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Wisconsin Chronic Disease Program (Health and Family Services -- Health)

[LFB 2003-05 Budget Summary: Page 246, #4]

CURRENT LAW

The Wisconsin chronic disease program (WCDP) funds medical services for eligible state residents with end-state renal disease, cystic fibrosis, and hemophilia.

There are no income requirements individuals must meet to enroll in these programs. However, enrollees with family incomes that exceed specified amounts are required to pay annual deductibles (currently $812 for inpatient services and $100 for outpatient services provided to persons enrolled in the chronic renal disease program and 0.75% to 4.0% of the family's income for persons enrolled in the chronic renal disease, the cystic fibrosis, and hemophilia programs), in addition to a portion of covered medical expenses, referred to as "coinsurance." The coinsurance amounts are equal to a percent of charges for medical services, and are based on family size and income, as shown in the attachment to this paper. The attachment also shows the caps on liability for enrollees based on income. The caps do not apply to prescription drugs for all three programs or to deductibles for the cystic fibrosis and hemophilia programs. For example, an enrollee in the cystic fibrosis program who earns $10,000 in income has no deductible, but has coinsurance of 2% up to a maximum of $300, which is the 3% cap for that income level. To ensure that needs for treatment of patients with lower incomes receive priority within the availability of funds, the Department of Health and Family Services (DHFS) is required to revise the coinsurance schedule every three years.

The following services are eligible for reimbursement under WCDP:

Chronic Renal Disease

- Inpatient and outpatient dialysis and transplant treatment;

- One pre-transplant dental examination, diagnosis, and x-ray;
- Kidney donor transplant-related medical services;
- Certain prescription medications;
- Certain home supplies; and
- Certain laboratory and x-ray services.

Adult Cystic Fibrosis

- Inpatient and outpatient services directly related to the disease;
- Certain physician services;
- Certain laboratory and x-ray services;
- Certain prescription medications; and
- Certain home supplies.

Hemophilia Home Care

- Recipients are eligible to receive services for blood derivatives and supplies necessary for home care.

WCDP has no statutorily established prescription drug copayment amounts. However, DHFS, by rule, has established copayments of $5 for each generic prescription drug and $10 for each brand name prescription drug.

The state is required to reimburse providers that render services under the chronic renal disease program at rates that equal the allowable charges under the federal Medicare program. However, providers may bill patients for any amount by which the charge for the service exceeds the state payment.

Generally, WCDP is considered the payer of last resort. However, there are no requirements that participants apply for other programs for which they may be eligible before they enroll in WCDP. Instead, the following statutory criteria apply: (a) for treatment of cystic fibrosis, persons must only meet the financial requirements established by DHFS by rule; (b) for aid to kidney disease patients, recipients must have no other form of aid available from Medicare or other insurance; and (c) for hemophilia treatment services, reimbursement is subject to costs which are not payable by any other state or federal program or under any grant, contract, or other financial arrangement.

In the 2001-03 biennium, $4,932,000 GPR is budgeted annually for this program.

GOVERNOR

Provide $17,200 (-$255,800 GPR and $273,000 PR) in 2003-04 and $528,800 ($255,800 GPR and $273,000 PR) in 2004-05 to reflect a reestimate of the amount of funding that will be

required to support medical services provided under WCDP in the 2003-05 biennium. The bill would provide a total of $4,676,200 GPR and $273,000 PR in 2003-04 and $5,187,800 GPR and $273,000 PR in 2004-05 for WCDP.

Modify the WCDP to reduce state program costs, as follows:

Drug Copayments. Require individuals enrolled in WCDP to pay a $5 copayment for each generic drug and a $15 copayment for each brand name drug in cases where a pharmacy directly bills DHFS or a contracted entity for the drug.

Patient Liability for Treatment Costs. Modify the current requirement that DHFS promulgate rules that require individuals enrolled in WCDP to obligate or expend specified portions of their income on medical care for treatment of chronic renal disease, hemophilia, and cystic fibrosis before receiving benefits by specifying that: (a) this cost sharing requirement would apply to individuals with estimated total family income that is at or above 200% of the federal poverty level (FPL), rather than to the income of individuals that exceed specified limits; and (b) the rules would require program participants to pay the following percentages of his or her family income for medical services covered under these programs before receiving benefits:

Income as a % of FPL	Percent of Total Family Income	
	Current Law	Governor
300% thru 325%	0.75%	1.00%
>325% thru 350%	1.50	1.75
>350% thru 375%	2.25	2.50
>375% thru 400%	3.00	3.25
>400%	4.00	4.25

Under the bill, DHFS would specify the percentage of income required for this deductible on income levels from 200% to 300% of the FPL.

Require DHFS to continuously review the sliding scale for patient liability coinsurance and revise it as needed to ensure that the amounts budgeted for WCDP are sufficient to cover treatment costs.

Provider Reimbursement for Chronic Renal Disease Services. Eliminate the current requirement that the state reimburse providers that render services under the chronic renal disease program at rates that equal the allowable charges under the federal Medicare program. Instead, require DHFS to reimburse providers at rates that do not exceed the allowable charges under Medicare.

Require a person that provides a service for which assistance is provided under the chronic renal disease program to accept the state payment as payment in full and prohibit the person from billing the patient for any amount by which the charge for the service exceeds the state payment.

Application to Other Programs. Specify that assistance under WCDP may only be provided to an individual if he or she has first applied for benefits under all other health care coverage programs specified by DHFS rule for which the person reasonably may be eligible. Direct DHFS to promulgate rules that specify these other programs, but require the rules to include Medicaid (MA), BadgerCare, and SeniorCare. Authorize DHFS to promulgate both emergency rules and permanent rules to implement this requirement, but exempt DHFS from the criteria that DHFS would otherwise be required to meet to promulgate emergency rules. Specify that this requirement would first apply to persons who apply for benefits under WCDP on the bill's general effective date.

Payer of Last Resort. Prohibit DHFS from making payments under WCDP for any portion of medical treatment costs or other expenses that are payable under any state, federal, or other health care coverage program, or any grant, contract, or other contractual arrangement.

Managed Care Methods. Authorize DHFS to adopt managed care methods of cost containment for WCDP.

DISCUSSION POINTS

Program Participation and Costs

1. In 2001-02, 8,273 individuals were enrolled in WCDP, including 7,922 individuals with chronic renal disease, 194 individuals with hemophilia, and 157 individuals with cystic fibrosis. Approximately 1,600 enrollees received state-funded benefits in 2001-02. The rest of the enrollees either incurred no expenses that were covered under WCDP, or their expenses did not exceed the required deductibles.

2. While there are no income eligibility criteria individuals must meet to enroll in the program, individuals with higher family incomes are required to pay a larger share of costs, as shown in the attachment.

Table 1 shows information on fiscal year 2001-02 program enrollment by the participants' income range. In the table, participants are enrollees for which claims were submitted, rather than the total number of persons enrolled in the program. The table shows that over 76% of enrollees for whom claims were submitted lived in families with income less than $30,000.

TABLE 1

Wisconsin Chronic Disease Program -- Participation by Income Range
Fiscal Year 2001-02

Income Range (Annual $)	Number	Percent of Total	Cumulative Percent
$0 - $10,000	690	27.7%	27.7%
$10,001 - $20,000	793	31.8	59.5
$20,001 - $30,000	422	16.9	76.4
$30,001 - $40,000	247	9.9	86.3
$40,001 - $50,000	131	5.2	91.5
$50,001 - $60,000	79	3.2	94.7
$60,001 - $70,000	49	2.0	96.7
$70,001 - $80,000	32	1.3	98.0
$80,001 - $90,000	16	0.6	98.6
$90,001 - $100,000	17	0.7	99.3
Over $100,000	19	0.7	100.0
Total	2,495	100.0%	

Table 2 shows information on fiscal year 2001-02 program expenditures by the range of participants' percent of coinsurance liability. The attachment illustrates the coinsurance liability percent assigned to families by income and family size. Table 2 shows that over 92% of enrollees for whom claims were submitted lived in families whose coinsurance liability was from 0% to 5% of the family's income.

TABLE 2

Wisconsin Chronic Disease Program -- Expenditures by Coinsurance Liability Range
Fiscal Year 2001-02

Coinsurance Liability	Expenditures	Percent of Total	Cumulative Percent
0%	$3,168,100	67.1%	67.1%
0 - 5%	1,192,500	25.2	92.3
5 - 10%	188,400	4.0	96.3
10 - 15%	110,200	2.3	98.6
15 - 20%	49,600	1.1	99.7
20 - 25%	6,000	0.1	99.8
25 - 30%	8,100	0.2	100.0
30 - 35%	0	0.0	100.0
35 -40%	0	0.0	100.0
40 - 45%	100	0.0	100.0
45 - 50%	0	0.0	100.0
50-55%	200	0.0	100.0
Total	$4,723,200	100.0%	

3. Historically, it has been difficult to accurately project program expenditures because of annual changes in caseload and average care costs. For example, it is difficult to predict when an individual enrolled in the hemophilia program will need a supply of a blood clotting factor due to an accident or some other reason. The average reimbursement for an individual participating in the hemophilia program during the period from July 1, 2002, through March 17, 2003, was approximately $4,200. However, during the week of January 28, 2003, DHFS received one claim in the amount of approximately $83,000 for pharmaceutical supplies.

4. Table 3 provides a summary of WCDP program expenditures for the last five biennia and current estimates of program expenditures in the 2001-03 and 2003-05 biennium. The 2003-05 estimates do not reflect estimated cost savings that would result by enacting the Governor's proposed statutory changes to the program.

TABLE 3

Wisconsin Chronic Disease Program Expenditures
1991-93 thru 2003-05 Biennia

Biennium	Chronic Renal Disease	Percent Change	Adult Cystic Fibrosis	Percent Change	Hemophilia	Percent Change	WCDP Total	Percent Change
1991-93	$7,988,600	-----	$477,800	-----	$295,300	-----	$8,761,700	-----
1993-95	7,200,000	-9.9%	303,500	-36.5%	187,500	-36.5%	7,691,000	-12.2%
1995-97	7,611,200	5.7	416,500	37.2	367,000	95.7	8,394,700	9.1
1997-99	7,862,600	3.3	413,200	-0.8	679,900	85.3	8,955,700	6.7
1999-01	8,150,100	3.7	229,400	-44.5	561,800	-17.4	8,941,300	-0.2
2001-03*	7,929,500	-2.7	435,200	89.7	881,400	56.9	9,246,100	3.4
2003-05*	8,523,200	7.5	424,600	-2.4	1,138,500	29.2	10,086,300	9.1

*Estimate

Funding

5. The Governor's bill would increase funding for the program by $17,200 (-$255,800 GPR and $273,000 PR) in 2003-04 and by $528,800 ($255,800 GPR and $273,000 PR) in 2004-05 to fully fund projected benefits costs in the 2003-05 biennium, based on the assumption that statutory changes for cost saving measures would be implemented in 2004-05. These amounts assume an increase in costs of 5% each year, drug rebate revenue of $273,000 PR annually, and an increase in prescription drug copayments of $54,500 in 2004-05 and deductibles of $49,200 in 2004-05 to offset the overall costs of WCDP. It is the administration's intent to provide no overall GPR funding increase in the 2003-05 biennium for this program.

6. Other than GPR funding, WCDP receives revenue from the drug rebate program. WCDP receives rebate money directly from drug manufacturers in exchange for the use of their

prescription drugs in WCDP. The drug rebate program became effective on January 1, 2002. In calendar year 2002, WCDP received approximately $195,500 in rebate revenue to offset program costs. WCDP received approximately $41,300 in the fourth quarter of calendar year 2002. DHFS staff indicate that the amount received in the fourth quarter of calendar year 2002 is indicative of what will be received in future quarters. Therefore, WCDP is projected to receive approximately $165,200 PR annually from the drug rebate program.

7. As shown in Table 3, it is estimated that expenditures from WCDP will total $4,829,700 ($4,664,500 GPR and $165,200 PR) in 2003-04 and $5,256,500 ($5,091,300 GPR and $165,200 PR) in 2004-05. These amounts reflect a reestimate of expected expenditures in 2002-03, as well as the rebate revenue. This represents a reduction of $119,500 (-$11,700 GPR and -$107,800 PR) in 2003-04 and $204,300 (-$96,500 GPR and -$107,800 PR) in 2004-05 compared with the amounts in the bill.

Drug Copayments

8. The Governor's bill would require enrollees to pay prescription drug copayments of $5 for each generic drug and $15 for each brand name drug. Currently, by DHFS rule, enrollees pay $5 for each generic drug and $10 for each brand name drug. This provision would reduce state costs of the program by requiring enrollees to pay more. The administration estimates that enrollees would pay an additional $54,500 annually towards their brand name prescription drug costs. This estimate represents an additional $5 for 10,900 annual brand name prescription drugs. The administration assumed that the increase would be implemented beginning fiscal year 2004-05.

9. DHFS staff indicate that in 2001-02, 5,395 prescriptions were filled for people who had met their deductible. Of these prescriptions, 2,391 were generic prescription drugs, and 3,004 were brand name prescription drugs. Therefore, it is estimated that enrollees would pay an additional $15,100 annually towards their brand name prescription drug costs if the copayment were increased from $10 to $15.

10. Table 4 shows amounts generated from drug copayments, which would reduce WCDP costs, under different copayment amount alternatives. In the copayment column, the first number represents the copayment amount for generic drugs, and the second number represents the copayment amount for prescription drugs. Table 4 shows the total amount enrollees pay in copayments for generic drugs and brand name drugs, as well as the amount of increased savings to reduce WCDP costs. The annual savings represents the increase in the amount enrollees would pay in copayments over what the enrollees currently pay in copayments. It is assumed that increased drug copayments would be implemented in 2004-05. Therefore, the annual savings also represents the entire savings over the 2003-05 biennium.

TABLE 4

Prescription Drug Copayments

Alternative	Copayment	Generic	Brand Name	Total	Annual Savings
B1 (Governor)	$5/$15	$12,000	$45,100	$57,100	$15,100
B2	$5/$12	12,000	36,000	48,000	6,000
B3	$7.50/$15	17,900	45,100	63,000	21,000
B4 (Current law)	$5/$10	12,000	30,000	42,000	0

Patient Liability for Treatment Costs

11. The Governor's bill would reduce state costs of the program by requiring enrollees to pay a higher deductible. DHFS is currently authorized to establish deductibles, which are a percentage of the enrollee's family income rather than a fixed amount, based on the enrollee's income level as a percentage of the FPL. The bill would require DHFS to increase deductibles by establishing the deductible amount at statutorily required, higher percentages of the family income level. Table 5 illustrates the deductible percentages under current law and under the Governor's bill.

TABLE 5

WCDP Deductible Amounts

Income as a % of Federal Poverty Level	Percent of Total Family Income	
	Current Law	Governor
200% thru 250%	none	set by DHFS
>250% thru 275%	none	set by DHFS
>275% thru 300%	none	set by DHFS
>300% thru 325%	0.75%	1.00%
>325% thru 350%	1.50	1.75
>350% thru 375%	2.25	2.50
>375% thru 400%	3.00	3.25
>400%	4.00	4.25

Without establishing deductibles for enrollees whose family income is from 200% to 300% of the FPL, the Governor's bill would increase deductible amounts for enrollees whose family income is from 300% to 400%, and reduce WCDP costs, by approximately $35,200 GPR annually. Again, it is assumed that this cost saving measure would not be implemented until 2004-05. Therefore the annual savings amount also represents the entire savings over the 2003-05 biennium.

In addition, all estimates of increases in deductible amounts that would be paid by enrollees only reflect increases for families of sizes up to three. Therefore, the actual increase in deductible amounts could be higher for all of the alternatives presented, which would further reduce state costs for WCDP.

12. Tables 6 thru 8 show alternative deductible percentages based on family income. The estimated savings are annual savings that would begin in 2004-05.

TABLE 6

Deductible Percentages - Alternative C2

Income as a Percent of FPL	Percent of Total Family Income
200% thru 250%	0.25%
>250% thru 275%	0.50
>275% thru 300%	0.75
>300% thru 325%	1.00
>325% thru 350%	1.75
>350% thru 375%	2.50
>375% thru 400%	3.25
>400%	4.25

Alternative C2 would increase coinsurance amounts, and reduce WCDP costs, by approximately $62,300 GPR.

TABLE 7

Deductible Percentages - Alternative C3

Income as a Percent of FPL	Percent of Total Family Income
200% thru 250%	0.75%
>250% thru 275%	0.75
>275% thru 300%	0.75
>300% thru 325%	1.00
>325% thru 350%	1.75
>350% thru 375%	2.50
>375% thru 400%	3.25
>400%	4.25

Alternative C3 would increase coinsurance amounts, and reduce WCDP costs, by approximately $85,200 GPR.

TABLE 8

Deductible Percentages - Alternative C4

Income as a Percent of FPL	Percent of Total Family Income
200% thru 250%	0.50%
>250% thru 275%	0.75
>275% thru 300%	1.00
>300% thru 325%	1.25
>325% thru 350%	2.00
>350% thru 375%	2.75
>375% thru 400%	3.50
>400%	4.50

Alternative C4 would increase coinsurance amounts, and reduce WCDP costs, by approximately $114,100 GPR.

13. The bill would also require DHFS to continuously review the sliding scale for patient liability coinsurance and revise it as needed, rather than every three years, to ensure that the amounts budgeted for WCDP are sufficient to cover treatment costs. The attachment illustrates the current coinsurance liability requirements.

Provider Reimbursement for Chronic Renal Disease Services

14. Currently, approximately 1,900 health care providers submit claims for services they provide to individuals enrolled in WCDP. These providers include physicians, clinics, hospitals, pharmacies, ambulances, and laboratories. The Governor's bill would repeal the current requirement that the state pay for services provided under the chronic renal disease (CRD) program at rates equal to allowable charges under the federal Medicare program. This provision would allow DHFS to reimburse providers that render services under the CRD program at rates lower than or equal to the allowable charges under Medicare as a means of reducing program costs.

15. Many programs, such as BadgerCare, SeniorCare, and the health insurance risk-sharing plan, have reimbursement rates at MA rates or MA rates with an enhancement. Medicare rates can be significantly greater than MA rates for some procedures. Table 9 shows a comparison of reimbursements rates for certain procedures under Medicare and MA.

TABLE 9

Comparison of Reimbursement Rates for Certain Services Between Medicare and Medicaid

Procedure	Medicare Rate	Medicaid Rate
Repair Blood Vessel, Direct	$863	$647
Immunocytochemistry	77	53
End Stage Renal Services	252	200
Office or Outpatient Visit	19	12
Hospital Discharge Day Management	67	27

16. However, MA rates may exceed Medicare rates for other procedures. Table 10 shows a comparison of reimbursements rates for certain other procedures under Medicare and MA.

TABLE 10

Comparison of Reimbursement Rates for Certain Services Between Medicare and Medicaid

Procedure	Medicare Rate	Medicaid Rate
Complete Acute Abdomens Series	$42	$45
Angiography, Internal Mammary, Radiological Supervision	506	533
Hemodialysis Procedure With Single Physician Evaluation	69	115
Hemodialysis Procedure Requiring Repeated Evaluations	112	173
Dialysis Procedure Requiring Repeated Evaluations	72	152
Spirometry	37	41

17. The Governor's bill would give DHFS the flexibility to reimburse providers at the Medicare rate, if the Medicare rate was the lower rate, or at a rate lower than the Medicare rate, if the Medicare rate was the higher rate. Reimbursing providers at lower rates would reduce state costs of the program. The bill could be amended to require DHFS to reimburse providers at either the Medicare or MA rate, whichever is lower, rather than to give DHFS permissive authority to establish rates in this manner. The extent of the savings from this provision is unknown.

18. The bill also would require providers to accept the state payment as payment in full and prohibit the provider from billing the patient for any amount by which the charge for the service

exceeds the state payment. Currently, providers may "balance bill" enrollees for costs above the reimbursement rate. The bill would prohibit providers from shifting costs to the enrollees.

Payer of Last Resort

19. The Governor's bill would specify that assistance under WCDP may only be provided if an individual has applied for assistance under all other health care coverage programs. DHFS would be required to promulgate rules to define these other programs, but the rules would specify that the programs include MA, BadgerCare, and SeniorCare. This requirement would first apply to persons who apply for benefits under WCDP on the bill's general effective date.

20. While the current WCDP is generally considered a payer of last resort, DHFS does not have the authority to require persons to apply for all other programs for which they may be eligible. Because WCDP offers limited services, individuals that are eligible for other programs would likely receive more comprehensive care under those programs than under WCDP. In addition, the extent to which individuals may be eligible for other programs could reduce overall state costs because some other health care programs, such as MA and BadgerCare, are partially supported by federal matching funds.

21. An agency may promulgate a rule as an emergency rule without the notice, hearing, and publication requirements involved in the standard rule making process. An emergency rule remains in effect for 150 days, and an agency can extend the rule for up to 120 additional days. The bill would authorize DHFS to promulgate both emergency rules and permanent rules regarding the requirement for application to other programs, but would exempt DHFS from the criteria that DHFS would otherwise be required to meet to promulgate emergency rules.

Managed Care Methods

22. The Governor's bill would authorize DHFS to adopt managed care methods of cost containment for WCDP. The provision does not specify what managed care requirements would include. DHFS staff indicate that managed care methods under consideration are the use of therapeutic alternatives, consumer education, an emphasis on the use of generic drugs, and a drug formulary. DHFS staff also indicate that many of these methods to control costs are already in practice. However, the provision would provide DHFS the statutory authority to use these methods.

Explanation of Alternatives

23. The alternatives in this paper enable the Committee to address both the current estimate of the cost of funding the current program (A1) and each of the proposed statutory changes to the program. Consequently, the Committee should select one alternative under A, B, C, D, E and F. The reestimate under alternative A1 represents the total amount that would be needed to fully fund projected benefits costs for WCDP in the 2003-05 biennium, based on more recent estimates. The reestimate does not include any expected savings from adopting any of the Governor's proposed cost saving measures. Adopting additional cost saving measures would further reduce the GPR funding needed for WCDP. Although the reduced GPR amounts listed in the alternatives

represent annual savings, it is assumed that any cost saving measure would be implemented in 2004-05, so the annual savings represent the entire savings over the biennium.

ALTERNATIVES

A. WCDP Funding Reestimate

1. Reduce funding in the bill by $119,500 (-$11,700 GPR and -$107,800 PR) in 2003-04 and $204,300 (-$96,500 GPR and -$165,200 PR) in 2004-05 so that a total of $4,829,700 ($4,664,500 GPR and $165,200 PR) in 2003-04 and $5,256,500 ($5,091,300 GPR and $165,200 PR) in 2004-05 would be budgeted for WCDP costs.

A1 -- Modification	GPR	PR	TOTAL
2003-05 FUNDING (Change to Bill)	**-** $108,200	**-** $215,600	**-** $323,800

B. Drug Copayments

1. Approve the Governor's recommendation to require enrollees to pay a $5 copayment for each generic drug and a $15 copayment for each brand name drug in cases where a pharmacy directly bills DHFS or a contracted entity for the drug. Reduce funding by $15,100 GPR in 2004-05 to correspond to the savings from the increased copayments.

Alternative B1	GPR
2003-05 FUNDING (Change to Bill)	**-** $15,100

2. Modify the Governor's recommendation by requiring enrollees to pay a $5 copayment for each generic drug and a $12 copayment for each brand name drug in cases where a pharmacy directly bills DHFS or a contracted entity for the drug. Reduce funding by $6,000 GPR in 2004-05 to correspond to the savings from the increased copayments.

Alternative B2	GPR
2003-05 FUNDING (Change to Bill)	**-** $6,000

3. Modify the Governor's recommendation by requiring enrollees to pay a $7.50 copayment for each generic drug and a $15 copayment for each brand name drug in cases where a pharmacy directly bills DHFS or a contracted entity for the drug. Reduce funding by $21,000 GPR in 2004-05 to correspond to the savings from the increased copayments.

Alternative B3	GPR
2003-05 FUNDING (Change to Bill)	**-** $21,000

4. Delete the provisions relating to prescription drug copayments.

C. Patient Liability

1. Approve the Governor's recommendation to require a deductible, as a percentage of the family's income, for families whose income is from 200% to 300% of the FPL, which would be set by DHFS. Require deductibles for families whose income is at or above 300% of the FPL as follows:

Income as a Percent of FPL	Percent of Total Family Income
300% thru 325%	1.00%
>325% thru 350%	1.75
>350% thru 375%	2.50
>375% thru 400%	3.25
>400%	4.25

Reduce funding to correspond with the savings from increased coinsurance percentages by $35,200 GPR in 2004-05.

In addition, require DHFS to continuously review the sliding scale for patient liability coinsurance and revise it as needed to ensure that the amounts budgeted for WCDP are sufficient to cover treatment costs.

Alternative C1	**GPR**
2003-05 FUNDING (Change to Bill)	**-** $35,200

2. Modify the Governor's recommendation to require deductibles, as a percentage of the family's income, as follows:

Income as a Percent of FPL	Percent of Total Family Income
200% thru 250%	0.25%
>250% thru 275%	0.50
>275% thru 300%	0.75
>300% thru 325%	1.00
>325% thru 350%	1.75
>350% thru 375%	2.50
>375% thru 400%	3.25
>400%	4.25

Reduce funding to correspond with the savings from increased coinsurance percentages by $62,300 GPR in 2004-05.

In addition, require DHFS to continuously review the sliding scale for patient liability coinsurance and revise it as needed to ensure that the amounts budgeted for WCDP are sufficient to cover treatment costs.

Alternative C2	**GPR**
2003-05 FUNDING (Change to Bill)	**-** $62,300

3. Modify the Governor's recommendation to require deductibles, as a percentage of the family's income, as follows:

Income as a Percent of FPL	Percent of Total Family Income
200% thru 250%	0.75%
>250% thru 275%	0.75
>275% thru 300%	0.75
>300% thru 325%	1.00
>325% thru 350%	1.75
>350% thru 375%	2.50
>375% thru 400%	3.25
>400%	4.25

Reduce funding to correspond with the savings from increased coinsurance percentages by $85,200 GPR in 2004-05.

In addition, require DHFS to continuously review the sliding scale for patient liability coinsurance and revise it as needed to ensure that the amounts budgeted for WCDP are sufficient to cover treatment costs.

Alternative C3	**GPR**
2003-05 FUNDING (Change to Bill)	**-** $85,200

4. Modify the Governor's recommendation to require deductibles, as a percentage of the family's income, as follows:

Income as a Percent of FPL	Percent of Total Family Income
200% thru 250%	0.50%
>250% thru 275%	0.75
>275% thru 300%	1.00
>300% thru 325%	1.25
>325% thru 350%	2.00
>350% thru 375%	2.75
>375% thru 400%	3.50
>400%	4.50

Reduce funding to correspond with the savings from increased coinsurance percentages by $114,100 GPR in 2004-05.

In addition, require DHFS to continuously review the sliding scale for patient liability coinsurance and revise it as needed to ensure that the amounts budgeted for WCDP are sufficient to cover treatment costs.

Alternative C4	**GPR**
2003-05 FUNDING (Change to Bill)	**-** $114,100

5. Delete the provisions relating to deductibles.

6. Delete the provision relating to coinsurance.

7. Delete the provisions relating to both the deductibles and coinsurance.

D. Provider Reimbursement for Chronic Renal Disease Services

1. Approve the Governor's recommendation to repeal the current requirement that the state reimburse providers that render services under the CRD program at rates equal to allowable charges under the federal Medicare program. Instead, require DHFS to reimburse providers at rates that do not exceed the allowable charges under Medicare. Also, require a provider to accept the state payment in full and prohibit the provider from billing the patient for any amount by which the charge for the service exceeds the state payment.

2. Modify the Governor's recommendation by requiring the state to reimburse providers that render services under the CRD program at the lower of Medicare rates or MA rates.

3. Delete the provisions in the bill regarding reimbursement rates paid under the CRD program.

4. Modify Alternative 1 by deleting the provisions in the bill prohibiting "balance billing."

5. Modify Alternative 2 by deleting the provisions in the bill prohibiting "balance billing."

6. Delete the provisions regarding reimbursement rates and "balance billing."

E. Payer of Last Resort

1. Approve the Governor's recommendation to: (a) specify that WCDP assistance may only be provided if an individual has applied for assistance under all health care coverage programs specified by DHFS; (b) require DHFS to promulgate rules, including emergency rules that are not subject to the criteria required to be met to promulgate emergency rules, to define other assistance programs, but specify that these programs would include MA, BadgerCare, and SeniorCare; and (c) prohibit DHFS from making payments under WCDP for any portion of medical treatment costs or other expenses that are payable under any state, federal, or health care coverage program, or any grant, contract, or other contractual arrangement.

2. Delete the provisions in the bill relating to WCDP as a payer of last resort.

F. Managed Care Methods

1. Approve the Governor's recommendation to authorize DHFS to adopt managed care methods of cost containment for WCDP.

2. Delete the provision relating to managed care methods for WCDP.

Prepared by: Kim Swissdorf
Attachment