Department of Planning and Budget
2002 Fiscal Impact Statement

1. Bill Number HB904

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 $10 co-payment for each prescription. 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*
2001-02	$0	0.0	GF
2001-02	$0	0.0	NGF
2002-03	$198,602	2.0	GF
2002-03	$0	0.0	NGF
2003-04	$85,274	2.0	GF
2003-04	$0	0.0	NGF

Item 322, Subprogram 47902

Fiscal Year	*Dollars*	*Positions*	*Fund*
2001-02	$0	0.0	GF
2001-02	$0	0.0	NGF
2002-03	$89,853	0.0	GF
2002-03	$0	0.0	NGF

2003-04	$89,695	0.0	GF
2003-04	$0	0.0	NGF

Item 328, Subprogram 46400

Fiscal Year	*Dollars*	*Positions*	*Fund*
2001-02	$0	0.0	GF
2001-02	$0	0.0	NGF
2002-03	$12,732,891	0.0	GF
2002-03	$0	0.0	NGF
2003-04	$12,710,512	0.0	GF
2003-04	$0	0.0	NGF

Total Department of Medical Assistance Services

Fiscal Year	*Dollars*	*Positions*	*Fund*
2001-02	$0	0.0	GF
2001-02	$0	0.0	NGF
2002-03	$13,021,346	2.0	GF
2002-03	$0	0.0	NGF
2003-04	$12,885,481	2.0	GF
2003-04	$0	0.0	NGF

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

Fiscal Year	*Dollars*	*Positions*	*Fund*
2001-02	$0	0.0	GF
2001-02	$0	0.0	NGF
2002-03	$722,698	0.0	GF
2002-03	$0	0.0	NGF
2003-04	$721,428	0.0	GF
2003-04	$0	0.0	NGF

7. Budget amendment necessary: Yes, Item 322, Subprograms 47901 and 47902; Item 328, Subprogram 46400 (Due to the non-Medicaid nature of this program, a new subprogram would have to be created.)

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 current MMIS. DMAS estimates that 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 estimated cost of implementing the systems changes in FY 2003 is approximately $100,000 (GF). In addition, the agency estimates $13,328 (GF) in start-up support costs in FY 2003.

Implementation of the VIPS during the testing phase of the new MMIS would create problems. The vendor is in the process of ending its systems testing. DMAS has begun its use acceptance testing. If additional modifications to the current MMIS were required to implement this program, the effect would be increased cost to the new system and further implementation delays.

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 19,000), DMAS estimates claims processing costs of $89,853 (GF) in FY 2003 and $89,695 (GF) in FY 2004. For FY 2003, this breaks down to an estimated 248,350 claims per year, 20,696 claims per month, or approximately 1.1 claims per person per month. For FY 2004, the estimated break down is slightly less at 247,913 claims per year, 20,659 claims per month, or approximately 1.1 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 require two additional positions: a Band 4, Policy and Planning Specialist I and a Band 5, Information Technology Specialist II. The cost of these positions with benefits is $85,274 (GF) per year.

Revenue

DMAS believes that it will be difficult to estimate the impact of the rebate part of this proposed bill, which the agency feels is unlikely to produce significant revenue in this program. 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. DMAS believes that it would have a more difficult time operating it with no guarantee of rebates. The agency currently recovers approximately 19.4 percent of gross pharmacy expenditures under the Medicaid program. In order to determine the potential revenue resulting from this bill, 19.4 percent was used.

While some states, such as Connecticut, have been successful implementing pharmaceutical manufacturer rebates in state only programs, others have not. However, DMAS believes that if it were able to receive the same level of rebates realized under Medicaid, collections would be approximately $2.9 million in each year of the 2002-2004 biennium. However, it should be understood that these are best-case scenario estimates. Of the estimated $2.9 million in annual pharmacy rebates, 25 percent, or approximately $722,698 in FY 2003 and $721,428 in FY 2004 would be repayments for prior year expenditures or revenue earmarked for the general fund. The other 75 percent, or approximately $2.2 million per year, would be repayments for expenditures that occurred during the same year or 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)

In FY 2001, there were approximately 12,000 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 (QMB)" and receive Medicaid assistance for their Medicare premiums, co-payments and deductibles. However, they do not receive Medicaid pharmaceutical

benefits. This population has income below 100 percent of the Federal Poverty Limit (FPL), but does not qualify for full Medicaid benefits. In addition, there is a population category between 100 and 133 percent of FPL known as "Special Low-Income Medicare Beneficiaries (SLMB)," which only receives coverage of its Medicare premiums. DMAS is unsure from the language of this bill if this population is eligible for coverage under this program. However, for the sake of determining the fiscal impact the agency has included this population, which is estimated to be approximately 7,000. DMAS elected to use these 19,000 estimated recipients in its calculations.

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 $1.3 million in total assistance per month, or $15.9 million per year.

DMAS then looked at its current QMB/SLMB enrollment forecast for fiscal years 2003 and 2004 and saw an estimated between the years. Between FY 2002 and FY 2003, the enrollment is expected to decrease approximately 6.6 percent. However, between FY 2003 and FY 2004, the enrollment is expected to decrease less drastically by approximately .18 percent. Taking the estimated 6.6 percent decrease and applying it to the initially calculated $15.9 million annual cost, DMAS estimated the total medical cost for FY 2003 to be approximately $14.9 million. Then, taking the estimated .18 percent decrease and applying it to the $14.9 million for FY 2003, DMAS estimated the medical cost for FY 2004 also to be approximately $14.9 million. However, the final step was to take the approximately $2.2 million per year in estimated current year expenditure refunds resulting from the proposed pharmaceutical rebates and netting the savings against the estimated expenditures. The resulting estimated expenditures for this program are approximately $12.7 million (GF) for each year of the 2002-2004 biennium.

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