Economic Impact Analysis
Virginia Department of Planning and Budget

12 VAC 30-120 –Department of Medical Assistance Services
Medallion II
May 6, 2004

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 2.2-4007.G of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007.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

One of the main proposed changes is providing regulatory authority to the Department of Medical Assistance Services to establish copays for the Medallion II managed care recipients. Other substantive changes are adding several provisions, pursuant to Item 325 R of the 2003 Appropriation Act, to conform to the federal law changes contained in the 1997 Balanced Budget Act. The remaining changes are clarifications of the rules that are already in effect.

Estimated Economic Impact

These regulations contain rules for the Medallion II managed care program. Currently, seven managed care organizations provide services to about 263,000 Medicaid recipients under these rules. The total Medicaid reimbursement to managed care organizations under the Medallion II program was approximately $766 million in fiscal year 2003.

Cost Sharing:

One of the significant proposed changes is providing regulatory authority to the Department of Medical Assistance Services (DMAS) to allow managed care organizations to impose the same cost sharing obligations on enrollees as set forth for the fee-for-service population. Current regulations prohibit managed care organizations to charge copays to categorically needy enrollees. The cost-sharing schedule that may be imposed on managed care recipients under the proposed regulations is provided below.

Cost Sharing Schedule:

Service	Deductible	Copay
Inpatient Hospital	$100	$0
Outpatient Hospital Clinic	$0	$3
Clinic Visit	$0	$1
Physician Office Visit	$0	$1
Eye Examination	$0	$1
Generic Prescriptions	$0	$1
Brand Name Prescriptions	$0	$3
Home Health Visit	$0	$3
Other Physician Services	$0	$3
Rehabilitation Therapy Services	$0	$3

Source: 12 VAC 30-20-150 and 12 VAC 30-20-160.

Currently, DMAS sets capitation rates for managed care enrollees as if managed care organizations actually collected copays. This is so because the managed care capitation rates are calculated based on DMAS' portion of fee-for-service payments, which does not include copays that may or may not be collected by the providers. In other words, DMAS assumes that the providers collect copays from the recipients and accordingly deducts the copays when reimbursing providers for their services. This also means that DMAS does not maintain any information with respect to the amount and volume of copays. This methodology amounts to

subtracting copay revenues from the capitation rates even though managed care organizations do not and cannot collect any copays from the enrollees.

Although DMAS does not have any immediate plans to allow managed care organizations to collect copays at this time and does not expect managed care organizations to seek this authority as well, if managed care organizations desire to do so, there is a good chance they may succeed. It will be very difficult for DMAS to deny such a request from managed care organizations, especially because the copay revenues are already subtracted from capitation rates and because DMAS will have the authority through these regulations to grant such a request. On the other hand, provided that managed care organizations wish to be able to collect copays, they will be able to negotiate either to be granted the authority to collect copays or demand that the estimated copay revenues no longer be deducted in rate setting process. However, it is not known whether the managed care organizations would want to implement these cost-sharing methods in practice because of the administrative cost concerns. Their decision will be based on whether they stand to gain or loose from implementation of copays in practice.

In the event managed care organizations are granted the authority to collect copays and implement copays in practice, some economic effects could be expected, as copays would affect recipients, providers, and the managed care organizations themselves. One of the main effects is the transfer of resources from recipients to the managed care organizations. It is also possible that managed care providers could end up absorbing the copays depending on the way the copays are collected. For example, under the fee-for-service model, DMAS deducts copays from reimbursements to providers regardless of whether the copays are collected by the provider. Similarly, some managed care providers may not collect copays, if the administrative costs are high, but the copays may be deducted from their capitation rates. In short, if copays are implemented, some economic resources will be transferred from recipients, or from providers to managed care organizations.

Another and perhaps more important effect of copays is their ability to reduce over-utilization of services and contain costs. Based on economic theory it can be reliably stated that as the cost-sharing increases, over-utilization of services in the managed care program would decrease. From a societal point of view, the main benefit of copays is to encourage the efficient use of Medicaid services. Economic theory indicates that free healthcare services will be used

inefficiently. Charging a copay for medical services would reduce the demand for these services relative to the demand for free care and discourage unnecessary care. 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 copays 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] While the proposed copay proposal reflects many aspects of the recommended structure, copays may be too small to significantly reduce overuse of expensive procedures. The potential copays that may be charged as a percent of income compare very favorably to standard copays required under private insurance plans. For example, for every dollar earned, a managed care recipient with a $1-copay and a $7,000-income pays three times less than a family with a $25-copay and a $50,000-income. However, there is no available study that can be used to estimate the potential enrollee response to these nominal copays.

Additionally, copays may make managed care coverage somewhat less attractive and may reduce crowding out relative to what would result without any copays. 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 pocket expenditures on bread. In this context, this means substitution of publicly funded health care for private insurance. However, as mentioned, the copays are relatively small. This leads to the expectation that copays would reduce crowding out by only a small amount. Furthermore, the size of potential benefits are significantly reduced because children, the largest group of recipients, are exempt from copays and the providers cannot deny services if a recipient cannot pay.

Another potential effect on recipients is the possibility that copays reduce the stigma associated with the program. It is possible that some recipients would feel less like they are receiving assistance from a charity or from welfare. On the other hand, there is a possibility that copays create a barrier to some other families (especially to those with low incomes) to

[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.

participate in the program. However, given the nominal copay structure, any such barrier will likely be very small.

The likelihood of copays being implemented is significantly reduced due to potentially significant administrative costs. As in the fee-for-service delivery model, managed care organizations would likely collect copays through the participating providers. It would be unlikely for most participating providers to assume this responsibility without additional compensation. However, since the copays are very nominal, some participating providers may find it more cost effective not to collect copays from recipients, but pay the managed care organizations out of pocket and be more reluctant to participate in the managed care organization. Either way managed care organizations are likely to incur non-negligible administrative costs to collect copays from the recipients. If administrative costs are too high and outweigh expected benefits in terms of additional copay revenues and reduced over-utilization, managed care organizations should not be expected to implement the copay schedule.

Balanced Budget Act:

Several other proposed changes are related to the amendments to the federal Balanced Budget Act in 1997, which required states to incorporate in their Medicaid regulations a number of new provisions. While states did not have any discretion with respect to many of these changes, a few allowed states some flexibility. Mandated changes with no state discretion have been incorporated in these regulations through an exempt regulatory action. This action incorporates several additional changes where the Commonwealth has discretion with respect to time frames. Since these changes had to be adopted by 2004, the 2003 Appropriation Act, Item 325 R, provided authority to DMAS to adopt emergency regulations. Emergency regulations have been in effect since December 2003.

The main proposed changes in this area are related to the client grievance and appeals process. The Balanced Budget Act required states to allow Medicaid clients to request appeals orally and required enrollees to follow up with a written request. However, it did not specify a time frame when the enrollee must follow up with a written request. The proposed regulations establish that oral appeals be followed up in writing within ten business days. Additionally, the Balanced Budget Act required managed care organizations to issue standard appeal decisions within 20 to 90 days. The proposed rules establish that appeal decisions be issued within 30

days. According to DMAS, the proposed time frames are closely consistent with the procedures followed in practice and therefore are unlikely to introduce any significant costs for the managed care organizations or the enrollees. The main benefit of the proposed rules however is conforming to the provisions of the Balanced Budget Act as amended in 1997 as well as to the 2003 Appropriation Act, Item 325 R.

Other:

The remaining changes are clarifications of the current rules. A number of these changes clarify which individuals are excluded from participating in the Medallion II program. The excluded individuals include: (1) individuals participating in the Family Planning Waiver, (2) individuals under age 21 in residential treatment or treatment foster care, (3) individuals with other comprehensive group or individual health insurance including Medicare, insurance provided to military dependents, and other insurance purchased through Health Insurance Premium Payment Program, (4) terminally ill individuals who request exclusion during pre-assignment or within a later timeframe designated by DMAS, (5) individuals who have an eligibility period that is less than three months, (6) individuals who receive services through State Children's Health Insurance Plan, (7) individuals whose eligibility period is retroactive only, (8) individuals who have been consistently non-compliant with policies and procedures of DMAS or their managed care organization. Other clarifications include (9) that automatic enrollment does not disqualify a newborn from disenrollment by choice, (10) that the newborn's continued enrollment is not contingent upon the mother's enrollment, (11) that the school health services are physical therapy, speech therapy, nursing, school assistant, and psychiatric and physiological services, and (12) that early periodic screening, diagnosis, and treatment services are covered by the managed care organization. All of the changes under this category are clarifications of the current rules and are not expected to result in any significant economic effects other than reducing communication costs that may otherwise be incurred to resolve confusions that may be caused by the current language.

Businesses and Entities Affected

Currently, seven managed care organizations are providing services to approximately 263,000 Medicaid recipients.

Localities Particularly Affected

The proposed regulations apply throughout the Commonwealth.

Projected Impact on Employment

No significant effect on employment is expected upon promulgation of these regulations.

Effects on the Use and Value of Private Property

The proposed regulations are not expected to create any significant effect on the use and value of private property upon promulgation.