COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 2422-01
Bill No.: SB 6
Subject: Social Services Department; Public Assistance
Type: Original
Date: September 6, 2001

FISCAL SUMMARY

ESTIMATED NET EFFECT ON STATE FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
General Revenue	($575,124)	($24,313,575)	($35,915,126)
Pharmaceutical Investment Program for Seniors	$1,778,900	$0	$0
Total Estimated Net Effect on All State Funds	**$1,203,776**	**($24,313,757)**	**($35,915,126)**

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
Federal	$0	$0	$0
Total Estimated Net Effect on All Federal Funds*	**$0**	**$0**	**$0**

***Revenues and expenditures of approximately $22 million annually would net to $0.**

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2002	FY 2003	FY 2004
Local Government	**$0**	**$0**	**$0**

Numbers within parentheses: ( ) indicate costs or losses.

This fiscal note contains 20 pages.

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Office of State Treasurer**, the **Office of State Courts Administrator**, and the **Department of Revenue** assume this proposal would not fiscally impact their agencies.

Department of Social Services (**DOS**) officials assume the following:

Officials from the **Division of Family Services** (**DFS**) state the following:

Income/Resources Expansion

The DFS would need to hire additional staff and develop policy to accommodate the necessary changes for the expansion of income and resources to the adult Medicaid populations. Implementation of this portion of the proposal would begin January 1, 2002.

The proposal provides that the income eligibility limit be expanded to 100% of the Federal Poverty Level (FPL) for those individuals receiving old age assistance benefits or permanent and total disability benefits. Currently 100% of the FPL is $716 for a single individual and $968 for a couple.

Based on data from the FY 2000 DOS Annual Data Report published by Research and Evaluation there are 11,882 QMB cases, and 6,860 SLMB cases. This data is based on average persons receiving monthly for FY 2000 and should provide a more accurate count of individuals impacted.

This proposal would have a negligible fiscal impact on both the GR and SAB programs. The GR population may have a small percentage of cases that have income in the month of application greater than $181 (Need standard for a 1 person household) but less than or equal to the SSI maximum of $530. This is typically a result of terminated income from employment. Affect on eligibility would be limited to the month of application. SAB individuals rejected in the past on excessive resources usually qualify for the Blind Pension program since it has a $20,000 resource maximum.

65% of the total population would qualify for the single resource maximum and 35% of the total population would qualify for the couple resource maximum, as reported by the Health Care Finance Administration (Medicare Current Beneficiary Survey Data Tables, 1997, Table 1.2)

65% of the current Qualified Medicare Beneficiary (QMB) and Specified Low-income Medicare

Beneficiary (SLMB) program participants are living alone. 37.5% of this population would be eligible for Medicaid based on the increased resource limits (1,500/4000 - Single QMB/SLMB ASSUMPTION (continued)

resource limit = 37.5%). For the SLMB population, the income limits is greater than 100% of the FPL therefore, this population would be spenddown.

18742	Active QMB/SLMB cases
x .65	% living alone
12,182	# eligible
x 37.5	% living alone with resources equal to or less than $1,500
4,568	# of new eligibles living alone

35% of the current Qualified Medicare Beneficiary (QMB) and Specified Low-income Medicare Beneficiary (SLMB) program participants are living with a spouse. 41.66% (2,500/6,000 Couple QMB/SLMB resource limit= 41.66%) of this population would be eligible for Medicaid based on the increased resource limits. For the SLMB population, the income limits is greater than the 100% of the FPL therefore, this population would be spenddown.

18,742	Active QMB/SLMB cases
x .35	% living with spouse
6,560 # eligible	
x .4166	% of married couples with resources equal to or less than $2,500
2,733	# of new eligible married couples

The global Medicare population in Missouri is 800,000. Assume this group to be the new population from outside of the current welfare rolls to seek Medicaid benefits.

800,000	Medicare Population
520,000	Living Alone (65%)
280,000	Living with a Spouse (35%)

According to a study completed by the Public Policy Institute of AARP #9914 dated September 1999 entitled: "How Much Are Medicare Beneficiaries Paying Out-of-Pocket for Prescription Drugs?", 10% of Medicare beneficiaries have income less than or equal to 100% of the FPL and resources at or below the QMB/SLMB resource maximums. Based on this information, DFS anticipates that one out of 10 or 10% of the Medicare population would be eligible to apply for Medicaid under the new expanded income limits.

37.5% of single Medicare beneficiaries have resources below $1,500. Assume 5% of this population will apply and be found eligible for Medicaid.

520,000 Medicare Population Living Alone
x 10% Income below 100% of the FPL
ASSUMPTION (continued)

52,000
x 37.5% Resources below $1,500
19,500
x 5% % applying and found eligible
975 New cases living alone

41.67% of the Medicare population living with a spouse have resources below $2,500. Assume that 5% of this population will apply and be found eligible for Medicaid.

280,000 Medicare Population Living with a Spouse
x 10% Income below 100% of the FPL
28,000
x 41.66% Resources below $2,500
11,665
x 5% % applying and found eligible
583 New cases living with a spouse

Fiscal Impact - Expanded Resource and Income Limits

Total populations included

7,301 - Active QMB/SLMB only cases with resources at $1,500/$2,500
10,908 - New full Medicaid eligibles (previously Spenddown)
975 - New cases (single Medicare)
+ 583 - New cases (couple Medicare)
19,767 - Total Eligibles

The Active QMB/SLMB only cases and additional spenddown cases that are currently being maintained in a caseload will not require additional staff for DFS.

975 - New single Medicare cases
+ 583 - New couple Medicare cases
1,558 - New Eligibles

An average adult Medicaid caseload is 480 cases.

1,558 / 480 = 3.24 or 3 new Caseworker FTEs needed to maintain new cases. Caseworker

duties and responsibilities include take and process applications for eligibility, respond and answer both written and telephone requests for information or reported changes, and maintain all active cases in caseload.

ASSUMPTION (continued)

Annual salary for a Caseworker is $29,040

Equipment and Expenses (E & E)	
One Time Costs: (For FY 2002)	
Systems furniture	4,500
Lateral File (4 drawer, 36" width)	552
Chair	245
Side chair (1)	125
Calculator	60
PC	2000
PC Software	300
Desktop Printer	310
Phone Installation	600
Data Line	175
Sub-Total	8,867

On-Going Costs for FY-2002 (Costs based on a 6 month year. .50 will be used to represent 6 months.)

	Full Year	6 Month Year	
Office Space	2,700	x .50 =	1,350
Utilities	520	x .50 =	260
Office Supplies	300	x .50 =	150
Copy Machine	200	x .50 =	100
Data Line	60	x .50 =	30
Phone Usage	500	x .50 =	250
DDP Maintenance	124	x .50 =	62
		Sub-Total	2,202

On-Going Costs: (FY 2003 & 2004)

Office Space	2,700

MW:LR:OD (12/00)

Office Supplies	300
Copy Machine	200
Utilities	520
Data Line	60
Phone Usage	500

ASSUMPTION (continued)

DDP Maintenance	124	
Sub-Total	4,404 x 2 =	8,808
Total E&E	19,877 x 3 =	$59,631

Travel Expenses

Travel expenses of $225 per year are being anticipated for caseworker FTEs

$225	Caseworker annual travel costs
x 3	# of new FTEs
$675	Annual travel cost

Pharmaceutical Investment Program for Seniors

The DFS assumes that the Division of Aging within the Department of Health and senior Senior Services would award an RFP to a third-party for the administration of the PIPS therefore its involvement would be negligible. No increases in Medicaid caseloads are anticipated.

The DFS assumes a zero fiscal impact for this portion of the proposal.

Officials from the **Division of Medical Services** (**DMS**) worked with the Division of Family Services to identify the population that is being proposed for full medical assistance. The population includes spenddown, Qualified Medicare Beneficiary (QMB) only, and Blind Pension eligibles. These populations are currently receiving a limited medical services benefit, but this proposal would allow the eligibles to receive the full benefit. Currently, there are 10,908 spenddown eligibles and 37 Blind Pension eligibles affected by increasing income limits. DMS believes there would be individuals that are eligible for the spenddown program, but are not enrolled. DMS assumed that this population might present themselves for medical coverage if this proposal would be adopted, but DMS is unable to estimate this population.

Spenddown - DMS assumed the 10,908 eligibles can be converted from spenddown status to

"regular" Medicaid immediately. DMS also assumed a monthly cost of $77.02 (FY 01) which is a weighted average of actual spenddown costs for spenddown eligibles as of August 2000. DMS assumed a 4% increase in medical cost each year and a caseload increase of 3.94% each year.

QMB Only - The estimate for the QMB only population is included in the increase in resource calculation.

ASSUMPTION (continued)

Blind Pension - The current caseload for this population is 2,611. DFS assumed that 37 eligibles of this population would be eligible for the full Medicaid benefits with the proposal. Since the medical payments for this population is currently 100% General Revenue (GR) and since they do not receive the full Medicaid benefits, DMS assumed a reduction in GR and an increase in federal funding for this population.

Claims Processing Cost - DMS estimates the claims processing costs associated with these eligibles at $50,000 per year. These costs are matched at the 50/50 GR/FF rate.

DMS further states a state plan amendment (SPA) would be required to expand the income limit to 100% of the FPL. DMS assumes 6 to 9 months would be required to submit the SPA and obtain approval from the Centers for Medicare and Medicaid Services (CMS). Therefore, the DMS assumes the expanded income limit to 100% of FPL would become effective July 1, 2002.

The Division of Medical Services worked with the Division of Family Services to determine the eligibles affected by expansion of the resource limits. According to the Division of Family Services, the following eligibles would be affected in FY 2002:

QMB/SLMB 7,301
New Cases 1,558

The QMB/SLMB cases would become eligible for full medical assistance by increasing the resource limits. It was assumed this population would remain constant every month. Caseload growth of 4% was calculated for years subsequent to FY 2002. Monthly medical assistance cost of $166 was used for FY 2002 with 4% growth in subsequent years.

The new cases would come on gradually the first year (FY 2003). In subsequent years 4% caseload growth was calculated. Monthly medical assistance cost of $862 was used in FY 2002 with 4% growth in subsequent years.

DMS assumes program (61.06% federal) and claims processing costs of $100,000 (50% GR, 50% Federal) annually would be as follows:

FY 2002	$0
FY 2003	$25,273,227
FY 2004	$35,973,628

Officials from the **Department of Health and Senior Services - Division of Aging** (**DA**) state:

Section 208.010 - Would increase resource limits to $1,500 for individual and $2,500 for a ASSUMPTION (continued)

couple and Section 208.151. 1. (25) Increases the Income Limit to 100% of Federal Poverty Level.

In determining the fiscal impact of this proposal, DA has made the following assumptions:
- Department of Social Services, Division of Family Services (DFS) would calculate the fiscal impact associated with determining eligibility for under the new requirements;
- Department of Social Services, Division of Medical Services (DMS) would determine the fiscal impact associated with the cost of services for the new group of eligible recipients; and
- Department of Social Services, Division of Legal Services (DLS) would determine the fiscal impact associated with the cost of any administrative hearings.

According to the Department Of Social Services, Research and Evaluation Unit, there were 69,928 Medicaid recipients age 65 and over in FY2000. As of June 30, 2000 the DHSS had authorized in-home services to just over 20,363 Medicaid in-home service recipients age 65 or over. Therefore, the department estimates the participation rate for in-home services is 29.12% (20,363 / 69,928). Additionally, it is projected the client population would grow at a rate of 4% per year based upon the growth experienced in the Old Age Assistance (OAA) and Permanently and Totally Disabled (PTD) population as provided by the Division of Medical Services. The Department of Health and Senior Services assumes that the spenddown clients and the Blind Pension (PB) clients who become eligible because of the increase in the income requirements who are currently receiving in-home services are already being case managed and, therefore, will not increase the number of potential eligibles.

Based on information provided by DFS, it is projected that additional Qualified Medicare Beneficiaries (QMB) eligibles and Specified Low-Income Medicare Beneficiaries (SLMB) will qualify for old age assistance benefits or permanent and total disability benefits due to the raise in resource limits. DFS estimates that 7,301 QMB/SLMB eligibles will qualify when the resource eligibility limit is raised to $1,500 for individuals and $2,500 for a couple resulting in cases requiring case management services. DFS estimates that 1,558 new eligibles will qualify when the resource eligibility limit is raised resulting in new cases requiring case management services.

Based on the 29.12% participation for in-home services, the department estimates 2,580 [(7,301 + 1,558) x 29.12%] additional Medicaid recipients will access home care as an alternative to facility placement and will require case management in fiscal year 2003; 2,683 (2,580 x 104.00%) clients will require case management in fiscal year 2004 and 2,791 (2,580 x 104.00% x 104.00%) clients will require case management in fiscal year 2005. The department will need thirty-two (32) additional Social Service Worker II (SSW) positions the first year (FY2003) to case manage the new Medicaid eligibles based on current average caseload size of 80 cases per Social Service Worker (2,580 / 80 = 32.2500). The department will need thirty-four (34) SSW or two (2) additional SSW positions the second year (FY2004) (2,683 / 80 = 33.5375) and
ASSUMPTION (continued)

thirty-five (35) SSW or one (1) additional SSW position the third year (FY2005) (2,791 / 80 = 34.8875). The department will also need four (4) Home and Community Services Area Supervisor positions based on current supervision levels of one supervisor for every nine Social Service Workers and four (4) Clerk Typist II positions to provide clerical support to the Area Supervisor and SSW staff. The department will add the supervisor and clerical support staff in the first year.

The Social Service Worker IIs will be placed in the following counties/locations:

Year 1 (FY2003) (32 workers) One worker to be located in each of the following counties: Christian, Taney, Cape Girardeau, Carter, Chariton, Pettis, Buchanan, Camden, Macon, Franklin and Jefferson. Greene, Jasper, Taney, Texas, Wright, Dunklin, New Madrid, Pemiscot, St. Francois, Scott, Stoddard, Cass, Jackson, Pettis, Saline, Vernon, Andrew, Clinton, Grundy, Livingston, Adair, Boone, Crawford, Marion, Phelps, Pike, Pulaski, Randolph, Jefferson, St. Charles, Prince Hall, and Wainwright.

Year 2 (FY2004) (34 workers or 2 additional workers). One worker each to be located in Cape Girardeau and Clay counties.

Year 3 (FY2005) (35 workers or 1 additional worker). Worker to be located in Scotland county.

One (1) Area Supervisor position and one (1) Clerk Typist II position will be placed as follows: one each in Taney, Cape Girardeau, Jackson and Macon counties.

Social Service Worker II duties: responsible for the investigation of hotlines, pre-long-term care screenings, the eligibility determination and authorization of state-funded in-home services.

Home & Community Services Area Supervisor duties: supervise Social Service Workers responsible for the investigation of hotlines, pre-long-term care screenings, the eligibility determination and authorization of state-funded in-home services; provide oversight and

accountability for the performance of the SSWs including case review, evaluation and guidance; act as the first point of contact for complaint resolution when clients are dissatisfied with services or staff performance.

Clerk Typist II duties: provide the necessary clerical support to the Area Supervisors, Social Service Workers, and the activities of the unit.

208.553 Establishes the Commission for the Pharmaceutical Investment Program for Seniors.

In determining the fiscal impact of this proposal, the Department of Health and Senior Services
ASSUMPTION (continued)

has made the following assumptions: The commission shall hold approximately 10 meetings during the first year and quarterly meetings in future years; The commission members shall be reimbursed for ordinary and necessary expenses incurred in the performance of their duties but shall receive no compensation for services; and The DHSS would employ staff necessary to support the performance of the commission's duties.

The DHSS staff will oversee and evaluate the work of the third-party administrator, support the commission, and perform program outreach with Area Agencies on Aging, public health clinics and other senior organizations. It is estimated the staff needed to perform these functions are a Public Health Manager (B2), two (2) Health Program Representative IIIs, a Research Analyst IV and two (2) Clerk Typist IIIs. These staff will be placed in Central Office.

Public Health Manager (B2) duties: responsible for program oversight and for supervising the health program representatives, research analyst and the clerk typist IIIs.

Health Program Representative IIIs duties: responsible for assisting with oversight of the third-party administrator; provide support to the commission; and assist with the development of program outreach materials.

Research Analyst IV duties: responsible for assisting with oversight of the third party administrator especially in areas of cost-control measures, fraud and abuse detection system and auditing programs; and provide support to the commission.

Clerk Typist IIIs duties: responsible for providing clerical support to the public health manager, the health program representatives and the research analyst staff and providing clerical support to the commission.

208.556 Establishes the Pharmaceutical Investment Program for Seniors.

The DHSS is using assumptions provided by actuarial consultants with William M. Mercer as a model for the third-party administration of a Pharmaceutical Investment Program for Seniors. The assumptions are as follows:

- Benefit Design
- Income Tier I Less than $12,000 for an individual and Less than $17,000 for a couple; Tier II $12,001 - $17,000 for an individual and $17,001 - $23,000 for a couple.
- Enrollment Fee $25 Tier I; $35 Tier II.
- Deductible of $250 Tier I; $500 Tier II.
- Annual Benefit Maximum of $5,000 (both Tier I and Tier II).
- Coinsurance of 40% (both Tier I and Tier II).

ASSUMPTION (continued)

- Eligible Seniors 287,820 Tier I; 94,830 Tier II.
- Participants - FY03 -- 37,260 Tier I, 13,220 Tier II; FY04 - 57,310 Tier I, 20,330 Tier II.
- Coinsurance applies to generic and preferred-brand prescription drugs. Drugs not on the voluntary preferred drug list are not covered under the program.
- 10% of all prescription drug costs will not be covered on the voluntary preferred drug list.
- A mandatory generic substitution provision applies whereby the participant pays coinsurance on the generic drug price + the difference in cost between the preferred brand and generic drug if a generic drug is available and the patient and/or the physician request that the preferred brand drug be dispensed.
- Medicaid eligibility will be increased to 100% of the Federal Poverty Level and the resource limit will be expanded by $500 (to $1500 individual/$2500 couple).
- Individuals who are enrolled in a prescription drug program with an actuarial value of equal or greater value as the State Pharmaceutical Investment Program for Seniors (PIPS) are not eligible to enroll in the program.
- Coordination of Benefits will be enforced for individuals enrolled in both the State PIPS and a prescription drug program whose actuarial value is less than the State PIPS.
- Brand discount of AWP - 10.43% will be legislated.
- Generic discount of AWP - 20% will be legislated.
- Dispensing fee of $4.09 per prescription will be legislated.
- Rebates of 15% (of AWP) will be negotiated for brand name drugs. Note that there will be a lag of approximately 180 days for the State to receive the rebates.
- Rebates of 11% (of AWP) will be negotiated for generic drugs. Note that there will be a lag of approximately 180 days for the State to receive the rebates.
- Claims processing fees of $0.60 per prescription will be negotiated. This includes PEP type activities to be performed by the third party administrator..
- Administrative expenses of $5.7 million in FY2003 and $3.7 million in FY2004 will be incurred in addition to the claims processing fees listed above. This also assumes that the State will have only one contractor to pay claims and perform utilization management and cost

containment activities.

- A claim processing system that contains the capability to both process claims and administer pharmacy management programs will be used. Additional costs to enhance a claims processing system have been considered in this analysis (see next bullet for examples of these enhancements).
- Pharmacy management programs including edits, patient profiling, retrospective drug utilization review, prior authorization, dose optimization, case management and voluntary preferred drug list management will result in program savings of 5-7% (of the state's portion of program costs net of discounts, rebates and member cost sharing.)
- Mail service will not be included in the program.
- An enrollment fee of $25-$35 per year will be charged based on income level and will not apply towards the deductible.

ASSUMPTION (continued)

- Proprietary prescription drug expenditure data for calendar year 1999 for over 1 million Medicare beneficiaries in Medicare+Choice HMOs, employer-sponsored retiree plans, Medigap Plans H-J, Medicaid programs and state pharmacy assistance programs was utilized to project program costs.

The following annual cost and utilization trends were utilized to project prescription drug expenditure data from calendar year 1999 to fiscal years 2003 and 2004:

2000 / 1999 - 19%
2001 / 2000 - 19%
2002 / 2001 - 18%
2003 / 2002 - 17%
2004 / 2003 - 16%

The enrollment fees and the rebates will be revenue deposited into the Pharmaceutical Investment Program for Seniors Fund. The cost for the administrator and other program costs are shown as PIPS Fund to the extent that revenues will support the expenses with the remainder of the costs shown as General Revenue.

Based on statewide guidelines and previous experience, the following amounts represent the average annual expense of an FTE:
Rent (Statewide Average) - $2,700 per FTE ($13.50 per sq. ft. x 200 sq. ft.);
Utilities - $320 per FTE ($1.60 per sq. ft. x 200 sq. ft.);
Janitorial/Trash - $200 per FTE ($1.00 per sq. ft. x 200 sq. ft.);
Travel and Other Expenses - $5,000 per FTE for professional staff;
Office and Communication Expenses - $4,800 per FTE for all staff.

In addition to the above standard costs, systems furniture for the new HCS staff in Taney, Texas,

Wright, Dunklin, New Madrid, Pemiscot, St. Francois, Stoddard, Cass, Jackson, Pettis, Andrew, Boone, Crawford, Pulaski and Macon counties and Prince Hall in St. Louis City in FY2003; Cape Girardeau and Clay counties in FY2004; and Scotland county in FY2005; and for the Commission of Pharmaceutical Investment Program for Seniors staff in Jefferson City in FY2002 will be needed at a cost of $4,500 per FTE. Desks will be needed for all HCS staff in locations without systems furniture.

Desktop PCs with software will be needed for the forty-three (43) HCS field staff and the six (6) PIPS Commission staff at a cost of $2,300 each.

FY02 costs for the PIPS Commission meetings and staff are based on the period January 1, 2002 through June 30, 2002. FY03 costs for the for the Area Supervisor, the Clerk Typist and Social Service Worker positions are based on the period July 1, 2002 through June 30, 2003. FY03 and ASSUMPTION (continued)

FY04 costs include a 3.0% inflation adjustment for expense & equipment costs and a 2.5% inflation adjustment for personal services.

Oversight assumes the following:

Total Households 65 and over 21,745 US (IN THOUSANDS)

Missouri Households 65 and over (x 1.34)		Missouri	Individuals 525,811	Households
Under $2,500	263	1.21%	6,360	8,522
$2,500 to $4,999	303	1.39%	7,327	9,818
$5,000 to $7,499	1,202	5.53%	29,065	38,947
$7,500 to 9,999	1,625	7.47%	39,294	52,654
$10,000 to $12,499	1,786	8.21%	43,187	57,870
$12,500 to $14,999	1,525	7.01%	36,876	49,413
$15,000 to $17,499	1,457	6.70%	35,231	47,210
$17,500 to $19,999	1,322	6.08%	31,967	42,836
$20,000 to $22,499	1,240	5.70%	29,984	40,179
$22,500 to $24,999	1,206	5.55%	29,162	39,077
Total	11,929	54.86%	288,452	386,526
Individuals	Participation			Prescription

MW:LR:OD (12/00)

w/o Insurance 47.00%	Rate 75.00%	Individuals 43.00%	Couples 57.00%	Costs per Person
4,005	3,004	1,292	1,712	667
4,614	3,461	1,488	1,973	667
18,305	13,729	5,903	7,826	667
24,747	18,560	7,981	10,579	667
27,199	20,399	8,772	11,628	888
23,224	17,418	7,490	9,928	888
22,189	16,642	7,156	9,486	1,300
20,133	15,100	6,493	8,607	1,300
18,884	14,163	6,090	8,073	1,233
18,366	13,775	5,923	7,852	1,233

ASSUMPTION (continued)

181,667	136,251	58,588	77,663

Costs Per Individual	Less Deductible	Coinsurance 40.00%	State Cost
861,532	322,923	215,444	323,165
992,563	372,036	248,211	372,316
3,937,494	1,475,867	984,651	1,476,976
5,323,151	1,995,244	1,331,163	1,996,744
7,788,310	2,192,927	2,238,154	3,357,230
6,650,153	3,744,919	1,162,093	1,743,140
9,302,482	3,577,933	2,289,820	3,434,730
34,855,686	13,681,848	8,469,535	12,704,302

Costs Per Couple	Less Deductible	Coinsurance 40.00%	State Cost
1,142,030	856,120	114,364	171,546
1,315,723	986,329	131,758	197,637
5,219,469	3,912,763	522,682	784,024
7,056,270	5,289,717	706,621	1,059,932
10,324,039	5,813,805	1,804,094	2,706,140

MW:LR:OD (12/00)

8,815,319	4,964,196	1,540,449	2,310,674
12,331,197	4,742,841	3,035,343	4,553,014
11,188,636	8,606,776	1,032,744	1,549,116
9,957,303	8,072,921	753,753	1,130,629
9,684,280	7,851,567	733,085	1,099,628
77,034,267	51,097,034	10,374,893	15,562,340

Using United States Bureau of Census data, Oversight assumes program costs of $111,889,952 annually. Oversight assumes enrollment fees of $1,778,900 annually and pharmaceutical rebates of $14,545,694 annually.

Officials from the **Office of Administration - Division of Budget and Planning** (**BAP**) state this proposal would eliminate the senior pharmacy tax credit beginning with calendar year 2002. Removing the credit would increase General Revenue by $94.5 million in FY03 and $99.2 ASSUMPTION (continued)

million in FY04. A 5% growth rate is assumed. This is based on actual data for FY01 of $85.7 million.

In addition, BAP states the enrollment fee for the pharmacy investment program for seniors would increase total state revenue. Department of Health and Senior Services should be providing information about the enrollment fee, as well as the costs of the pharmacy investment program for seniors.

FISCAL IMPACT - State Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
GENERAL REVENUE FUND			
Savings - Office of Administration			
Repeal of prescription tax credit	$0	$94,500,000	$99,200,000
Transfer Out - Office of Administration			
To Pharmaceutical Investment Program for Seniors Fund	$0	($102,838,205)	($114,586,650)
Costs - Department of Social Services - Division of Family Services			
Personal services (2.01)	($29,185)	($59,830)	($61,325)

MW:LR:OD (12/00)

FISCAL IMPACT - State Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
Fringe benefits	($9,727)	($19,941)	($20,440)
Expense and equipment	($22,475)	($9,583)	($9,871)
Total Costs - DFS	($61,387)	($89,354)	($91,636)
Costs - Department of Social Services - Division of Medical Services			
Processing costs - resource increase	$0	($50,000)	($50,000)
Program costs - resource increase	$0	($9,802,455)	($13,969,191)
Processing costs - federal poverty	$0	($25,000)	($25,000)
Program costs - federal poverty	$0	($4,226,043)	($4,564,305)
Total Costs - DMS	$0	($14,103,498)	($18,608,496)
Costs - Department of Health and Senior Services - Division of Aging			
Personal services (33.3 FTE)	($121,239)	($1,175,462)	($1,204,849)
Fringe benefits	($40,409)	($391,781)	($401,576)
Expense and equipment	($352,089)	($215,457)	($221,919)
Total Costs - Division of Aging	($513,737)	($1,782,700)	($1,828,344)
ESTIMATED NET EFFECT ON GENERAL REVENUE FUND	**($575,124)**	**($24,313,757)**	**($35,915,126)**
PHARMACEUTICAL INVESTMENT PROGRAM FOR SENIORS FUND			
Income - Department of Health and Senior Services - Division of Aging			
Enrollment fees	$1,778,900	$1,778,900	$1,778,900
Pharmaceutical rebates	$0	$7,272,847	$14,545,694
Total Income - Division of Aging	$1,778,900	$9,051,747	$16,324,594
Transfer In - Office of Administration			
From General Revenue Fund	$0	$102,838,205	$114,586,650
Costs - Department of Health and Senior Services - Division of Aging			
Drug Costs	$0	($111,889,952)	($130,911,244)

MW:LR:OD (12/00)

FISCAL IMPACT - State Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
ESTIMATED NET EFFECT ON PHARMACEUTICAL INVESTMENT PROGRAM FOR SENIORS	**$1,778,900**	**$0**	**$0**
FEDERAL FUNDS			
Income - Department of Social Services			
Medicaid reimbursements	$442,419	$16,274,391	$22,775,125
Costs - Department of Social Services - Division of Family Services			
Personal services (.99)	($14,375)	($29,468)	($30,205)
Fringe benefits	($4,791)	($9,822)	($10,067)
Expense and equipment	($11,070)	($4,720)	($4,862)
Total Costs - DFS	($30,236)	($44,010)	($45,134)
Costs - Department of Social Services - Division of Medical Services			
Processing costs	$0	($50,000)	($50,000)
Program costs	$0	($15,370,772)	($21,904,437)
Total Costs - DMS	$0	($15,420,772)	($21,954,437)
Costs - Department of Health and Senior Services - Division of Aging			
Personal services (14.7 FTE)	($248,063)	($508,529)	($521,242)
Fringe benefits	($82,679)	($169,493)	($173,730)
Expense and equipment	($81,441)	($131,587)	($80,582)
Total Costs - Division of Aging	($412,183)	($809,609)	($775,554)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**

FISCAL IMPACT - Local Government	FY 2002 (10 Mo.)	FY 2003	FY 2004
	$0	**$0**	**$0**

MW:LR:OD (12/00)

FISCAL IMPACT - Small Business

Small pharmacies may be impacted by this proposal due to the change in administration of the program.

DESCRIPTION

This proposal would establish a Pharmaceutical Investment Program for eligible seniors who reside in Missouri. In its main provisions, the proposal would: (1) Repeal the current $200 prescription tax credit for eligible seniors; (2) Revise the current resource limit used to determine eligibility for persons who apply for public assistance. The resource limit for an individual would be increased from $1,000 to $1,500; for a married couple, the resource limit is increased from $2,000 to $2,500; (3) Increase the income limit to 100% of the federal poverty level for persons eligible to receive Medicaid; (4) Establish an 11-member Commission for the Pharmaceutical Investment Program for Seniors within the Division of Aging in the Department of Health and Senior Services. The composition and selection of members and duties of the DESCRIPTION (continued)

commission are contained in the proposal; (5) Establish the Pharmaceutical Investment Program for Seniors within the Division of Aging in the Department of Health and Senior Services. Various terms are defined; (6) Require the commission to govern the program and to solicit requests for proposals to administer the program from private contractors; (7) Require the commission to select a bid from the submitted proposals. If no bids are received, the program would be jointly administered by the Department of Health and Senior Services and the Department of Social Services; (8) Set eligibility criteria for participation in the program. Residents would be eligible to apply to the program if they are 65 years of age, have not received pharmaceutical benefits for at least 6 months prior to applying to the program, have not received Medicaid benefits, and meet income eligibility guidelines; (9) Establish income eligibility limits of $17,000 for individuals and $23,000 for married couples; (10) Make the program the payer of last resort and not an entitlement; (11) Require that seniors submit an annual application to the Division of Aging or the division's designee. The commission would develop and implement a means test requiring applicants to meet the income requirement of the program; (12) Prohibit requiring applicants to accept Medicaid benefits in lieu of participating in the program; (13) Require that participants pay a deductible to participate in the program. Deductible amounts would be $250 or $500 per participant, depending on marital status and household income; (14) Require that all household income levels established for participation in the program be adjusted annually by an amount equal to the cost-of-living adjustment for the federal poverty level established by the federal Department of Health and Human Services; (15) Require that enrollees pay 40% of the purchase price of prescription drugs. In addition, eligible enrollees would be required to pay an annual co-insurance amount of $25 or $35 based on marital status and income

level; (16) Establish an annual program benefit limit of $5,000 per enrollee; (17) Allow the Department of Health and Senior Services to enter into a contract with any private individual, corporation, or agency to implement the program; (18) Require the division to utilize Area Agencies on Aging;senior citizen centers, and related entities to provide outreach, enrollment assistance, and education relating to the program; (19) Require the commission to submit quarterly reports to the Governor, Senate Appropriations Committee, House of Representatives Budget Committee, Speaker of the House of Representatives, and President Pro Tem of the Senate; (20) Require that program benefits be supported by moneys appropriated by the General Assembly; (21) Require the commission to implement cost control measures if projected costs exceed the current program appropriation; (22) Allow the division to request a supplemental appropriation to meet additional costs and requires implementation of cost control measures; (23) Require the program to cover eligible costs not covered by a federal pharmaceutical assistance program if established; (24) Require the commission to develop rules to implement the program; (25) Make any person who engages in fraudulent activities in order to participate in the program guilty of a misdemeanor and forfeits his or her rights to participate in the program; (26) Require the program to be fully operational by July 1, 2002. An initial enrollment period would be from April 1, 2002 through May 30, 2002. Beginning with calendar year 2004, open enrollment periods would be held from November 1 through December 15 of the preceding calendar year;
DESCRIPTION (continued)

(27) Allow an individual a 30-day enrollment period outside the established enrollment periods; (28) Require that the program use generic prescription drugs when available. Enrollees may receive brand name prescription drugs when a generic prescription drug is available only if both the prescribing physician and the enrollee request the brand name prescription drug, the enrollee pays the co-insurance on the generic drug, and the enrollee pays the difference in price between the brand name drug and the generic drug; (29) Require that pharmacists participating in the program be reimbursed for costs resulting from obtaining and dispensing medications. Reimbursement formulas for brand name and generic medications are contained in the proposal; (30) Require the division to issue a certificate of participation to pharmaceutical manufacturers who participate in the program. A manufacturer can apply for participation in the program by submitting an application approved by the commission; (31) Require pharmaceutical manufacturers to provide quarterly rebates under the program. The division would be required to negotiate annually with manufacturers for the rebate amounts. Rebates for brand name prescription drugs may not be less than 15% and rebates for generic prescriptions may not be less than 11%. Rebates would be used to fund the program; (32) Prohibit a pharmaceutical manufacturer's status under the current Medicaid program from being affected if the manufacturer refuses to participate in the program; and (33) Create a Pharmaceutical Investment Program for Seniors Fund which would be administered by the State Treasurer. The revenue sources for the fund are specified in the proposal and funds would not revert to the General Revenue Fund.

The proposal contains an emergency clause.

This legislation is not federally mandated, would not duplicate any other program and would not require additional capital improvements or rental space.

SOURCES OF INFORMATION

Office of Attorney General
Office of State Courts Administrator
Department of Health and Senior Services
Department of Revenue
Department of Social Services
Office of State Treasurer

Jeanne Jarrett, CPA
Director

September 6, 2001

MW:LR:OD (12/00)