Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30-141 – Family Access to Medical Insurance Security Plan
Department of Medical Assistance Services (DMAS)

December 20, 2001

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 9-6.14:7.1.G of the Administrative Process Act and Executive Order Number 25 (98). Section 9-6.14:7.1.G 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. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the Proposed Regulation

The proposed regulation permanently implements the redesigned and restructured Family Access to Medical Insurance Security (FAMIS) plan, which replaced the Children's Medical Security Insurance Plan (CMSIP) on August 1, 2001 under emergency regulations. In addition to the name change, the new program increases the maximum income eligibility levels, establishes a employer health insurance premium assistance component, creates a new benefit package, establishes cost sharing requirements, and creates a central processing unit for administration of the program.

Estimated Economic Impact

Virginia implemented CMSIP in October 1998 as its version of the federal State Children's Health Insurance Program (SCHIP), which was funded by the Balanced Budget Act of 1997 in order to enable States to initiate and expand child health assistance to uninsured, low-income children. In response to low enrollment and program design issues, the 2000 General

Assembly adopted legislation to restructure CMSIP, renaming the program the Family Access to Medical Insurance Security Plan (FAMIS). Where CMSIP was a Medicaid look-alike program, FAMIS has been modeled after private sector and resembles a private health care insurance plan. The proposed changes are individually discussed below.

Eligibility

The FAMIS plan increases the maximum income eligibility levels from 185 percent to 200 percent of the Federal Poverty Income Guidelines. FAMIS also uses gross income, where, under CMSIP, many sources of income were disregarded or excluded. DMAS estimates that 200 percent of poverty using gross income equates to 185 percent of poverty when evaluating eligibility using Medicaid monthly income disregards, and therefore expects no increase in enrollment due to this particular change.

In the new FAMIS plan, stepparents are included in the definition of family for financial eligibility purposes. CMSIP followed Medicaid policy and did not count a stepparent's income when determining eligibility of the child. DMAS believes that stepparents are part of the family unit and their income should be used in determining the family's financial situation. Opponents of this policy note that stepparents are not legally responsible for the care of their stepchildren and that this policy discourages remarriage, is likely to reduce the number of children potentially eligible for FAMIS thereby decrease enrollment in the program, and makes transition from Medicaid to FAMIS more difficult. This change illustrates an inherent trade-off between providing coverage for families who could otherwise afford insurance and excluding children whose stepparents choose not to provide health insurance. No empirical evidence can be found, however, to indicate which is more likely to occur.

CMSIP required a child to be uninsured for12 months before becoming eligible for coverage; FAMIS reduces that period to six months. The waiting period is designed to discourage families from dropping private health insurance and substituting state-supported insurance, often referred to as "crowding out." Six months is the standard used by many states. This change may result in an economic benefit if the time period remains long enough to provide an adequate disincentive for crowding out while reducing the time children must be without insurance before being eligible for FAMIS.

The requirement for cooperating with the Division of Child Support Enforcement is no longer mandatory for eligibility as it was in CMSIP. By removing a potential barrier, this change is likely to increase enrollment in the FAMIS program.

Employer-Sponsored Health Insurance

FAMIS establishes a premium assistance program called Employer-Sponsored Health Insurance (ESHI), which allows FAMIS-eligible families who have access to employer-sponsored health insurance coverage to enroll their children in their employers' health plan. DMAS will make the premium payments on behalf of these eligible participants if it determines that such enrollment is cost effective, i.e., the cost of covering the child under FAMIS would be more than the total cost of covering the child under the employer sponsored plan. The FAMIS plan will provide any supplemental coverage needed to ensure that FAMIS ESHI children have equivalent health benefits as those provided under FAMIS. Participation is completely voluntary and families may opt out of ESHI at any time and enroll their eligible children in a FAMIS health plan.

The ESHI program represents an alternative way of providing FAMIS benefits and, assuming the costs of administration will be less than the savings, this program will represent a net economic benefit to the Commonwealth.

Benefit Package

CMSIP was a Medicaid look-alike plan and the benefits reflected those offered in Virginia's Medicaid program. FAMIS creates a new benefit package modeled after the Key Advantage benefit package offered to state employees. However, non-emergency transportation, case management services, intensive rehabilitative services, podiatry, nursing facility services, nursing midwife services, psychiatric services rendered by non-physicians and other medical, diagnostic, screening, preventative, restorative, remedial therapy or rehabilitative services are no longer covered and limitations are placed on previously fully covered mental health benefits, vision, hearing aids, dental, and medically necessary orthodonture services. There is likely to be a significant reduction in the amount of these services received by children in the FAMIS program. DMAS states that the proposed benefit package is intended to reflect services covered under a commercial insurance plan. It is not clear why this is a desirable objective. In addition,

since FAMIS services are offered at a 66 percent federal match rate, it is very likely that the cost of providing them would not outweigh their value to the Commonwealth.

Central Processing Unit

CMSIP relied on local Departments of Social Services to process applications and enroll participants. This system was difficult to manage since it involved training personnel and distributing program information at over 120 local social services offices around the state. Monitoring implementation of the program and tracking the status applications was also difficult under this system. FAMIS creates a central processing unit (CPU) for administration of the program. The CPU will distribute applications and program information, respond to inquiries, receive and process applications for eligibility, and provide personal assistance to callers.

Creating one centralized office for all aspects of the application process will allow for specialized staffing and training and provide more access to detailed data on applications, including reasons for case denials. Based on increased efficiency, the time period specified in the regulations for processing an application has been decreased from 45 days to 10 days. Changing the contact point for the program also reduces stigma associated with welfare or public assistance programs that might have existed when the program was administered by local departments of social services. DMAS expects enrollment in the FAMIS program to increase as a result of the restructured application process. The cost of the new CPU is being funded with money that was previously provided to local social service agencies to assist with eligibility determinations and application assistance.

Cost-Sharing

The CIMSIP program did not require cost sharing by recipients. The FAMIS program implements a set of monthly premiums for participation in the program and co-payments for services received. Cost sharing premiums only apply to those families with incomes between 150% and 200% of the poverty income cut-off. Cost-sharing copays are higher for families in this income category than for families with lower incomes.

DMAS provides no significant rationale for cost sharing. The agency indicates that charging copays and premiums makes the program look more like a commercial insurance plan. It is not at all clear why this should be a goal for a program designed to increase medical care of

the children of near-poor families. DMAS has been unable to justify this as an appropriate policy goal. DMAS does make the assertion that cost sharing will "promote personal responsibility while extinguishing the stigma of welfare." DMAS does not indicate why charging someone for something will make that person "responsible" where they were not "responsible" before having to make the payments. Nor does the agency prevent any evidence that paying a subsidized copay and premium changes any stigma that might have existed prior to the requirements. People have always had the opportunity to offer money for care they could receive for free. That such donations have not been widely reported may be an indication that there is not a great stigma associated with the program. If this is not true, then the agency should be able to provide some evidence to the contrary before asserting reduced stigma as a benefit of implementing charges. If the agency can provide such evidence, then surely it should provide the same benefits to all recipients of FAMIS benefits rather than just to the most well-off.

Two possible reasons for implementing cost sharing are apparent. First, the agency may argue that the money earned from cost sharing will reduce net expenditures on the program and will thus free up funds for use in other areas with a higher expected benefit. This argument is difficult to accept for the FAMIS program since every 100 dollars spent on the program results in $66 of payments from the federal government. The addition of this $66 to the state economy results in increased economic activity and hence increased tax revenue. Thus, the fiscal cost of a $100 worth of health care services is less than $33. Due to the federal match funds lost, a dollar of cost-sharing income only earns the Commonwealth $0.33. This substantial federal match greatly reduces the likelihood that the revenues saved through cost sharing could easily be put to a use more productive for the economy than FAMIS services.

The second reason for co-payments and premiums is to encourage the efficient use of health care resources. Theory and experience both indicate that free health care services will be used inefficiently. However, there is ample empirical evidence that premiums and co-payments do discourage the use of both necessary and unnecessary medical procedures among both children and adults. This implies that cost sharing must be used very carefully to avoid doing more harm than good.

Premiums will make FAMIS coverage somewhat less attractive relative to other possible sources of coverage and may reduce crowding out. If one were to expect that charging a

premium would reduce crowding out by a substantial amount and would cause only a small reduction in medically necessary care, then a premium may generate economic benefits. There is only limited data in this area, but what data does exist suggests that just the opposite is true. The premiums proposed here are small relative to the cost of employer-provided plans and are very small relative to options for the uninsured near-poor. This leads to the conclusion that crowding out would be little affected by the premiums proposed in this regulation. On the other hand, $15 to $45 per month can be expected to be a significant disincentive to some families for participation in FAMIS.[1] These families will tend to self-insure, placing family financial well-being at significant risk.

One commenter suggests that, if premiums are used, they should be charged on an annual basis. Given the capital constraints faced by the near-poor, this option would likely further reduce participation in the program. Nothing prevents participants from setting aside the annual amount all at once and drawing on this fund monthly. However, given capital constraints and the time-value of money, such an option would rarely be chosen voluntarily unless it were accompanied by very substantial discounts.

Charging a co-payment for all medical services does reduce the demand for medical care relative to the demand for free care. A flat co-payment on services is a very blunt instrument. It discourages necessary care and unnecessary care alike. There is convincing empirical evidence on this point.[2] In addition, it does not provide adequate disincentive to overuse the most expensive services. In addition, if the payments are too small to reduce overuse of expensive procedures, then they do not provide a benefit. If the payments are effective at reducing care but do not distinguish between necessary and unnecessary care, then they may produce a net reduction in the economic benefit available from the program.

Available studies suggest that the economically optimal structure for cost sharing includes "a low [or possibly even zero] premium, a high deductible for inpatient care (except, perhaps for young children), and co-payments targeting certain types of services (e.g. brand

[1] Empirical evidence on this point is summarized in Markus, Rosenbaum and Roby, "CHIP, health Insurance Premiums and Cost-sharing: Lessons from the Literature." October 1998. The George Washington University Medical Center, Washington, DC.

[2] See Markus, Rosenbaum and Roby for a critical review of empirical studies.

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."[3] The DMAS co-payment proposal does reflect this structure to a small degree. However, the prescription drug benefit does not steer patients to generic drugs, a policy now frequently used to control prescription drug costs. Nor does the DMAS co-payment structure appear to provide a contribution likely to affect the rate of inpatient hospital stays. The premium proposal appears to be inconsistent with the structure that would maximize the economic benefits of the program.

Businesses and Entities Affected

As of September 2001, there were 34,602 children enrolled in FAMIS. DMAS projects enrollment to reach 51,125 by September 2003.

Localities Particularly Affected

The proposed regulation will not uniquely affect any particular localities.

Projected Impact on Employment

As the FAMIS program grows, we can expect to see an increase in employment in the health care sector in Virginia.

Effects on the Use and Value of Private Property

There is not likely to be any significant effects on the use and value of private property in Virginia as a result of the proposed regulation.

[3] See Markus, Rosenbaum and Roby.