

State/Territory: California

State Methodology on Cost-Effectiveness of Individual and Group Health Plans

- I. The methodology used by California for determining cost-effectiveness of paying private or employer related health insurance premiums for existing coverage shall be as follows:
- A. Any Medi-Cal beneficiary who has an existing, medically confirmed, medical condition that has been determined by the Department of Health Care Services (DHCS) to be a cost-effective condition is deemed to meet the cost-effectiveness criteria for the Health Insurance Premium Payment (HIPP) program.
 - B. If A is not applicable, then the following steps are used to determine cost-effectiveness:
 - Step 1.** Use the insurance carrier evidence of coverage policy booklet to identify that health care services provided to the individual and/or family is covered for the specific condition.
 - Step 2.** Calculate cost-effectiveness by using the amount Medi-Cal would pay for the specific condition annually, deduct the individual's and/or family's Share of Cost (SOC), then divide by the annual insurance premium cost.
 - Step 3.** If the result is 1.1 or more, it is cost-effective to pay the premiums for an individual and/or family.

NOTE: The HIPP program shall pay the premiums for additional family members, who are not HIPP eligible, if the individual's premium amount cannot be separated from the family premium amount. In determining cost-effectiveness, the entire cost of the premium will be calculated against the estimated medical costs associated with the Medi-Cal eligible beneficiary.

- II. Purchasing or paying for health insurance coverage is deemed NOT cost-effective when:
- A. A Medi-Cal/Medicare beneficiary is enrolled in Medicare.
 - B. A Medi-Cal beneficiary's insurance is provided through the Major Risk Medical Insurance Board or the Managed Risk Medical Insurance Program.
 - C. A non-custodial parent has been ordered by the court to provide medical support.

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