Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30-30, 40 and 50 – Rules Governing Groups Covered, and Agencies Responsible for Eligibility Determinations; Eligibility Conditions and Requirements; Amount, Duration and Scope of Medical and Remedial Services of Medicaid
Department of Medical Assistance Services
May 5, 2006

Summary of the Proposed Regulation

The Board of Medical Assistance Services (Board) proposes to amend regulations on Medicaid to coordinate with the new Medicare Prescription Drug Program (Part D) as mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). As of January 1, 2006, Medicaid recipients who are entitled to receive Medicare benefits under Part A or Part B are no longer eligible to receive their pharmacy benefits under the State's Medicaid Program, except for drugs that are excluded under the Medicare Prescription Drug Program.

Results of Analysis

The costs likely exceed the benefits for one or more proposed changes.

Estimated Economic Impact

Medicare is a federal health insurance program for people aged 65 or older, disabled workers, and individuals that have permanent kidney failure or amyotrophic lateral sclerosis (Lou Gehrig's disease). Before 2006,[1] there were three different parts to Medicare Coverage: Hospital Insurance (Part A) that helps pay for inpatient care in a hospital or skilled nursing facility (following a hospital stay), some home health care and hospice care; Medical Insurance (Part B) that helps pay for doctors' services and many other medical services and supplies that are not covered by hospital insurance; and Medicare Advantage (Part C) formerly known as Medicare + Choice plans that allows beneficiaries to select from a private health plan provider

[1] The Medicare prescription drug benefit started in 2004 with the Medicare Prescription Drug Discount Card and Transitional Assistance Program, a credit for low-income beneficiaries. The full Medicare part D prescription drug benefit takes effect January 1, 2006

(e.g. a Health Maintenance Organization or HMO) that contracts with Medicare to provide all of the covered health services.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 established the Medicare Prescription Drug Program (Part D), which provides coverage of outpatient drugs for Medicare beneficiaries that enroll in a Part D Plan from January 1, 2006.[2] Anyone who has Medicare hospital insurance (part A), medical insurance (Part B) or a Medicare Advantage plan is eligible for prescription drug coverage (Part D). Joining a Medicare prescription drug plan is voluntary except for "dual eligibles" (Medicaid enrollees who are also Medicare eligible) and will involve an additional monthly premium for the coverage.[3] For individuals who are entitled to Medicare and have low income, the MMA established the Low-Income Subsidy (LIS) to assist them with payment of the premiums, deductibles, and co-payments required under Part D.

Compliance with the MMA is a condition for states' participation in the federally-funded Medicaid program. Although states have the option of not requiring Medicare enrollment as a condition of Medicaid eligibility, the federal government will provide no federal reimbursement for the costs of any drugs that could otherwise have been covered under Medicare Part D. Also, states are required to help finance Medicare Part D by paying the federal government the state share of the cost of prescription drug coverage for the dual eligibles, which is known as "clawback".[4]

In response to this federal mandate, the Board amended its Medicaid regulations via an emergency regulation (effective January 1, 2006) that reflected the Commonwealth's compliance with the MMA and met the criteria for receipt of any federal financial assistance claimed in conjunction with Virginia's compliance with the MMA. Now the Board proposes to promulgate a permanent regulation that will replace the emergency regulation.

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[2] Ibid.

[3] According to the standard drug benefit structure established by the MMA, the average monthly premium in 2006 is $34. The standard benefit requires payment of a $250 deductible. The beneficiary then pays 25% of the cost of a covered Part D prescription drug up to an initial coverage limit of $2250. Once the initial coverage limit is reached, the beneficiary is subject to another deductible, known as the "doughnut hole," in which they must pay the full cost of medicine. When total out-of-pocket expenses on formulary drugs for the year, including the deductible and initial coinsurance, reach $3600 the beneficiary pays $2 for a generic or preferred drug and $5 for other drugs, or 5% coinsurance, whichever is greater. (42 U.S.C.A. §1395w-102(b)).

[4] The clawback is calculated based on the 2003 cost of prescription drug coverage. The Phased-Down State Contribution is set at 90% of costs for 2006 and decreases to 75% by 2015.

The proposed regulations will require Medicaid applicants who are eligible for Medicare to enroll in Medicare Part A, B and/or D in order to be covered by Medicaid. The state agrees to pay any applicable premiums and cost-sharing except those applicable under Part D.[5] Previously, Virginia's Medicaid Program provided outpatient drugs for its Medicaid recipients, both the categorically needy and medically needy. As of January 1, 2006, Medicaid recipients who are entitled to receive Medicare benefits under Part A or Part B are no longer eligible to receive their pharmacy benefits under the State's Medicaid Program, except for drugs that are excluded under the Medicare Prescription Drug Program.[6] The "dual eligibles" will have to select from a number of Medicare-approved private prescription drug plans, or be auto-assigned to one, which may or may not include all of their needed medications in the plan's formulary.[7] Although the "dual eligibles" qualify for a full drug subsidy (no premium, no deductible, low co-payments) under Medicare Part D, they will have to pay the minimum required co-payments for prescriptions, which is $1 for a generic and $3 for brand-name drugs, whereas under Medicaid an individual could not be compelled to make co-payments if he/she could not afford it.

Pharmacies may be slightly affected by the proposed regulations[8] in that now they may refuse to fill the prescription if the individual can not afford the co-payments, while previously they had to provide prescription even without co-payments. The positive effect will likely not be large and may be offset by the possibility that Medicare may not compensate them as well as Medicaid did.

The proposed regulation will increase administrative costs for Department of Medical Assistance Services (DMAS) in transitioning from Medicaid to Medicare,[9] providing for determination of elgibility for Medicare Low-Income Subsidy, as well as screening individuals

[5] The MMA established Low-Income Subsidy that will pay the premium, deductible, and part of the cost sharing under Part D.
[6] According to 12 VAC 30-50-35 and 12VAC 30-50-75, these drugs include barbiturates, benzodiazepines, nonprescription drugs, prescription vitamins and minerals, drugs for the symptomatic relief of coughs and colds, and drugs for anorexia, weight loss, and weight gain.
[7] For example, the Inspector General of the Department of Health and Human Services has determined that nearly one-third of dually eligible beneficiaries were assigned to drug plans that included less than 85% of the 178 most commonly used Part D drugs. Some of the drugs excluded from a substantial number of plan formularies (lists of covered drugs) are drugs for high blood pressure, high cholesterol and pain relief. (Source: http://www.medicareadvocacy.org)
[8] Pharmacies will benefit from the Medicare Part D Program with wider access to elderly patients.
[9] According to DMAS, these administrative costs will be shared by the federal government, as other costs under Medicaid.

for all Medicaid programs including Medicare Savings Program. An estimate for the increased administrative costs is not available according to DMAS. The local departments of social services (LDSS) will incur a small amount of increase in working hours in responding to inquiries and assisting in applications for the Part D LIS and drug plan selection. Virginia Department for the Aging (VDA), local Area Agencies on Aging or Virginia Insurance Counseling and Assistance Program (VICAP) may experience increased working hours in assisting individuals with LIS application and drug plan selection, and responding to inquiries. State and local agencies that used to provide prescription drug services to "dual eligibles" may be negatively affected because of the transition from Medicaid to Medicare, such as the Department of mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and its inpatient and outpatient facilities, the Virginia Association Community Services Boards (VACSB) and local Community Services Boards (CSBs), Virginia Department of Health (VDH) and local health departments.

For the Commonwealth, transition of "dual eligibles" to Medicare Part D will save the state share of costs of prescription drugs. On the other hand, Virginia is required to pay the federal government the state share of the cost of prescription drug coverage for the dual eligibles, with phased-down contribution set at 90% in 2006 and 75% by 2015. The state share of the prescription drug costs is calculated based on per capita costs for the "dual eligibles" in 2003, while DMAS has implemented a number of pharmacy savings initiatives after 2003 that have significantly reduced the Medicaid drug costs. Therefore, the "clawback" far exceeds the saved cost - the cost that would be for Virginia if the state were to continue to provide drug coverage to "dual eligibles" through Medicaid. DMAS has worked with Centers for Medicare & Medicaid Services to reduce the impact of "clawback" payments. Currently the estimated net cost for Virginia is approximately $16.5 million in FY 2007 and $19.3 million in FY 2008. It needs to point out that these costs are not direct impact of the proposed regulation, but rather the impact of the "clawback" as mandated by the MMA.

Businesses and Entities Affected

Dual eligibles will have their prescription drug covered under Medicare Part D instead of Medicaid. They will have to select from a number of Medicare-approved private prescription drug plans, or be auto-assigned to one, which may or may not include all of their needed

medications in the plan's formulary. Also, they will have to pay the minimum required co-payments for prescriptions, while previously they could not be forced to pay co-insurance if they could not afford it. According to DMAS, currently there are 140,000 Medicaid enrollees who are eligible for Medicare.

Pharmacies may be slightly affected by the proposed regulations because now they may refuse to fill the prescription if the individual cannot afford the co-payments. Currently there are 1,594 licensed pharmacies in Virginia, including the chain drug stores.

The proposed regulation will increase administrative costs and working hours for DMAS, LDSS, VDA, local Area Agencies on Aging or VICAP. According to DMAS, currently Virginia has 120 LDSS, 25 local Area Agencies on Aging or VICAP. Agencies that used to provide prescription drug services to "dual eligibles" may be negatively affected because of the transition from Medicaid to Medicare, such as DMHMRSAS, VACSB and local CSBs, VDH and local health departments. According to DMAS, currently there are 40 CSBs, and 227 administrative and health department offices.

Although the "clawback" is not intended to impose additional costs to states, Virginia will incur a net cost of $16.5 million in FY 2007 and $19.3 million in FY 2008 because post-2003 cost savings are not recognized in calculating the "clawback".

Localities Particularly Affected

The proposed regulation affects localities throughout the Commonwealth.

Projected Impact on Employment

The proposed regulation will have a slight positive effect on pharmacies and will likely not have any direct impact on employment.

Effects on the Use and Value of Private Property

The proposed regulation will likely not have any significant impact on the use and value of private property.

Small Businesses: Costs and Other Effects

The proposed regulations may have a slight positive effect on pharmacies. Currently there are 1,594 licensed pharmacies in Virginia including the chain drug stores. The exact number of small businesses is not known.

Small Businesses: Alternative Method that Minimizes Adverse Impact

The proposed regulations may have a slight positive effect on pharmacies

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.