# Department of Planning and Budget
## 2003 Fiscal Impact Statement

**1. Bill Number** HB 1469

**House of Origin** ☒ Introduced ☐ Substitute ☐ Engrossed

**Second House** ☐ In Committee ☐ Substitute ☐ Enrolled

**2. Patron** Purkey

**3. Committee** Health, Welfare and Institutions

**4. Title** Virginia Insurance Plan for Seniors

**5. Summary/Purpose:**
This bill establishes the Virginia Insurance Plan for Seniors (VIPS) to provide assistance in the purchase of prescription drugs for those individuals who are dually eligible for Medicaid and Medicare, but who do not qualify for prescription assistance. Payment assistance will be limited to $80 per month per eligible individual. However, unused amounts may be rolled over and credited to that individual for future use. There will be no direct cash payment made to any eligible individual. Participants will be required to pay a co-payment of 10 percent of the acquisition cost. In addition, they will be required to use generic drugs unless they are willing to pay the difference between the generic and name brand drug.

Approved drugs in this plan are those manufactured by pharmaceutical companies that agree to provide manufacturer rebates equal to the rebate required by the Medicaid program; and to make the drugs available to the plan at a cost that is similar to that made available to the Medicaid program. Any licensed pharmacist may participate and shall be paid a reasonable reimbursement to address the costs of the drug and its dispensing. Payments to pharmacists will not vary based on the size of the entity dispensing the prescription. Beneficiary cost-sharing amounts will not vary based on the source of dispensing or method of distribution of the prescription.

**6. Fiscal Impact Estimates are:** Preliminary

6a. Expenditure Impact: (see Section 8)

***Item 322, Subprogram 47901***

| *Fiscal Year* | *Dollars* | *Positions* | *Fund* |
|---|---|---|---|
| 2002-03 | $0 | 0.0 | GF |
| 2002-03 | $0 | 0.0 | NGF |
| 2003-04 | $0 | 0.0 | GF |
| 2003-04 | $0 | 0.0 | NGF |
| 2004-05 | $264,200 | 1.0 | GF |
| 2004-05 | $0 | 0.0 | NGF |

***Item 322, Subprogram 47902***

| *Fiscal Year* | *Dollars* | *Positions* | *Fund* |
|---|---|---|---|
| 2002-03 | $0 | 0.0 | GF |
| 2002-03 | $0 | 0.0 | NGF |
| 2003-04 | $0 | 0.0 | GF |
| 2003-04 | $0 | 0.0 | NGF |

| | | | |
|---|---|---|---|
| 2004-05 | $84,922 | 0.0 | GF |
| 2004-05 | $0 | 0.0 | NGF |

***Item 328, Subprogram 46400***

| *Fiscal Year* | *Dollars* | *Positions* | *Fund* |
|---|---|---|---|
| 2002-03 | $0 | 0.0 | GF |
| 2002-03 | $0 | 0.0 | NGF |
| 2003-04 | $0 | 0.0 | GF |
| 2003-04 | $0 | 0.0 | NGF |
| 2004-05 | $11,266,752 | 0.0 | GF |
| 2004-05 | $0 | 0.0 | NGF |

***Total Department of Medical Assistance Services***

| *Fiscal Year* | *Dollars* | *Positions* | *Fund* |
|---|---|---|---|
| 2002-03 | $0 | 0.0 | GF |
| 2002-03 | $0 | 0.0 | NGF |
| 2003-04 | $0 | 0.0 | GF |
| 2003-04 | $0 | 0.0 | NGF |
| 2004-05 | $11,615,874 | 1.0 | GF |
| 2004-05 | $0 | 0.0 | NGF |

6b. Revenue Impact: (see Revenue under Section 8)

| *Fiscal Year* | *Dollars* | *Positions* | *Fund* |
|---|---|---|---|
| 2002-03 | $0 | 0.0 | GF |
| 2002-03 | $0 | 0.0 | NGF |
| 2003-04 | $0 | 0.0 | GF |
| 2003-04 | $0 | 0.0 | NGF |
| 2004-05 | $0 | 0.0 | GF |
| 2004-05 | $0 | 0.0 | NGF |

**7. Budget amendment necessary:** No. This bill includes a clause, which delays the implementation of the program until the 2004-2006 biennium.

**8. Fiscal implications:**

***Administrative and Support Services***

The Department of Medical Assistance Services (DMAS) proposes to implement the VIPS using its Medicaid Management Information System (MMIS) and the Medicaid provider network. The requirement to track the cost per recipient to the $80 per month ceiling and other reporting requirements would place additional demands on the agency's MMIS. DMAS estimates that some systems work would be required to create a new eligibility code on the system and ensure that the benefits for these individuals are limited to pharmacy claims. DMAS' systems cost estimate is based on a recommendation that the co-payment requirement be modified to a standard dollar amount (such as $5 or $10 per prescription). The agency estimates the cost of implementing the systems changes in FY 2005 to approximately $200,000 (GF).

Besides systems development costs, there would also be claims processing costs. The fiscal agency currently charges DMAS $.3618 per processed claim. The total claims processing cost is dependent upon the number of individuals covered under this program. Based on the enrollment estimates for this proposed program (approximately 17,000), DMAS estimates claims processing costs of $84,922 (GF) in FY 2005. This breaks down to an estimated 234,721 claims per year, 19,560 claims per month, or approximately 1.2 claims per person per month.

DMAS feels that the monitoring of benefit limits, rebate collections, and program monitoring/evaluation required by this bill places such demands upon the current staff that sufficient attention could not be given to the implementation and daily operation of the program. The agency estimates that in order to sufficiently monitor the program, it would need an additional Band 5, Program Administrative Specialist II. The cost of this position with benefits is $64,200 (GF) per year.

***Revenue***

The Medicaid program is a federal mandate and pharmaceutical companies participating in Medicaid are required to participate in this program. The rebate program proposed in this bill would not be a federal mandate. However, this bill mandates that participation in this program be limited to drugs manufactured by pharmaceutical companies that agree to provide rebates similar to the Medicaid program. The agency currently recovers approximately 20 percent of gross pharmacy expenditures in the form of rebates. Therefore, in order to determine the potential revenue resulting from this bill, 20 percent was used.

While some states, such as Connecticut, have been successful implementing pharmaceutical manufacturer rebates in state only programs, others have not. DMAS believes that if it were able to receive the same level of rebates realized under Medicaid, collections would be approximately $2.8 million in FY 2005. However, it should be understood that this is a best-case scenario estimate.

Since FY 2005 would be the first year of the program, these collections would be considered expenditure refunds because they would be repayments for expenditures that occurred during that year. However, in every year after that, of the estimated $2.8 million in annual pharmacy rebates, 25 percent, or approximately $704,000 would be repayments for prior year expenditures or revenue earmarked for the general fund. The remaining 75 percent, or approximately $2.1 million per year, would continue to be expenditure refunds.

The problem in those states which are attempting to establish in-state-only rebate programs appears to be that the agencies that are responsible for implementing and operating the programs have been given little legal authority to enforce compliance from the participating pharmaceutical companies. At least under the Medicaid program, the pharmaceutical companies realize that if they wish to participate in the states' Medicaid programs, they must also agree to participate in Medicaid's pharmaceutical rebate program. If states wish their in-state-only rebate programs to work, they must provide sufficient authority to the responsible agencies to enforce compliance from the participating pharmaceutical companies. Otherwise, states cannot expect the programs to generate substantial revenues.

***Medical Assistance Services (Non-Medicaid)***

As of December 2002, there were approximately 16,400 Medicaid/Medicare dually eligible recipients over the age of 65 who would qualify for this program. These individuals are classified as "Qualified Medicare Beneficiaries – only" (QMBs) or "Special Low-Income Medicare Beneficiaries" (SLMBs). These groups receive Medicaid assistance for their Medicare premiums (QMBs and SLMBs) and co-payments and deductibles (QMBs). However, they do not receive Medicaid pharmaceutical benefits. The QMBs have incomes below 100 percent of the Federal Poverty Level (FPL), but do not qualify for full Medicaid benefits; while the SLMBs have incomes between 100 and 133 percent of the FPL. Based on the December 2002 enrollment level and the current trends, DMAS estimates that the average monthly enrollment for this program in FY 2005 would be 16,766 individuals.

Due to the cost and utilization of pharmaceuticals among the age 65 and over population, DMAS understood why the $80 per member per month ceiling was proposed in this bill. However, for this analysis, the agency chose to be more conservative in its estimate and assumed that the actual average monthly cost per recipient would be closer to $70. This equates to approximately $1.2 million in total assistance per month, or $14.1 million for FY 2005.

Finally, the approximately $2.8 million in estimated current year expenditure refunds resulting from the proposed pharmaceutical rebates are considered savings and must be netted against the estimated expenditures. The final estimated expenditures for this program for FY 2005 are approximately $11.3 million (GF).

**9. Specific agency or political subdivisions affected:** In addition to DMAS, it appears that the Department of Social Services (DSS) would have to modify the eligibility process for qualified recipients. However, DMAS maintains that DSS would not have to perform any new determinations and would require little to no new training. Therefore, the estimated impact to DSS is believed to be minimal.

**10. Technical amendment necessary:** As this bill is currently written, with the co-payment set at 10 percent of the acquisition cost, DMAS believes that it poses major system and administrative burdens. In addition, for the sake of administrative simplification, DMAS proposes an annual limit benefit of $960 per person as opposed to a monthly limit in which any of the unused limit can be rolled over to the next month. Furthermore, DMAS believes that a flat fee for a co-payment is substantially easier operationally.

**11. Other comments:** Since this program would not be considered a Medicaid program, it would not be entitled to any federal matching funds.

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cc: Secretary of Health and Human Resources