medically needy program.

NMAP has determined that payment of premiums for a group health plan is not cost effective for the eligibility category of Aged.

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