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Prescription Drug Assistance Programs (DHFS -- Medical Assistance)

Informational Paper

A number of proposals have been introduced in both the 1999 and 2001 legislative sessions that would establish a prescription drug assistance program for some Wisconsin residents. In his 2001-03 biennial budget, the Governor included a proposal to use the medical assistance (MA) program to provide prescription drug coverage to certain elderly Wisconsin residents. Additionally, in February, the Senate adopted Senate Substitute Amendment 1 to 2001 Senate Bill 1, which would establish a prescription drug assistance program for Wisconsin residents 65 years of age or older with income at or below 300% of the federal poverty level. A number of bills have been introduced in the Assembly that would establish a prescription drug assistance program for certain Wisconsin residents. These bills are pending approval in the Assembly.

This paper is intended to assist the Committee and the Legislature in considering both the Governor's proposal and the legislative proposals by providing information on prescription drug use and the availability of coverage and other issues that could be deliberated.

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SECTION 1

Background

As of April 2001, 26 states have established some type of prescription drug assistance program. Eleven of these programs were created before 1990. Many of the remaining programs were created since 1999. Additionally, many states have recently expanded their prescription drug assistance programs. The creation and expansion of these programs represent these states' response to significantly rising prescription drugs costs in the late 1990's and the lack of a prescription drug benefit available under Medicare.

According to the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), national expenditures for prescription drugs increased from $40.3 billion in 1990 to $116.9 billion in 2000, representing a 19% average annual increase over that time period. Much of this increase was funded by public and private third-party payers, including private health insurance plans and government health care programs. In 1990, public and private third-party payers paid approximately 41% of national prescription drug costs. In 1999, public and private third-party plans paid approximately 65% of these costs. Nonetheless, the increases in out-of-pocket costs for prescription drugs, from $23.8 billion in 1990 to $34.9 billion in 1999, have focused attention on those individuals that do not have third-party coverage for prescription drugs.

The increasing costs associated with prescription drugs are primarily a result of research and technological advancements that have significantly increased prescription drug utilization and costs. One of the largest groups affected by this trend are individuals without prescription drug coverage and individuals with high drug costs. Because these are national trends, many people believe that the problem is most appropriately addressed at the federal level. For a number of years, there has been congressional support to provide at least some Medicare enrollees with some prescription drug coverage to address the issue. However, to date, no federal legislation has been enacted. Due to the lack of federal action, many states have enacted programs to assist individuals, particularly Medicare enrollees, in paying for their prescription drugs.

Some of the programs established in other states and proposals currently being considered by Wisconsin's Legislature have focused on persons over the age of 65 ("seniors") as a way of targeting those most affected by the rising trend in prescription drugs. Seniors are most likely to be disproportionately affected by the increasing trend in prescription drug costs for two reasons. First, they rely more heavily on prescription drugs than non-elderly individuals and are more likely to have chronic conditions that require a daily routine of medications to maintain their health. Second, seniors are less likely to have third-party coverage for prescription drugs than nonelderly individuals.

Income and Prescription Drug Use Among Seniors

There are approximately 700,000 seniors in Wisconsin. Based on data available from the federal Social Security Administration, it is estimated that approximately 169,000, or 24%, of seniors live in households that have income that is at or below 150% of the federal poverty level (FPL). This compares with approximately 23% of all Wisconsin residents that live in households with income below 150% of the FPL, based on data available from the 1990 U.S. Census. In 2001, 150% of the FPL is equal to $12,885 annually for one person and $17,415 annually for two persons.

Seniors spend a significantly larger portion of their income on medications than the rest of the population. According to the U.S. Census Bureau, in 1998, all consumers spent approximately $346 annually, or 1% of their total household expenditures, on prescription and non-prescription drugs. Seniors spent $670 annually on prescription and non-prescription drugs, representing 2.7% of their total household expenditures.

Higher out-of-pocket drug costs for seniors is partly due to higher use of medications by this group. In a report issued in July 2000, the Kaiser Family Foundation indicated that the average number of prescriptions filled nearly triples from ages 45 to 75 years, from an average of 4.3 prescriptions per person to 11.4 prescriptions per person annually. As a result, average expenditures also increase with age. Even among seniors, age matters in terms of cost. According to data available from the 1996 Medicare Current Beneficiary Survey, average per capita spending for prescription drugs for individuals 65-69 years of age was $595 annually, compared to $729 for individuals 80-84 years of age.

The second reason that the increasing trends in prescription drug costs disproportionately affect seniors is because a higher proportion of them do not have third-party coverage of prescription drugs compared with nonelderly persons. This is primarily because seniors rely on Medicare as the primary source of their health care coverage and Medicare has never provided coverage of outpatient prescriptions drugs.

According to HCFA, in 1996, an estimated 23% of non-Medicare beneficiaries had no drug coverage at any time during the year, while approximately 31% of Medicare beneficiaries had no drug coverage at any time during the year. Additionally, the portion of Medicare beneficiaries without any drug coverage increases with age. Approximately 36% of Medicare beneficiaries, 80-84 years of age, had no prescription drug coverage in 1996, compared with 28% for Medicare beneficiaries, 65-69 years of age.

Data available from HCFA also indicates that the portion of Medicare beneficiaries without prescription drug coverage increases as income decreases. In 1996, 39% of Medicare beneficiaries with income between 100% and 150% of the FPL had no prescription drug coverage, compared to 25% of the Medicare beneficiaries with income above 300% of the FPL.

Additionally, the 1996 Medicare Current Beneficiary Survey found that Medicare beneficiaries living in urban areas were more likely to have drug coverage (69%) than beneficiaries living in non-metropolitan areas (54%).

Available Coverage for Prescription Drugs

There are a number of sources for prescription drug coverage for seniors. However, many seniors do not have access to these sources, or the coverage available from these sources is limited or expensive.

Employer-Sponsored Health Care. In 1996, employer-sponsored plans were the source of coverage for about 60% of the non-Medicare population and 28% of Medicare beneficiaries. Large size firms, firms with more than 1,000 employees, are the most likely to offer health care beneficiaries to their retirees. Based on an employer survey, approximately 41% of large firms offered health benefits to retirees in 1998. Surveys indicate that approximately 22% of firms with 500-1,000 employees offered health care benefits to retirees in 1999 and only 8% of firms with fewer than 200 employees offered such health care coverage in 1998.

The percentage of employers that offer health care coverage to retirees has decreased in recent years. According to HCFA, this is partly because of accounting rule changes that require firms to account for benefits promised to future retirees as a current liability, but rising health care costs in general, and prescription drug costs in particular, are also believed to be a contributing factor. In addition, according to different surveys, employers are increasing the portion of costs retirees must to pay for their health care coverage or increasing eligibility requirements before an employer would provide coverage to a retiree.

Medical Assistance. Certain low-income Medicare beneficiaries have coverage for prescription drugs because they also qualify for medical assistance (MA), which offers a comprehensive pharmacy benefit. However, not all Medicare beneficiaries enrolled in MA have prescription drug coverage. For "qualified Medicare beneficiaries" and "special low-income Medicare beneficiaries," MA only pays for certain Medicare premiums, coinsurance and deductibles. It does not pay for services for these individuals that are not covered under Medicare, including outpatient prescription drugs.

It is estimated that approximately 59,200 Wisconsin residents over 65 years of age currently have MA coverage for prescription drugs. All of these individuals would have income below 100% of the FPL.

Medicare. The Medicare program was established in 1965 under Title XVIII of the Social Security Act to provide health insurance for aged persons to complement the retirement, survivors, and disability insurance benefits available under social security. Medicare consists of two primary parts -- hospital insurance (HI), also known as Part A, and supplementary medical insurance (SMI), also known as Part B. Part A includes coverage of inpatient hospital, skilled nursing facility care, home health and hospice care. Part B is described as providing outpatient

care because it includes coverage of physician services, clinical laboratory tests, durable medical equipment, diagnostic tests and ambulance services. However, Part B does not cover outpatient prescription drugs.

In Wisconsin, there are approximately 777,000 individuals enrolled in Medicare Parts A and B, of whom approximately 690,000 are individuals at least 65 years of age. The rest are individuals that are under 65 years of age but qualify for Medicare due to a disability.

As part of the federal 1997 Balanced Budget Act, Congress created the Medicare+Choice program, also known as Part C. Under Medicare+Choice, beneficiaries can choose to participate in a managed care plan that covers services offered under both Parts A and B and often provides additional benefits. The ability of these plans to offer additional benefits is based on the Medicare payment rate. These rates are based on historical fee-for-service costs in each county and therefore the payment rate varies by county. An analysis conducted by the Department of Health and Family Services (DHFS) found that the Medicare+Choice monthly payment rates in Wisconsin were low relative to the rest of the country, averaging $382.48 for Wisconsin beneficiaries, compared to $488.45 nationally.

Because of the lower than average payment rates, Medicare+Choice plans in Wisconsin do not provide many additional services compared with plans in other states. For example, no Medicare+Choice plan in Wisconsin offers prescription drug benefits. This is likely the reason that Wisconsin's beneficiaries' participation in Medicare+Choice plans is low, 5.3% compared to 17.6% nationally in 2000.

Medicare Supplement Policies. According to the 1996 Medicare Current Beneficiary Survey, approximately 10% of Medicare beneficiaries receive limited prescription drug coverage through the purchase of supplemental Medicare policies, known as "Medigap" policies.

The Office of the Commissioner of Insurance (OCI) establishes, by rule, and in conformance with federal requirements, minimum coverage requirements for basic Medicare supplemental coverage, additional coverage provided under separate riders and "high deductible drug plans." First, every basic Medicare supplemental policy must provide coverage for at least 80% of charges for outpatient prescription drugs after the beneficiary pays a deductible of up to $6,250 in any calendar year. Thus, every Medigap policy provides prescription drug coverage for individuals, but only after the $6,250 deductible is met. These minimum coverage requirements apply to Medigap policies issued on or after September 1, 1994.

Second, outpatient prescription drug riders on a Medigap policy must cover at least 50% of charges for outpatient prescription drugs after the beneficiary pays a deductible of up to $250 per calendar year, up to a maximum of at least $3,000 in benefits for the insured per year. Only one of the individual Medigap policies available as of January, 2001, offers a rider for prescription drugs. The annual premium for this rider totaled $922, regardless of age.

HIRSP. The health insurance risk-sharing plan (HIRSP) offers health insurance coverage to individuals with adverse medical histories and others who cannot obtain affordable health care coverage in the private sector. Comprehensive prescription drug coverage is available under HIRSP, but individuals 65 years of age or older are not eligible to participate unless they applied for, and were enrolled in, HIRSP before they turned 65 years of age. Coverage is subject to payment of deductibles and coinsurance. As of March, 2001, there were approximately 10,800 individuals enrolled in HIRSP. Of these, 250 were 65 years of age or older.

SECTION 2

Components of a Prescription Drug Assistance Program

In developing a prescription drug assistance program, several issues should be considered including: (a) who would be eligible; (b) how the plan would be funded and how costs would be shared between the enrollees, the state, pharmacies and the pharmaceutical manufacturers; (c) how the program would be administered; (d) what features would maintain the integrity of the program; and (e) when such a program would first be available. This section identifies some of the issues that could be considered in developing a prescription drug assistance program. The section includes references to proposals that were, or are currently being considered by Wisconsin's Legislature, including the Governor's proposal in his 2001-03 budget bill.

Eligibility

There are a number of criteria that could be used to determine eligibility, including both financial and non-financial criteria. It may be appropriate to develop eligibility criteria that targets groups of individuals that are most likely in need of assistance with the purchase of prescription drugs, such as those that pay a significant portion of their income for prescription drugs, individuals with the lowest incomes, or individuals with multiple chronic conditions that require routine medications as a way to maintain their health.

Age. All of the current proposals would require enrollees to be at least 65 years of age. However, a proposal could include individuals who are under age 65 if those individuals are disabled or have chronic conditions that require maintenance medication. Of the 17 state prescription drug assistance programs reviewed by the U.S. General Accounting Office (GAO) in 1999, all but six provided coverage to individuals with disabilities, in addition to covering elderly individuals.

Many of the arguments for providing assistance to seniors could also apply to persons with disabilities. Prescription drug costs for the disabled are on average higher than prescription drug costs for seniors. For example, the New Jersey program provides coverage to both elderly individuals and individuals with disabilities. Under that program, in 2000, the average net benefit to an elderly enrollee was $1,116, while the average net benefit to a disabled enrollee was $1,974, according to the National Pharmaceutical Council.

Income Criteria. To ensure that assistance is targeted to those least able to afford purchasing prescription drugs, it may be appropriate to determine a maximum level of income at which individuals would be eligible for the program. This income maximum could be based on a percentage of the FPL or it could be established as a fixed amount. If the income maximum were based on a percentage of the FPL, the income level would automatically be indexed for

inflation, meaning the maximum level would increase each year, based on annual changes in the federal poverty level.

If the income maximum is based on a fixed amount, the percentage of the target population that would be eligible would likely decrease over time as incomes rise with inflation, but the income eligibility criterion would remain constant. Establishing a fixed amount, however, would not preclude the Legislature from adjusting the income limits in the future. According to the GAO, in 1999, seven state pharmacy assistance programs used a percentage of the FPL to determine income eligibility, another five used other income thresholds that could be adjusted for inflation. Two states had fixed amounts for the income eligibility requirement.

The following table identifies income levels as a portion of the current FPL.

Annual Income as a Percent of the 2001 Federal Poverty Level

Percent of the FPL	Income for a One-Person Household	Income for a Two-Person Household
100%	$8,590	$11,610
110	9,449	12,771
115	9,879	13,352
125	10,738	14,513
130	11,167	15,093
150	12,885	17,415
175	15,033	20,318
185	15,892	21,479
200	17,180	23,220
225	19,328	26,123
250	21,475	29,025
275	23,623	31,928
300	25,770	34,830
350	30,065	40,635

The GAO reported that income limits varied from 100% of the FPL to 225% of the FPL for state pharmacy assistance programs in effect in 1999. Since that time, however, a number of states have established prescription drug assistance programs or expanded existing programs to include individuals with higher incomes. For example, beginning in January, 2001, New York's program, which was initially created in 1986, increased its income eligibility limit from approximately 225% of the FPL to approximately 400% of the FPL for single individuals and approximately 430% of the FPL for two-person households.

Assets. None of the current proposals would consider an individual's assets when determining eligibility. However, of the current state pharmacy assistance programs, three

states--Maryland, Minnesota and Michigan--require individuals to meet an asset requirement in order to be eligible. Under Maryland's prescription drug assistance plan, the asset limit for individuals is $3,750 and $4,500 for couples. Minnesota's asset limit for an individual is $10,000. Michigan limits assets to $3,000, however the Michigan program will end later this year and be replaced by a new program. It is not known whether this new program will have an asset limit.

Under MA, for the elderly and the disabled, eligibility is limited to individuals with assets below $2,000 for an individual and $3,000 for a couple. However, certain assets are excluded, such as a car, a home, assets related to burial, including insurance, trusts, funds or plots. While no information is available to determine the effect of including an asset limit in any proposal, doing so would likely decrease participation in the program, reducing total program costs.

Including an asset limit could achieve a policy goal that funding budgeted for a prescription drug program only be used to benefit those that otherwise could not afford prescription drug coverage. However, establishing an asset limit would reduce participation in the program and would increase administrative costs to verify the information submitted by applicants.

Availability of Other Drug Coverage. Under the current proposals, both individuals with drug coverage and those without coverage would be eligible to participate. The proposals specify that the state-funded program would be a payer of last resort, meaning that coverage would be limited to costs not otherwise covered under another policy. Under the Governor's budget proposal, only individuals without drug coverage for the past 12 months, excluding eligibility for MA, would be eligible for the program.

By limiting eligibility only to individuals without drug coverage, a proposal would target those most in need of coverage and limit costs. However, if coverage would be limited to only those without drug coverage, it is likely that some "crowd out" would occur. Crowd out is the phenomenon of shifting privately funded health care benefits to publicly funded programs. It is reasonable to assume that some individuals would discontinue their current coverage to be eligible for coverage under a state program, if they determined that the state program had more generous benefits. However, most alternative coverage includes coverage of services other than prescription drugs. Therefore, these individuals would have to determine whether it is advantageous to discontinue coverage for a variety of services and costs to receive more generous coverage of prescription drugs.

On the other hand, it may be desirable to provide coverage to individuals with other coverage, since many individuals with drug coverage have high out-of-pocket costs, either because their other coverage requires payment of large deductibles or places limits on the amount of coverage available. The 1996 Medicare Current Beneficiary Survey indicates that, on average, individuals with drug coverage pay for approximately 35% of their total drug costs out-of-pocket.

The cost to provide coverage to individuals with other drug coverage would vary significantly, depending on the proposal. Proposals with lower deductibles would have significantly higher costs because more persons enrolled in the program would meet the deductible, even with other available coverage. However, for proposals with higher deductibles, the effect of covering individuals with other coverage would be significantly less, since fewer of these individuals would meet the plan's deductible.

Residency. It is reasonable to require that, as a condition of eligibility, an enrollee be a resident of Wisconsin. However, under some proposals, the definition of residency would only require that the individual maintain a permanent home in Wisconsin and provide evidence of domiciliary intent by having a state driver's license, or by voting and paying income taxes in the state. It may be reasonable to specify that to be eligible, an individual must be considered a resident for some period of time before being eligible, perhaps 30 days to six months. This may be appropriate if there is concern that individuals could relocate from other states to enroll in Wisconsin's program. Generally, the programs in surrounding states -- Minnesota, Iowa, Illinois and Indiana -- are limited in terms of eligibility and availability of benefits, compared with the proposals currently being considered by Wisconsin's Legislature.

Spend Down. Some proposals include a provision that would enable individuals with annual household income above the income limit, but who meet the other eligibility criteria, to be eligible to enroll in the program if, after deducting their out-of-pocket costs for prescription drug covered under the program from their income, they have income at or below the income limit. These individuals are referred to as persons that "spend down" to the income eligibility limit.

No data is available to identify the potential costs associated with proposals to include individuals that spend down to the income limit. For purposes of developing cost estimates for current proposals, it is assumed that such a provision would add an additional 5% to the costs of the program. In addition, it is anticipated that including a spend down feature in a program would increase administrative costs, since applicants would be required to document previous spending on drugs.

Out-of-Pocket Expenses. Some states have developed eligibility criteria partially based on the portion of an individual's income that is spent on prescription drugs. For example, under one of Maine's programs, for individuals with out-of-pocket drug expenditures representing at least 40% of income, the income limit increases by approximately 25%. Such an approach could be used as an alternative to a spend down provision as a way to ensure that those with high out-of-pocket drug costs relative to their income receive coverage. To date, none of the current proposals include such options.

Eligibility Period. Each of the current proposals would have annual eligibility periods, meaning that once determined eligible, an individual would remain eligible for 12 months. Individuals would have to reenroll in order to remain eligible for the program following the 12-month eligibility period. Each proposal require enrollees to pay an enrollment fee, ranging from

$20 to $25, annually. Revenue from these fees would be used to fund the program's administrative costs.

Enrollment Period. Under each of the proposals, individuals could enroll at any time during the year. In an effort to manage enrollment in the program, enrollment could be limited to a four, six, or eight-week period each year. Once the program is implemented, projecting costs each year would be much more reliable if enrollment were limited to a specific period of time. However, a limited period for annual enrollment could be perceived as a barrier for those in need of assistance and therefore, could limit participation in the program.

Participant Cost-Sharing

Cost-sharing components require participants to share in the cost of drugs purchased under a prescription drug assistance program. Deductibles and copayments are often used by private insurance plans to reduce overall costs and discourage inappropriate or excessive use of services.

Deductible. A deductible is the amount that an individual must pay out-of-pocket before benefits would be paid on an individual's behalf. Plans that do not require payment of a deductible before coverage is available are sometimes referred to as plans that provide "first dollar" coverage, meaning coverage is available on the first dollar spent for services. Deductibles are not as common among publicly funded health plans. For example, under MA and BadgerCare, individuals are not required to pay a deductible before receiving services. However, under the state's health insurance risk-sharing plan, deductibles apply.

Only four of the state prescription drug assistance programs require some recipients to pay a deductible before being eligible for services. The Illinois and Minnesota programs have monthly deductibles, meaning the individual must pay a certain amount (between $15 and $35) per month before the individual is eligible for benefits. The New York and Pennsylvania programs require deductibles for those at higher income levels.

Most of the current proposals require at least some individuals to meet a deductible requirement. The Governor's budget proposal includes several deductible options. For individuals below 110% of the FPL, no deductible would be required. Individuals with income of at least 110% of the FPL but less than 130% of the FPL would be required to pay a $300 annual deductible. Individuals with income of at least 130% of the FPL, but less than 155% of the FPL would be required to pay a $600 annual deductible. Another approach is to require everyone enrolled to pay a deductible, such as under 2001 AB 120, which would require every enrollee to pay an $840 deductible annually before the state pays a claim.

Each current proposal would require pharmacists to charge participants no more than the program's payment rate for each drug purchased during the deductible period. Therefore, every enrollee would receive a discount on drugs purchased during a deductible period, even if the individual does not have sufficient drug costs to reach the deductible. The amount of the

discount would vary, depending on the payment rate for each drug relative to the retail price of the drug. In no case would the program payment rate exceed the retail cost of the drug.

Copayments. Copayments represent the portion of a drug's cost that must be paid by a participant for each purchase after the deductible is met. Copayments could be established at a fixed amount per prescription, such as $5, or a percent of the prescription price, such as 20%. If a health care or other prescription drug plan has a fixed copayment per prescription, it will most often have at least two different copayments, depending on whether the purchased drug is a brand-name drug or a generic drug. Under private plans, lower copayments are typically required for generic drugs to encourage the use of generics when available to control costs.

Under private plans, establishing copayments as a percent of the drug's purchase price to determine the copayment encourages utilization of generic drugs, since the more expensive the drug, the more the participant would pay. However, because some prescriptions are quite expensive, requiring individuals to pay 20% of the cost could a be significant cost for some individuals. Requiring a fixed amount per prescription limits a participant's liability per prescription.

The current proposals have various copayment requirements, but all are based on fixed amounts per prescription. It would be possible to develop a program that would require a copayment of a fixed amount or a percentage, whichever is less. For example, a proposal could require copayments of $20 for brand name drugs, $10 for generic drugs, or 20%, whichever is less. If a participant purchased a generic drug with a reimbursement rate of $15, the copayment would be $3, or 20% of the cost of the drug. Under this same proposal, an individual that needs a brand name drug for which no generic is available with a reimbursement rate of $250, the copayment would be $20.

Establishing different copayments for brand name and generic drugs would not likely increase utilization of generic drugs, if DHFS were authorized to use the same cost and utilization control procedures it uses for the MA program. Approximately 67% of the drugs purchased under MA are generic drugs, compared with 30-40% for private insurance plans and some state prescription drug assistance programs. Under MA, pharmacists are required to substitute a generic drug when a brand name drug is prescribed and a generic drug is available, as allowed under current law. However, if a physician that prescribed the drug provides a handwritten indication that the brand name is medically necessary, the pharmacist may not substitute a generic drug for the brand name drug. Using this cost control procedure, the MA program maximizes use of generic drugs. Most of the proposals authorize DHFS to use the same cost and utilization control procedures as available under MA.

Reimbursement Rate

The current proposals specify that the reimbursement rate paid under these programs would use the same pricing structure used under MA. Under MA, pharmacies are reimbursed the lower of the provider's usual and customary charge or the estimated acquisition cost (EAC)

of the drug, plus a fee for the pharmacists' cost to dispense the drug. The total amount reimbursed to the pharmacist represents the EAC plus the dispensing fee, less $0.50.

Currently, the EAC for most brand name drugs is based on the average wholesale price (AWP), as reported in the First Databank Blue Book, less a 10% discount. Generic drugs are priced according to the maximum allowable cost (MAC) list. This list is initially developed by HCFA, based on a survey of prices at which generics are available from wholesalers. DHFS modifies the list to include additional drugs based on information available to DHFS about the price of generic drugs.

The dispensing fee for most prescriptions is $4.88. Other dispensing fees apply under limited circumstances.

Currently, on average, MA reimburses pharmacies at a rate that is approximately 77% of the pharmacies' usual and customary charges, or the retail price of the drug. This represents a 23% average discount from the retail price.

Some current proposals would specify that the reimbursement rate for prescription drugs would be equal to AWP less a 5% discount or the MAC listed price, whichever is less. Additionally, pharmacies would receive the MA dispensing fee. Other proposals would specify that the reimbursement rate would be the MA payment rate plus 5% and the dispensing fee. For purposes of estimated costs, these payments are determined to be approximately equivalent, providing an average discount of 18% from retail prices.

However, the Governor's budget includes a proposal to reduce the MA reimbursement rate for most prescription drugs, from AWP-10% to AWP-15%. If enacted, the estimated cost for proposals based on the MA payment rate plus 5% would be reduced to reflect the change to the MA reimbursement rate. Proposals that specify a payment rate of AWP less a 5% discount or the MAC listed price would not be affected by the Governor's recommendations.

One of the arguments for providing a reimbursement rate that is greater than the MA reimbursement rate is to offset the loss in revenue that pharmacies would receive, since drugs purchased under some proposals would have previously been purchased at retail prices. As indicated, this would be an average discount of approximately 18% that would be absorbed by pharmacies.

However, research indicates that individuals with prescription drug coverage use significantly more drugs than individuals without coverage. Based on the 1996 Medicare Current Beneficiary Survey, in 1995, Medicare enrollees without drug coverage spent an average of $432 annually on prescription drugs, compared to individuals with drug coverage ($689), or approximately 60% more. Therefore, while pharmacies would likely receive a lower reimbursement per prescription compared to retail, if a prescription drug program were enacted, it is reasonable to assume that the volume of prescriptions sold would increase by as much as 60% for those individuals that previously had no coverage.

Manufacturer Rebates

Under MA, each state prescription drug assistance program and most private health insurance plans receive rebate revenue from manufacturers. Under MA, the manufacturers sign rebate agreements with the U.S. Department of Health and Human Services on behalf of the state MA programs. Federal law defines how the rebate amount is calculated. This revenue represents approximately 18% of prescription drug expenditures under Wisconsin's MA program.

Each of the proposals would require that only prescription drugs manufactured by companies that sign rebate agreements with the state would be covered. Further, these provisions specify that the rebate agreements must be based on the rebate formula identified in federal law.

Each state with a prescription drug assistance plan has entered into rebate agreements with manufacturers. In some states, some manufacturers were reluctant to sign the rebate agreements if the state's program did not specify that a rebate agreement was required for the manufacturer's drug to be covered under the program. For example, programs in Minnesota and New York had some difficulty in this regard. Both states have since modified their programs to specify that only drugs manufactured by companies that enter into rebate agreements are covered. After those changes were made, almost all manufacturers have signed the rebate agreements.

Coordination with Medical Assistance

While it is expected that any prescription drug assistance program would be closely coordinated with MA, the Legislature could decide not to link the administration of these two programs. Many states with prescription drug assistance programs chose not to link their drug assistance program with MA to avoid the possible stigma associated with MA as a public welfare program. As a result, these states have separately contracted for administration of the program and have placed the responsibility for administration of the program with an agency other than the agency that administers the state's MA program.

Administration

Under the current proposals, DHFS would administer the program but would contract with a vendor for many of the administrative functions. The costs to administer a prescription drug program would include: (a) enrollment processing; (b) claims processing; (c) outreach and customer services; (d) contract monitoring; (e) monitoring rebate agreements with manufacturers; and (f) coordination of benefits with other third-party payers. These costs could vary significantly, depending on the features of the proposal.

Start-Up Costs. There would be one-time costs to establish a new program. These costs would include staff time to establish a request-for-proposal and negotiate a contract with a

vendor to perform many of the administrative functions. Programming changes would be required to the current MA claims processing system or for development of a separate system. Additionally, staff time would be required to secure rebate agreements with pharmaceutical manufacturers.

Each of the current proposals, other than the Governor's budget proposal, would appropriate $2.0 million GPR in the first year of the biennium to address these one-time costs. One proposal would provide $2.0 million GPR in the Joint Committee on Finance supplemental appropriation to fund DHFS start-up costs after DHFS submits a plan for the use of the funds. Other proposals would appropriate $1.0 million GPR directly in DHFS so that DHFS can begin program implementation immediately upon enactment of legislation and provide another $1.0 million GPR in the Committee's supplemental appropriation to fund start-up costs after DHFS submits a plan for the use of the funds.

The proposal included in the Governor's budget would not provide any funds for start-up costs. The administration indicates that it anticipates that, if enacted, DHFS would request the Joint Committee on Finance to transfer funds for this purpose from other appropriations using its authority under s. 13.101 of the statutes, if sufficient base funding were not available.

Ongoing Costs. Under the current proposals, ongoing costs would be funded from an annual enrollment fee paid by enrollees. The amount of the fee would vary from $20 to $25 annually. The amount of revenue available from the fee would vary depend on the number of individuals enrolled in the program.

Based on information obtained from other states, it appears that the ongoing administrative costs to operate a prescription drug assistance program average between 2% and 3% of a program's budget for benefits paid under the program. New York's plan, which has a $252 million program budget, provides $6 million, or 2.3%, for administration. Pennsylvania's plan, with a $359 million budget in 2002, is budgeting $9.5 million, or approximately 2.6%, for administration. While both of these plans have been in operation for a number of years and have much larger enrollment than projected under any of the current proposals, these programs have components which require participants to pay a deductible, which is similar to many of the current proposals being considered.

However, a comparison of other states' administrative costs can be misleading in terms of estimating DHFS' costs to administer a prescription drug program. For example, current MA policies on prior authorization and the use of drug utilization review require resources to administer. Both of these components would help to control benefit costs in the program by encouraging use of lower cost drugs when available and appropriate, but would likely add a program's administrative costs. It appears that both the New York and Pennsylvania programs do not use prior authorization to the extent used under Wisconsin's MA program, nor does the New York program perform extensive drug utilization reviews. Therefore, administrative costs as a portion of Wisconsin's program budget could be higher than these programs to the extent the

MA cost and utilization control procedures are used in any prescription drug assistance program that would be enacted in Wisconsin.

Eligibility and Enrollment. The state contracts with counties to determine eligibility under MA. Under federal law, eligibility determinations for MA must be performed by public employees and cannot be contracted out to a private entity.

If a prescription drug program were enacted, it may be desirable to separately contract for enrollment processing, rather than use the current MA process performed by counties to ensure that the enrollment process is cost effective.

Alternatively, some current proposals have components that would allow individuals to spend down to the income limits. This component is more administratively complex to process. Since counties have experience determining eligibility for individuals that spend down to the MA eligibility limits, it may be advantageous to have counties determine eligibility under a prescription drug proposal if it includes a spend down component. However, private entities could develop the capacity to determine eligibility for individuals that spend down and it may be more cost-effective to competitively bid for enrollment processing, regardless of whether or not a program has a spend down provision.

Program Integrity Features

Two features of the MA program could be incorporated into a prescription drug program to minimize potential abuse of the program and thus reduce program costs.

Penalties for Fraud and Abuse. Requiring DHFS to promulgate rules relating to prohibitions on fraud that are substantially similar to MA could prevent individuals that otherwise might be motivated to abuse the program from committing such abuses. To ensure that there would be enforcement of these prohibitions, the proposals could specify the penalties for violations under rules promulgated by DHFS. Some current proposals specify that individuals furnishing prescription drugs in violation of the rules promulgated by DHFS could be fined not more than $25,000 or imprisoned for not more than seven years and six months, or both. Other individuals found to violate these prohibitions could be fined not more than $10,000 or imprisoned for not more than one year in county jail, or both.

Because the Governor's budget proposal would expand the MA program, any prohibitions on fraud or abuse and any penalties for such fraud or abuse would apply to individuals that would participate in the program established in the Governor's bill.

Estate Recovery. A proposal could include an estate recovery provision to ensure that individuals participating in the program contribute appropriately to the cost of services provided under such a program, after death through payments from their estates. Estate recovery is currently used under the MA, community options program and disease aids program for such purposes.

Currently, the MA estate recovery program allows the state to recover MA payments for nursing home care, hospital care, personal care services, home- and community-based waiver services and related hospital and prescription drug services provided to recipients age 55 years and over. State law requires the state to file claims against the estate of a MA recipient to recover certain costs, except in cases that would cause undue hardship. The Governor's budget bill would expand estate recovery under MA to seek recovery for all services provided under the MA state plan to noninstitutionalized recipients 55 years and older.

Effective Date

Most of the current proposals would specify that the prescription drug assistance program would make benefits first available on March 1, 2002. The Governor's proposal does not specify an effective date, but the administration anticipates that it could begin by July 1, 2002.

It is reasonable to assume that once a program is enacted, the earliest that DHFS would be able to implement a program would be nine to 12 months from the effective date of the legislation. This assumption is based on past experience of the time needed for DHFS to implement new programs and based on the number of tasks that would need to be completed before a program would first be available.

SECTION 3

Cost Factors

This section discusses the major cost components of a prescription drug assistance program, factors affecting future costs of such a program, ways to address growth in the program and possible options to address action at the federal level regarding prescription drug coverage for Medicare beneficiaries.

Major Cost Components

The major factors contributing to the costs of the current proposals include: (a) the estimated number of individuals eligible for the program; (b) the amount of a deductible and other cost-sharing components; and (c) whether some enrollees would be exempt from a deductible. The following section describes how these factors would affect the estimated costs under some of the current proposals.

Estimated Number of Eligible Individuals. The number of people eligible for the program would depend on whether the program is limited to seniors or whether individuals under age 65 with disabilities would be eligible, and the maximum income an individual could have to be eligible. Additionally, if individuals with other drug coverage are eligible, participation would be significantly greater than if eligibility is limited only to persons without drug coverage.

According to the 1999-00 State of Wisconsin Blue Book, there are approximately 700,000 Wisconsin residents 65 years of age or older. Of this number, it is estimated that approximately 60,000 are enrolled in MA. No recent information is available on Wisconsin residents by income. For purposes of estimating the number of individuals eligible for the prescription drug proposals, this office used national information available from the federal Social Security Administration. Based on this data, the following table identifies the estimated number of Wisconsin residents, not enrolled in MA and 65 years of age or older, by income.

Estimated Wisconsin Residents 65 Years of Age or Older Not Enrolled in MA

Household Income as a Percent of the FPL	Estimated Number of Individuals
At or Below 100%	13,400
At or Below 150%	109,200
At or Below 185%	175,000
At or Below 200%	200,000
At or Below 250%	278,200
At or Below 300%	338,300
All Incomes	640,000

According to HCFA, there are approximately 88,000 Wisconsin residents under age 65 that are enrolled in Medicare because of a disability. Of this number, it is estimated that approximately 40,000 are enrolled in MA. Therefore, there are an estimated 48,000 individuals with disabilities in Wisconsin that are not enrolled in MA. These estimates do not include individuals with disabilities that are able to work and therefore would not qualify for Medicare or MA. No data is available to estimate the income distribution of these individuals.

The estimated number of individuals eligible has a significant impact on the cost of a proposal. For example, 2001 Senate Substitute Amendment 1 to Senate Bill 1 would provide coverage to elderly residents with income at or below 300% of the FPL and has an estimated annual cost of approximately $105.9 million. If eligibility were limited to individuals at 250% of the FPL, the estimated cost would be reduced to $92.1 million. 2001 Assembly Bill 120 would provide eligibility to individuals at or below 185% of the FPL. If AB 120 were modified to extend eligibility to individuals at or below 250% of the FPL, the estimated cost would increase from $26.4 million to $38.7 million.

Deductibles and Cost-Sharing. The amount of a deductible has a significant effect on the cost of a proposal. For example, the program that would be created in AB 120 would have an $840 deductible. It is estimated that approximately 39,500, or 44% of those enrolled, would have expenditures that meet the deductible. If all other elements of AB 120 remained the same, but the deductible were reduced to $600, an estimated 54,600, or 61% of those enrolled would have expenditures that exceed the deductible. This change would increase estimated annual program expenditures from $26.4 million to $35.3 million.

The amount of any required copayments can significantly affect the estimated cost of a proposal. For example, SSA 1 to SB 1 would require individuals to pay a copayment of $10 for each brand name drug purchased after the deductible and $5 for each generic drug purchased after the deductible. If these copayments were increased to $7.50 for each generic drug and $15 for each brand name drug, estimated annual program expenditures would decrease from $105.9 million to $94.5 million.

Deductible Exemption. Under AB 120, all individuals would be required to have drug expenditures that meet the deductible before the state would make payments on their behalf. AB 132 and SSA 1 to SB 1 would exempt individuals with household income at or below 175% of the FPL from paying a deductible under the proposals. Under SSA 2 to SB 2, individuals at or below 150% of the FPL would be exempt from the deductible requirement. Under the Governor's proposal, individuals with income at or below 110% would not be required to pay a deductible. For these individuals, the proposals would provide first dollar coverage, meaning the state would provide a payment on the first dollar spent by these individuals for drugs purchased under the program.

Whether or not certain individuals would be exempt from paying a deductible and the level at which individuals would be exempt can have a significant effect on the estimated cost of a proposal. For example, the estimated cost of AB 132 would decrease from $105.9 million to

$88 million if the proposal were modified to only exempt individuals at or below 125% of the FPL. AB 120 estimated costs would increase from $26.4 million to $47.2 million if individuals at or below 125% of the FPL would be exempt from the deductible requirement.

Future Costs

If a proposal is enacted, program costs would be expected to grow significantly in each year, based on enrollment growth and increasing average costs per enrollee. The reasons for this are varied and several options to address these rising costs could be considered.

The percentage of personal health care expenditures represented by drugs is increasing, from 5.6% in 1980 to 9.4% in 1999. Since 1996, national spending on prescription drugs has increased by an average of 18.5% annually, compared with an average increase of 6.3% annually for all personal health care expenditures, according to HCFA. Additionally, HCFA projects that the conditions that accelerated prescription drug costs since 1995 will continue over the next decade, although the effect of the conditions in the latter period of this decade is assumed to be less than in the initial period. Therefore, any prescription drug assistance program that would be enacted would likely experience significant growth in demand for benefits over the next ten years.

Several trends are affecting the recent increases in spending on prescription drugs. The National Institute for Health Care Management found that the increase in prescription drug spending is attributable to: (a) an increase in the number of prescription drugs dispensed (42%); (b) a replacement of lower cost drugs with higher-priced drugs (36%); and (c) price increases (22%).

Number of Prescriptions Dispensed. A Kaiser Family Foundation (KFF) report noted that the number of prescriptions dispensed in the United States increased from 7.3 billion in 1992 to 9.6 billion in 1998. The annual number of prescriptions dispensed per person increased from 1.9 to 2.6 over that same time period. The KFF report indicates that this trend is partially attributable to an increase in the average age of the population and an increase in the number of health care professionals who may prescribe medications. In 1984, the median age of the U.S. population was 31.1 years. By 1998, the median age increased to 35.2 years. The number of physicians per 1,000 persons increased from 2.25 in 1985 to 2.70 in 1997.

Promotional spending by pharmaceutical manufacturers has also contributed to this trend. Spending on promotion includes; (a) sales calls to physicians and other professionals authorized to prescribe medication; (b) presentations at professional meetings and events; and (c) direct-to-consumer advertising. Between 1995 and 1998, the KFF report indicates that promotional spending by manufacturers increased an average of 15.2% annually, with the largest increases in direct-to-consumer advertising (53.4% annually over that time period).

Availability of Higher Cost Therapies. The number of new drugs available on the market has been increasing since the 1980's. For the period 1980 through 1984, the average number of

new drugs approved by the Food and Drug Administration (FDA) in each year was 19.0. For the period 1989 through 1994, the average number of new drugs approved increased to 25.2. Between 1995 and 1998, the average number had increased to 37.5.

Spending on research and development has resulted in the development of drug therapies for a number of conditions for which drug treatment was previously not available, such Alzheimer's disease, cancer and AIDS. Other drugs are being developed that represent improvements to older therapies, including treatment of hypertension, ulcers and depression. The Pharmaceutical Research and Manufacturers of America (PhRMA) reports that total expenditures for research and development by major pharmaceutical manufacturers increased from $2.0 billion in 1980 to $21.1 billion in 1998. PhRMA indicates that the percent of sales spent on research and development has also been increasing, from 8.9% in 1980 to 16.9% in 1998.

The increase in the number of new drugs approved is also the result of changes in the FDA's drug approval process that have been implemented in the 1990s. The average length of time for a new drug to be approved has decreased from 2.7 years in 1986 to 1.0 year in 1998. This is partly the result of enactment of the 1992 federal Prescription Drug User Fee Act, which authorized the FDA to charge manufacturers a fee for approval of new drugs. The FDA increased the number of reviewers and support staff at the Center for Drug Evaluation and Research, the agency responsible for review and approval of new drugs, by several hundred to expedite the review process.

Cost increases occur when individuals switch from lower cost therapies to the newer, higher priced therapies. For example, Prozac, the first of a new class of drugs to treat depression, has an average cost per day of $2.12. Prozac is currently under patent protection. The average cost of Elavil, a brand name drug that treats depression, but is no longer under patent, is $0.71 per day. The prescription drug costs for an individual would increase by approximately 300% if that individual switches from Elavil to Prozac. Prozac's patent protection will expire in August of this year. As a result, it is expected that generic forms of Prozac will be available later this year, which will reduce the cost of Prozac. If individuals currently prescribed Prozac do not switch to higher cost drugs under patent protection, then these individuals' drug costs would decrease. However, if these individuals switch to newer therapies to treat depression, drug costs for these individuals would not decrease and may instead increase.

While a drug is still on patent, the pharmaceutical manufacturer can charge any price for that drug. Once a drug is no longer on patent, the market determines the price of a prescription drug. The differences in prices between newer therapies on patents and older therapies that are no longer under patent can be significant, as shown in the example described above. Attachment 1 to this paper is a table included in Factors Affecting the Growth of Prescription Drug Expenditures, published by the National Institute for Health Care Management, July, 1999. The attachment identifies the price of new drugs, compared with older therapies used to treat a variety of conditions.

Price Inflation. According to the KFF report, increased prices charged by manufacturers, wholesalers or pharmacies have had less of an effect on increased prescription spending than other factors. The report indicates that between 1996 and 1998, inflation for existing drugs increased between 1.6% annually and 3.2% annually. However, the increase in the average price per prescription increased between 6.5% and 9.2% annually for that same time period as a result of the other trends described above.

Cost and Utilization Control Features

There are several features that could be incorporated into a prescription drug assistance program that could partially offset some of the trends described above. Many of these features are used in MA to control expenditures.

Formularies. The use of formularies by private insurance plans is one effective way to reduce the use of higher cost drugs when lower cost alternatives are available. Formularies are the list of drugs that are covered by the plan. Closed formularies may not cover the cost of higher-priced drugs when less costly alternatives are available. Formularies can also be used in conjunction with copayments to encourage the use of lower cost therapies. For example, a private insurance plan may require copayments of $5 for each generic prescription. Copayments of $15 would be required for brand name drugs if included on the plan's formulary, or 50% of the cost of the drug if not included on the plan's formulary.

Federal law requires MA programs to cover drugs manufactured by companies that enter into rebate agreements with HCFA on behalf of the states. Therefore, states are prohibited from establishing closed formularies under MA.

Prior Authorization and Therapeutic Substitution. Prior authorization can be used to encourage the use of lower cost alternatives when such alternatives are available. Prior authorization is a feature in many health care plans, including MA, that requires the pharmacy to obtain prior approval from a plan before it provides a product or service in order to receive reimbursement for that product or service.

Under Wisconsin's MA program, pharmacists are required to receive approval of certain drugs from DHFS before they may be reimbursed. This may be done electronically for most drugs. According to DHFS, prior authorization is used to: (a) prevent potential drug abuse or misuse; (b) prohibit reimbursement for drugs used for cosmetic purposes only; (c) encourage the use of therapeutically equivalent drugs when generics are available in that classification.

Under MA, the use of prior authorization to encourage the use of therapeutically equivalent drugs has been targeted to certain classes of drugs. Under this targeted use of prior authorization, approval will only be provided if the pharmacist can indicate that the patient has already tried one of the therapeutically equivalent, lower-cost drugs. If the individual had tried one of the other alternatives and had an adverse reaction or it was not effective, then the prior authorization is granted. The prior authorization transaction occurs on-line and in real time,

meaning that the pharmacist is able to request prior authorization through an on-line computer system. The system is designed to provide a response to the pharmacist almost immediately.

Use of prior authorization in this way has provided some dramatic results. In September, 1999, DHFS implemented targeted prior authorization of Axid and Pepcid, two brand name drugs that are used to treat ulcers. In order to receive approval of Axid or Pepcid, a patient must have tried and failed two other medications, Ranitidine or Cimetidine, for 30 days or had an adverse reaction to either of these drugs. Ranitidine and Cimetidine are generic drugs in the same class as Axid and Pepcid. DHFS reports that since this change was made, prescriptions for Pepcid and Axid decreased over 65%. Expenditures in this category increased by 1.4% from 1998-99 to 1999-00 despite an 11.9% increase in the number of prescription drugs dispensed. DHFS estimates that the use of prior authorization in this instance saved the MA program over $1.0 million in its first year.

DHFS has also used targeted prior authorization for a certain type of pain-reliever, non-steriodal anti-inflationary drugs (NSAIDs), effective July 15, 2000. In 1999, MA spent over $6.5 million on NSAIDs. For the period January through March, 2000, the average cost of generic NSAIDs was approximately $11, while the average cost for a brand-name NSAID was over $60. Therefore, to the extent prior authorization encourages an increase in the use of generic NSAIDs, the potential savings to MA could be significant.

Because of the potential savings available through the use of targeted prior authorization, as demonstrated in MA, any proposal should provide the administering agency the authority to generate savings through therapeutic substitutions.

Generic Substitution. Under state law, pharmacists may provide a generic substitute in place of a brand name drug without permission from a patient's physician unless the physician indicates the brand name drug is medically necessary. Under MA, such substitution is required, unless the prescribing physician hand writes on the prescription form that the brand name is medically necessary. As a result, MA's use of generic drugs compared with brand name drugs has been much lower than most other plans. Approximately two-thirds of drugs reimbursed under MA are generic drugs, although more recently the portion has decreased due to the increasing availability of newer drugs not available in generic form. Other plans, including other state prescription drug assistance programs and private health care plans that do not require automatic generic substitution, typically experience generic use of approximately 40%.

Some individuals are concerned that generics are not as safe or effective as brand name drugs. According to the FDA, generic drugs contain exactly the same active ingredients as the brand name counterpart and are just as safe and effective. The FDA indicates that approval of generic drugs requires substantially the same level of review as its approval for brand name drugs. For example, the FDA indicates that a firm seeking to sell a generic drug must show that its drug delivers the same amount of active ingredient in the same timeframe as the original product. The FDA further indicates that there is no evidence that generic drugs cause more side effects than the brand name counterpart. The FDA indicates that it monitors reports of adverse

drug reactions and has found no difference in the rates of adverse reactions between generic and brand-name drugs. Attachment 2 to this paper is a copy of an article published by the FDA's Center for Drug Evaluation Research that describes the review process for approval of generic drugs and addresses certain myths about generic drugs.

Drug Utilization Review. Federal law requires MA programs to have a drug utilization review (DUR) program. There are three components to a DUR program: (1) prospective DUR; (2) retrospective DUR; and (3) and education.

Prospective DUR assists pharmacists in screening certain drug categories for potential drug therapy problems. These problems include therapeutic duplication, drug interactions, early and late refills, cumulative side effects, contraindications for pregnancy, certain diseases and specific ages. Prospective DUR is required before a drug is dispensed. Information provided by the MA program is available to the pharmacist through the on-line system.

Retrospective DUR provides for ongoing periodic examination of paid claims data and other records to identify patterns of fraud, abuse, overuse and inappropriate or medically unnecessary care associated with specific drugs or groups of drugs.

The third component, education, is used by DHFS to educate prescribing professionals and pharmacists on common drug therapy problems to improve prescribing and dispensing practices. The MA program convenes a board of practicing physicians and pharmacists from around the state to review and approve all criteria used for both prospective and retrospective DUR.

Any drug assistance program should include a DUR component to assist in managing program costs and to help to ensure that the drugs purchased under the program are being used safely, effectively and appropriately.

Other Provisions

Several other issues should be considered that would affect the Legislature's commitment to fund increasing costs.

Sum Sufficient versus Waiting Lists. A proposal could either provide funding from a sum certain appropriation or a sum sufficient appropriation. If a sum certain appropriation is provided, expenditures under the program are limited to the amounts appropriated by the Legislature. If a sum sufficient appropriation is provided, expenditures are not limited to any amount other than the amounts necessary to meet the needs of the program.

The use of a sum sufficient appropriation would ensure that any individual that is eligible to participate and applies would be enrolled in the program. However, if a sum sufficient appropriation is created, there could be significant risk to the general fund, since the estimated cost of any proposal is considerably uncertain. Much of the data that has been used to estimate the projected costs of proposals is up to five years old and therefore does not reflect the most

recent trends discussed above. Additionally, the data is primarily based on national data extrapolated to Wisconsin. Therefore, the estimated costs of any proposal could be significantly over or under the actual costs. The draw on the state's general fund could be significant if actual costs exceed projections.

A sum certain appropriation minimizes the risk to the state's general fund because the amounts spent would be limited to the amounts appropriated by the Legislature. However, it is not clear what would happen if actual costs exceed projections if a sum certain appropriation is provided. If costs exceed projections and the Legislature does not appropriate additional funding, it is presumed that DHFS would have to establish waiting lists so that expenditures do not exceed the amounts appropriated for the program.

Limits on Benefits. An alternative to the use of waiting lists would be the use of limits on benefits. The Committee could authorize DHFS to place limits on the amount of benefits available per person should actual costs exceed the amounts appropriated. Using this authority would be one way to ensure that everyone that would apply and be found eligible would receive some assistance, but would ensure that the program would be able to stay within budget.

Alternatively, if a sum certain appropriation is provided and no provision specifying whether waiting lists or limits on benefits are authorized, it is unclear what would happen. For two programs established in the 1997-99 biennial budget where expenditures exceeded the amounts budgeted, the Legislature provided additional funding to prevent the use of waiting lists or reducing eligibility limits. The Joint Committee on Finance has twice transferred additional funding for kinship care in order to address waiting lists in certain counties. Additionally, 2001 Wisconsin Act 1 provided an additional $11.2 million GPR for BadgerCare to ensure that the eligibility limit for the program was not reduced. If such a situation occurs in a prescription drug program, the Legislature could address such a problem by appropriating additional funds or modifying the program.

Federal Action

It is not known whether Congress will act to address the demand for prescription drug coverage for Medicare beneficiaries in the current session. The President has proposed the creation of a block grant program to states that could be used to create prescription drug assistance plans in each state or be used in conjunction with existing programs in those states that already have such programs. Congress appears poised to address the program at the federal level rather than a state-based approach. However, there is much disagreement among members of Congress in terms of the approach such action should follow.

If any proposal enacted by the Legislature specifies that the program would be a payer of last resort, any drugs purchased under the program would first be reimbursed under a Medicare benefit or other federal program and only costs not reimbursed by Medicare or other federal program would be paid under the state program. This is consistent with the MA program, which

is a payer of last resort. For individuals eligible for both MA and Medicare, Medicare is first billed for services and MA only pays for those services that are not reimbursed under Medicare.

A proposal could be developed that would require DHFS to submit a report to the Governor and the standing committees of the Legislature if it certifies that a federal benefit is available that provides substantially the same coverage as available under the state program. The report could provide a comparison of the federal benefit and the benefit available under the state program and identify options for modifying or repealing the state program in order to conform with the federal benefit.

Another option would be to specify that any state program would sunset if DHFS certifies that a federal benefit is available that provides substantially the same benefit and coverage as the state program.

ATTACHMENT 1

Price of New Drugs Compared to Old Drugs, by Therapeutic Category, 1998

Therapeutic Category	Top Two New Drugs in Therapeutic Category	Price of New Drug	Average Price of Old Drugs	Price of New Drug Relative to Average Price of Older Drugs
Antidepressants	Zoloft	$76.08	$48.82	155.8%
	Paxil	$70.59		144.6%
Anti-ulcerants	Prevacid	$112.46	$86.99	129.3%
	Prilosec	$122.80		141.2%
Antibiotics, broad based	Zithromax	$39.19	$25.99	150.8%
	Cefzil	$57.53		221.3%
Cholesteral reducers	Lipitor	$75.59	$71.89	105.1%
	Zocor	$98.26		136.7%
Calcium blockers	Norvasc	$55.64	$49.57	112.3%
	Sular	$33.29		67.2%
Antihypertnensive drugs	Cozaar	$49.64	$40.03	124.0%
	Diovan	$44.64		111.5%
Beta-blockers	Coreg*	$89.32	$26.49	337.1%
Sex hormones	Prempro*	$28.10	$26.53	105.9%
Oral antidiabetics	Glucophage	$48.54	$27.27	178.0%
	Rezulin	$142.82		523.8%
Antihistamines	Claritin	$61.79	$65.27	94.7%
	Zyrtec	$51.57		79.0%
Analgesics, non-narcotic	Imitrex	$153.58	$20.64	744.2%
	Ultram	$42.15		204.2%
Oral contraceptives	Desogen*	$27.02	$29.57	91.4%
Bronchodilators	Serevent*	$60.75	$27.54	220.6%

Therapeutic Category	Top Two New Drugs in Therapeutic Category	Price of New Drug	Average Price of Old Drugs	Price of New Drug Relative to Average Price of Older Drugs
Antiseizure	Neurontin	$97.15	$44.16	220.0%
	Lamictal	$167.50		379.3%
Respiratory steroids (inhaled)	Flonase	$46.95	$51.48	91.2%
	Rhinocort	$36.63		71.2%
Antipsychotics	Zyprexa	$242.66	$42.12	576.1%
	Risperdal	$141.58		336.1%
Fungicides	Lamisil	$182.01	$31.22	582.9%
	Sporanox	$195.65		626.6%
HIV Antivirals	Viracept	$516.03	$318.68	161.9%
	Zerit	$252.77		79.3%
Oral cold preparations	Claritin 12 hour	$48.76	$17.30	$281.8%
	Allegra - D	$41.85		241.8%

*Note: Only one new drug introduced between 1993 and 1998 in therapeutic category.

Source: Barents Group LLC analysis of Scott-Levin Source Prescription Audit Data.