State of Wisconsin
1999 - 2000 LEGISLATURE

LRB-4576/1
DAK:wlj:jf

1999 ASSEMBLY BILL 815

February 29, 2000 – Introduced by Representatives WIECKERT, PETTIS, PETROWSKI, UNDERHEIM, KESTELL, GRONEMUS, MONTGOMERY, SKINDRUD, HUNDERTMARK, KELSO, HAHN, SYKORA, RHOADES, TOWNSEND, SERATTI, LADWIG, STONE, M. LEHMAN, URBAN, MUSSER, VRAKAS, GOETSCH, HOVEN, JENSEN, KREIBICH, OWENS, F. LASEE, OTT, HUTCHISON, JOHNSRUD and DUFF, cosponsored by Senators ROSENZWEIG, DARLING, ROESSLER and WELCH. Referred to Committee on Health.

AN ACT ***to create*** 20.435 (4) (j), 49.45 (48) and 49.688 of the statutes; **relating to:** requiring pharmacies and pharmacists, as a condition of medical assistance participation, to charge low–income persons eligible for medicare for certain prescription drugs no more than specific amounts, authorizing the department of health and family services to enter into rebate agreements with drug manufacturers and making appropriations.

Analysis by the Legislative Reference Bureau

Under current state law, pharmacies and pharmacists that are certified providers of medical assistance services are reimbursed for the provision of certain prescription drugs to medical assistance (MA) recipients at a rate established by the department of health and family services (DHFS). Under current federal law, persons entitled to coverage under part B of medicare do not receive coverage for prescription drugs for outpatient care as a benefit.

This bill specifies that, beginning January 1, 2001, as a condition of participation by a pharmacy or pharmacist in the MA program, the pharmacy or pharmacist may not charge persons who are eligible for medicare, ineligible for MA and whose incomes do not exceed 185% of the federal poverty line an amount for certain prescription drugs for outpatient care that exceeds the average wholesale price minus 11% or the maximum allowable cost, as determined by DHFS, whichever is lower, for providing that drug, plus a dispensing fee. Prescription drugs for which the reduced charges must be made are those for treatment of a chronic condition, as defined in the bill, as determined by DHFS. Persons who are eligible to purchase the prescription drugs under the reduced charges must provide a card, issued by DHFS after a determination of eligibility, to qualify for the reduced charges. DHFS must calculate and transmit to pharmacies and pharmacists that participate in the MA program the amounts that may be charged for providing the specified prescription drugs and must periodically update this information and transmit the updated information to pharmacies and pharmacists. DHFS must monitor compliance by pharmacies and pharmacists with the requirement to charge low–income medicare–eligibles for the specified prescription drugs at the reduced amounts and annually report to the legislature concerning the compliance.

DHFS is authorized, under the bill, to enter with drug manufacturers into rebate agreements, which are modeled on federal medicaid rebate agreements, under which the manufacturer must make payments to DHFS for each of the manufacturer's drugs that is prescribed for outpatient care for treatment of a chronic condition to persons who are eligible to pay reduced charges for the drugs. The amount of the rebate payment under the agreement is required to be determined by the method that is specified under the federal medicaid rebate agreements. The amounts of the rebate payments must, in turn, be paid by DHFS to pharmacies or pharmacists that have reduced charges for prescription drugs for the eligible persons. In addition, DHFS may not, after January 1, 2001, and before June 30, 2003, subject the prescription drugs manufactured by manufacturers that enter into the rebate agreements to prior authorization requirements for prescription drugs for the eligible persons or to any expansion of prior authorization requirements under MA.

DHFS is authorized to enter into a contract with an entity to perform DHFS' duties and exercise its powers under the prescription drug assistance program.

DHFS must report to the legislature if federal law is changed to provide coverage for outpatient prescription drugs as a benefit under medicare. The bill appropriates $1,000,000 in general purpose revenues in fiscal year 2000–01 to DHFS for administration of the program.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.435 (4) (j) of the statutes is created to read:

20.435 **(4)** (j) *Prescription drug assistance for low–income medicare beneficiaries; payment of manufacturer rebates to pharmacies.* All moneys received from rebate payments by manufacturers under s. 49.688 (7), to be used for payments under s. 49.688 (8) to pharmacies or pharmacists that provide prescription drugs at discount.

SECTION 2. 49.45 (48) of the statutes is created to read:

49.45 **(48)** PRIOR AUTHORIZATION FOR LEGEND DRUGS. After January 1, 2001, and before June 30, 2003, if a manufacturer enters into a rebate agreement under s. 49.688 (7), the department may not expand the prior authorization requirements for prescription drugs manufactured by the manufacturer for which coverage is provided under s. 49.46 (2) (b) 6. h. beyond those prior authorization requirements that are in effect on January 1, 2001.

SECTION 3. 49.688 of the statutes is created to read:

49.688 Prescription drug charges; low-income medicare beneficiaries. (1) In this section:

(a) "Chronic condition" means a cardiac condition, high blood pressure, diabetes, arthritis, blood coagulation or hematologic disease, hyperlipidemia, osteoporosis, chronic obstructive pulmonary disease, asthma, incontinence, thyroid disease, glaucoma, Alzheimer's disease, Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (Lou Gehrig's disease) and cancer.

(b) "Entitled to coverage under part A of medicare" means eligible for and enrolled in part A of medicare under 42 USC 1395c to 1395i–5.

(c) "Entitled to coverage under part B of medicare" means eligible for and enrolled in part B of medicare under 42 USC 1395j to 1395w–28.

(d) "Medicare" means coverage under 42 USC 1395 to 1395y.

(e) "Poverty line" means the nonfarm federal poverty line for the continental United States, as defined by the federal department of labor under 42 USC 9902 (2).

(f) "Prescription drug" has the meaning given in s. 450.01 (20).

(g) "Prescription order" has the meaning given in s. 450.01 (21).

(2) A person who is entitled to coverage under part A of medicare or entitled to coverage under part B of medicare, who is ineligible for medical assistance and whose income does not exceed 185% of the poverty line is eligible to purchase a prescription drug for outpatient care for treatment of a chronic condition, at the amount specified in sub. (6). The person may apply to the department, on a form provided by the department, for a determination of eligibility and issuance of a prescription drug card for purchase of prescription drugs under this section.

(3) The department shall devise and distribute a form for application for the program under sub. (2), shall determine eligibility of applicants and shall issue to eligible persons a prescription drug card for use in purchasing prescription drugs, as specified in sub. (5).

(4) The department shall determine the categories of prescription drugs that are appropriate for outpatient care for treatment of a chronic condition.

(5) Beginning January 1, 2001, as a condition of participation by a pharmacy or pharmacist in the program under ss. 49.45, 49.46 or 49.47, the pharmacy or pharmacist may not charge a person who presents a valid prescription order and a card indicating that he or she meets eligibility requirements under sub. (2) an amount for a prescription drug, as determined by the department under sub. (4), for outpatient care for treatment of a chronic condition under the order that exceeds the amount specified in sub. (6).

(6) The amount that a pharmacy or pharmacist may charge for a prescription drug for outpatient care for treatment of a chronic condition is the average wholesale price minus 11% or the maximum allowable cost, as determined by the department, whichever is less, plus a dispensing fee. The department shall, for the purposes of this subsection, calculate and transmit to pharmacies and pharmacists that are certified providers of medical assistance amounts that may be charged under this subsection. The department shall periodically update this information and transmit the updated amounts to pharmacies and pharmacists.

(7) The department or an entity with which the department contracts may enter into a rebate agreement that is modeled on the rebate agreement specified under 42 USC 1396r–8 with a drug manufacturer that sells drugs for prescribed use in this state. The rebate agreement shall include all of the following as requirements:

(a) That the manufacturer shall make rebate payments for each drug of the manufacturer that is prescribed for persons who are eligible under sub. (2) for outpatient care for treatment of a chronic condition to the state treasurer to be credited to the appropriation under s. 20.435 (4) (j), each calendar quarter or according to a schedule established by the department.

(b) That the amount of the rebate payment shall be determined by a method specified in 42 USC 1396r–8 (c).

(c) That the department or the entity with which the department contracts shall inform pharmacies and pharmacists concerning the rebate amount for each drug specified under the agreement.

(8) From the appropriation under s. 20.435 (4) (j), beginning January 1, 2001, the department shall provide payments, under a schedule that is identical to that used by the department for payment of pharmacy provider claims under medical assistance, to pharmacies or pharmacists that provide at a discount specified under sub. (6) prescription drugs designated by the department for a chronic condition to persons who meet criteria for eligibility under sub. (2). The payments shall equal amounts of manufacturer rebates, if any, for prescription drugs purchased by eligible persons under sub. (5) during a specific period of time, as reported by the pharmacy or pharmacist to the department. The department shall devise and distribute a form for reports by pharmacies and pharmacists under this subsection.

(9) The department shall monitor compliance by pharmacies and pharmacists that are certified providers of medical assistance with the requirements of sub. (5) and shall annually report to the legislature under s. 13.172 (2) concerning the compliance. The report shall include information on any pharmacies or pharmacists that discontinue participation as certified providers of medical assistance and the reasons given for the discontinuance.

(10) If federal law is amended to provide coverage for prescription drugs for outpatient care as a benefit under medicare, the department shall submit a report concerning this fact to appropriate standing committees of the legislature under s. 13.172 (3).

(11) After January 1, 2001, and before June 30, 2003, the department may not subject a manufacturer that enters into a rebate agreement under sub. (7) to prior authorization requirements for a prescription drug for outpatient care for treatment of a chronic condition.

(12) Except as provided in subs. (9) to (11), the department may enter into a contract with an entity to perform the duties and exercise the powers of the department under this section.

SECTION 4. Appropriation changes; health and family services.

(1) PRESCRIPTION DRUG CHARGES; ADMINISTRATION. In the schedule under section 20.005 (3) of the statutes for the appropriation to the department of health and family services under section 20.435 (4) (a) of the statutes, as affected by the acts of 1999, the dollar amount is increased by $1,000,000 for fiscal year 2000–01 to increase

funding for administration of the prescription drug charges program under section 49.688 of the statutes, as created by this act.

(END)