Department of Planning and Budget
2004 Fiscal Impact Statement

1. Bill Number SB 377

House of Origin ☒ Introduced ☐ Substitute ☐ Engrossed

Second House ☐ In Committee ☐ Substitute ☐ Enrolled

2. Patron Deeds

3. Committee Education and Health

4. Title Virginia Prescription Drug Payment Assistance Program.

5. Summary/Purpose:
This bill establishes a program to be administered by the Department of Medical Assistance Services (DMAS), modeled on Delaware's Prescription Drug Payment Assistance Program, to assist eligible elderly and disabled Virginians in paying for their prescription drugs. Payment assistance would not be permitted to exceed $2,500 per person per year. The agency would be able to contract with a third-party administrator to provide administrative services that include enrollment, outreach, eligibility determination, data collection, premium payment and collection, financial oversight and reporting. The benefit is limited to prescription drugs manufactured by pharmaceutical companies that agree to provide manufacturer rebates.

Eligible individuals would be required to have incomes at or below 150 percent of the federal poverty level (FPL) or have prescription drug expenses that exceed 40 percent of their annual income, as set forth in the Appropriations Act. These individuals would also be age 65 or older, or eligible for federal Old Age, Survivors and Disability Insurance Benefits, not be receiving a prescription drug benefit through a Medicare supplemental policy or other third-party payor prescription benefit as of July 1, 2004, and be ineligible for Medicaid prescription benefits. However, nothing would prohibit the enrollment of a person in the program during the period in which his or her Medicaid eligibility is determined.

Enrollees would receive an identification card to be presented to pharmacists and would start receiving the benefit the month after their eligibility is determined. The card would need to conform to administrative standards developed and published by the National Council for Prescription Card Programs. Benefits would be paid to pharmacies under a point-of-service claims procedure to be established by DMAS. There would be a co-payment for each prescription, which in general would not exceed 25 percent of the cost, but not less than five dollars. All licensed pharmacists would be allowed to participate in the program so long as the provider is willing to abide by the terms and conditions the Board of Medical Assistance Services (BMAS) establishes to participate.

Money to pay the claims would come from the newly established Prescription Assistance Fund (Fund), which would be financed by 10 percent of the annual proceeds received by the Commonwealth under the Master Tobacco Settlement Agreement (MTSA) and any federal funds available for this purpose. Interest earned on money in the Fund would remain in the Fund and be credited to it. In addition, any money in the Fund, including interest, would not revert to the general fund at the end of each fiscal year, but would remain in the Fund. Administrative costs

are to be paid from the pharmaceutical manufacturer rebates to the extent available and the $20 annual enrollment fees.

The Board would be required to develop a comprehensive statewide community-based outreach plan to enroll eligible persons and DMAS would report annually on the program's implementation. No entitlement to prescription drug coverage on the part of any eligible person or any right or entitlement to participation is created and such coverage would only be available to the extent that funds are available.

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	7.0	GF
2005-06	$0	7.0	GF
2006-07	$0	7.0	GF
2007-08	$0	7.0	GF
2008-09	$0	7.0	GF
2009-10	$0	7.0	GF

Item 329, Subprogram 46400

Fiscal Year	*Dollars*	*Positions*	*Fund*
2003-04	$0	0.0	GF
2004-05	$10,397,667	0.0	GF
2005-06	$10,478,365	0.0	GF
2006-07	$10,591,245	0.0	GF
2007-08	$11,367,491	0.0	GF
2008-09	$11,477,682	0.0	GF
2009-10	$11,566,184	0.0	GF

Total Department of Medical Assistance Services

Fiscal Year	*Dollars*	*Positions*	*Fund*
2003-04	$0	0.0	GF
2004-05	$10,397,667	7.0	GF
2005-06	$10,478,365	7.0	GF
2006-07	$10,591,245	7.0	GF
2007-08	$11,367,491	7.0	GF
2008-09	$11,477,682	7.0	GF
2009-10	$11,566,184	7.0	GF

Item 358, Subprogram 46003 (Department of Social Services)

Fiscal Year	*Dollars*	*Positions*	*Fund*
2003-04	$0	0.0	GF
2004-05	$3,569,200	0.0	GF
2005-06	$4,465,600	0.0	GF
2006-07	$4,465,600	0.0	GF
2007-08	$4,465,600	0.0	GF
2008-09	$4,465,600	0.0	GF
2009-10	$4,465,600	0.0	GF

Item 290, Subprogram 72503 (Department of the Treasury)

Fiscal Year	*Dollars*	*Positions*	*Fund*
2003-04	$0	0.0	GF
2004-05	$9,830	0.0	GF
2005-06	$9,498	0.0	GF
2006-07	$9,176	0.0	GF
2007-08	$9,153	0.0	GF
2008-09	$8,849	0.0	GF
2009-10	$8,620	0.0	GF

6b. Revenue Impact: (see Section 8)

7. Budget amendment necessary: Yes, Item 290, Subprogram 72503; Item 322, Subprogram 47901; Item 329, Subprogram 46400 (Due to the non-Medicaid nature of this program, a new subprogram would have to be created.); and Item 358, Subprogram 46003.

8. Fiscal implications:

Administrative and Support Services

If DMAS were to administer the program internally, the agency would implement the program as a Medicaid look-alike program using the Medicaid Management Information System (MMIS) and the same co-payment amounts as what is currently being paid by Medicaid recipients. DMAS would manually track the annual benefit amount to ensure that the maximum per person reimbursement rate is not exceeded. The enactment clause in this bill is unclear. Therefore, the agency's estimates assume an implementation date of July 1, 2005.

The agency 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. An accounts receivable subsidiary system would also be required to manage the annual enrollment fees. The estimated cost of implementing the systems changes in FY 2005 are assumed to be absorbed within the scope of the current contract for the MMIS using existing resources, with the exception of approximately $50,000 to cover implementation costs.

Besides systems development, there would also be claims processing costs. The agency's contract with its fiscal agent sets out charges of $.3709 in FY 2005 and $.3618 in FY 2006 per processed claim. Charges for future years are uncertain but have been projected forward based on a $.01 growth rate per two-year period. The agency estimates approximately 26.43 claims per recipient in FY 2005 up to 29.43 claims per recipient by FY 2010. These estimates result from dividing the estimated annual cost per recipient by the non-nursing home pharmacy cost per prescription (after reduction in dispensing fee), which is included in DMAS' official Medicaid forecast.

The total claims processing cost is dependent upon the number of individuals covered under the program. The agency estimates the number of recipients to be as many as 7,302 in FY 2005 and decreasing to 5,644 by FY 2010. These estimates reflect the 10 percent funding from the MTSA divided by the estimated cost per recipient. Multiplying the average number of claims by the estimated recipients results in 193,002 claims expected to be processed in FY 2005 decreasing to 166,118 claims by FY 2010. Multiplying the estimated number of claims annually process by the fee per processed claim results in estimated claims processing costs of $71,584 in FY 2005 and $63,424 by FY 2010.

This bill requires that an annual enrollment fee of $20 be collected from each person enrolled to cover a portion of the administrative costs. The agency feels that this collection requirement and the other demands placed upon its staff are such that sufficient attention cannot be paid to the implementation and daily operation of the program. The agency estimates that in order to sufficiently administer and monitor the program, it would require three additional positions in program operations: one Band 4, Program Specialist I, two Band 4, Health Care Compliance Specialists I; and four additional positions in fiscal operations: one full-time Band 3, Administrative Office Specialist III, one part-time Band 3, Administrative Office Specialist III, one Band 5 Financial Services Manager I, and one Band 4, Financial Services Specialist I. The cost of these positions with benefits would be $326,950 per year.

This bill gives DMAS the option to contract out the operation of the program. The agency estimates that if it were to contract out the operation through a stand-alone system, it would cost approximately $4.3 million in one-time development costs. In addition, DMAS would require staff for contract oversight, financial auditing, and appeals. In addition to one-time costs, DMAS estimates that a stand-alone system would cost approximately $2.49 per enrollee per month in claims processing costs. These estimates are based on information provided to DMAS by a private contractor that provides this service to other states. Given the uncertainty of DMAS' exercising this option, these costs are not included in this bill's fiscal impact estimates.

Since this bill provides that DMAS' overhead and administrative costs be paid from the pharmaceutical manufacturer rebates and the $20 annual enrollment fees, no additional funding is reflected for Item 322, subprograms 47901 and 47902 in Section 6a of this fiscal impact statement. However, the agency would need sufficient appropriation to apply the collections to staffing and overhead costs. Also, seven full-time positions (FTE) would need to be appropriated.

Medical Assistance Services (Non-Medicaid)

Census data indicates that there are approximately 207,000 Virginians over age 65 at or below 150 percent of the federal poverty guidelines and an additional 160,636 individuals between ages 18 and 64 receiving Social Security OASDI in Virginia.[1] Of this number, approximately 144,356 are Medicaid-enrolled individuals who would not be eligible for the proposed program. That leaves an estimated population for this program of 223,280 individuals. Of this estimated population, approximately 20,000 aged and disabled low-income individuals are eligible to receive some Medicaid benefits. However, they do not receive coverage for pharmacy prescriptions through Medicaid. These individuals would be immediately eligible for this program.

As the bill indicates, it will be up to the BMAS to develop a statewide community-based outreach plan to enroll eligible individuals. However, since this in not an entitlement program like Medicaid, enrollment will be limited to available funding. Given this non-entitlement status, DMAS will enroll individuals on a first-come, first-served basis.

The estimated annual cost per recipient goes from $1,728 for FY 2005 to $2,500 for FY 2010. This cost is based on information from other states that show an average cost of approximately $1,400 per full year enrollee in similar programs during FY 2001. The agency took the $1,400 figure and inflated it by the forecasted growth in pharmacy cost per unit from FY 2001 to FY 2005. By dividing the estimated amounts Virginia stands to receive from the MTSA by the annual cost per recipient, the program could cover 7,302 recipients in FY 2005 with enrollment declining in subsequent years to 5,644 by FY 2010.

[1] Annual Statistical Report on the Social Security Disability Insurance Program, 2002.

This bill states that the Fund created to support this program would contain all funds collected for the program, any funds appropriated by the General Assembly, and any interest earned on these funds. In addition, these funds would remain in the Fund and be used for the implementation and operation of the program. Therefore, the assumption included in these estimates is that the balance of the manufacturer rebates not applied to administrative costs could be used to offset the payments made for the prescriptions. Thus, while this program would have the authority to make payments up to the 10 percent amount of the MTSA, these payments could be offset by credits of approximately $2.2 million in FY 2005 through $2.5 million by FY 2010 from the manufacturer rebates. The estimated amounts shown in Item 329, Subprogram 46400 of Section 6a, reflect the netting of the estimated program expenditures with the balance of the estimated manufacturer rebates.

Department of Social Services

The Department of Social Services (DSS) would be responsible for performing the eligibility work for this program. DMAS estimates that it could cost as much as $20 per applicant. This estimate is based on operations experience with similar programs in the past.

Although the funding would limit the number of individuals served, that would not stop every individual in the potential population from applying. The estimated annual cost for DSS to perform the eligibility determination for this program would be approximately $4.5 million; assuming that approximately 223,280 applications were processed each year. Given that eligible individuals would have to have incomes at or below 150 percent of the FPL or have prescription drug expenses that exceed 40 percent of their annual income, annual determinations would be necessary. In addition, DSS would need $220,000 in FY 2005 for one-time costs, including adjustments to the Application Benefit Delivery Automation Project (ADAPT). Also, for FY 2005 DSS assumes lag time in the eligibility work for this new program, therefore, only 75 percent of estimated annual cost for eligibility determination is being reflected.

Department of the Treasury

The agency estimates that it would need a lock box (a.k.a. an automated interface with an accounts receivable system) to manage the checks it would receive for the annual enrollment fees. This would ensure that these checks do not intermingle with other checks being collected and processed by DMAS for its other Medicaid and non-Medicaid programs. The estimated cost for this lock box would be start at $9,830 in FY 2005 and decrease in cost to $8,620 by FY 2010.

Revenue (Collections)

As stated earlier, this bill provides that DMAS overhead and administrative costs are covered by the pharmaceutical manufacturer rebates and the collected $20 annual enrollment fees. Based upon the assumed enrollment level, DMAS expects enrollment fee collections to range from $146,036 in FY 2005 to $112,887 by FY 2010 with the balance of the remaining administrative costs being covered by the collected rebates.

The agency believes that it would be difficult to estimate the impact of the rebate proposal of this bill, which it 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. The agency currently recovers approximately 20 percent of gross pharmacy expenditures under the Medicaid program.

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 range from $2.5 million in FY 2005 to $2.8 million by FY 2010. These estimates reflect 20 percent of the MTSA funding earmarked for the program. However, these estimates should be considered best-case scenario.

The problem in those states that are attempting to establish in-state-only rebate programs appears to be that the agencies responsible for implementing and operating the programs have been give 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. It cannot be emphasized enough that 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, they cannot expect the programs to generate substantial revenues.

9. Specific agency or political subdivisions affected: DMAS, DSS, and Treasury

10. Technical amendment necessary: The enactment clause in this bill is unclear as to when DMAS should implement this program. Clause 3 appears to authorize the promulgation of emergency regulations, requiring the agency to adopt regulations to be effective within 280 days of the enactment of the act, which would lead to an implementation date prior to July 1, 2005. Therefore, it is unclear why clause 4 references a July 1, 2005 date.

Section 32.1-367 section 5 states that in order or an individual to be eligible they must "not be receiving a prescription drug benefit through a Medicare supplemental policy or any other third party payor prescription benefit as of July 1, 2004: and". This language does not address an individual who begins receiving a prescription drug benefit on or after July 2, 2004. This should be amended to say "… prescription benefit at the time they are to be enrolled in the program."

11. Other comments: The major issue with this bill is that it depends on a limited funding source. Although there is no way to predict when or if this funding source may cease, there is always the potential that the situation with the tobacco companies could change, thus reducing or possibly eliminating these settlement funds. An even larger concern is what to do with the individuals who become dependent upon this program when the funding source does change.

In addition, the MTSA funding requirements of this bill conflict with the 40 percent MTSA funding used to establish the Virginia Health Care Trust Fund included in the Introduced Budget to address increasing Medicaid costs.

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cc: Secretary of Health and Human Resources