DEPARTMENT RESPONSE TO DPB ECONOMIC IMPACT ANALYSIS

The Department has reviewed the Economic Impact Analysis prepared by the Department of Planning and Budget regarding the proposed regulations concerning the Family Access to Medical Insurance Security (FAMIS) Plan. A summary of DPB's issues, concerning the benefit package and cost sharing requirements, with the agency's responses follow.

Benefit Package

Basically DPB stated that the VCMSIP program had a Medicaid look-alike benefit package while FAMIS was modeled after the (Trigon) Key Advantage benefit package. To DPB, it was not clear why such a change was desirable in light of the significant differences in these two benefit packages.

Agency Response: *DMAS stated in its accompanying discussion document for this proposed regulation that significant changes had been designed into the FAMIS program to facilitate the disassociation, in the minds of the potential applicants, of the FAMIS program from 'welfare programs'. DMAS has encountered difficulty with achieving its projected enrollment goals. In light of this concern, DMAS attributed a significant portion of the poor enrollment response to the fact that surveys have stated that potential applicants did not wish to join another 'welfare program'. DMAS could not have been responsive to this survey information and simultaneously maintained the Medicaid look-alike benefit package.*

In addition, the analysis incorrectly states that midwifery, podiatry, and psychiatric services rendered by non-physicians, screenings, and preventive services are no longer covered. In general, if certified midwives, podiatrists and licensed professional counselors or clinical social workers participate in the health plan a recipient chooses, midwife, podiatric or psychiatric services provided by a licensed professional counselor or clinical social workers will be covered if medially necessary. Screenings and preventive services are covered under the description of well-baby and well-child care and do no require co-payments. Also, the analysis incorrectly states that the regulation places limitations upon dental services. Services such as routine preventive and diagnostic dental services (i.e. oral examinations, prophylaxis, topical fluoride applications, sealants and x-rays) are covered under the FAMIS program with no required co-payment. Only complex restorative dental services such as inlays, onlays, crowns, dentures, bridges, relining dentures for a better fit, and implants have a cost sharing limitation.

DMAS proposed, in its revised Title XXI State Plan to CMS that the Trigon Key Advantage benefits package be implemented in the revised child health program. Since both federal statute and federal regulations permit the use of such an alternative benchmark benefit package, CMS approved this element of the Title XXI Plan.

The State Plan is a comprehensive written statement submitted to CMS for approval. The Plan describes the purpose, nature, and scope of the State's SCHIP and gives an assurance that the program is administered in conformity with the specific requirements of title XXI, title XIX (as appropriate), and the regulations in this chapter. The Plan also contains all the information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program, 42 C.F.R. § 457.50.

DMAS, in light of having received federal approval of its Plan, was not at liberty to include anything else in its proposed regulations. To do so would have endangered its 66% federal funds for child health. Furthermore, there is no evidence to suggest that the thousands of children of state employees are medically underserved by the Key Advantage benefit package.

Cost Sharing

DPB suggested in its analysis that there may be two arguments for why DMAS included cost sharing components (co-payments and premium charges) in its FAMIS design: money earned from cost sharing could be used to offset other costs; co-payments and premium charges tend to encourage the efficient use of health care resources.

Agency Response: DMAS does concur with the concept that sharing the cost of health care expenses does increase participants' perceived value of health care services. However, this was not why cost sharing was included in the FAMIS program design.

Cost sharing was included in the program design because DMAS was directed, by the 2000 session of the General Assembly in COV 32.1-351B, to do so. Since the agency had a legislative mandate to address, this element was included in the State Plan proposal that was submitted to CMS. CMS ultimately approved this element of the concept. To have omitted this element in the agency's proposed regulations could endanger the Commonwealth's receipt of its federal matching funds for child health services.

The analysis incorrectly states that no significant rational exists for cost sharing. The legislation enacting FAMIS explicitly states:

> *Family Access to Medical Insurance Security Plan participants whose incomes are above 150 percent of the federal poverty level shall participate in cost-sharing to the extent allowed under Title XXI of the Social Security Act, as amended, and as set forth in the Virginia Plan for Title XXI of the Social Security Act. The annual aggregate cost-sharing for all eligible children in a family at or above 150 percent of the federal poverty level shall not exceed five percent of the family's gross income or as allowed by federal law and regulations. Cost-sharing for all eligible children in a family between 100 percent and 150 percent of federal*

> *poverty level shall be limited to nominal copayments and the annual aggregate cost-sharing shall not exceed 2.5 percent of the family's gross income.*

In its proposed regulation DMAS implements cost-sharing mechanisms compliant with State law and the Title XXI State Plan. Cost sharing has been set at amounts that do not exceed amounts that are considered "nominal" under Medicaid law. Therefore, DMAS has proposed a regulation, which complies with the Code of Virginia while requiring minimal cost-sharing participation.

In addition, the analysis incorrectly assumes that co-payments are charged for all medical services. In accordance with Federal law and the Code of Virginia § 32.1-351, DMAS does not charge co-payments for well-baby and well-child services. These services include important preventative care such as all healthy newborn in patient physician visits, routine screenings (inpatient or outpatient), routine physical examinations, laboratory tests, immunizations, and related office visits.