Economic Impact Analysis
Virginia Department of Planning and Budget

112 VAC 30-141 –Family Access to Medical Insurance Security Plan (FAMIS): Coverage for Pregnant Women (FAMIS MOMS)
Department of Medical Assistance Services
March 14, 2006

Summary of the Proposed Regulation

The proposed regulations will provide publicly subsidized health insurance coverage to uninsured pregnant women by establishing the FAMIS MOMS program, a new Title XXI program for pregnant women who are not eligible for Medicaid. Currently, Medicaid does not provide coverage to pregnant women with incomes above 133 percent of the Federal Poverty Limit (FPL). FAMIS MOMS will provide health care coverage to pregnant women with incomes greater than 133 percent of FPL, but less than or equal to 150 percent of FPL. Pregnant women with incomes between 133 and 150 percent of FPL represent a new population of individuals covered by the Commonwealth.

Result of Analysis

The benefits likely exceed the costs for all proposed changes. A different design would likely yield greater benefits at the same cost for at least one proposed change.

Estimated Economic Impact

The proposed FAMIS MOMS program will provide health coverage to a new population of pregnant women whose income is too high to qualify for Medicaid. Health coverage will be extended to pregnant women whose income is above 133 percent of FPL, but less than or equal to 150 percent of FPL. The proposed program is closely modeled after the existing FAMIS program because both are Title XXI programs. Title XXI programs have an enhanced federal match rate of 65% compared to the Medicaid match rate of 50%. Also, because Medicaid already provides coverage to pregnant women with incomes less than or equal to 133 percent of FPL, the income eligibility requirements, co-payments, and benefits package are modeled after the Medicaid program.

Under the current rules, pregnant women with incomes higher than 133 percent of FPL are not eligible for Medicaid benefits. However, once they deliver, their children become eligible for FAMIS benefits provided family income is below 200 percent of FPL. In other words, the pregnant women whose children will be eligible for FAMIS are not covered during their pregnancy. The proposed changes will provide health coverage to pregnant women whose children will become eligible for FAMIS and whose income is higher than 133 percent of FPL, but less than or equal to 150 percent of FPL. At this time, the proposed FAMIS MOMS will not provide coverage to pregnant women whose incomes are between 150 percent and 200 percent of FPL even though their children will also become eligible for FAMIS once they are born.

In addition, the proposed regulations will exclude a pregnant child with prior health insurance from the four-month waiting period requirement of FAMIS. When FAMIS MOMS goes into effect, a pregnant child who is eligible for FAMIS will be also eligible for FAMIS MOMS. However, currently FAMIS has a four month waiting period and the proposed FAMIS MOMS does not. Without this particular exemption, a pregnant child who had health insurance and who is eligible for both programs will not be covered for four months if she applies for FAMIS, or she will be able to receive benefits immediately if she applies for FAMIS MOMS, but will lose coverage after two months of birth. In this case, this particular individual will have interruption in her health coverage at the beginning of enrollment into FAMIS following the loss of insurance coverage. The proposed exemption will allow a pregnant child with prior health insurance to access both prenatal and ongoing health care.

However, the proposed changes do not clearly address the case in which a pregnant child who enrolled in FAMIS MOMS and whose coverage ended after two months of pregnancy and who is eligible for FAMIS after birth is enrolling in FAMIS. Under the proposed language, it is not clear whether enrollment in FAMIS MOMS constitute “being covered under a health insurance plan other than through the ESHI component of FAMIS” and would make the applicant subject to a four-month waiting period. According to DMAS, coverage under a state’s Medicaid or SCHIP program does not meet the definition of prior health insurance and consequently no 4-month waiting period would be imposed. Based on this interpretation, perhaps the proposed language could be clarified by adding “or through the FAMIS MOMS” to the previous phrase in quotation marks. Otherwise, recipients transferring from FAMIS MOMS to FAMIS will experience a disruption in their postpartum health coverage.

Finally, the proposed regulations will clarify that participation in Virginia's Local Choice program no longer is a barrier to access to FAMIS or FAMIS MOMS as a result of a confirmation from the federal Centers for Medicare and Medicaid that participation in this program no longer meets the definition of access to the State Health Plan.

The main goal of providing coverage to uninsured low-income pregnant women is to improve their and their infants' access to and utilization of prenatal health care. The economic rationale for improving access to and utilization of prenatal health services relies on the notion that providing these services is a good investment for the society. The provision of prenatal care to pregnant women is expected to improve the health status of the pregnant women and the children that are born.

The proposed regulations will improve uninsured pregnant women and their infants' access to health care because additional pregnant women will be eligible for FAMIS MOMS. The target enrollment goal in federal fiscal year 2009 for FAMIS MOMS is 450. If this goal is met, FAMIS MOMS will reduce the estimated number of uninsured pregnant women in the eligible cohort. This will mean that the percentage of uninsured among all the pregnancies that are expected to occur to Virginian women with incomes between 133% of FPL and 150% of FPL will decrease from 24% to 8%. Thus, there should be an improvement in access to health care in the Commonwealth.

The proposed regulations will also reduce total health care costs in the Commonwealth. According to DMAS, timely provided prenatal care is essential to reduce the likelihood of complications and premature deliveries. DMAS notes that a woman who does not receive prenatal care is three times more likely to deliver a low birth weight baby. Complications and premature births usually result in long-term health problems for the child and are very expensive. According to DMAS, hospital charges for severely premature/low birth weigh babies are sixty times more than an uncomplicated birth. Also, healthy children could do better in schools and eventually be more productive members of the society.

Because the costs of complicated and premature births occurring to uninsured individuals, to a large extent, are borne by the tax payers and possibly by private entities in terms of defaults, FAMIS MOMS should introduce net benefits to the society as a whole. The federal dollars that will be used for pregnant women under FAMIS MOMS probably substitute the high-

cost emergency room visits paid by state indigent care funds, or absorbed by providers, and benefit the Commonwealth. The Commonwealth will realize these benefits at 1/3 of the true cost because the 65% of the expenditures will be drawdown from the federal government. So, the proposed regulations will not only avoid significant health care costs, but also make it possible to obtain these benefits at a fraction of their true costs.

The proposed regulations will likely create additional costs to administer the program. However, by mirroring certain aspects of FAMIS and Medicaid, FAMIS MOMS could benefit from existing program and delivery structures. For example, FAMIS MOMS will be administered by a central processing unit (CPU) just as FAMIS is administered currently. The CPU will distribute applications and program information, maintain a call center and multiple electronic interfaces, respond to inquiries, receive and process applications for eligibility, and provide personal assistance to callers, monitor cost sharing, provide reports, and will be responsible for provider and health plan enrollment. The CPU is believed to simplify eligibility determination and enrollment process and increase administrative efficiency.

Also, the CPU is believed to reduce stigma associated with welfare or public assistance programs as the applications could be completed at a unit other than local departments of social services, which are the contact points for other welfare programs.

Local departments of social services will also determine eligibility for the FAMIS MOMS program. When a local department receives an application, the local agency will first determine the pregnant women's eligibility for Medicaid. If the applicant is determined Medicaid ineligible first and FAMIS ineligible second, the local agency will proceed with a FAMIS MOMS eligibility determination and enroll eligible applicants in FAMIS MOMS. Because applicants will be checked for Medicaid and FAMIS eligibility, there is the added benefit of finding Medicaid and FAMIS eligible applicants while screening for FAMIS MOMS. Either the FAMIS MOMS CPU or local agency will determine eligibility and enroll the pregnant women in the correct plan. Receiving applications at multiple contact points appears to be an efficient way of receiving applications. An efficient application process should reduce the transaction costs and increase the overall net benefits.

Additionally, having local departments of social services involved in the process will provide a local contact in every community where a pregnant woman can receive assistance with

such applications if she prefers. This proposed process is expected to improve the application and enrollment processes and increase access to FAMIS MOMS.

A government-funded insurance program provides some financial relief to working uninsured families. Government sponsored health coverage for uninsured infants by covering pregnant woman may also be justified on the grounds that while adults may choose to remain uninsured, infants themselves are not responsible for decisions about their coverage.

The enrollment in the FAMIS MOMS program largely depends on whether and how much the enrollees are expected to pay. Based on the economic theory it can be reliably stated that as the cost sharing increases, the enrollment in the program would decrease. The main reason for co-payments is to encourage the efficient use of publicly funded healthcare resources. The economic theory indicates that free healthcare services will be used inefficiently. Charging a co-payment for some medical services would reduce the demand for these services relative to the demand for free care and discourage unnecessary care.

The FAMIS MOMS program will not require any cost sharing by recipients for pregnancy related services. Then, based on economic principles, we can expect some inefficiency in the utilization of pregnancy related services. However, requiring copays would discourage the use of pregnancy related services and limit access to care. Thus, the proposed no-copay structure for pregnancy related services can be considered as a trade off between maximizing access to care at the expense of accepting some inefficiency in the use of publicly funded services. On the other hand, copays will be $1 to $3 for non-pregnancy related services. For these services the copay structure will be a trade off between encouraging efficient use of services at the expense of somewhat limiting access to care.

The significance of the economic effects of the copays depends on their size. The FAMIS MOMS copays for non-pregnancy related services appear to be nominal. Available studies suggest that the economically optimal structure for cost sharing includes “a low [or possibly even zero] monthly premium, a high deductible for inpatient care (except, perhaps for young children), and co-payments targeting certain types of services (e.g. brand name vs. generic prescriptions) and certain sites of care (e.g. emergency room vs. physician office) to encourage a

more cost-conscious use of resources."[1] The proposed no-copay structure for pregnancy related services and copay structure for non pregnancy services reflect some aspects of the recommended structure. However, copays for non-pregnancy related services may be too small to significantly reduce overuse of these services.

Additionally, copays for non-pregnancy related services may make FAMIS MOMS coverage somewhat less attractive and may reduce crowding out relative to what would result without any copays. However, as mentioned, the copays are relatively small. This leads to the expectation that copays would reduce crowding out by only a small amount.

Further, the procedures to implement copay requirements seem to be cost effective. Providers will collect copays. The department does not maintain a database for the copays actually paid. If a family documents to the FAMIS CPU that they reached the maximum limit, they are relieved of any further copayments for the remainder of the year. Assigning responsibility to families to track the annual copayments provides an option to families to take advantage of this provision while providing savings to the department in administrative costs that would otherwise be incurred.

Finally, the copays may reduce the stigma associated with the program. It is possible that some recipients will feel less like they are receiving assistance from a charity or from welfare. On the other hand, there is possibility that copays may create a barrier to some other applicants to participate in the program. However, given the nominal copay structure, any such barrier will likely be very small.

The net impact on Medicaid providers is likely to be positive. FAMIS MOMS is estimated to increase public health care expenditures in Virginia by $4.8 million annually. The Commonwealth will finance one third of this amount and the 2/3 will be financed by federal matching dollars. This means that provider revenues will increase by $4.8 million and improve their profitability.

The net impact on Virginia's economy is likely to be positive because of the federal match. While 1/3 of the funds will come from state resources, the rest will come from the federal government. Thus, the federal match will be a net injection into the state's economy as it

[1] Markus, Anne, Sara Rosenbaum, and Dylan Roby, 1998, "CHIP, health Insurance Premiums and Cost-sharing: Lessons from the Literature," The George Washington University Medical Center, Washington, DC.

does not have a corresponding offset elsewhere and will have a net positive impact on state output.

One of the important unintended economic effects expected from FAMIS MOMS which will increase the population of eligible individuals for public health insurance is the substitution of publicly funded healthcare for private insurance. This is often referred to as "crowding out." Crowding out occurs when rational individuals substitute a costless alternative provided by the government for an otherwise costly service. For instance, if the government provides free bread, individuals would not purchase bread out of their pocket, but would rather rely on the government. In other words, government funds spent on bread would crowd-out, or replace out of pocked expenditures on bread.

Similarly, the FAMIS MOMS expenditures for pregnant women's insurance will likely replace, or crowd out some of the privately funded insurance. Crowding-out is relevant because its presence may hinder improvements in access to care and may lead to higher program costs than expected. The magnitude of this effect would increase with the income eligibility level, the failure in preventing the substitution of FAMIS MOMS for private coverage, high premium cost sharing, and generosity of the benefit package.[2] The challenging trade off is that without these features, the ability of FAMIS MOMS to reach its objective will be limited. There does not seem to be a solution in the current literature to eliminate this problem without creating inequities in access to coverage. Thus, some level of substitution of public coverage for private coverage may be an unavoidable effect of any program designed to make sure that those eligible individuals who need health coverage get it.

While crowding out occurs with almost any programs that offer public assistance, economic effects of FAMIS MOMS crowding out may not be as significant for Virginia as those under other programs. The 150% of federal poverty level for eligibility results in lower "acceptable" level of crowding out because most low-income families do not have insurance to begin with. There do not appear to be any good empirical studies of the magnitude of substitution of publicly provided insurance for privately provided insurance resulting from this program. The fact that a large fraction of this population is not covered by private health

[2] Dubay, Lisa and Genevieve M. Kenney, 1997, "Lessons from the Medicaid Expansions for Children and Pregnant Women: Implications for Current Policy," Testimony Before the House Committee on Ways and Means, Subcommittee on Health.

insurance greatly reduces the potential for substitution. It is, then, quite possible that, while the incentives for crowding-out do exist, their actual impact may be small.

More importantly, under FAMIS MOMS, potential crowding out of private coverage will be financed 65% from federal funds and the Commonwealth will finance only one third. One dollar crowding out in private insurance will save the families exactly one dollar which will increase the federal dollars coming to the Commonwealth by 65 cents, and increase state expenditures by 34 cents. Moreover, crowding out will likely provide some financial relief to parents with children, which could be considered as a form of subsidy to low-income families.

Another potential unintended consequence may result from establishing an income cut off for FAMIS MOMS benefits rather than reducing benefits on a sliding scale. This feature may reduce some individuals' incentives to accept promotions and higher paying positions. A small change in income may qualify or disqualify some families if their income is slightly above or below the income cut off for eligibility. Those who are slightly above the cut off may intentionally reduce their income to qualify for FAMIS MOMS if the gains in insurance benefits exceed the lost income. Similarly, those who are slightly below the cut off may intentionally pass up opportunities to increase their income in order not to lose the FAMIS MOMS coverage if the additional income does not exceed the FAMIS MOMS benefits. If this occurs, as expected, such a behavior would further crowd out private insurance. Shifting the income cut off from 133% of federal poverty level to 150% for pregnant women would expose different families to this potential disincentive to work. However, the fact that this change affects probably only a small number of families and the duration of the eligibility for pregnant women is temporary should result in a minimal crowding out effect.

Businesses and Entities Affected

The proposed FAMIS MOMS program is expected to affect approximately 450 pregnant women, Medicaid health care providers, the department, and the local departments of social services.

Localities Particularly Affected

The proposed regulation will not uniquely affect any particular locality.

Projected Impact on Employment

As the FAMIS MOMS grows, we can expect to see an increase in demand for labor in Virginia's healthcare sector.

Effects on the Use and Value of Private Property

Similarly, as the program grows, we can expect to see an increase in healthcare provider revenues, profits, and consequently the asset value of their businesses.

Small Businesses: Costs and Other Effects

The proposed regulations are not anticipated to have an adverse impact on small businesses.

Small Businesses: Alternative Method that Minimizes Adverse Impact

The proposed regulations are not anticipated to have an adverse impact on small businesses.

Legal Mandate

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 2.2-4007.H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007.H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has adverse effect on small businesses, Section 2.2-4007.H requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the

regulation. The analysis presented above represents DPB's best estimate of these economic impacts.