NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

June 30, 2026

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave, Suite 600
Chicago, IL 60601

RE: SPA #26-0022
Health Insurance Premium Payment Cost Effective Determination Method

Dear Director McMillion:

The State requests approval of the enclosed amendment #26-0022 to the Title XIX (Medicaid) State Plan effective April 1, 2026 (Appendix I).

A summary of the plan amendment is provided in Appendix II. A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III).

In keeping with our continued agreement, this amendment is being sent to you prior to the end of the second quarter.

If you or your staff have any questions or need further assistance, please do not hesitate to contact Regina Deyette of my staff at (518) 473-3658.

Sincerely,

[redacted]

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26 — 0022

2. STATE: NY

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 01, 2026

5. FEDERAL STATUTE/REGULATION CITATION
§ 1906(a) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/26-09/30/26 $ 0
b. FFY 10/01/26-09/30/27 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.22-C Pages: 1, 2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.22-C Pages: 1, 2

9. SUBJECT OF AMENDMENT
Health Insurance Premium Payment Cost Effective Determination Method

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
June 30, 2026

15. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

SPA 26-0022

Attachment A

Annotated Pages

Annotated Page: 2

~~**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**~~

~~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 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?~~
- ~~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 Cost Appraisal Program (HICAP)" make sure that the premium payment used in the calculation is the Medicaid portion of the premium payment.~~

Appendix I
2026 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Citation	Condition or Requirement
§1906(a) of the Act	State Method on Cost Effectiveness ~~of~~ and Voluntary Participation in 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.~~ Due to mandatory managed care enrollment, cost effective determination is made by comparing the cost of the Medicaid managed care premiums to the cost of the employer-based group health plan.

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.

A. 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. The group or individual health plan must include a comprehensive set of benefits including: inpatient care, home health, emergency room, clinic, physician, pharmacy, substance abuse, psychiatric, ex-ray, lab and end of life care.

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.~~ Determine the amount of deductible for the health insurance policy. If the deductible is equal to or exceeds the amount of the current IRS high-deductible amounts, the policy is considered as not cost effective.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

3. If the criteria in 1. is met then, compare the Medicaid recipient's monthly share of the group or individual plan premium, yearly deductible, coinsurance, the cost of Medicaid wrap-around services which may include pharmacy, dental, vision, transportation, durable medical equipment, and an administrative fee to the monthly Medicaid managed care rate for the individual.

4. When the cost for the premium, yearly deductible, coinsurance, wrap services, and administrative fee for the premium assistance program added together is less than the cost of the Medicaid managed care rate for the individual, then the health plan meets the criteria for premium reimbursement.

B. Redetermination Review

1. A review must be completed at least yearly for all Health Insurance Premium Program (HIPP) enrollees . The yearly review will consist of:

   a. Verifying Medicaid eligibility;

   b. Verifying continued enrollment in Employer Sponsored Coverage;

   c. Completing a cost-effective analysis

2. If determined to be cost-effective, then re- determine HIPP eligibility at any point if:

   a. A change to the employee portion of the premium rate is identified;

   b. The Medicaid Managed Care premium rate is updated;

   c. There is a change to any Medicaid wrap around services or the administrative fee in the Cost-Effective calculation.

   d. There is a change (identified systematically or manually):

      i. In Medicaid eligibility;

      ii. In the services covered under the policy;

      iii. In the Medicaid eligible individuals on the policy.

3. Failure to submit required documents for redetermination may result in disenrollment from the HIPP program.

4. Failure to meet HIPP enrollment eligibility during redetermination, will result in HIPP disenrollment.

C. Purchasing or paying for health insurance coverage is deemed not cost- effective when:

1. Medicaid beneficiary is also enrolled in Medicare;
2. A court has ordered a non-custodial parent to provide medical insurance;
3. An individual or employee has been fully reimbursed for his/her payment of health care premiums; or
4. A recipient is also enrolled in a Medicaid managed care plan
5. A recipient is residing in a nursing home
6. The applicable deductible is above the IRS defined limit for a High Deductible Health Plan (HDHP).

Appendix II
2026 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #26-0022

This State Plan Amendment proposes to amend the Title XIX (Medicaid) State Plan for State Method on Cost Effectiveness and Voluntary Participation in Employer-Based Group Health Plans to comply with Social Security Act §1906A. The following changes are proposed:

Participation in Employer-Based Group Health Plans

New York State Medicaid is requesting to update the State Plan Amendment (SPA) to reflect the process currently utilized for determining cost effectiveness of employer-based group health plans. The process compares the cost of Medicaid Managed Care premium(s) to the cost of group health plan coverage, adhering to Social Security Act §1906A. Applicants and recipients (A/R's) who have access to, or are currently enrolled in, employer sponsored group health coverage will be determined for cost effectiveness using NYS DOH form 5106 and any additional documentation necessary. The cost of the employer sponsored coverage, deductible, cost sharing, additional costs of services not covered by the health plan, cost for services paid as Fee-for-Service, and administrative fees will be compared to the cost of the Medicaid Managed Care premium to determine if the coverage is cost effective. The previous process compared the costs of the employer sponsored coverage to average claim expenditures based on age, sex, geographic region.

The requirements in Social Security Act §1906A, for determining if the employer-based group health plan may be considered for cost effective determinations include:

- The coverage must qualify as creditable under section 2701 (c) (1) of the Public Health Service Act.
- The employer must contribute 40 percent of the total premium.
- The coverage must be offered to all individuals in a manner that is considered a nondiscriminatory eligibility classification.

In addition to the requirements of Social Security Act §1906A, NYS Medicaid also requires the coverage to be comprehensive.

An updated Employer Sponsored Health Insurance Request for Information, DOH Form 5106, will be utilized to collect all necessary information. Information regarding the employer contribution will be captured within the new form.

Enrollment in the cost-effective coverage is optional and will allow Medicaid to reimburse the A/R for such costs after they have been paid and A/R can request a cost-effective determination prior to or after enrolling in coverage. As participation is optional, the A/R will also be able to terminate the coverage and will no longer receive reimbursement of the healthcare premium(s).

There is no estimated changes to gross Medicaid expenditure as a result of this proposed amendment. Based on the updated processes, there is minimal change expected, and any changes are anticipated to be offsetting.

Appendix III
2026 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA 26-0022

PREMIUM ASSISTANCE

Sec. 1906A. [42 U.S.C. 1396e-1] (a) In General.—A State shall[214] offer a premium assistance subsidy (as defined in subsection (c)) for qualified employer-sponsored coverage (as defined in subsection (b)) to all individuals [215] who are entitled to medical assistance under this title (and in the case of an individual under age 19,[216] to the parent of such an individual) who have access to such coverage if the State meets the requirements of this section and the offering of such a subsidy is cost-effective, as defined for purposes of section 2105(c)(3)(A)[217].

(b) Qualified Employer-Sponsored Coverage.—

(1) In general.—Subject to paragraph (2)), in this paragraph, the term "qualified employer-sponsored coverage" means a group health plan or health insurance coverage offered through an employer—

(A) that qualifies as creditable coverage as a group health plan under section 2701(c)(1) of the Public Health Service Act;

(B) for which the employer contribution toward any premium for such coverage is at least 40 percent; and

(C) that is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of paragraph (3)(A)(ii) of section 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

(2) Exception.—Such term does not include coverage consisting of

(A) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

(B) a high deductible health plan (as defined in section 223(c)(2) of such Code), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

(3) Treatment as third party liability.—The State shall treat the coverage provided under qualified employer-sponsored coverage as a third party liability under section 1902(a)(25).

(c) Premium Assistance Subsidy.—In this section, the term "premium assistance subsidy" means the amount of the employee contribution for enrollment in the qualified employer-sponsored coverage by the individual [218] or by the individual's family. Premium assistance subsidies under this section shall be considered, for purposes of section 1903(a), to be a payment for medical assistance.

(d) Voluntary Participation.—

(1) Employers.—Participation by an employer in a premium assistance subsidy offered by

a State under this section shall be voluntary. An employer may notify a State that it elects to opt-out of being directly paid a premium assistance subsidy on behalf of an employee.

(2) Beneficiaries.—No subsidy shall be provided to an individual[219] under this section unless the individual (or the individual's parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of medical assistance. A State may not require, as a condition of an individual (or the individual's parent) being or remaining eligible for medical assistance under this title, that the individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage under this section.[220]

(3) Opt-out permitted for any month.—A State shall establish a process for permitting an individual (or the parent of an individual)[221] receiving a premium assistance subsidy to disenroll the individual from the qualified employer-sponsored coverage.

(e) Requirement To Pay Premiums and Cost-Sharing and Provide Supplemental Coverage.—In the case of the participation of an individual[222] (or the individual's parent) in a premium assistance subsidy under this section for qualified employer-sponsored coverage, the State shall provide for payment of all enrollee premiums for enrollment in such coverage and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this title (exceeding the amount otherwise permitted under section 1916 or, if applicable, section 1916A). The fact that an individual[223] (or a parent) elects to enroll in qualified employer-sponsored coverage under this section shall not change the individual's (or parent's) eligibility for medical assistance under the State plan, except insofar as section 1902(a)(25) provides that payments for such assistance shall first be made under such coverage.

[213] P.L. 111-148, §2003(b), struck "OPTION FOR CHILDREN" after “PREMIUM ASSISTANCE”, effective January 1, 2014.
[214] P.L. 111-148, §2003(a)(1)(A), struck “may elect to” and inserted “shall”, effective January 1, 2014.
P.L. 111-148, §10203(b)(2)(B), provided that “This Act shall be applied without regard to subparagraph (A) of section 2003(a)(1) of this Act and subparagraph and the amendment made by that subparagraph are hereby deemed null, void, and of no effect.”
[215] P.L. 111-148, §2003(a)(1)(B), struck “under age 19”, effective January 1, 2014.
[216] P.L. 111-148, §2003(a)(1)(C), inserted “in the case of an individual under age 19,”, effective January 1, 2014.
[217] P.L. 111-148, §10203(b)(2)(A), inserted “and the offering of such a subsidy is cost-effective, as defined for purposes of section 2105(c)(3)(A)”, effective as if included in the enactment of P.L. 111-3, effective February 4, 2009.
[218] P.L. 111-148, §2003(a)(2), struck “under age 19”, effective January 1, 2014.
[219] P.L. 111-148, §2003(a)(3)(A)(i), struck “under age 19”, effective on January 1, 2014.
[220] P.L. 111-148, §2003(a)(3)(A)(ii), struck the third sentence, which read “State may not require, as a condition of an individual under age 19 (or the individual’s parent) being or remaining eligible for medical assistance under this subchapter, apply for enrollment in qualified employer-sponsored coverage under this section.” and inserted the current sentence instead. Effective January 1, 2014.
[221] P.L. 111-148, §2003(a)(3)(B), struck “the parent of an individual under age 19” and inserts “an individual (or the parent of an individual)”, effective January 1, 2014.
[222] P.L. 111-148, §2003(a)(4), struck “under age 19”, to take effect on January 1, 2014.
[223] P.L. 111-148, §2003(a)(4), strikes out “under age 19”, to take effect on January 1, 2014.