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Disease Aids (DHFS)

[LFB Summary of the Governor's Budget Reform Bill: Page 55, #13]

CURRENT LAW

The Wisconsin chronic disease program (WCDP) funds medical services for eligible state residents with end-stage 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 $792 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 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. To ensure that needs for treatment of patients with lower incomes receive priority within the availability of funds, DHFS is required to revise the coinsurance schedule every three years.

The following services are eligible for reimbursement under the disease aids program.

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.

Generally, the disease aids program is considered the payer of last resort. However, there are no requirements that participants apply for other programs for which they may be eligible prior to enrolling in the disease aids program. 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 the program.

GOVERNOR

Modify the disease aids program to reduce state program costs, as follows:

Waiting lists. Authorize DHFS to establish waiting lists for enrollment in the disease aids program if the amounts that are available for disease aids are insufficient to provide assistance to all persons who are eligible to receive assistance. Authorize DHFS to assign priorities to persons who are on waiting lists, based on criteria that DHFS would promulgate by rule.

Rates for Kidney Disease Services. Repeal the current requirement that the state pay for services provided under the kidney disease program at rates equal to the allowable charges under the federal Medicare program.

Payer of Last Resort. Specify that assistance under the WCDP may only be provided to an individual if he or she has applied for assistance under all other state-funded health care assistance programs for which the person may be eligible. Require DHFS to promulgate rules to

define these other state-funded health care assistance programs, but specify that these programs would include medical assistance, the heath insurance risk-sharing plan, BadgerCare, SeniorCare and any other state-funded programs under which assistance may be payable for the treatment of kidney disease, cystic fibrosis or hemophilia. In addition, for the treatment of cystic fibrosis, specify that costs would be reimbursed for treatment, only if those costs are not reimbursable under Medicare or private health insurance.

Rules. Require DHFS to promulgate rules to contain the costs of assistance under the disease aids program. Provide that the rules could include managed care requirements.

DISCUSSION POINTS

Program Participation and Costs

1. In 2000-01, 6,802 persons were enrolled in the WCDP, including 6,473 individuals with chronic renal disease, 182 individuals with hemophilia and 147 individuals with cystic fibrosis. Approximately 41% of persons enrolled in the program received state-funded benefits in 2000-01, the rest either incurred no expenses that were covered under these programs, 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.

The table on the following page shows information on fiscal year 1999-00 program costs 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 90% of persons for whom claims were submitted lived in families with income less than $30,000 and over 90% of state-funded benefits were provided to these enrollees.

Wisconsin Chronic Disease Program
Participation by Income Range
Fiscal Year 1999-00

Income Range (Annual $)	Participants: Number	Participants: Percent of Total	Participants: Cumulative Percent	Expenditures: State Costs	Expenditures: Percent of State Costs	Expenditures: Cumulative Percent
$0-10,000	1,007	38.6%	38.6%	$1,015,859	24.7%	24.7%
$10,001-20,000	953	36.5	75.1	1,880,183	45.7	70.4
$20,001-30,000	410	15.7	90.8	827,550	20.1	90.5
$30,001-40,000	171	6.6	97.4	287,546	7.0	97.5
$40,001-50,000	43	1.6	99.0	72,867	1.8	99.2
$50,001-60,000	16	0.6	99.6	22,440	0.5	99.8
$60,001-70,000	5	0.2	99.8	8,051	0.2	100.0
$70,001-80,000	2	0.1	99.9	14	0.0	100.0
$80,001-90,000	2	0.1	100.0	975	0.0	100.0
$90-001-100,000	0	0.0	100.0	0	0.0	100.0
Over $100,000	1	0.0	100.0	458	0.0	100.0
Total	2,610	100.0%		$4,115,943	100.0%	

3. Over the years, it has been difficult to project program expenditures because of annual changes in caseload and average care costs. For example, the average reimbursement for an individual enrolled in the hemophilia program was $1,718 in 2001. However, DHFS recently had a claim for over $600,000 for a two- to three-day supply of a blood clotting factor. While DHFS has determined that most of the costs of this claim will be covered under Medicare, this claim demonstrates how unpredictable program costs are.

4. Historically, DHFS has administered the WCDP as an entitlement program. While DHFS has, and continues to, implement changes to reduce program costs, DHFS has sought supplemental funding when necessary to ensure that all persons who are eligible for benefits receive covered services. In fact, when the chronic renal disease program was created by Chapter 308, Laws of 1973, it was funded from a sum-sufficient appropriation. Chapter 308 included a provision that remains in current law that expresses the Legislature's intent to "assure that all persons are protected from the destructive cost of kidney disease treatment by one means or another."

5. 2001 Wisconsin Act 16 (the 2001-03 biennial budget act) provides a total of $9,864,000 GPR to fund the disease aids program in the 2001-03 biennium. DHFS estimates that $10,626,500 will be required to fully fund the program for the 2001-03 biennium, or $762,500 more than the amount budgeted for the program.

6. In its 2001-03 biennial budget request, DHFS had projected a need for additional funding for the WCDP. Instead of providing addition funding, the Governor included a provision in his 2001-03 biennial budget that would have authorized DHFS to revise the sliding scale to determine patient liability for costs as frequently as necessary to ensure that needs for treatment of

patients with lower incomes receive priority within the amounts budgeted. Currently, DHFS is required to review and revise the scale every three years.

7. The Legislature deleted the Governor's recommendation and required DHFS to implement a drug rebate program for the WCDP as a means of reducing state program costs. At the time, it was estimated that DHFS would collect $923,600 in rebate revenue in the 2001-03 biennium to offset costs that would otherwise be funded with GPR.

8. DHFS staff continue to work at implementing the drug rebate program. Currently, DHFS estimates that the rebate will generate net savings of $450,000 in 2002-03, and $600,000 annually, thereafter.

Waiting Lists

9. To ensure that program costs do not exceed current funding budgeted for the program, the Governor included a provision that would authorize DHFS to establish waiting lists for the program if DHFS determines that funding is insufficient to meet projected program costs.

10. DHFS staff do not anticipate having to place individuals on waiting lists for the program at this time. Instead, DHFS staff expect other cost saving measures included in the bill, including allowing DHFS to reduce reimbursement rates for kidney disease services and strengthen the current provisions that establish the WCDP as a payer of last resort, would reduce program costs. In addition, DHFS staff are currently working on implementing other cost saving measures for the program that are described under Discussion Point #13.

11. While DHFS staff do not believe that it will be necessary to establish waiting lists in the 2001-03 biennium, it is possible that this will be necessary in 2001-03 and future biennia. Because the program is a payer of last resort, persons on a waiting list would probably have few opportunities to receive services elsewhere. Some may receive hospital services through charity care, others may be eligible for benefits from SeniorCare, the state's new drug assistance program for persons over the age of 65, which will begin offering benefits to enrollees on September 1, 2001. However, others may not be eligible for other publicly-funded programs.

12. Another option the Committee could consider, either instead of, or in addition to authorizing waiting lists, would be to restore the Governor's 2001-03 biennial budget proposal that would permit DHFS to review and revise the sliding scale to determine patient liability as frequently as necessary to ensure that the needs for treatment of patients with lower incomes receive priority within the amounts budgeted. This proposal would allow DHFS to review the coinsurance amounts, as needed, to ensure that eligible individuals would continue to receive assistance, but enrollees may have to contribute a higher proportion of their income to the cost of treatment.

13. DHFS is currently investigating a number of ways to reduce costs under the program, including: (1) increasing the current co-payment for drugs from $1 to $3 for generic drugs and $10 for brand-name drugs (this change is expected to reduce state costs by $240,900 annually); (2) reviewing covered drugs to see if there are less expensive, generic drugs available; (3) requiring

applicants to provide documentation to support status as a Wisconsin resident; and (4) trying to find less expensive suppliers for nutritional supplements.

14. The options that DHFS is pursuing could reduce program costs significantly, but it is not known how much savings would result from implementing these initiatives.

15. The program is funded from a biennial appropriation, which enables DHFS to fund costs in 2001-02 with funding appropriated in 2002-03 if 2001-02 costs exceeds the amount budgeted in that year. The Committee could delete the Governor's recommendation to authorize waiting lists for the program, and review potential funding needs next year when more information will be available about rebate revenue available to offset state costs and the effectiveness of other cost savings measures DHFS expects to implement.

Rates for Kidney Disease Services

16. The bill would repeal the current requirement that the state pay for services provided under the kidney disease program at rates equal to allowable charges under the federal Medicare program. This provision would allow DHFS to reduce reimbursement rates as a means of reducing program costs. Because DHFS staff have not determined what the revised rates would be, it is not possible to estimate the savings that would result from this provision.

17. Health care providers would likely oppose lower reimbursement rates. Further, DHFS staff indicate that, in some instances, providers are billing participants for the difference between DHFS reimbursement rates and the providers' usual and customary charges, despite the current statutory limits on the amount individuals are required to contribute toward the cost of their treatment.

18. The practice of "balance billing" would likely increase if reimbursement rates under the program were reduced. Therefore, the Committee could modify the bill to prohibit this practice of "balance billing" to specify that providers may not require enrollees to contribute to the cost of services they receive, other than to pay copayments and coinsurance amounts determined by DHFS.

Payer of Last Resort

19. The bill would specify that assistance may only be provided if an individual has applied for assistance under all other state-funded health care assistance programs for which the person may be eligible. DHFS would be required to promulgate rules to define these other state-funded assistance programs, but would specify that these include medical assistance, the health insurance-risk sharing plan (HIRSP), BadgerCare, SeniorCare and any other state-funded programs under which such assistance may be available. In addition, for treatment of cystic fibrosis, the bill provides that only costs that are not reimbursable under Medicare or private health insurance would be reimbursed.

20. While the current disease aids program 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 the disease aid program offers limited services, individuals that are eligible for other programs would likely receive more comprehensive care under those programs than under the disease aids program. In addition, the extent to which individuals may be eligible for other programs could reduce overall state costs because the other health care programs are not fully supported with GPR, as under the disease aids program.

21. There could be some problems with the proposal to require individuals to apply for HIRSP before they apply for assistance under the disease aids program. Under HIRSP, there is a six-month waiting period before individuals with pre-existing conditions can become eligible. In addition, there is some concern that individuals may not be able to afford HIRSP premiums. For these reasons, the Committee could modify the Governor's bill to delete the requirement that individuals apply for HIRSP before they are considered eligible for the disease aids program.

Rules

22. The bill would require DHFS to promulgate rules to contain the costs of assistance under the disease aids program, and provide that such rules may include managed care requirements. The provision does not specify what managed care requirements would include. DHFS staff indicate that these provisions are intended to enable DHFS to use the same methods that managed care organizations use to contain costs, such as using drug formularies, and does not refer to requiring individuals to join managed care organizations.

23. The rule-making process may take nine months to a year to complete. In order for DHFS to reduce program costs as quickly as possible, the Committee could modify the bill to provide DHFS emergency rule-making authority to implement these changes. 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.

ALTERNATIVES TO BILL

A. Waiting Lists

1. Approve the Governor's recommendation to: (1) authorize DHFS to establish waiting lists for enrollment in the disease aids program if the amount available for disease aids is insufficient to provide assistance to all persons who are eligible; and (2) authorize DHFS to assign priorities to persons who are on waiting lists, based on criteria that DHFS would promulgate by rule.

2. Delete the provisions in the bill regarding waiting lists.

3. In addition to either A1 or A2, authorize DHFS to review and revise the sliding scale to determine patient liability as frequently as necessary to ensure that the needs for treatment of patients with lower incomes receive priority within the amounts budgeted.

B. Rates for Kidney Disease Services

1. Approve the Governor's recommendation to repeal the current requirement that the state pay for services provided under the kidney disease program at rates equal to allowable charges under the federal Medicare program.

2. Delete the provisions in the bill regarding rates paid for kidney disease services.

3. In addition to either B1 or B2, prohibit health care providers participating in the disease aids program from collecting any reimbursement for services other than the copayments and coinsurance amounts established by DHFS.

C. Payer of Last Resort

1. Approve the Governor's recommendation to: (1) specify that disease aid assistance may only be provided if an individual has applied for assistance under all other state-funded health care assistance programs for which the person may be eligible; (2) require DHFS to promulgate rules to define other state-funded assistance programs, but specify that these programs would include medical assistance, HIRSP, BadgerCare, SeniorCare and any other state-funded programs under which assistance may be available; and (3) provide that for the treatment of cystic fibrosis, only costs that are not reimbursable under Medicare or private health insurance would be reimbursed.

2. Modify the Governor's recommendation to eliminate the requirement that persons that apply for disease aids first apply for HIRSP.

3. Delete the provisions in the bill relating to the disease aids program as a payer of last resort.

D. Rules

1. Approve the Governor's recommendation to promulgate rules to contain the costs of assistance under the disease aids program, and require those rules to include managed care requirements.

2. Delete the Governor's provisions relating to the Department's authority to promulgate rules to contain costs in the program, including the explicit authority to include managed care requirements in the rules.

3. In addition to D1 or D2, modify the Governor's recommendation to grant DHFS emergency rule making authority for all provisions in the bill relating to the Departments rule-making authority under the disease aids program.

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ATTACHMENT

Patient Coinsurance Liability for the Direct Cost of Treatment

Annual	Percent of Charges for Which Patient is Liable, by Family Size									
Family Income	1	2	3	4	5	6	7	8	9	0
$0 - 7,000	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
$7,001 - 10,000	2	1	0	0	0	0	0	0	0	0
$10,001 - 15,000	4	2	1	0	0	0	0	0	0	0
$15,001 - 20,000	7	4	2	1	0	0	0	0	0	0
$20,001 - 25,000	11	7	4	2	1	0	0	0	0	0
$25,001 - 30,000	14	10	7	5	3	2	1	0	0	0
$30,001 - 35,000	17	13	10	8	6	4	2	1	0	0
$35,001 - 40,000	20	16	13	11	9	7	5	3	2	1
$40,001 - 45,000	24	19	15	13	11	9	7	5	3	2
$45,001 - 50,000	29	24	20	17	15	13	11	9	7	5
$50,001 - 55,000	34	29	25	21	19	17	15	13	11	9
$55,001 - 60,000	39	34	29	25	23	21	19	17	15	13
$60,001 - 65,000	44	39	34	30	28	25	22	20	18	16
$65,001 - 70,000	49	44	39	35	32	29	27	25	23	21
$70,001 - 75,000	55	49	44	40	37	34	32	30	28	26
$75,001 - 80,000	61	55	50	46	43	40	37	35	33	31
$80,001 - 85,000	67	61	56	52	49	46	43	40	38	36
$85,001 - 90,000	74	68	63	59	56	53	50	47	45	43
$90,001 - 95,000	81	75	70	66	63	60	57	55	53	51
$95,001 - 100,000	88	82	77	73	70	67	64	62	60	58
$100,000+	97	91	86	82	79	76	73	71	69	67