Department of Planning and Budget
2004 Fiscal Impact Statement

1. Bill Number HB 197

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 and are age 65 or over, but who do not qualify for prescription coverage under Medicaid. 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 percent 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. Three enactment clauses require the Board of Medical Assistance Services to promulgate emergency regulations; the agency to seek a waiver for VIPS from the Centers for Medicare and Medicaid Services, if necessary; and set the effective date of the act as July 1, 2005, with implementation to occur on the earlier of 90 days following the adoption of emergency regulations or July 1, 2006.

6. Fiscal Impact Estimates are: Preliminary

6a. Expenditure Impact: (see Section 8)

Item 322, Subprogram 47901

Fiscal Year	*Dollars*	*Positions*	*Fund*
2003-04	$0	0.0	GF
2004-05	$0	0.0	GF
2005-06	$144,600	0.0	GF

2006-07	$144,600	0.0	GF
2007-08	$144,600	0.0	GF
2008-09	$144,600	0.0	GF
2009-10	$144,600	0.0	GF

Item 329, Subprogram 46400

Fiscal Year	***Dollars***	***Positions***	***Fund***
2003-04	$0	0.0	GF
2004-05	$0	0.0	GF
2005-06	$12,570,604	0.0	GF
2006-07	$12,718,056	0.0	GF
2007-08	$12,856,736	0.0	GF
2008-09	$12,987,480	0.0	GF
2009-10	$13,110,705	0.0	GF

Total Department of Medical Assistance Services

Fiscal Year	***Dollars***	***Positions***	***Fund***
2003-04	$0	0.0	GF
2004-05	$0	0.0	GF
2005-06	$12,715,204	0.0	GF
2006-07	$12,862,656	0.0	GF
2007-08	$13,001,336	0.0	GF
2008-09	$13,132,080	0.0	GF
2009-10	$13,255,305	0.0	GF

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

Fiscal Year	***Dollars***	***Positions***	***Fund***
2003-04	$0	0.0	GF
2004-05	$0	0.0	GF
2005-06	$0	0.0	GF
2006-07	$739,447	0.0	GF
2007-08	$748,121	0.0	GF
2008-09	$756,279	0.0	GF
2009-10	$763,969	0.0	GF

7. Budget amendment necessary: Yes. Item 322, Subprogram 47901 and Item 329, Subprogram 46400 (due to the non-Medicaid nature of this program, a new subprogram would have to be created).

8. Fiscal implications:

The following analysis assumes that the Virginia Insurance Plan for Seniors (VIPS) would become effective July 1, 2005. This analysis does not take into account the upcoming Medicare prescription drug card, followed by the Medicare prescription drug benefit – recently passed by Congress – which is scheduled to begin January 1, 2006. If the federal program goes forward as

scheduled, it may supplant VIPS and reduce or even eliminate the following estimated expenditures. However, at this time the Department of Medical Assistance Services (DMAS) has not been informed of the details of this congressional action to determine its impact on Virginia because much depends on federal regulations yet to come.

Administrative and Support Services

The Department of Medical Assistance Services (DMAS) would implement the VIPS by employing 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. Therefore, some systems work would be required to create a new eligibility code and ensure that the benefits for the VISPS recipients are limited to pharmacy claims. The agency's 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). While adjustments would be necessary, DMAS believes that they can be accomplished within the scope of the current contract for the MMIS using existing resources. However, if a co-payment of 10 percent of the acquisition cost is required then the agency estimates substantial programming costs.

The agency's contracted fiscal agent currently charges DMAS approximately $.36 per processed claim. The total claims processing cost is dependent upon the number of individuals covered under this program. The agency is estimating over 17,000 monthly enrollees in FY 2006, increasing to over 18,000 by FY 2010. However, it is difficult to estimate how many claims per enrollee per month would be submitted. For the sake of determining claims processing costs resulting from this bill, approximately 18,500 claims per month are assumed at an annual cost of approximately $80,000 (GF) each year.

The agency 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 VIPS, it would require an additional Band 5, Program Administrative Specialist II. The cost of this position with benefits is $64,600 (GF) per year.

Revenue

The Medicaid rebate 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 federal 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. The agency believes that if it were able to receive the same level of rebates realized under Medicaid, collections would be approximately $2.9 million from the estimated $14.8 million in expenditures in FY 2006. However, it should be understood that this is a best-case scenario estimate.

Since FY 2006 would be the first year of the program, these collections would for the most part 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 $2.9 million in annual pharmacy rebates, 25 percent, or over $700,000 would be repayments for prior year expenditures or revenue earmarked for the general fund. The remaining 75 percent, or approximately $2.2 million per year, would continue to be expenditure refunds that would be reapplied to the program.

The problem in those states that 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 January 5, 2004, there were approximately 17,156 Medicaid/Medicare dually eligible recipients over the age of 65 who would qualify for this program. These individuals are classified as "Qualified Medicare Beneficiaries" (QMBs), "Special Low-Income Medicare Beneficiaries" (SLMBs), "Qualified Individuals" (QI), and "Qualified Disabled and Working Individuals" (QDWI). These groups receive Medicaid assistance for their Medicare premiums and, in the case of QMBs, their Medicare co-payments and deductibles. However, they do not receive Medicaid pharmaceutical benefits. Based on the January 2004 enrollment level and the current trends, DMAS estimates that the average monthly enrollment for this program in FY 2006 would be 17,606 individuals, eventually exceeding 18,000 by FY 2010.

With expenditures limited to $80 per member per month, the majority of the recipients will quickly reach this limit. However, average expenditures per recipient will not reach this level as some recipients will not meet the limit all of the time. This analysis assumes 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 $14.8 million for FY 2006. By FY 2010, the medical costs are estimated to surpass $15.0 million.

Finally, as mentioned in the previous section, the approximately $2.2 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 range from approximately $12.6 million (GF) for FY 2006 to $13.1 million (GF) for FY 2010.

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. While some training would be required, it does not appear that there would be significant demands in time or resources placed upon DSS.

10. Technical amendment necessary: As this bill is currently written, with the co-payment set at 10 percent of the acquisition cost, the agency believes that it poses major system and administrative burdens. A flat co-payment ($5 or $10 per prescription) would be significantly easier to program and less expensive to implement in the agency's MMIS. In addition, it would be less complicated for the providers and recipients. 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 could be rolled over to the next month.

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

Date: 01/19/04 / sas
Document: f:\sas\2004 ga session\bills\dpb fiss\house\hb197.doc

cc: Secretary of Health and Human Resources