

**Department for Children and Families**

**Analysis of Costs and Benefits of Retroactive Coverage  
for Vermont's Pharmacy Programs**

**In Accordance with H.531 ACT 71 - Section 16**

**Submitted to:** House Committee on Health Care  
House Committee on Human Services  
Senate Committee on Health And Welfare  
Commission on Health Care Reform

**Submitted by:** Stephen R. Dale, Commissioner



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Last session, the legislature considered moving the coverage start dates for the Vermont Health Access Plan (VHAP) and the state’s pharmacy plans to the date of application. Ultimately, in Act No. 71, An Act Relating to Ensuring Success in Health Care Reform, the legislature enacted the reform for VHAP, but not the pharmacy programs. Rather, it asked the Department for Children and Families (DCF) to provide a detailed analysis of the costs and benefits of enacting retroactivity for the pharmacy programs. More specifically, in section 16 of the Act, it directed:

(a) The commissioner for children and families shall analyze the costs and benefits of providing coverage from the date of application for those applying for any state-funded pharmacy program, provided all conditions of eligibility were met as of such date.

(b) The commissioner shall consult with the medical care advisory committee in performing this analysis and shall report his or her findings to the health access oversight committee no later than November 15, 2007. The report should include an explanation of why, if at all, there should be any disparate treatment in this regard between applicants for VHAP and applicants for pharmacy programs.

Vermont employs two strategies to help elderly and disabled low-income residents pay for prescription drugs. For those who are eligible for a Medicare Part D Drug Plan, the state offers VPharm 1, 2, and 3—three levels of assistance to help with Part D premium costs, cost-sharing, and the costs of drug classes that are excluded from Part D. The level of assistance is based upon income. Those who are ineligible for Medicare are also eligible for one of three levels of assistance. The income standards for the three programs—VHAP Pharmacy, VScript, and VScript Expanded—align with those that apply to the VPharm programs. The VHAP Pharmacy and VScript programs’ benefits include payment for specified medications and, depending upon the program, diabetic supplies and eye exams. The programs’ income standards, benefits, and cost-sharing requirements are summarized in the table below:

Income	Program	State Pays	Beneficiary Pays
≤150% FPL	VPharm 1	<ul style="list-style-type: none"> <li>▶ Medicare Part D deductibles and co-payments that are not covered by Low-Income Subsidy</li> <li>▶ Drug classes excluded from Part D</li> <li>▶ Eye exams</li> </ul>	<ul style="list-style-type: none"> <li>▶ \$15/person/month premium</li> </ul>
	VHAP Pharmacy	<ul style="list-style-type: none"> <li>▶ Prescriptions covered by Medicaid</li> <li>▶ Diabetic supplies</li> <li>▶ Eye exams</li> </ul>	<ul style="list-style-type: none"> <li>▶ \$15/person/month premium</li> </ul>
>150% but ≤175%	VPharm 2	<ul style="list-style-type: none"> <li>▶ Medicare Part D deductibles and co-payments for maintenance medication</li> <li>▶ Drug classes excluded from Part D for maintenance medication</li> </ul>	<ul style="list-style-type: none"> <li>▶ \$20/person/month premium</li> <li>▶ Medicare Part D deductibles and co-payments for non-maintenance medication</li> </ul>
	VScript	<ul style="list-style-type: none"> <li>▶ Maintenance Medication</li> <li>▶ Diabetic supplies</li> </ul>	<ul style="list-style-type: none"> <li>▶ \$20/person/month premium</li> </ul>
>175% but ≤ 225%	VPharm 3	<ul style="list-style-type: none"> <li>▶ Medicare Part D deductibles and co-payments for maintenance medication</li> <li>▶ Drug classes excluded from Part D for maintenance medication</li> </ul>	<ul style="list-style-type: none"> <li>▶ \$42/person/month premium</li> <li>▶ Part D deductibles and co-payments for non-maintenance medication</li> </ul>
	VScript Expanded (Manufacturer has to sign rebate agreement with the state)	<ul style="list-style-type: none"> <li>▶ Maintenance medication</li> <li>▶ Diabetic supplies</li> </ul>	<ul style="list-style-type: none"> <li>▶ \$42/person/month premium</li> </ul>

Vermont has a seventh pharmacy program–The Healthy Vermonters Program (HVP)–for people with moderate incomes who have no insurance for prescriptions or who have a commercial insurance plan with a yearly limit. It permits beneficiaries to purchase medications at the Medicaid rate. Eligibility is as follows:

- ▶ Age 65 or older, or disabled and receiving Medicare or social security benefits, and have income at or below 400% FPL.
- ▶ Beneficiaries of any age with income at or below 350% FPL.
- ▶ Pharmacy-program beneficiaries with incomes at or below 225% FPL, for drugs prescribed to treat acute conditions that are not otherwise covered.

These pharmacy-assistance programs are based upon three conceptually different strategies: When the person is eligible for Medicare and the pharmacy assistance offered by that program, the state offers assistance with premiums and cost-sharing. Where, however, the individual does not qualify for federal pharmacy assistance, Vermont steps into the role of insurer and pays all or a part of the cost of covered medications. Finally, in HVP, the state provides neither coverage nor a subsidy. Rather, eligibility entitles beneficiaries to purchase medications at the Medicaid

rate. Pharmacies may not claim reimbursement from the state for this benefit. These three different approaches do not lend themselves equally to retroactive eligibility.

For programs in which the state acts as the insurer (*i.e.*, VHAP Pharmacy, VScript, and VScript Expanded), providing a retroactive benefit is relatively straightforward: If retroactivity is implemented, after the eligibility process is completed, the beneficiary may request reimbursement from the pharmacy for prescriptions filled between the time of filing and approval of eligibility. The pharmacy is not obligated to honor such a request. However, if it elects to do so, it may, in turn, submit a claim to the state. This is the process that is currently employed in the Medicaid program. It is also the process that will be employed, once VHAP eligibility is made retroactive to the date of application.

The situation differs when the state does not assume the role of the insurer, but rather, provides a benefit in the form of assistance with the cost of insurance coverage and cost-sharing. This is the case with VPharm.

For all three VPharm programs, enrollment in a Medicare Part D Prescription Drug Plan (PDP) is a condition of eligibility. VPharm Rule 3502.5. Also, VPharm 1 applicants must secure a Limited Income Subsidy (LIS) if it appears that they may be eligible for that federal benefit. VPharm Rule 3502.6.<sup>1</sup> Only about half of these program applicants have satisfied these conditions at the time of application. Exemption from these conditions is not feasible: For these programs, the benefit is based upon the premium and cost-sharing provisions of the underlying PDP. Thus, there is no benefit until after the individual selects and is enrolled in the PDP.

For a VPharm applicant who is already enrolled in a PDP at the time of application, the state could provide retroactive payment for the PDP premiums that the individual had paid during the period covered by retroactivity. Also, the beneficiary could request reimbursement from the pharmacy for medications covered under their particular programs. However—as with VHAP Pharmacy, VScript, and VScript Expanded—pharmacies are not obligated to honor such requests.

Retroactivity in the HVP program would resemble something of both of the above. In cases where individuals are only enrolled in HVP, after eligibility is approved, the beneficiary would be in a position to return to the pharmacy to request reimbursement for prescriptions filled between the time of filing and approval. Again, there is no obligation to honor the request. If the pharmacy does elect to reimburse the individual for the difference between the Medicaid price and the price paid, however, the pharmacy will not have a claim to submit to the state.

In cases where the HVP applicant is also Medicare-eligible, the person must be enrolled in a PDP as a condition of eligibility for HVP. Thus, the issues addressed above regarding retroactivity for the VPharm programs would also apply in these cases.

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<sup>1</sup> LIS is designed to provide help to certain people with Medicare who have limited income and resources. Eligible people will receive full or partial help with Part D premiums, deductible and co-pays for prescription drugs.

As the HVP program does not have a fiscal impact on the state budget and the implementation costs would be largely subsumed within implementation of retroactivity for other pharmacy programs, this program is not included in the cost-benefit analysis set forth below.

While it is technically feasible to make pharmacy eligibility retroactive to the date of application for those who have met the eligibility requirements as of that date, the scope of the benefit—both in terms of numbers served and benefit value—is relatively small. While there are about 15,000 pharmacy-program beneficiaries statewide, the population is very stable. Thus, at any given time, there are relatively few program applicants. Moreover, the vast majority of applicants will be eligible for Medicare and, therefore, one of the three VPharm programs. But, as noted above, many of these individuals will not be enrolled in a PDP or LIS and, therefore, will not meet program conditions at the time of application. Also, the individual’s ability to secure the most valuable portion of the benefit that could be conferred by retroactivity—recoupment of monies expended on covered medications during the application period—is dependent upon the willingness of pharmacies to honor such requests. Finally, as the average benefits that retroactivity would confer are relatively small, and the period that would be covered by retroactivity is short, the proposed enhancement would add relatively little value to the average beneficiary. The data supporting these conclusions are summarized as follows:

<b>Program</b>	<b>Average Annual Number of Applicants Meeting Eligibility Conditions On Application Date</b>	<b>PMPM (SFY’08 Budget Adjustment)</b>	<b>Monthly Medicare Part D Premium</b>	<b>Total Average Benefit Conferred by Retroactivity</b>
VPharm 1	407	\$54	\$13	\$150
VPharm 2	162	\$87	\$13	\$226
VPharm 3	191	\$120	\$13	\$301
VHAP Pharm.	19	\$317	N/A	\$728
VScript	7	\$317	N/A	\$728
VScript Exp.	2	\$296	N/A	\$680
<b>Total Pharm.</b>	<b>788</b>			

The programs’ per-member-per-month figures reflect payments for medications at the Medicaid rate of reimbursement. That rate is 70.49% of the billed cost. The billed cost is the pharmacies’ usual and customary charge.

This analysis assumes that retroactivity would cover a period of about eight weeks. The eligibility determination is made within the first three weeks. During that time, applicants for VHAP Pharmacy, VScript, and VScript Expanded must now continue to obtain their medications at their own expense at the usual and customary charge. However, after eligibility is determined, they are enrolled in the Healthy Vermonters Program (HVP). That program permits the individuals to purchase drugs at the Medicaid rate. Individuals continue in that program until the first day of the month following payment of the first month’s premium. At that point pharmacy benefits are initiated. This latter period is about five weeks. This analysis accounts for these cost variations.

For the VPharm programs, the situation differs. Initially, there is no benefit without PDP enrollment. For those who meet this requirement, the benefit is reimbursement for PDP premiums paid, and reimbursement for covered drug purchases. Again, however, receipt of this latter portion of the benefit depends upon the pharmacy’s willingness to bill VPharm and reimburse the beneficiaries.

Weighed against providing a relatively small benefit for a small group of people is the substantial task of reprogramming ESD and OVHA’s eligibility, premium-payment, and claims-payment IT systems to accommodate the changes. DCF’s Information Services Division estimates that the development tasks will require the equivalent of a full-time programmer working on this project for a period of six months. The work would cost approximately \$120,000 to complete, if the project is put out for contract.

The estimated annual cost of the proposed premium and benefit expansion is as follows:

<b>Vermont Program Monthly Premium</b>	<b>Vermont Program Premiums for Periods of Retroactivity</b>	<b>Annual State Benefit Cost</b>
\$15	\$12,210	\$43,956
\$20	\$6,480	\$28,188
\$42	\$16,044	\$45,840
\$15	\$570	\$12,046
\$20	\$280	\$4,438
\$42	\$168	\$1,184
	\$35,752	\$135,652

Premium requirements also present a challenge in implementing retroactivity for pharmacy programs. Presently, shortly after eligibility is determined, the applicant receives a bill for the first month’s premium, along with a notice advising that coverage will begin on the first of the month following payment. If coverage is to be retroactive to the date of application, the state must choose between two options for the collection of the premium associated with the extended period of coverage. The state could either waive the premium for the period subject to retroactivity, or it could include the premium for the retroactive period in the first bill sent after eligibility is determined. Given the enrollment numbers reported above, the first option would result in a cost of \$35,752 in lost premium revenues. The second option would allow for the collection of premiums during the period of retroactivity. For VPharm beneficiaries, the premiums could be partially offset with the reimbursement of PDP premiums. However, they and other program applicants would have a steeper cost hurdle to overcome to gain access to the Vermont program. In addition, this approach will likely increase the IT costs.

Retroactive coverage will also present pharmacists with a new and ongoing business cost. Those who choose to honor reimbursement requests would lose nearly 30% of the amount they currently receive from the beneficiary and be required to reprocess all of the transactions subject to the retroactive benefit. These new burdens would come at a time when this industry is already seeking an increase in its Medicaid and state-program reimbursement.

Finally, the legislature asked for an explanation of why, if at all, retroactivity should be afforded to VHAP applicants but not to those who apply for pharmacy benefits. While both expansions will require significant program and IT investments, VHAP retroactivity will yield more benefit to a greater number of people. We estimate that, each year, this initiative is likely to provide 15,219 VHAP applicants with an average additional benefit of about \$272. By contrast, a similar pharmacy expansion would benefit about 790 people. The median benefit would be about \$124.<sup>2</sup> Also, VHAP provides full coverage for the uninsured while the pharmacy programs are limited to one component of health care.

If the legislature does elect to enact retroactive eligibility for these programs, we request that—given the technical complexities of implementing these changes, and the current demands of other ongoing initiatives—the implementation date be set after January 1, 2009.

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<sup>2</sup> The median benefit is used in this case, as the numbers are sharply skewed toward lower benefit levels: About 51.6% of pharmacy applicants—407 individuals—would receive total additional benefit of about \$124. About 44.8%—353 people—would receive between \$200 and \$275. About 3.6%—28 individuals—would receive an average benefits ranging between \$680 and \$728.

### **Advice Received from Members of the Medicaid Advisory Board**

In fulfillment of the Act's consultation requirement, the department shared drafts of this report with designated members of the Medicaid Advisory Board (MAB). We received five comments from three members. The comments are summarized in italics below, and are followed by the department's responses.

- 1. The analysis in the draft report is based on monthly numbers. Use annual counts instead.*

We adopted this approach in the final report.

- 2. The draft report uses the per-member-per-month cost to estimate the benefit level. Do retail drug prices better reflect the value of the contemplated expansion?*

As is explained above, the final report employs retail drug prices for those programs and periods in which applicants would incur such costs. However, for affected programs, this change yields only a slight increase in benefit.

- 3. Applicant losses will repeat themselves year after year, while the start-up administrative costs are mostly one-time.*

This is of course accurate and should be factored into the decision-making process. It is also true that the program costs related above would be ongoing expenses.

- 4. The explanation of why it might be appropriate to extend retroactivity to VHAP applicants but not to those who apply for pharmacy benefits should include a comparison of population sizes and benefit amounts.*

We adopted this approach in the final report.

- 5. While the non-Medicare beneficiaries are small in number, for each person, the benefit from a month or six weeks of additional coverage is large.*

Decision-makers will need to balance the value of affording that benefit to a very small number of people against the cost of creating the infrastructure needed to deliver that benefit.