SENATE BILL 466

Relates to the Health Insurance Risk Sharing Plan (HIRSP).

- I have prepared talking points for you on this bill.
- Representative Underheim held a hearing on the Assembly companion bill on 2-17-04.

W.A.L.H.I.

Wisconsin Association of Life & Health Insurers

SB466

Memorandum

DATE: February 19, 2004
TO: Members, Senate Health, Children, Families, Aging & Long Term Care Committee.
FROM: Pat Osborne, on behalf of WALHI
RE: WALHI Support for Senate Bill 466

The Wisconsin Association of Life and Health Insurers supports Senate Bill 466 and has been working on this legislation in an effort to help control costs in the HIRSP program and provide for a broader funding base.

BACKGROUND

The HIRSP Program serves as the insurer of last resort for state residents unable to obtain insurance in the individual market due to pre-existing medical conditions or other eligibility factors. It is an important component of the state's overall policy of promoting access to health care coverage. However, the current program is faced with significant increases in enrollment and costs that demand the attention of the Governor and the State Legislature. Since 1998 enrollment has grown from 7,200 to over 17,000 in 2003. Claim costs have nearly tripled in this same time period.

The program is currently funded by premiums paid by enrollees (60%), assessments levied on insurers (20%) and discounts provided by medical providers (20%). The State of Wisconsin provides no general-purpose revenue to support the program as a result of budget reductions of $10.2 million per year in the 2003-05 biennial budget.

The combination of cost increases and elimination of state GPR places a disproportionate burden on those insurers and providers who currently support 40% of total program costs. Insurer assessments alone have increased from $10 million in FY 2001 to $26.4 million in FY 2003 — and will significantly increase again in FY 2004, to an estimated $35.4 million. These costs end up being shifted to the private market, including the small group market, which is already facing premium cost pressures.

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SUPPORT SB 466

WALHI supports SB 466, particularly as it relates to the following key provisions.

- **Restore Governing Authority to the HIRSP Board of Governors**. The bill would transfer administrative and decision-making authority back to the Board of Governors and provide full rule-making authority to the Board including emergency rules. HIRSP is an insurance program and we feel this governance structure will enable it to operate more efficiently as an insurance program.

- **Eliminate Statutory Language Setting Benefits, Co-pays and Deductibles.** The bill authorizes the Board to set benefit design by rule. It also requires the Board to conduct a survey of existing standard plans and make adjustments to the HIRSP program at least every three years. This would allow for more flexibility in plan design and better utilization of contemporary cost saving plan features. The current benefit design has not been significantly updated since the program was established in 1979, while the health insurance market has changed dramatically since then.

- **Broaden the Assessment Base by Including an Assessment on Drug Manufacturers.** Increases in drug costs and utilization of drugs have contributed significantly to increases in overall program costs. Drug costs are currently estimated to comprise 1/3 of total claim costs in 2004. Accordingly, drug manufacturers should provide an equitable share of program funding. Under SB 466, an assessment on drug manufacturers would be collected equal to the rebate amount the drug manufacturers provide under Medical Assistance. Drug rebates under MA are approximately 21 percent of the amount paid for drugs in MA. Under the current HIRSP program, drug rebates are roughly three to four percent of total drug costs and 45% of that 3 to 4% goes to PBM administration rather than reducing program costs. In FY 2003, total drug rebate revenue in HIRSP was $1,084,409 or 3.3% of drug claims of $32.5 million. The HIRSP program received $596,425 of the $1,084,409 in total rebates for that year.

- **Means Test Premium Based on Household Income.** Enrollees with household income over $100,000 should pay more than a 60% share of premium. Under SB 466, additional premium revenue generated by high-income enrollees would be used to help fund additional premium subsidies for eligible low-income enrollees.

OTHER CONSIDERATIONS

In addition to the provisions in SB 466, we believe that other base broadening funding issues should be considered. Particularly the following:

- **Modify the Insurance Assessment to More Equitably Assess Stop-loss Carriers.** Roughly one-half of the insured in Wisconsin are covered under self-insured plans. Under the federal ERISA law, the state is restricted from directly assessing self-insured plans to support HIRSP. As a result, half of the insurance market is paying nearly 100% of the insurance assessment. In turn, the state's small group market is bearing the brunt of the HIRSP tax. A more equitable assessment on stop loss carriers could be adopted, which would provide for indirect contribution from the self-insured market.

- **Restore the State ~~GPR C~~ommitment to the Program.** The State should be an active partner in funding a portion of the HIRSP Program. GPR support should be restored, particularly as it relates to subsidizing the premium costs of low-income enrollees. In FY 1999 and FY 2000, GPR represented roughly 25% of program costs. State support decreased in each of the following years until it was totally eliminated in the 2003-05 biennial budget bill.

We appreciate your interest in these matters and look forward to working with you on this bill and the future of the HIRSP Program.

WEA TRUST

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February 19, 2004

The Honorable Carol Roessler
Chair, Senate Health Committee
Room 8 South
P.O. Box 8953
Madison, WI 53708

RE: Support for Senate Bill 466—HIRSP Reform Legislation

Dear Senator Roessler:

Thank you for your leadership and assistance in working to reform the Health Insurance Risk Sharing Plan (HIRSP). We write in support of Senate Bill 466.

We believe HIRSP is necessary and important to the citizens of this state, and we strongly support it. However, we also believe HIRSP is in desperate need of reform.

As you know, HIRSP is an insurance program of last resort for individuals—a safety net for people who, through no fault of their own, have lost or are no longer eligible for their private health insurance coverage. HIRSP was created by the Legislature in 1980 to make health insurance available to individuals who could not obtain coverage in the private marketplace. In 1997, the Legislature designated HIRSP as Wisconsin's Health Insurance Portability and Accountability Act (HIPAA) compliance program for individuals who lose their employer-sponsored group health insurance coverage.

We are all well aware of the fiscal constraints the state has been facing lately and the difficult funding choices before the Legislature. The Legislature made the decision during this last budget cycle to entirely eliminate all remaining state GPR support of HIRSP. Now it is time to let those of us who have a vested interest in HIRSP help to reform it.

The HIRSP program has experienced explosive growth since 1999 when enrollment was 7,904 individuals to the current enrollment of more than 17,000 individuals. During the same time period, the HIRSP program expenditures went from $47.2 million in 1999 to the current year budget of approximately $170 million. These numbers underscore the urgent need to reform this program. These increases not only negatively affect the insurers and providers in Wisconsin, but more acutely, they adversely affect the enrollees of the program that bear 60% of the program costs. These costs will continue to rise rapidly as the health care cost crisis causes the number of businesses, large and small, that cut back on or eliminate their employer-based health care coverage to increase.

One contributing factor to the skyrocketing costs of HIRSP is the dramatic increase in drug costs and utilization. Drug expenditures for HIRSP now represent approximately 35% of a near $170 million program. Ironically, the current funding formula for HIRSP does not include a required contribution from drug manufacturers, yet this industry reaps a direct benefit from the increased drug utilization in the program. In 2002, HIRSP received a modest supplemental rebate of $548,000—equal to approximately $1 per prescription. The time has arrived for a more equitable cost-sharing formula to alleviate some of the burden on Wisconsin businesses currently being assessed to fund the HIRSP program.

The proposal before you today makes several changes to the HIRSP program and is supported by a wide variety of Wisconsin employers including insurers, hospitals, physicians, and small businesses.

First, the proposal restores authority to the HIRSP Board of Governors to manage the program and transfers administrative responsibilities from DHFS to the Board. The Board selects the chair, and it continues to be attached to and staffed by DHFS for administrative purposes.

Second, it provides for an assessment of drug manufacturers to help pay for the costs of HIRSP. A representative of PhRMA would be added to the Board.

Third, the Board is granted full administrative rule-making authority. The proposal allows the Board to select the plan administrator through a competitive bid process, and they may also contract for professional services as needed.

Fourth, the proposal authorizes the Board to establish a premium rate schedule for enrollees with household income over $100,000. All additional premiums must be used to supplement the low-income subsidy for premium and deductibles.

Fifth, the bill requires that two or more insurers must reject an individual to establish eligibility. Current law requires only one rejection.

Sixth, the proposal requires DHFS to initially verify that a person is not eligible for employer-sponsored coverage and to periodically check on eligibility status. Additionally, the proposal requires DHFS to maintain a database of such information and to submit quarterly reports to the Board.

Lastly, the proposal requires that any federal grant money received by the state for a high-risk pool must be used to buy down HIRSP costs. Grant dollars are applied first before determination of premium, insurer and drug manufacturer assessment, and provider discounts.

HIRSP is an insurance program that should be allowed to operate as such—applying proven administrative efficiencies and utilizing cost-containment mechanisms. Current statutory constraints prevent the Board from making significant program design changes in order to positively affect the efficiency and cost effectiveness of this program. We strongly urge you and the Committee to support the proposal before you today.

Again, thank you for your leadership on this very important issue. Please feel free to contact either one of us if you have any questions or need additional information. We look forward to working with you and the Committee to reform this vital program.

Sincerely,

Alan J. Jacobs
Executive Director

Sandra Lonergan
External Relations Specialist

AJ/SL/sp

cc: Members, Senate Committee on Health

Jim Doyle
Governor

Helene Nelson
Secretary

State of Wisconsin

Department of Health and Family Services

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Testimony Delivered at February 19, 2004
Senate Committee on Health, Children, Families, Aging and Long Term Care

Good morning chair and committee members,

My name is Mark Moody. I am the Administrator of the Division of Health Care Financing. I am also Chairman of the HIRSP Governing Board. I am here to provide information about the HIRSP program and the administration's position on several key provisions of the bill.

Background

HIRSP is a very important part of Wisconsin's overall health insurance market and safety net. People covered by HIRSP cannot get coverage in the private market but have too much income or assets to qualify for public programs like Medicaid or BadgerCare. Catastrophic medical expenses are a leading cause of personal bankruptcy in the US. According to a national study by Norton's Bankruptcy Advisor, 40% of bankruptcy filings in 1999 – approximately 500,000 - were due to huge medical expenses.

Nationally, about 1 to 2% of the population is both uninsured and uninsurable

There are 31 high-risk pools nationwide. As of December 2001, Wisconsin's was fifth in total enrollment behind Minnesota, Texas, California and Illinois (in that order).

A 1998 study by the Urban Institute concluded that high-risk pools contribute to keeping health insurance markets competitive, insurance rates more affordable and help reduce Medicaid enrollment and increase private coverage. In other words, the benefits of risk-pools inure to more than HIRSP policyholders.

By one measure of market concentration, the percent of the market of the largest insurer, Wisconsin has the least concentrated individual insurance market in the US. By another measure of market concentration, the percent of the market of the top three insurers, Wisconsin has the second least concentrated individual insurance market in the US.

A number of states have attempted to solve the problem of the uninsurable by mandating guaranteed issue in the individual market but have had to retreat after their individual markets collapsed.

HIRSP should not be considered "broken". It is in the best condition it has been in many years.

Never the less, the insurance industry which is assessed 20% of HIRSP costs is interested in financial relief to reduce the rate of growth of their HIRSP assessment. In state FY 2004, the insurance industry assessment is $35.4 million, an increase of $9.4 million over 2003. The increases in HIRSP costs in recent years have been driven primarily by the increases in enrollment and by the increases in prescription drug and medical costs experienced by all payors.

Two factors contribute to HIRSP enrollment growth; probable tightening of underwriting criteria in the individual market as insurers look for ways to improve their medical loss ratios and prevailing economic conditions that have resulted in people losing group insurance coverage. In 2002, more than 65% of the people that were approved for HIRSP qualified for HIRSP because the commercial market would not insure them. The remaining 35% qualified under the provisions that make HIRSP the state's solution for complying with federal law protecting people who exhaust continuation coverage after losing their jobs or changing employers.

Cost containment within the HIRSP program can be improved. The new plan administrator contract should address this substantially, but within the current statutory framework.

We have examined and explored a number of options for reducing the burden of the current assessment. The current HIRSP statutes embody a balance of consumer, health care provider, insurer and insurance market interests. While change is possible, virtually any change that improves conditions for one of the parties adversely affects others. For example, broadening the base upon which assessments are levied to include self-funded plans would lower the assessment for some current insurers but increase it for other and potentially increase premiums for self funded plans. Lowering provider rates to the level paid by Medical Assistance could lower policyholder premiums and insurer assessments but would make providers unhappy and potentially reduce the number of participating providers and reduce access for policyholders. Raising deductibles and otherwise altering benefits could save money but reduce coverage.

Specific Bill Provisions

General Principle
By statute, 100% of HIRSP program administration costs are funded by policyholder premiums, provider payment reductions and insurance company assessments, not by DHFS. Any additional administrative costs required by these changes would increase plan administrative costs and would be delegated to the plan administrator and not performed by state staff. The administrative costs of changes that benefit only insurers and providers should not be borne by policyholders.

1. **Assessment on Drug Manufacturers**
   - **Requires a manufacturer to pay an assessment as a condition of having the drug covered**
   - **Apply 100% of assessment revenue to reduce provider and insurer assessments.**

The administration strongly supports assessing drug manufacturers their proportionate share of HIRSP costs. It has been very difficult to find an effective legal basis for assessing them.

The current LRB draft, unfortunately is not workable. It will have the likely effect that some, if not most, manufacturers will refuse to elect to participate. This would result in HIRSP members not getting coverage for some or many drugs.

The only practical way to determine which drugs will be covered would be to execute a contractual agreement so we could know which manufacturers will elect to participate. But under this bill the amount of the contractual discount would vary unpredictably from year to year and would not be knowable at the time the contract is signed, making it less attractive.

Until a sufficient and practical basis for assessing *all* drug companies can be found, the best alternative would probably be through voluntary contractual rebate agreements. The bill could create the requirement that entering such an agreement would be a condition precedent to coverage of a manufacturer's products and set a minimum discount level. It is not, however, possible to know in advance what the effect of any particular discount level would have on manufacturer participation and consequently on consumer access to drugs.

Wisconsin has such a requirement for SeniorCare. For SeniorCare the contractual discount threshold is equal to the CMS rebate level. Of the 472 manufacturers who have signed an MA rebate agreement, 315 manufacturers have signed the SeniorCare supplemental rebate agreement for the eligible population above 200% of the federal poverty level (67%). You need to be aware that not all drug manufacturers would sign a rebate agreement and therefore some drugs would end up not being covered. To illustrate the risk, one specific manufacturer of an immunosuppressant drug typically used post transplant has so far not signed the SeniorCare agreement. And, unlike SeniorCare, policyholders are paying 60% of the premium.

We also oppose allocating 100% of the rebate or assessment revenue to reduce the assessment to insurers and providers, particularly in light of the fact that consumers will bear the consequences of manufacturers' decisions not to participate and their proportionate costs of administration. Currently, policyholders are credited with 60% of the pharmacy rebates. The Department would favor an allocation that applies part of the assessment revenue to reduce policyholder premiums.

Federal policy prevents tying coverage for a plan like HIRSP to coverage under Medicaid so that cannot be used as leverage.

Establishing the "assessment" contractually would also simplify collection activities. The Department would delegate performing the function of computing, billing and collecting the drug manufacturer assessment to the HIRSP plan administrator.

The contract for the HIRSP plan administrator is currently out for bid and we anticipate substantial improvement to the pharmacy cost management and rebate provisions as a result. A SeniorCare-like variant of the current bill would likely increase the rebate revenue, although it would result in fewer drug manufacturers participating.

2. **Transfer administrative responsibilities and decision-making authority from DHFS to the HIRSP Board.**

The Department opposes this proposal.

There is no clear indication how this will address the problem of insurance company assessments. It is unclear what real problem this is intended to resolve and it could actually make accountability and responsibility for the program more confusing. This ambiguity may actually create problems that do not now exist.

The bill proposes to shift administrative authority from DHFS to the HIRSP Board; in essence restoring authority that the Board once had.

For the nine-year period from SFY 1989 until the year HIRSP was transferred from the Office of the Commissioner of Insurance to DHFS in SFY 1998, average policyholder premiums increased by 156%. Insurance assessments increased 350% from $3.7 million to $13 million despite a 43% drop in enrollment. Average claims costs per policyholder increased from $1,700 to almost $6,000 per year. HIRSP enrollment declined dramatically from a high of 12,707 in 1992 to 7,318 in 1997.

HIRSP was in trouble and there was growing concern within the Legislature that HIRSP would become insolvent. HIRSP actually ran out of cash and claims were held for four months until enough cash could be generated to pay claims. The Board was forced to approve an emergency assessment on insurers. All of this happened in the months just before the Legislature transferred the program to DHFS and reduced the Board's authority.

Since 1998 under the current administrative structure premiums are now set at the lowest level permitted by the law, HIRSP changed from a cash to an accrual basis of accounting and has returned to financial solvency. The most recent Legislative Audit Bureau report is the best audit report the LAB has ever issued on this program. As of January 31, 2004, the plan had $40.8 million in the bank, $15.4 million of which is set aside for claim liabilities and another $13.3 million of which is set aside as a policyholder surplus that can be used in future years to keep premiums at the lowest levels permitted by law. There have been no emergency assessments and enrollment is no longer declining. In fact, enrollment has increased steadily. While insurance company assessments have increased 270%, state GPR support has been eliminated and enrollment has more than doubled.

HIRSP solvency and financial stability have been restored through the effective partnership and joint oversight of the HIRSP Board and the Department. Arguably, the financial stability of the plan suggests that the current governance structure is effective and appropriate.

3. **The Board selects a new Board chairperson each year and a representative of PhRMA is added to the Board.**

The Department opposes changing how the Chair of the HIRSP Governing Board is selected.

The Department is neutral with respect to a PhRMA representative, but if enacted, it should be contingent on the successful implementation of a drug company assessment.

4. **Requires the Board to establish plan design, including covered expenses and exclusions, by rule.**

The HIRSP Governing Board did not endorse this recommendation when it was put to a vote.

The Department concurs with the majority of the board who do not believe that the rule-making process is either more expedient or flexible.

We believe the bill sponsors should propose specific benefits changes they would like to see included in the bill for the Administration to consider. The Department is willing to consider supporting specific benefits changes that might be proposed.

5. **Requires the Board, instead of DHFS, to select a plan administrator through an RFP process and allows the Board to contract for professional services to the Board and HIRSP.**

The Department opposes this proposal. The Board already has the authority to approve the plan administrator contract. Procurement through RFP is already underway. Closer Board involvement in procurement would raise serious conflict of interest issues. Governing boards should generally not be involved in vendor evaluation as a matter of sound policy and governance.

6. **Allows the Board to create a separate premium schedule for policyholders with household income over $100,000 and use the additional premium revenue to further reduce subsidized premiums and deductibles.**

The Department is willing to support this option.

HIRSP does not now collect income information apart from people applying for subsidies. We do not have sufficient data to determine the impact of this change. The administrative costs of this provision will be material because income reporting and verification procedures will have to be developed and implemented. This function will be delegated to the plan administrator and will increase administrative expenses by an as yet undetermined amount. Administrative costs must be paid from premium and assessment revenue from policyholders, insurers and providers. A very real possibility exists that this would cost more to administer than it would generate in revenue to increase subsidies.

The language should be permissive so that a determination regarding costs and benefits could be made.

7. **Requires an applicant to obtain 2 rejections from insurers instead of 1.**

The Department is willing to support this proposal but it is not clear what effect this would actually have on HIRSP enrollment.

8. **Requires DHFS to verify information about applicants' eligibility for group coverage, periodically verify the information, maintain a database and report to the Board.**

The Department is willing to support this proposal. This will, however, increase administrative expenses by an as yet undetermined amount. With 17,000 members and many thousands of employers, this will be a significant undertaking for which there is no automated solution. *This task*

would be delegated to the plan administrator and costs must be paid from premium and assessment revenue from policyholders, insurers and providers.

The language should be permissive so that a determination regarding costs and benefits could be made.

9. **Requires Trade Adjustment Act (TAA) grant funds to be used for HIRSP to pay for plan costs before any costs are paid with premium or insurer or drug manufacturer assessments and provider payment discounts.**

The Department opposes this proposal. This language is unnecessary. Use of any such funds must comply with CMS rules and policy.

The TAA provides limited funding for three years for high risk pools that:
a) charge policyholders no more than 150% of the standard rate, and
b) are experiencing operating losses.

HIRSP did not qualify for FY 02 because the premium was over 160% of the standard plan. We do expect to qualify for an estimated $2.7 million for FY 03 and a still unknown amount for FY 04.

Thank you for your concern for this very important program.

Testified for info. only.

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Senator Carol Roessler, Chair
Members, Senate Committee on Health

FROM: Alice O'Connor, Senior Vice President
Wisconsin Medical Society, Government Relations

DATE: February 19, 2004

RE: Senate Bill 426 – Allowing a Second-Year Pharmacy Student to Administer Vaccinations Under Direct Supervision – For Information Only

The Wisconsin Medical Society (Society), representing more than 10,000 Wisconsin physicians and their patients, appreciates the opportunity to share its concerns with the Committee about Senate Bill 426, a bill to allow persons who have completed their second year of accredited pharmacy school to administer vaccinations under the direct supervision of a licensed pharmacist.

This issue has been the source of great debate within the Society over the past month. After extensive discussion, it was determined that the Society review its policy on pharmacist vaccinations to determine if there is sufficient evidence-based data to alleviate patient safety concerns of the Society. Unfortunately, the council that is assigned to review public health issues will not meet again until June. To this end, the Society would like to request that this legislation not proceed at this time and be revisited following a complete review of physician safety concerns.

In 1997, the Society testified in opposition of Assembly Bill 628, which gave pharmacists the authority to administer vaccinations and inject a prescribed drug or device into a patient for the purpose of teaching a patient self-administration. The Society was concerned then, as we are now, with continuity of care, coordination of care, and health care record keeping that have never been satisfactorily addressed statutorily. However, the Society recognizes that adults, especially seniors, obtain their flu shots in a variety of settings as convenience dictates.

The ongoing concern for physicians is if a patient is taking other medications, or is suffering from a condition that would make a vaccination more problematic for the patient. When a patient visits their physician, the physician has the benefit of a detailed medical record that identify previous and existing health problems, as well as a complete listing of the medications that the patient is taking. Health care records also flag medications allergies and previous adverse reactions that a patient may have forgotten about.

Our physicians have told us that since this law passed seven years ago they have received very little feedback about adult patients' continuity of care, such as records indicating whether an elderly patient received a flu shot. In our view, this situation could constitute a potential danger to public health and safety.

Again, the Society appreciates the opportunity to address our concerns on SB 426 and looks forward to working closely with this Committee on this issue next legislative session.

If you wish further information, please contact Alice O'Connor, Mark Grapentine, or Jeremy Levin at 442-3800.

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TESTIMONY BEFORE THE SENATE COMMITTEE ON HEALTH, CHILDREN, FAMILIES, AGING AND LONG TERM CARE

FEBRUARY 19, 2004

SENATE BILL 426

I am Susan Sutter, R.Ph., Vice-Chairperson of the Pharmacy Examining Board (PEB). Thank you for the opportunity to speak on behalf of the PEB in favor of Senate Bill 426.

Last fall the Pharmacy Examining Board was asked a practice question by an interested pharmacist as to whether a pharmacy student that has taken the required vaccination training could give immunizations under the supervision of a trained pharmacist. Our legal counsel advised the Board a statute language change was needed to allow the student to immunize under such supervision. At this time, pharmacy students after their second year of professional pharmacy education are allowed, under direct supervision of a licensed pharmacist, to engage in all the responsibilities of a pharmacist except for this area of practice.

The PEB voted in favor of working to change the statute to allow students to immunize after completing the required training and under the supervision of a trained pharmacist. The Pharmacy Society of Wisconsin was also in favor of advancing this change to the statute. We worked together by contacting Senator Fitzgerald and asking for his sponsorship.

In 1997, pharmacists joined other Wisconsin healthcare providers to provide immunizations for persons 18 and older with the goal of raising immunization rates in Wisconsin. Pharmacy students are obtaining this required training in their Doctor of Pharmacy curriculum and then are not allowed to use that training until after they have graduated and been licensed. This is the equivalent to having nursing or medical students trained in such skills and not allowing them to perform such duties until they are finished with all of their educational requirements and licensed. Performing such skills under the direct supervision of trained preceptors after the completion of the required didactic education is an important aspect of all healthcare training.

The Pharmacy Examining Board asks for your support of this bill. Such support will reflect your understanding of this vital step in the educational process and its contribution to advancing better healthcare by helping to increase the immunization rates of Wisconsin.

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The role of pharmacists in the delivery of influenza vaccinations

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Received 9 June 2003; received in revised form 21 August 2003; accepted 25 August 2003

Abstract

Objectives: The purpose of this study is to determine whether influenza vaccine rates have increased in states where pharmacists can give vaccines. *Methods*: Secondary analysis of the Behavioral Risk Factor Surveillance System (BRFSS) from the years 1995 and 1999. Information regarding legislation allowing pharmacists to administer vaccines was obtained from the American Pharmaceutical Association. *Results*: Individuals aged 65 years and older who lived in states where pharmacists could provide vaccines had significantly higher ($P < 0.01$) influenza vaccine rates than individuals of this age who resided in states where pharmacists could not provide vaccines. *Conclusions*: Allowing pharmacists to provide vaccinations is associated with higher influenza vaccination rates for individuals aged 65 years and older.

Keywords: Pharmacists; Influenza; Vaccinations

1. Background

Influenza is a major cause of morbidity and mortality in the US. More than 200,000 hospitalizations and 20,000 deaths each year can be attributed to influenza [1,2]. Immunization is a key element in the prevention of influenza. However, adult immunization rates for influenza are well below the Healthy People 2010 goal of 90% [3]. Influenza immunization rates in 1995 ranged from 54 to 74% of the US population aged 65 years and over [4,5].

Obstacles to immunization have been reported in various studies [6–8]. These include patient-related (apathy, lack of knowledge, inability to pay, transportation), provider-related (missed opportunities, misconceptions regarding contraindications to immunizations), and clinic-related (inadequate staff and service hours) obstacles. Because the focus of health care has shifted towards prevention, it is of utmost importance to remove these obstacles.

Several strategies have been explored to help improve immunization rates against influenza. These include standing nursing orders, physician chart reminders, physician education, walk-in visits for vaccinations, and direct mailings to patients [9–11]. Another strategy that has been employed is allowing pharmacists to provide immunizations in their practice setting. As of August 2002, there were 35 states that allowed pharmacists to provide immunizations [12].

Pharmacists are in a unique position to help overcome many of the obstacles listed above because they are arguably the most accessible of all health care professionals [13]. Community pharmacies have the advantage of extended business hours and convenient locations [14]. In fact, approximately 250 million people walk into a pharmacy every week [15]. Pharmacists can not only educate patients about vaccines and promote immunization, but they can also administer these vaccinations in many states.

Several small-scale studies have examined pharmacists' abilities to increase vaccine awareness and administration [16–24]. Overall, immunization rates were shown to increase in these studies and patients were satisfied with pharmacists providing these immunizations. According to a report by the American Pharmaceutical Association (APhA), more than 300,000 vaccine doses were administered by over 2500 pharmacists nationwide in 1999 [16]. Allowing pharmacists to provide immunizations, however, does not remove all obstacles of the vaccine delivery process. Pharmacists themselves rated lack of time, concern for legal liability, and lack of reimbursement as the top three obstacles to the provision of immunization services [15].

The purpose of this study is to determine, using a large national dataset, whether immunization rates for influenza have increased in states where pharmacists can give vaccines.

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doi:10.1016/j.vaccine.2003.08.045

2. Methods

For this analysis, the 1995 and 1999 Behavioral Risk Factor Surveillance System (BRFSS) was used. The BRFSS is an annual telephone survey conducted by the Centers for Disease Control and Prevention that assesses health risks in the US. In this survey, individuals are asked, "During the past 12 months, have you had a flu shot?" The answer to this question was used to determine an individual's influenza vaccine status.

Information regarding legislation allowing pharmacists to administer vaccinations was obtained from the American Pharmaceutical Association (e-mail communication from Mitch Rothholz, APA, August 2002). States were then divided into two categories: those that allowed pharmacists to give immunizations and those that did not. A 1-year delay to allow for implementation of the legislation was allowed.

This study assessed influenza vaccine in two subgroups of the population: those aged 18–64 years and those aged 65 years and older. This breakdown was made because of the recommendation that all individuals 65 years and older should have the influenza vaccine while only a subset of individuals aged 18–64 years are recommended to be immunized [4].

2.1. Analysis

To address the complexity of the study question, two different analyses were performed.

2.2. Quasi-experimental

To assess the impact of legislation allowing pharmacists to administer vaccine, a quasi-experimental analysis was performed. As the number of states that allowed pharmacists to give vaccines varied from year to year, we conducted our analysis using a matched-pairs design. Sixteen states were taken from the BRFSS to compare influenza vaccination rates for individuals both 18–64 and 65 years and older. Eight of these states (Arkansas, Kansas, Nebraska, North Dakota, Oklahoma, Tennessee, Texas and Virginia) passed legislation in 1997 allowing pharmacists to administer vaccines while eight (Louisiana, Missouri, Iowa, Wyoming, Utah, West Virginia, Florida, and Maryland) had no legislation prior to 2000. Data for the years 1995 and 1999 were then analyzed. Chi-square analysis was used to compare the rates of vaccinations for each year and the location of vaccine delivery. The weighted percentages from the datasets were used in SUDAAN to determine nationally representative population estimates for comparison.

2.3. Logistic regression model

To determine the impact of allowing pharmacists to provide vaccines in a given year, a logistic regression model was created to account for other factors that may change influenza vaccine rates.

2.4. Variables

The external factors that were accounted for included the following.

State of residence: Two categories were created for this variable. These were states where pharmacists are allowed to provide vaccines and states where pharmacists cannot administer vaccines.

Sociodemographic variables: These included sex; income dichotomized into less than US$ 20,000 or greater than or equal to US$ 20,000; education classified as less then high school, high school graduate, some college, college graduate or higher; and race, which was classified by the BRFSS as White, Black, Asian/Pacific Islander, American Indian/Alaska native and other.

Health status was determined by the answer to the question, "How would you rate your overall health: excellent, very good, good, fair, or poor?"

Health insurance was determined by the answer to the question, "Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?"

The issue of the cost of health care as a barrier was addressed using the proxy, "Was there a time during the last 12 months when you needed to see a doctor, but could not because of the cost?"

Again, SUDAAN was used to account for the complex sampling design of the BRFSS and nationally representative population estimates were made using weighted data.

3. Results

Fig. 1 shows the evolution of states allowing pharmacists to administer vaccinations. In 1995, nine states allowed pharmacists to administer vaccines. By 1999, this had increased to 30 states.

In 1995, states that were eventually to pass laws had more individuals aged 18–64 years immunized than states who did not pass these laws ($P < 0.01$). There was no significant difference for influenza vaccination rates for individuals greater than 65 years old between these two sets of states ($P = 0.10$). By 1999, states that allowed pharmacists to provide immunizations had significantly ($P < 0.01$) more individuals aged 18–64 years immunized than states without this legislation. These states also had significantly more individuals aged 65 years and older immunized against influenza than states that did not allow pharmacists to give immunizations ($P < 0.01$). These results are illustrated in Table 1.

The location where the flu vaccine was administered did not differ between the two groups of states. The majority of individuals received their flu vaccine in a physician's office. These results are shown in Table 2.

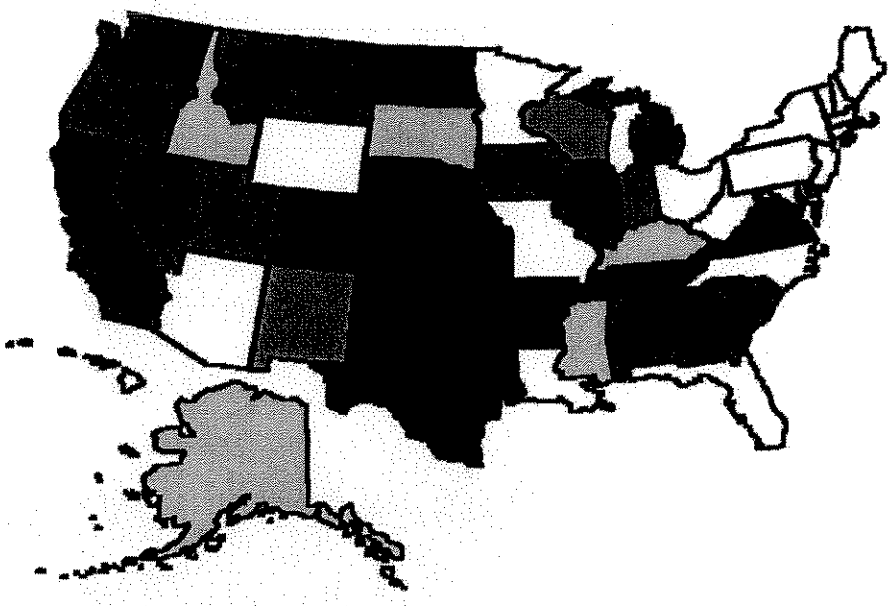

Fig. 1. Map of states allowing pharmacists to give immunizations and year of passage. Red: legislation passed in 1995 or earlier; yellow: legislation passed in 1996; blue: legislation passed in 1997; green: legislation passed in 1998; purple: legislation passed in 1999 (for interpretation of the references to color in this figure legend, the reader is referred to the web version of this article).

Table 1
Comparison of influenza vaccination rates

	States allowing pharmacists to immunize after 1997 (%)	States not allowing pharmacists to immunize after 1997 (%)	*P*-value
18–64 years old			
Immunization rates in 1995	20.5	16.6	<0.01
Immunization rates in 1999	25.5	21.6	<0.01
Overall change	5.0	5.0	
≥65 years old			
Immunization rates in 1995	57.7	61.2	0.10
Immunization rates in 1999	68.4	64.7	<0.01
Overall change	10.7	3.5	

The results of the logistic regression model are given in Table 3. As shown, in states where pharmacists are allowed to provide vaccinations, both individuals aged 18–64 years (odds ratio (OR) = 1.27; 95% confidence interval (CI) = 1.19–1.36) and individuals aged 65 years and older (OR = 1.22; 95% CI = 1.07–1.39) are more likely to receive influenza vaccines than individuals in states where pharmacists cannot provide vaccinations. For both individuals aged 18–64 years and those aged 65 years and older, poorer health status and presence of health insurance also

Table 2
Location of vaccine administration in 1999

Location of vaccine	States where pharmacists can provide vaccines (%)		States where pharmacists cannot provide vaccines (%)	
	18–64 years	≥65 years	18–64 years	≥65 years
A doctor's office or health maintenance organization	30.0	62.9	38.6	68.0
A health department	6.0	6.5	7.0	5.9
Another type of clinic or health center	11.0	12.0	9.7	10.2
A senior, recreation, or community center	1.0	5.0	1.2	4.7
A store	5.0	3.1	5.2	3.4
A hospital or emergency room	7.0	5.6	7.1	3.7
Workplace	33.6	1.7	25.4	1.0
Other	6.4	3.2	5.8	3.1

Table 3
Logistic regression model for influenza vaccination in 1999

	18–64 years		≥65 years	
	Odds ratio	95% CI	Odds ratio	95% CI
Residence				
State where pharmacists can immunize	1.27	1.19–1.36	1.22	1.07–1.39
State where pharmacists cannot immunize	1.00		1.00	
Gender				
Male	1.05	0.98–1.12	0.94	0.82–1.08
Female	1.00		1.00	
Race				
White	1.00		1.00	
Black	0.84	0.75–0.94	0.41	0.32–0.52
Asian/Pacific Islander	0.99	0.77–1.28	1.24	0.40–3.82
American Indian/Alaskan	1.07	0.81–1.42	0.65	0.32–1.32
Other	0.74	0.59–0.93	0.51	0.29–0.89
Income				
Less than US$ 20,000	1.07	0.99–1.16	0.86	0.75–1.00
More than US$ 20,000	1.00		1.00	
Health status				
Excellent/good/very good	1.00		1.00	
Fair/poor	1.76	1.58–1.95	1.16	1.01–1.34
Time could not afford to see a doctor				
Yes	0.64	0.57–0.73	0.70	0.51–0.96
No	1.00		1.00	
Health insurance				
Yes	1.89	1.68–2.12	2.22	1.49–3.32
No	1.00		1.00	

increased the chance of being vaccinated against influenza. Individuals who were black or had a self-perceived cost barrier to receiving health care had a decreased likelihood of being immunized in both age categories.

4. Discussion

In this comparison of two groups of states, legislation allowing pharmacists to administer vaccinations improved influenza vaccine rates for individuals 65 years and older. In addition, when looking at data from one specific year, individuals who resided in states where pharmacists were allowed to administer vaccines were more likely to be immunized than individuals who lived in states where pharmacists could not immunize. This difference held true after controlling for other demographic factors such as gender, race, income, health insurance and self-perceived health status.

The growth in influenza vaccine rates for individuals aged 18–64 years appears to be equal between the two states. However, both in 1995 and 1999, states where pharmacists could immunize patients after 1997 had higher influenza vaccination rates than states where this legislation was not passed. This is an important trend to note, especially in light of influenza vaccine shortages in recent years. During these times, it is imperative that those with the highest risk for influenza complications be immunized first.

For individuals aged 65 years and older, the influenza vaccination rates were also higher in states where pharmacists could immunize patients. The percent of individuals aged 65 years and older immunized against influenza was higher when examining aggregate number of individuals across states. Moreover, although legislation is state specific, aggregate numbers do not show changes per state but rather among a whole, defined as states with legislation. For example, one state with a large population may have experienced substantial growth while several smaller states had little growth, yet the overall estimate would show substantial growth. It is also important to note that the states may have had other operating policies or population differences that could account for this increase. Further research is needed to understand this phenomenon. Using states as a unit of analysis as opposed to population estimates may be a way to further explore this hypothesis.

As the logistic regression model for 1999 data shows, individuals are more likely to receive influenza vaccines in states where pharmacists can immunize. However, it is not known if this increase is a direct result of allowing pharmacists to vaccinate individuals. While demographic characteristics of the population do not explain this difference, other factors could explain this phenomenon. This could

include more direct to consumer advertising on the availability of the vaccine, more competitive pricing for the vaccine, or increased public awareness of the need for influenza vaccination in states where pharmacists provide immunization services. Further research is needed in this area to better understand why this difference exists.

In looking at where individuals received vaccines, we can see that the majority of individuals in both groups of states received their vaccines at a physician's office. While this explores the question of "where" patients received their vaccines it does not address the question of "who" administered their vaccination. Further research needs to explore this question to better understand what individuals are actually administering the vaccinations to individuals.

This study using existing national datasets supports previous exploratory studies that showed allowing pharmacists to provide immunizations increased local rates of influenza vaccines [17,19–24]. Pharmacists may be an important players in the delivery of immunizations. Pharmacists have long educated patients regarding the benefits of the influenza vaccination and have encouraged patients to get immunized by their primary care provider. However, the immunizer role has been a more difficult process, in part due to lack of state legislation and also due to misconceptions on the part of patients, primary care providers and pharmacists. Thus, even though legislative support is increasing, there are still obstacles that may limit this process for pharmacists. Because of the potential for increased vaccination rates, subsequent decreases in illness and cost benefits to the health care system with pharmacist-administered vaccinations, these barriers must be addressed.

There are several limitations to this data. First, this study is based on a secondary analysis of data that was collected for general health risk surveillance. As such, we could not determine what type of health care provider gave the vaccine to the individual surveyed. Also, the data were all self-report survey questions and verification of actual immunization status was not performed.

Secondly, the data used in this study was a secondary analysis of data collected in the 1995 and 1999 BRFSS. Due to the sampling method used by the BRFSS, national estimates for influenza vaccine rates can only be made from the data collected during odd-numbered years. There may have been other factors that occurred during this time period that led to an increase in influenza vaccine rates that could not be controlled for in our logistic regression model.

Despite its limitations, this study is important as it shows that individuals who live in states where pharmacists can administer vaccinations have higher influenza vaccination rates than individuals who reside in states where pharmacists cannot provide this service. Further research is needed to better understand the impact that allowing pharmacists to provide vaccinations can have on improving immunization rates in the US.

Acknowledgements

This study was funded in part through grant 1D12H-P00023-03 from the Health Resources and Services Administration. The authors wish to thank Mark Geesey, MS for his assistance with the statistical analysis and Tara Hogue for her editorial assistance.

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PHARMACY SOCIETY OF WISCONSIN

"Leading Our Profession in a Changing Health Care Environment"

To: Members of the Senate Health Committee

From: Tom Engels, Vice President of Public Affairs
Pharmacy Society of Wisconsin

Re: **Senate Bill 426, to modify current law and allow pharmacy students to administer vaccinations.**

Senate Bill 426 is a necessary addition to current state law as it relates to the education of pharmacist students.

This bill is supported by the University of Wisconsin-Madison School of Pharmacy, Wisconsin Pharmacy Examining Board, Wisconsin Society of Pharmacy Students and Pharmacy Society of Wisconsin.

Current law already allows pharmacy students to perform all the functions of a pharmacist while under the direct supervision of a pharmacist. Pharmacists in Wisconsin have been allowed in Wisconsin to administer vaccinations and prescribed drug products since 1997. When the Pharmacy Practice Act was revised seven-years ago to allow pharmacists to provide immunizations and administer certain medications, those choosing to provide the services were required to complete extensive training.

When the legislation was adopted, a provision was included that prohibited pharmacists from delegating the vaccination authority (presumably to a pharmacy technician or another pharmacy employee.) The Wisconsin Pharmacy Examining Board believes that a technical correction needs to be made to current law in order to allow qualified pharmacy students to perform these functions under the direct supervision of a licensed pharmacist. In order to qualify, both the student and pharmacist must meet the required educational criteria.

The intent of Senate Bill 426 is to clarify current law and to provide for the full educational needs of pharmacists.

Although, the bill is simply a technical modification to a current law, it's a necessary correction. Pharmacy students are required to have 1,500 hours of clinical clerkship as a condition of licensure. Clinical clerkships allow hands-on patient care experience that is no different than that of medical or nursing students. Learning how to properly give immunizations is simply a component of a comprehensive pharmacy education.

Working under the direct supervision of a pharmacist, students can gain the experience they will need in all levels of pharmacy. Without this educational experience they will be denied the opportunity to learn these skills before they are licensed. Without the passage of this bill, students will continue to be denied an opportunity to assist with the administration of vaccines that save lives and prevent serious illness to thousands of Wisconsin citizens.

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JOHN PHILIP BOHLMAN, RPh, FASCP

205 Pearl Street **Boscobel, WI 53805** **(608)375-5077**

RE: TESTIMONY BEFORE THE SENATE COMMITTEE ON HEALTH, CHILDREN, FAMILIES, AGING AND LONG TERM CARE

In Support of
2003 SENATE BILL 426

FEBRUARY 19, 2004

I am John Bohlman, R.Ph., a practicing pharmacist in Southwest Wisconsin.

Thank you for the opportunity to speak in support of Senate Bill 426 relating to the administration of vaccines by a person having completed their 2nd year of and is still enrolled at an accredited school of pharmacy under the direct supervision of a pharmacist who must also meet the provisions of current WI Chap 450.0.35(1g) thru(3).

Since pharmacists have been allowed to provide immunizations to persons 18 and older since 1997, my pharmacy has administrated over 10,000 influenza vaccinations alone. Our anecdotal conclusion is that the majority of these individuals would not have been vaccinated due to work situations, vaccine availability, lack of convenient vaccine clinics, etc. We take great pride in elevating the vaccination rate of our area and believe it should be a matter of pharmacy student pride in doing the same during their career. Unfortunately to date those students trained, to administer vaccinations, have been able to be involved only in patient teaching, clerical and practitioner follow-up roles but no actual vaccine administration.

Currently pharmacy students are allowed, under direct supervision of a licensed pharmacist, to engage in all the responsibilities of a pharmacist. Prior to Wisconsin licensure, these students must complete a minimum aggregate of 1500 such hours. In all health care professions direct experiential patient care training is provided as a part of academic studies. Such directly supervised professional practice allows the "student" to learn the "artful" application of the didactic professional knowledge with guidance of a skilled mentor to guide and assure the appropriate patient outcome. With such supervised experience, the patient consumer benefits from receiving the best care available, both now and in the future.

Currently, pharmacy students can elect to obtain the required training in their Doctor of Pharmacy curriculum but are not allowed to use that training until after they have graduated and are licensed.

This bills's enactment accomplishes two things:

1) it is a straightforward simple clarification of certain terminology to add consistency with other related statutory and regulatory language,
2) as delineated by the Legislative Reference Bureau analysis, the Bill allows a Pharmacy Student meeting the criteria set forth in WI Chap 450.0.35(1g) thru(3) to gain experience prior to licensure.

Not making this change is the equivalent of a recently licensed Medical Doctor doing vaccinations without having done any supervised vaccinations until they can do the same independently of supervision. Performing such skills under the direct supervision of trained preceptors, after the completion of the required didactic education, is an important aspect of all healthcare training.

I urge this committee's support for this Bill before the whole legislature.

Thank you.

TESTIMONY BEFORE THE SENATE COMMITTEE ON HEALTH, CHILDREN, FAMILIES, AGING AND LONG TERM CARE

FEBRUARY 19, 2004

SENATE BILL 426

I am Susan Sutter, R.Ph., Vice-Chairperson of the Pharmacy Examining Board (PEB). Thank you for the opportunity to speak on behalf of the PEB in favor of Senate Bill 426.

Last fall the Pharmacy Examining Board was asked a practice question by an interested pharmacist as to whether a pharmacy student that has taken the required vaccination training could give immunizations under the supervision of a trained pharmacist. Our legal counsel advised the Board a statute language change was needed to allow the student to immunize under such supervision. At this time, pharmacy students after their second year of professional pharmacy education are allowed, under direct supervision of a licensed pharmacist, to engage in all the responsibilities of a pharmacist except for this area of practice.

The PEB voted in favor of working to change the statute to allow students to immunize after completing the required training and under the supervision of a trained pharmacist. The Pharmacy Society of Wisconsin was also in favor of advancing this change to the statute. We worked together by contacting Senator Fitzgerald and asking for his sponsorship.

In 1997, pharmacists joined other Wisconsin healthcare providers to provide immunizations for persons 18 and older with the goal of raising immunization rates in Wisconsin. Pharmacy students are obtaining this required training in their Doctor of Pharmacy curriculum and then are not allowed to use that training until after they have graduated and been licensed. This is the equivalent to having nursing or medical students trained in such skills and not allowing them to perform such duties until they are finished with all of their educational requirements and licensed. Performing such skills under the direct supervision of trained preceptors after the completion of the required didactic education is an important aspect of all healthcare training.

The Pharmacy Examining Board asks for your support of this bill. Such support will reflect your understanding of this vital step in the educational process and its contribution to advancing better healthcare by helping to increase the immunization rates of Wisconsin.

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Wisconsin Medical Society

Your Doctor. Your Health.

TO: Senator Carol Roessler, Chair
Members, Senate Committee on Health

FROM: Alice O'Connor, Senior Vice President
Wisconsin Medical Society, Government Relations

DATE: February 19, 2004

RE: Senate Bill 426 – Allowing a Second-Year Pharmacy Student to Administer Vaccinations Under Direct Supervision – For Information Only

The Wisconsin Medical Society (Society), representing more than 10,000 Wisconsin physicians and their patients, appreciates the opportunity to share its concerns with the Committee about Senate Bill 426, a bill to allow persons who have completed their second year of accredited pharmacy school to administer vaccinations under the direct supervision of a licensed pharmacist.

This issue has been the source of great debate within the Society over the past month. After extensive discussion, it was determined that the Society review its policy on pharmacist vaccinations to determine if there is sufficient evidence-based data to alleviate patient safety concerns of the Society. Unfortunately, the council that is assigned to review public health issues will not meet again until June. To this end, the Society would like to request that this legislation not proceed at this time and be revisited following a complete review of physician safety concerns.

In 1997, the Society testified in opposition of Assembly Bill 628, which gave pharmacists the authority to administer vaccinations and inject a prescribed drug or device into a patient for the purpose of teaching a patient self-administration. The Society was concerned then, as we are now, with continuity of care, coordination of care, and health care record keeping that have never been satisfactorily addressed statutorily. However, the Society recognizes that adults, especially seniors, obtain their flu shots in a variety of settings as convenience dictates.

The ongoing concern for physicians is if a patient is taking other medications, or is suffering from a condition that would make a vaccination more problematic for the patient. When a patient visits their physician, the physician has the benefit of a detailed medical record that identify previous and existing health problems, as well as a complete listing of the medications that the patient is taking. Health care records also flag medications allergies and previous adverse reactions that a patient may have forgotten about.

Our physicians have told us that since this law passed seven years ago they have received very little feedback about adult patients' continuity of care, such as records indicating whether an elderly patient received a flu shot. In our view, this situation could constitute a potential danger to public health and safety.

Again, the Society appreciates the opportunity to address our concerns on SB 426 and looks forward to working closely with this Committee on this issue next legislative session.

If you wish further information, please contact Alice O'Connor, Mark Grapentine, or Jeremy Levin at 442-3800.

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2-19-04
Hearing

SB 1116

CR testified - support

Mark Moody - DHFS
- testimony provided
- how many people make over 100% that are in the program.

If Dept. didn't have permissive lang— it would not be able to react

- CR further recommendation other than making language re: [illegible] permissive.

Tom Moore against
- agrees w/ Moody w/ exception of pharm. assessments.
- enrollment is driving costs - new. Audit by Audit bureau.
- 419 new policy holders.

ESB
- HIRSP expensive because it is designed that way.

Roessler / Underhorn / Lagarde — different issue
letter to Leg Counsel Study of obesity.

Pat Osborne
- W.A.L.H.I.
- Supports
- policy reform needed
- 17,000 > enrolled
- Gone from $10.0 million to $350 million assessment.
- Costs they incur for assessment — passed along to private pay.
- Additional Considerations — in testimony.

Senate Committee on Health, Children, Families, Aging and Long-Term Care

Public Hearing

2003 Senate Bill 466

(LRB-4222/2)

Relating to:

Making various miscellaneous changes to the Health Insurance Risk-Sharing Plan, granting rule-making authority, and providing a penalty.

Place: State Capitol, Room 201 NE

Date & Time: February 19, 2004, 10:00 a.m.

Testimony of: Robert T. Wood
Corporate Vice President, Government Relations
Wisconsin Physicians Service Insurance Corporation (WPS)

Member, HIRSP Board of Governors

Introduction

Madam Senate

Chair~~man Underheim~~, Members of the ~~Assembly~~ Committee on Health:

My name is Robert Wood. I am Corporate Vice President of Government Relations for Wisconsin Physicians Service Insurance Corporation (WPS), one of Wisconsin's leading health insurers.

I have served on the Health Insurance Risk Sharing Plan (HIRSP) Board of Governors since December 1987 as one of the two members representing non-profit insurance corporations on the HIRSP Board.

I appear before you today in support of 2003 Senate Bill 466.

SB 466 proposes a number of important changes in HIRSP program funding and operations. These proposed changes reflect unprecedented growth in HIRSP program enrollments and costs, and the transformation of the HIRSP program from a program with a once equitably balanced base of state GPR revenue funding to a program now entirely funded in the 2003-05 executive budget by non-state funding sources.

The changes to the HIRSP statutes proposed in SB 466 are intended to establish better management control over HIRSP program policy, operations and administration, and to help moderate the increasing cost burden which the HIRSP program imposes on taxpayers and on consumers of health care services throughout Wisconsin.

The most important changes proposed in SB 466 are changes relating to HIRSP funding, governance, and plan design, and are as follows:

HIRSP Funding

- Broaden the non-state funding base for HIRSP by establishing a fiscal year assessment on drug manufacturers and labelers equivalent to approximately 20% of the total cost paid by HIRSP for prescription drugs in the preceding calendar year. If total HIRSP costs were $100 million in a calendar year, of which prescription drug claim costs were $30 million, the assessment on drug manufacturers and labelers provided for in SB 466 would generate $6 million in HIRSP funding in the following fiscal year.

- Require that any federal grant moneys received by the state under the federal Trade Adjustment Assistance Reform Act of 2002 be used to pay HIRSP plan costs before any costs are paid with premiums or insurer and drug manufacturer and labeler assessments and provider payment discounts.

HIRSP Governance

- Remove most of the administrative responsibilities from DHFS and transfer them to the HIRSP Board, thus restoring HIRSP Board of Governors governance and authority over HIRSP program policy, operations and administration, including contracting authority.

HIRSP Plan Design

- Provide the HIRSP Board of Governors with rule making authority to revise plan design (e.g., covered benefits, exclusions, cost sharing provisions such as deductibles, coinsurance, copayments).

- Allow the HIRSP Board to establish a separate schedule of higher premium rates for covered persons with annual household incomes over $100,000, and to use the additional premium amounts collected to further reduce the out-of-pocket premium costs paid by lower-income covered persons who receive HIRSP subsidies.

HIRSP Board Members Support of SB 466

- Under current HIRSP statutes there are 13 members of the HIRSP Board of Governors. In December 2003, there were three members of the HIRSP Board who are State employees, nine members who are not State employees, and one vacant position.

- During the first week of December 2003, I personally spoke with eight of the nine members of the HIRSP Board who are not State employees and confirmed their support of the legislative changes to HIRSP statutes relating to HIRSP funding, governance, and plan design, as proposed at the time in an Assembly draft (LRB-2476/3) of HIRSP reform

legislation similar in scope and purpose to SB 466.

Background - Growth of HIRSP Enrollments and Costs

During the 5-year period since year-end 1997, when jurisdiction over the HIRSP program was transferred from the Office of the Commissioner of Insurance to the Department of Health and Family Services, there has been more than a two-fold increase in the HIRSP population served by the program:

- At year-end 1997, there were 7,248 individuals enrolled in HIRSP. During 1999, the population increased by 9.1% to 7,904 individuals. Over the next three years, the population increased by 25% to 27% in each year so that by year-end 2002, the HIRSP population had more than doubled to 15,882 individuals. During 2003, growth in the HIRSP population slowed to 9.9%, with a population of 17,447 individuals enrolled at year-end 2003.

During this same 5-year period, there has been more than a three-fold increase in total program operating, administrative and subsidy costs:

- At year-end 1997, total HIRSP operating, administrative and subsidy costs were $43.7 million. During 1999, program costs increased by 15.7% to $50.5 million. Over the next three years, total HIRSP operating, administrative and subsidy costs more than doubled to $106.5 million. During 2003, growth in HIRSP costs slowed somewhat to 25.1%. Total HIRSP operating, administrative and subsidy costs at year-end 2003 were $133.2 million.

Background - Elimination of State Funding for HIRSP

The State general purpose revenue (GPR) funding share for HIRSP during FY 1999 through FY 2003 was not tied to growth in HIRSP program costs (as are policyholder, insurer, and provider funding shares), but was set as a sum certain appropriation in the State budget.

- State GPR funding represented approximately 28% of total HIRSP program costs in FY 1999, declined to 23% in FY 2000, to 18% in FY 2001, to 12% in FY 2002, and to 8.8% in FY 2003.

- The State GPR funding share for HIRSP was $12.7 million in FY 1999, $10.7 million in FY 2000, $12.7 million in FY 2001, $10.8 million in FY 2002, $10.2 million in FY 2003, and is totally eliminated in the current biennium.

As the State GPR share of funding for HIRSP has declined since 1998 as a percent of total HIRSP program costs, increases in HIRSP enrollments and in operating, administrative and subsidy costs have become ever more burdensome on policyholders who must pay proportionately higher out-of-pocket premiums, on insurers who must pay proportionately higher assessments, and on providers who must accept proportionately higher rate reductions in HIRSP reimbursement for covered benefits.

Background - The Increasing Cost Burden of Assessments on Insurers

The larger share of the increasing cost burden of insurer assessments to fund HIRSP is increasingly born as an indirect tax on insurance premiums by those small employers in Wisconsin who provide their employees with insured health care benefits.

The number of insurers assessed every six months over the past three years has varied over that same period from 244 insurers in the first half of 2001 to 296 insurers in the second half of 2001. Thus, the burden of increased insurer assessments to fund HIRSP deficits is assessed on a relatively fixed number of insurers.

Assessments levied on insurers totaled $8.3 million in FY 1999, $6 million in FY 2000, $10 million in FY 2001, $19.6 million in FY 2002, $26 million in FY 2003, and are budgeted at $35.4 million in FY 2004.

If HIRSP insurance assessments can be regarded as an indirect tax on other health insurance premiums, which they are, this is more than a four-fold tax increase over the last five fiscal years.

Because the burden of insurer assessments to fund HIRSP is allocated on the basis of an insurer's market share of business in Wisconsin, HIRSP insurer assessments are highly concentrated among a small number of highly ranked insurers.

Assessments levied on the ten highest ranked insurers accounted for 52% of all insurer assessments levied in FY 2001, 57% of all insurer assessments levied in FY 2002, and 58.5% of all insurer assessments levied in FY 2003.

- Total assessments levied on the ten highest ranked insurers were $4 million in FY 1999, $3 million in FY 2000, $5 million in FY 2001, $11 million in FY 2002, $15 million in FY 2003, and can be estimated at $21 million in FY 2004.

- Thus, for these ten insurers in Wisconsin, HIRSP assessments more than doubled from FY 2001 to FY 2002, and will have doubled again from FY 2002 to FY 2004. For these ten insurers, assessments that averaged $400,000 five years ago will have increased five-fold over the last five fiscal years to more than $2 million per insurer in the current fiscal year.

SB 466 — Proposed Assessment on Drug Manufacturers and Labelers to Help Fund HIRSP

The methodology proposed in AB 480 would ask DHFS two questions:

(1) How much did HIRSP pay for prescription drug claims in the last calendar year?

(2) What percent was the amount of Medicaid rebate that DHFS received from drug manufacturers and labelers in the last calendar year?

Multiplying the dollar amount of the answer to question (1) by the percent answer to question (2) would determine the target assessment to be levied on drug manufacturers and labelers in the next fiscal year. As noted above, if total HIRSP costs were $100 million in a calendar year, of which prescription drug claim costs were $30 million, the assessment on drug manufacturers and labelers provided for in SB 466 would generate $6 million in HIRSP funding in the following fiscal year. Fiscal year assessments on drug manufacturers and labelers would be subject to HIRSP calendar year reconciliations.

It is important to note that under SB 466, drug manufacturers and labelers would ***not*** be assessed for any share of the costs of HIRSP subsidies, which were $5 million in CY 2003.

Under existing HIRSP statutes, provider funding for HIRSP is generated by reducing provider reimbursements for HIRSP claims, except that under s. 149.142 (b) prescription drug claims are specifically exempted from rate reductions under ss. 149.143 and 149.144, which are the statutes governing provider rate

reduction funding of HIRSP.

HIRSP actuaries advise the HIRSP Board that prescription drug costs are budgeted in the current fiscal year at approximately 35% of the $170 million HIRSP budget for FY 2003-2004, or about $60 million. This would mean that in the current fiscal year 35% of HIRSP claim costs (approximately $60 million) will be exempted from provider rate reduction funding of HIRSP.

The assessment on drug manufacturers and labelers proposed in SB 466 will help to remedy this inequity.

- Prescription drug claims are the only HIRSP claims exempted from provider rate reduction funding of HIRSP.

- HIRSP currently receives only very limited rebates from the current HIRSP Pharmacy Benefit Manager (PBM).

  - DHFS reports that in CY 2002 HIRSP received $508,034 in rebate revenue. HIRSP Monthly Reports show there were 472,939 net PBM prescription drug claims paid in CY 2002 (1 claim = 1 prescription).

    Thus, HIRSP prescription drug rebates received in CY 2002 averaged approximately $1.07 per prescription, hardly enough to buy a cup of coffee.

  - For the first 10 months of CY 2003, DHFS reports that HIRSP received $494,914 in rebate revenue. HIRSP Monthly Reports show there were 492,320 net PBM prescription drug claims paid in the first 10 months of CY 2003 (1 claim = 1 prescription).

    Thus, HIRSP prescription drug rebates received in the first 10 months of CY 2003 averaged approximately $1.01 per prescription.

As noted above, a clear majority of the HIRSP Board confirmed their support of assessments on drug manufacturers and labelers to help fund HIRSP, as such assessments were proposed in December 2003 in an Assembly draft (LRB-2476/3) of HIRSP reform legislation similar in scope and purpose to SB 466. Board member support of assessments on drug manufacturers and labelers to help fund HIRSP remains unchanged despite the fact that the assessment methodology proposed in SB 466 will generate less than half of the revenue that would have been generated by the assessment methodology proposed in the earlier Assembly draft.

SB 466 — Provisions Relating to the Federal U.S. Trade Act of 2002

As noted above, a clear majority of the HIRSP Board confirmed their support of the provisions in SB 466 that require that any federal grant moneys received by the state under the federal Trade Adjustment Assistance Reform Act of 2002 must be used to pay HIRSP plan costs before any costs are paid with premiums or insurer and drug manufacturer and labeler assessments and provider payment discounts.

SB 466 — Proposed Changes in HIRSP Governance

Wisconsin has had historical experience with a strong high-risk pool governance structure from 1980-1997,

and with a weak high-risk pool governance structure from1998 to date.

From the inception of the HIRSP program in 1980, and for the next 17 years, HIRSP operated under the jurisdiction of the Office of the Commissioner of Insurance, and the HIRSP Board of Governors operated as an actual governing board with actual supervisory oversight and approval authority over HIRSP program policy, operations and administration.

When HIRSP was transferred to the Department of Health and Family Services in 1998, the Board ceased to be a governing board except in name only, and became instead an advisory board with no real authority over HIRSP program policy, operations or administration.

- The HIRSP Board of Governors' Financial Oversight Committee reviews and approves the development of fiscal year budgets, the reconciliation of calendar year funding shares, and the setting of HIRSP premium rates, requests information on related policies, problems or issues, and makes related recommendations to the Board.

- However, the HIRSP Board of Governors cannot of or by itself undertake or require any actions relating to HIRSP program policy, operations or administration. The Board can advise the Department of Health and Family Services on such matters, but the Department is entirely free to accept Board advice in whole or in part, or to entirely reject or disregard Board advice.

The Board's lack of any real authority over HIRSP program policy, operations or administration is the central challenge the HIRSP Board faces in trying to govern the program and control program costs.

The foundation for the governance changes to HIRSP statutes proposed in SB 466 was the determination by the State to withdraw all GPR funding for HIRSP, and to fully fund HIRSP operating, administrative and subsidy costs through policyholders, insurers and providers beginning in the 2003-05 executive budget biennium.

Accordingly, the governance changes to HIRSP statutes proposed in SB 466 will give the funding parties who pay the full costs of the HIRSP program commensurate governance authority, and will provide the HIRSP Board of Governors the authority it needs to establish better management control over HIRSP program policy, operations and administration, and to moderate the increasing indirect cost burden which the HIRSP program imposes on taxpayers and on consumers of health care services throughout Wisconsin.

At the HIRSP Board of Governors meeting on April 24, 2003, the Board voted to "endorse legislation to restore the governing authority of the HIRSP Board so that HIRSP operates "subject to the supervision and approval of the HIRSP Board of Governors with regard to HIRSP program operations and administration."

Since then, as noted above, a clear majority of the HIRSP Board have confirmed their support of the governance changes to HIRSP statutes proposed in SB 466, including the contracting authority provisions of SB 466.

SB 466 — Proposed Changes in HIRSP Plan Design Authority

HIRSP benefits and other plan design features are not market based. HIRSP plan design features (e.g., covered benefits, exclusions, cost sharing provisions such as deductibles, coinsurance, copayments) are fixed in statute and administrative rule.

The Department has rule making authority under ss. 149.14 (5) (d), 149.146 (2) (am) 4., and 149.17 (4) to promulgate changes in HIRSP deductibles, copayments, and coinsurance and to promulgate other cost containment provisions, including managed care provisions, but to date has not used this authority.

Changes to HIRSP plan design features are determined by politics, not markets, and can take years to accomplish.

Changes to plan design features of market based plans are driven by market forces. Market based insurers regularly review and adjust plan design of the health insurance products they offer, including cost control features, in order to remain competitive in the marketplace, and can do so fairly rapidly.

As noted above, a clear majority of the HIRSP Board have confirmed their support of the changes to HIRSP statutes proposed in SB 466 relating to plan design authority.

Also as noted above, a clear majority of the HIRSP Board have confirmed their support of the provisions in SB 466 to allow the HIRSP Board to establish a separate schedule of higher premium rates for covered persons with annual household incomes over $100,000, and to use the additional premium amounts collected to further reduce out-of-pocket premium costs paid by lower-income covered persons who receive HIRSP subsidies.

HIRSP Board Members Supporting SB 466

The members of the HIRSP Board of Governors who are not State employees and who confirmed in December 2003 their support of the legislative changes to HIRSP statutes relating to HIRSP funding, governance, and plan design, as proposed at the time in an Assembly draft (LRB-2476/3) of HIRSP reform legislation similar in scope and purpose to SB 466, are:

Mr. Bill Felsing
United Health Care of Wisconsin, Inc.
Member, HIRSP Board of Governors

Mr. Claire Johnson
Group Health Cooperative of Eau Claire
Member, HIRSP Board of Governors
Chair, HIRSP Financial Oversight Committee

Mr. Richard A. Leer, M.D.
Marshfield Clinic
Member, HIRSP Board of Governors

Mr. George Quinn
Wisconsin Health & Hospital Association
Member, HIRSP Board of Governors
Chair, HIRSP Actuarial Advisory Committee

Mr. Bill G. Smith
National Federation of Independent Business
Member, HIRSP Board of Governors

Ms. Annette L. Stebbins
HIRSP Policyholder
Member, HIRSP Board of Governors
Chair, HIRSP Consumer Affairs Committee

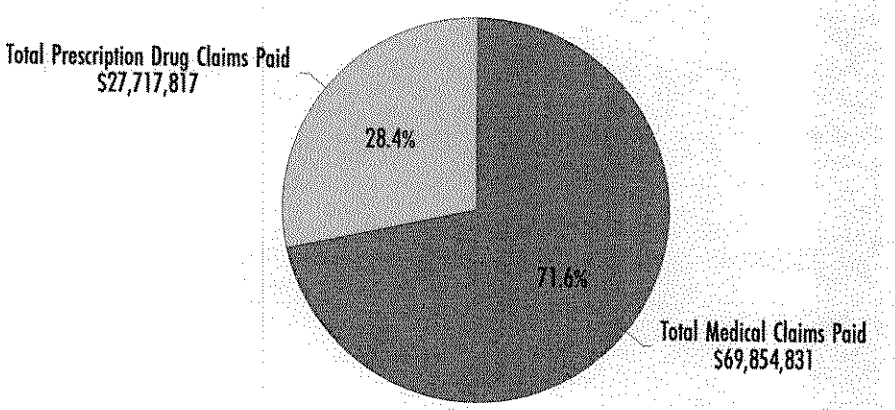
Mr. Robert T. Wood
Wisconsin Physicians Service Insurance Corporation
Member, HIRSP Board of Governors
Chair, HIRSP Legislative Committee

Mr. Larry Zanoni
Group Health Cooperative of South Central Wisconsin
Member, HIRSP Board of Governors

Charts and Data

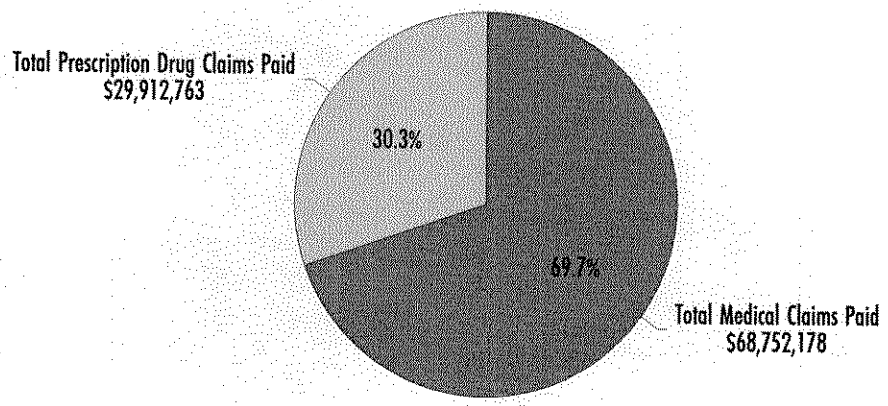
Health Insurance Risk-Sharing Plan (HIRSP)

HIRSP Medical & Prescription Drug Claims Paid
CY 2002
DHFS Reported Totals, December 5, 2003, as updated



Total Claims Paid = $97.6 Million = $8.1 Million Monthly

HIRSP Medical & Prescription Drug Claims Paid
CY 2003 [10 Months]
DHFS Reported Totals, December 5, 2003, as updated



Total Claims Paid = $98.7 Million = $9.9 Million Monthly = 21.3% Increase

February 19, 2004

HEALTH INSURANCE RISK SHARING PLAN (HIRSP)

PRESCRIPTION DRUG CLAIM COST vs. NON-PRESCRIPTION DRUG CLAIM COST
PRESCRIPTION DRUG CLAIM VOLUMES AND REBATES

CALENDAR YEAR DATA - CY 2002 and CY 2003 [10 MONTHS]

[NOTE: PRESCRIPTION DRUG AND MEDICAL COST DATA EXCLUDES POLICYHOLDERS' OUT-OF-POCKET DEDUCTIBLE AND COINSURANCE PAYMENTS FOR COVERED SERVICES.]

CY 2002

	A	B	C	D	E	F
	DRUG COST	MEDICAL COST	TOTAL	DRUG REBATES	DRUG REBATES	DRUG CLAIMS
MONTH	LOSSES PAID OR APPROVED FOR PAYMENT	LOSSES PAID OR APPROVED FOR PAYMENT	LOSSES PAID OR APPROVED FOR PAYMENT	PRESCRIPTION DRUG REBATES ACCRUED	PRESCRIPTION DRUG REBATES RECEIVED	NET PBM PRESCRIPTION DRUG CLAIMS PAID/APPROVED
JAN 2002	$1,067,705	$5,229,927	$6,297,632	$26,000	$43,684	17,803
FEB	$1,734,847	$5,463,343	$7,198,190	$67,062	$99,433	30,583
MAR	$1,917,637	$6,269,162	$8,186,799	$95,760		34,022
APR	$2,013,015	$5,451,328	$7,464,343	$45,000	$72,106	34,844
MAY	$3,131,538	$6,020,865	$9,152,403	$45,000		55,433
JUN	$2,157,137	$4,777,756	$6,934,893	$117,651		37,545
JUL 2002	$2,225,818	$5,693,963	$7,919,781	$50,000		38,261
AUG	$2,257,379	$6,717,464	$8,974,843	$50,000	$154,976	38,490
SEP	$2,321,783	$4,913,229	$7,235,012	$50,000	$252	39,232
OCT	$3,676,445	$5,250,671	$8,927,116	$53,257		40,657
NOV	$2,578,825	$7,713,516	$10,292,341	$49,268	$137,583	62,271
DEC	$2,635,689	$6,353,606	$8,989,295	$51,332		43,798
1. SUB-TOTAL	$27,717,817	$69,854,831	$97,572,648	$700,330	$508,034	472,939
2. REBATES RECEIVED	$508,034		$508,034	VARIANCE ACCRUED vs. RCVD REBATES = D.1. - E.1. = $192,296	AVERAGE COST PER CLAIM PRIOR TO REBATES = A.4 / F.1. = $60.59	AVERAGE Rx REBATE RECEIVED = E.1. / F.1 = $1.07
3. REBATES WITHHELD	$428,855		$428,855			
4. TOTAL COST	$28,654,706	$69,854,831	$98,509,537			
5. PERCENT	29.09% DRUG COST	70.91% MEDICAL COST		2.44% Rebate as % Total Cost	1.77% Rebate as % Total Cost	

NOTES:

Drug and medical costs do not include subsidies
Medical Cost Losses Paid Or Approved For Payment in Columns B and C =
Cost Paid or Approved for Payment Prior to Application of Provider Rate Reductions Required to Generate Provider Funding
Net PBM Prescription Drug Claims Paid/Approved in Column F = Net Prescriptions Paid/Approved [1 Claim = 1 Prescription]

CY 2003 [10 MONTHS]

	A	B	C	D	E	F
	DRUG COST	MEDICAL COST	TOTAL	DRUG REBATES	DRUG REBATES	DRUG CLAIMS
MONTH	LOSSES PAID OR APPROVED FOR PAYMENT	LOSSES PAID OR APPROVED FOR PAYMENT	LOSSES PAID OR APPROVED FOR PAYMENT	PRESCRIPTION DRUG REBATES ACCRUED	PRESCRIPTION DRUG REBATES RECEIVED	NET PBM PRESCRIPTION DRUG CLAIMS PAID/APPROVED
JAN 2003	$2,382,668	$7,954,323	$10,336,991	$43,844		41,082
FEB	$2,454,023	$6,266,071	$8,720,094	$43,000	$156,713	42,430
MAR	$2,561,774	$5,336,124	$7,897,898	$77,825		43,842
APR	$3,867,284	$5,873,253	$9,740,537	$80,980	$146,900	43,323
MAY	$2,725,689	$8,429,323	$11,155,012	$89,231		67,284
JUN	$2,747,136	$7,524,609	$10,271,745	$38,380		44,857
JUL 2003	$2,803,572	$6,944,984	$9,748,556	$55,000	$191,301	45,701
AUG	$2,853,554	$8,190,259	$11,043,813	$83,128		45,542
SEP	$4,466,241	$6,409,494	$10,875,735	$74,520		46,920
OCT	$3,050,822	$5,823,738	$8,874,560	$65,000		71,339
NOV						
DEC						
1. SUB-TOTAL	$29,912,763	$68,752,178	$98,664,941	$650,908	$494,914	492,320
2. REBATES RECEIVED	$494,914		$494,914	VARIANCE ACCRUED vs. RCVD REBATES = D.1. - E.1. = $155,994	AVERAGE COST PER CLAIM PRIOR TO REBATES = A.4 / F.1. = $62.61	AVERAGE Rx REBATE RECEIVED = E.1. / F.1 = $1.01
3. REBATES WITHHELD	$417,044		$417,044			
4. TOTAL COST	$30,824,721	$68,752,178	$99,576,899			
5. PERCENT	30.96% DRUG COST	69.04% MEDICAL COST		2.11% Rebate as % Total Cost	1.61% Rebate as % Total Cost	

NOTES:

Drug and medical costs do not include subsidies
Medical Cost Losses Paid Or Approved For Payment in Columns B and C =
Cost Paid or Approved for Payment Prior to Application of Provider Rate Reductions Required to Generate Provider Funding
Net PBM Prescription Drug Claims Paid/Approved in Column F = Net Prescriptions Paid/Approved [1 Claim = 1 Prescription]

HEALTH INSURANCE RISK SHARING PLAN (HIRSP)

PRESCRIPTION DRUG CLAIM COST vs. NON-PRESCRIPTION DRUG CLAIM COST
PRESCRIPTION DRUG CLAIM VOLUMES AND REBATES

FISCAL YEAR DATA: FY 2002, FY 2003 and FY 2004 [4 months]

[NOTE: PRESCRIPTION DRUG AND MEDICAL COST DATA EXCLUDES POLICYHOLDERS' OUT-OF-POCKET DEDUCTIBLE AND COINSURANCE PAYMENTS FOR COVERED SERVICES.]

FY 2002

MONTH	A DRUG COST: LOSSES PAID OR APPROVED FOR PAYMENT	B MEDICAL COST: LOSSES PAID OR APPROVED FOR PAYMENT	C TOTAL: LOSSES PAID OR APPROVED FOR PAYMENT	D DRUG REBATES: PRESCRIPTION DRUG REBATES ACCRUED	E DRUG REBATES: PRESCRIPTION DRUG REBATES RECEIVED	F DRUG CLAIMS: NET PBM PRESCRIPTION DRUG CLAIMS PAID/APPROVED
JUL 2001	$1,267,042	$4,099,974	$5,367,016			
AUG	$1,822,579	$5,434,480	$7,277,059	$206,400		
SEP	$1,395,518	$4,076,249	$5,471,767	$25,800		
OCT	$1,491,619	$4,416,825	$5,908,443	$25,800		
NOV	$2,379,115	$5,374,178	$7,753,293	$25,800		
DEC	$1,669,040	$7,069,816	$8,738,856	$25,800		
JAN 2002	$1,067,705	$5,229,927	$6,297,632	$26,000	$43,684	17,303
FEB	$1,734,847	$5,463,343	$7,198,190	$67,062	$99,433	30,593
MAR	$1,917,637	$6,269,162	$8,186,799	$95,760		34,922
APR	$2,013,015	$5,451,328	$7,464,343	$45,000	$72,106	34,844
MAY	$3,131,538	$4,020,865	$9,152,403	$45,000		55,453
JUN	$2,157,137	$4,777,756	$6,934,893	$117,651		37,545
1. SUB-TOTAL	$22,046,790	$63,703,904	$85,750,694	$706,073	$215,223	210,330
2. REBATES RECEIVED	$215,223		$215,223	VARIANCE ACCRUED vs. RCVD REBATES = D.1. - E.1. = $490,850	AVERAGE COST PER CLAIM PRIOR TO REBATES	AVERAGE Rx REBATE RECEIVED = E.1. / F.1. = $1.02
3. REBATES WITHHELD	$183,781		$183,781			
4. TOTAL COST	$22,445,793	$63,703,904	$86,149,698			
5. PERCENT	26.05% DRUG COST	73.95% MEDICAL COST		5.15% Rebate as % Total Cost	0.96% Rebate as % Total Cost	

NOTES:
Drug and medical costs do not include subsidies
Medical Cost Losses Paid Or Approved For Payment in Columns B and C =
Cost Paid or Approved for Payment Prior to Application of Provider Rate Reductions Required to Generate Provider Funding
Net PBM Prescription Drug Claims Paid/Approved in Column F = Net Prescriptions Paid/Approved [1 Claim = 1 Prescription]

FY 2003

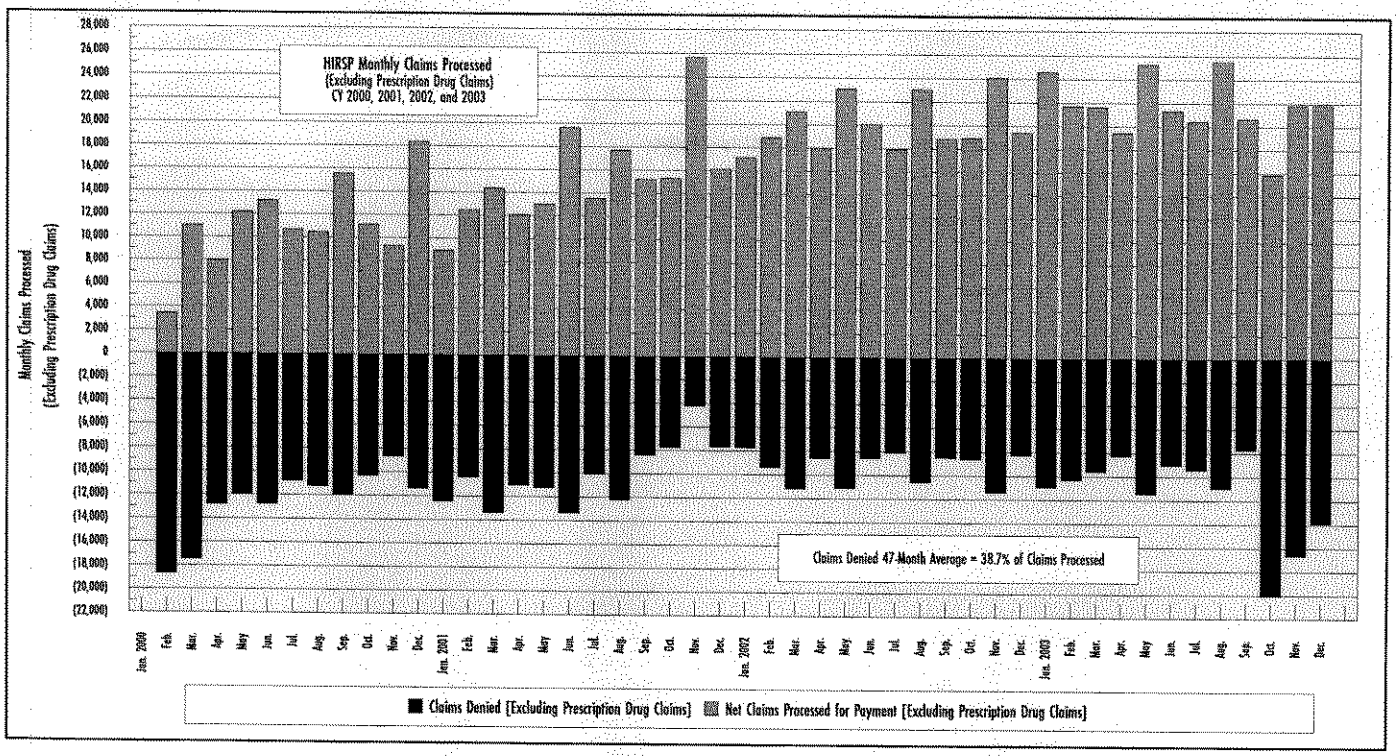
MONTH	A DRUG COST: LOSSES PAID OR APPROVED FOR PAYMENT	B MEDICAL COST: LOSSES PAID OR APPROVED FOR PAYMENT	C TOTAL: LOSSES PAID OR APPROVED FOR PAYMENT	D DRUG REBATES: PRESCRIPTION DRUG REBATES ACCRUED	E DRUG REBATES: PRESCRIPTION DRUG REBATES RECEIVED	F DRUG CLAIMS: NET PBM PRESCRIPTION DRUG CLAIMS PAID/APPROVED
JUL 2002	$2,225,818	$5,693,963	$7,919,781	$50,000		38,261
AUG	$2,257,379	$6,717,464	$8,974,843	$50,000	$154,976	38,490
SEP	$2,321,783	$4,913,229	$7,235,012	$50,000	$252	39,232
OCT	$3,676,445	$5,250,671	$8,927,116	$53,257		40,657
NOV	$2,578,825	$7,713,516	$10,292,341	$49,268	$137,583	62,271
DEC	$2,635,689	$6,353,606	$8,989,295	$51,332		43,798
JAN 2003	$3,382,668	$7,954,323	$10,336,991	$43,844		41,092
FEB	$2,454,023	$6,266,071	$8,720,094	$43,000	$156,713	42,436
MAR	$2,561,774	$5,336,124	$7,897,898	$77,825		43,842
APR	$3,867,284	$5,873,253	$9,740,537	$80,980	$146,900	43,323
MAY	$2,725,689	$8,429,323	$11,155,012	$89,231		67,284
JUN	$2,747,136	$7,924,609	$10,271,745	$38,380		44,857
1. SUB-TOTAL	$32,434,514	$78,026,151	$110,460,665	$677,117	$596,425	545,527
2. REBATES RECEIVED	$596,425		$596,425	VARIANCE ACCRUED vs. RCVD REBATES = D.1. - E.1. = $80,692	AVERAGE COST PER CLAIM PRIOR TO REBATES = A.4 / F.1. = $61.47	AVERAGE Rx REBATE RECEIVED = E.1. / F.1. = $1.09
3. REBATES WITHHELD	$502,230		$502,230			
4. TOTAL COST	$33,533,168	$78,026,151	$111,559,326			
5. PERCENT	30.06% DRUG COST	69.94% MEDICAL COST		2.02% Rebate as % Total Cost	1.78% Rebate as % Total Cost	

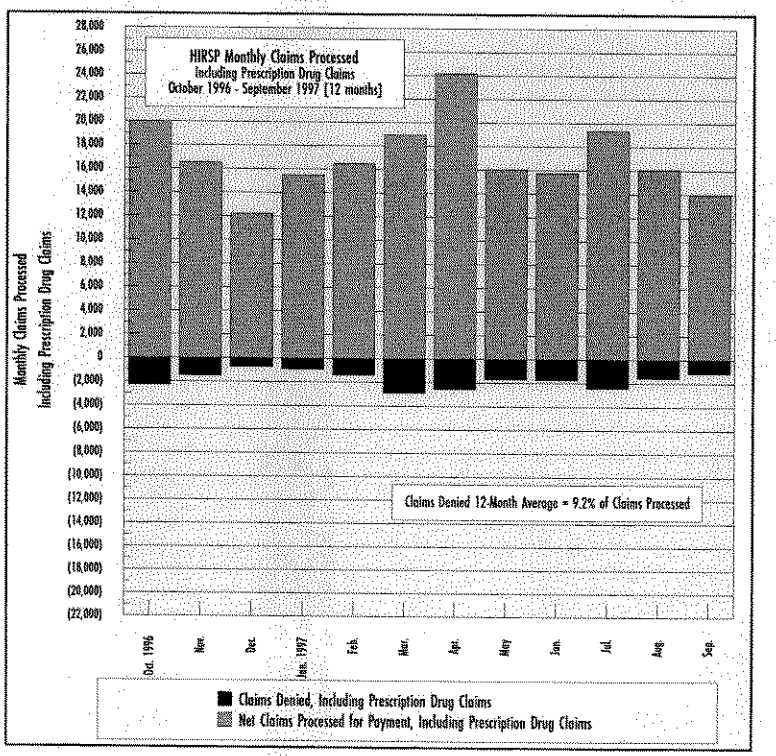
NOTES:
Drug and medical costs do not include subsidies
Medical Cost Losses Paid Or Approved For Payment in Columns B and C =
Cost Paid or Approved for Payment Prior to Application of Provider Rate Reductions Required to Generate Provider Funding
Net PBM Prescription Drug Claims Paid/Approved in Column F = Net Prescriptions Paid/Approved [1 Claim = 1 Prescription]

FY 2004 [4 MONTHS]

MONTH	A DRUG COST: LOSSES PAID OR APPROVED FOR PAYMENT	B MEDICAL COST: LOSSES PAID OR APPROVED FOR PAYMENT	C TOTAL: LOSSES PAID OR APPROVED FOR PAYMENT	D DRUG REBATES: PRESCRIPTION DRUG REBATES ACCRUED	E DRUG REBATES: PRESCRIPTION DRUG REBATES RECEIVED	F DRUG CLAIMS: NET PBM PRESCRIPTION DRUG CLAIMS PAID/APPROVED
JUL 2003	$2,803,572	$6,944,984	$9,748,556	$55,000	$191,301	45,701
AUG	$2,853,554	$8,190,259	$11,043,813	$83,128		45,542
SEP	$4,466,241	$6,408,494	$10,875,735	$74,520		46,920
OCT	$3,050,822	$5,823,738	$8,874,560	$65,000		71,339
NOV						
DEC						
JAN 2004						
FEB						
MAR						
APR						
MAY						
JUN						
1. SUB-TOTAL	$13,174,189	$27,368,475	$40,542,664	$277,648	$191,301	209,502
2. REBATES RECEIVED	$191,301		$191,301	VARIANCE ACCRUED vs. RCVD REBATES = D.1. - E.1. = $86,347	AVERAGE COST PER CLAIM PRIOR TO REBATES = A.4 / F.1. = $64.57	AVERAGE Rx REBATE RECEIVED = E.1. / F.1. = $0.91
3. REBATES WITHHELD (est)	$161,202		$161,202			
4. TOTAL COST	$13,526,691	$27,368,475	$40,895,166			
5. PERCENT	33.08% DRUG COST	66.92% MEDICAL COST		2.09% Rebate as % Total Cost	1.41% Rebate as % Total Cost	

NOTES:
Drug and medical costs do not include subsidies
Medical Cost Losses Paid Or Approved For Payment in Columns B and C =
Cost Paid or Approved for Payment Prior to Application of Provider Rate Reductions Required to Generate Provider Funding
Net PBM Prescription Drug Claims Paid/Approved in Column F = Net Prescriptions Paid/Approved [1 Claim = 1 Prescription]


HIRSP Monthly Claims Processed
(Excluding Prescription Drug Claims)
CY 2000, 2001, 2002, and 2003
Monthly Claims Processed
(Excluding Prescription Drug Claims)
28,000
26,000
24,000
22,000
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
(2,000)
(4,000)
(6,000)
(8,000)
(10,000)
(12,000)
(14,000)
(16,000)
(18,000)
(20,000)
(22,000)
Claims Denied 47-Month Average = 38.7% of Claims Processed
Jan. 2000
Feb.
Mar.
Apr.
May
Jun.
Jul.
Aug.
Sep.
Oct.
Nov.
Dec.
Jan. 2001
Feb.
Mar.
Apr.
May
Jun.
Jul.
Aug.
Sep.
Oct.
Nov.
Dec.
Jan. 2002
Feb.
Mar.
Apr.
May
Jun.
Jul.
Aug.
Sep.
Oct.
Nov.
Dec.
Jan. 2003
Feb.
Mar.
Apr.
May
Jun.
Jul.
Aug.
Sep.
Oct.
Nov.
Dec.
Claims Denied [Excluding Prescription Drug Claims]
Net Claims Processed for Payment [Excluding Prescription Drug Claims]


HIRSP Monthly Claims Processed
Including Prescription Drug Claims
October 1996 - September 1997 [12 months]
Monthly Claims Processed
Including Prescription Drug Claims
28,000
26,000
24,000
22,000
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
(2,000)
(4,000)
(6,000)
(8,000)
(10,000)
(12,000)
(14,000)
(16,000)
(18,000)
(20,000)
(22,000)
Claims Denied 12-Month Average = 9.2% of Claims Processed
Oct. 1996
Nov.
Dec.
Jan. 1997
Feb.
Mar.
Apr.
May
Jun.
Jul.
Aug.
Sep.
Claims Denied, Including Prescription Drug Claims
Net Claims Processed for Payment, Including Prescription Drug Claims

HIRSP Monthly Claims Processed
(Excluding Prescription Drug Claims)
CY 2000, 2001, 2002, 2003

	PROCESSED	DENIED	% DENIED	NET
Jan. 2000	18,596			
Feb.	22,097	(18,660)	**84.4%**	3,437
Mar.	28,500	(17,456)	**61.2%**	11,044
Apr.	20,800	(12,828)	**61.7%**	7,972
May	24,135	(11,910)	49.3%	12,225
Jun.	25,989	(12,785)	49.2%	13,204
Jul.	21,537	(10,816)	**50.2%**	10,721
Aug.	21,741	(11,238)	**51.7%**	10,503
Sep.	27,555	(11,986)	43.5%	15,569
Oct.	21,498	(10,319)	48.0%	11,179
Nov.	18,043	(8,681)	48.1%	9,362
Dec.	29,724	(11,386)	38.3%	18,338
Jan. 2001	21,403	(12,430)	**58.1%**	8,973
Feb.	22,858	(10,372)	45.4%	12,486
Mar.	27,759	(13,386)	48.2%	14,373
Apr.	23,146	(11,046)	47.7%	12,100
May	24,279	(11,244)	46.3%	13,035
Jun.	32,999	(13,359)	40.5%	19,640
Jul.	23,593	(10,050)	42.6%	13,543
Aug.	29,947	(12,213)	40.8%	17,734
Sep.	23,635	(8,428)	35.7%	15,207
Oct.	23,091	(7,764)	33.6%	15,327
Nov.	29,901	(4,225)	14.1%	25,676
Dec.	23,827	(7,677)	32.2%	16,150
Jan. 2002	24,894	(7,732)	31.1%	17,162
Feb.	28,278	(9,398)	33.2%	18,880
Mar.	32,287	(11,193)	34.7%	21,094
Apr.	26,625	(8,591)	32.3%	18,034
May	34,206	(11,111)	32.5%	23,095
Jun.	28,643	(8,572)	29.9%	20,071
Jul.	26,014	(8,110)	31.2%	17,904
Aug.	33,659	(10,604)	31.5%	23,055
Sep.	27,370	(8,517)	31.1%	18,853
Oct.	27,555	(8,653)	31.4%	18,902
Nov.	35,467	(11,392)	32.1%	24,075
Dec.	27,679	(8,262)	29.8%	19,417
Jan. 2003	35,534	(10,945)	30.8%	24,589
Feb.	32,060	(10,325)	32.2%	21,735
Mar.	31,277	(9,628)	30.8%	21,649
Apr.	27,774	(8,311)	29.9%	19,463
May	36,759	(11,459)	31.2%	25,300
Jun.	30,398	(9,056)	29.8%	21,342
Jul.	29,863	(9,422)	31.6%	20,441
Aug.	36,517	(10,983)	30.1%	25,534
Sep.	28,406	(7,731)	27.2%	20,675
Oct.	35,939	(20,036)	**55.8%**	15,903
Nov.	38,511	(16,651)	43.2%	21,860
Dec.	35,751	(13,878)	38.8%	21,873
Feb. 2000 - Dec. 2003				
47-Month Average =	28,075	(10,868)	38.7%	17,206

HIRSP Monthly Claims Processed
Including Prescription Drug Claims
October 1996 - September 1997

	PROCESSED	DENIED	% DENIED	NET
Oct. 1996	22,282	(2,287)	10.3%	19,995
Nov.	18,021	(1,476)	8.2%	16,545
Dec.	12,938	(732)	5.7%	12,206
Jan. 1997	16,401	(916)	5.6%	15,485
Feb.	17,879	(1,400)	7.8%	16,479
Mar.	21,816	(2,884)	13.2%	18,932
Apr.	26,729	(2,561)	9.6%	24,168
May	17,760	(1,705)	9.6%	16,055
Jun.	17,472	(1,731)	9.9%	15,741
Jul.	21,776	(2,434)	11.2%	19,342
Aug.	17,639	(1,557)	8.8%	16,082
Sep.	15,087	(1,143)	7.6%	13,944
Oct. 1996 - Sep. 1997				
12-Month Average =	18,817	(1,736)	9.2%	17,081

REPRESENTING WISCONSIN BUSINESS

Wisconsin Manufacturers & Commerce

Memo

To: Chairperson Carol Roessler
Members, Senate Committee on Health, Children, Families, Aging and Long Term Care
From: R.J. Pirlot, Director of Legislative Relations
Date: February 19, 2004
Subject: Senate Bill 466, relating to the Health Insurance Risk-Sharing Pool.

Wisconsin's Health Insurance Risk-Sharing Pool (HIRSP) provides health care insurance for Wisconsin residents who cannot obtain health care insurance in the private market. HIRSP, in short, provides coverage for the state's medically uninsurable. HIRSP has been funded with a combination of state dollars, assessments on health insurance companies doing business in Wisconsin, HIRSP policyholder premiums, and reduced payments to health care providers. The 2003-2005 budget act, last year signed into law, eliminated all state dollars allocated to fund HIRSP.

Wisconsin Manufacturers & Commerce (WMC) recognizes that reform of the HIRSP program is warranted due to increased enrollment, and a funding mix that is problematic and, arguably, unfair. WMC strongly objects to the notion that, as the state is eliminating its own support for the program (by cutting GPR funds), Wisconsin should be shifting some of the burden for HIRSP to pharmaceutical manufacturers. Imposing new business taxes is not, in WMC's estimation, HIRSP reform.

WMC does support the rest of the bill's provisions, in particular strongly supporting removing most of the administrative responsibilities from the Department of Health and Family Services and transferring them to the HIRSP Board of Governors. The HIRSP Board of Governors, because it contains strong representation from Wisconsin entities which actually pay to fund the program, would be well-equipped and keenly interested in appropriate management of HIRSP. WMC also supports AB 840's provisions which tighten and verify HIRSP eligibility.

WMC contends that if Wisconsin legislative and other government officials desire to provide a social program such as HIRSP, the state ought to, at the very least, help pay to run the program—not by imposing new "assessments" on pharmaceutical manufacturers or other businesses engaged in the production of health care-related goods and services. Moreover, Wisconsin should not drive up the cost of health insurance for small employers in Wisconsin by exacting ever higher assessments from Wisconsin insurers and deeper concessions from Wisconsin health care providers.

HIRSP funding reform is highly desired; however the answer is not to create a new tax on pharmaceutical manufacturers.

If you have any questions or comments, please do not hesitate to contact me.

501 East Washington Avenue
Madison, WI 53703-2944
P.O. Box 352
Madison, WI 53701-0352
Phone: (608) 258-3400
Fax: (608) 258-3413
www.wmc.org

Wisconsin Association
of Health Plans

February 19, 2004

TO: Members, Senate Committee on Health, Children, Families, Aging & Long Term Care

FROM: Louie Schubert, J.D., Director of Government Affairs
Kelly Rosati, J.D., Consultant

RE: Senate Bill 466, Changes to the Health Insurance Risk Sharing Plan

The Wisconsin Association of Health Plans supports Senate Bill (SB) 466, which would modify certain aspects of the state's Health Insurance Risk Sharing Plan (HIRSP). It is the Association's desire to see HIRSP continue to effectively serve the people of Wisconsin while evolving to reflect the changes in health care and health care financing.

HIRSP serves a valuable role in providing a proper safety net for people who do not qualify for individual insurance. However, HIRSP faces significant challenges. **The program is growing at a rapid rate in both enrollment and costs. Yet, despite this rise, the state has eliminated General Purpose Revenue (GPR) funding, thus increasing the burden on insurers, providers and policyholders.**

A significant portion of these costs result in a hidden HIRSP tax because costs must be shifted on to commercially insured small businesses. Subsidies paid through insurer assessments are borne primarily by small and medium employers, because large employers that self-fund their benefit plans are pre-empted from these assessments. For 2004, that means small and medium employers will pay most of the $35 million tax assessed on health insurers to fund HIRSP.

This legislation improves the current structure of HIRSP to address these challenges and lessens the hidden HIRSP tax. The legislation accomplishes these goals through the following means:

Broadening the Funding Base

SB 466 requires pharmaceutical companies to pay rebates at the same level as are paid to state Medicaid programs, significantly increasing their participation in HIRSP program funding. This proposal spreads the funding of the program, decreasing the inequitable tax paid by small and medium employers.

10 East Doty Street • Suite 503 • Madison, WI 53703
608-255-8599 • Fax 608-255-8627 • www.wihealthplans.org

Means Testing:

SB 466 charges enrollees with a household income of over $100,000 a higher premium that more fully reflects the average cost of the program and redistributes that money to enrollees in greater financial need. This provision recognizes the program has limited resources and aims to direct those resources in the most appropriate manner.

Governance:

SB 466 restores several components of governance to the HIRSP Board of Directors and gives that Board the ability to more effectively impact the direction of the program. These changes to HIRSP governance will enhance the current structure and create a plan that adapts to changes in technology and administration.

Benefits and Eligibility:

SB 466 allows benefits to be established by the Board of Directors by administrative rule. The rule process would allow the Board to more easily modify benefits to capitalize on the changing health care market.

The bill also requires a more thorough process to verify eligibility and confirm that applicants do not have access to employer sponsored coverage. As the cost burden of the program grows, it is important to be sure that the program provides coverage to those for whom it was intended.

The Wisconsin Association of Health Plans strongly encourages your support for the proposed changes in SB 466. These changes will create a better program for HIRSP enrollees, provide the flexibility necessary to meet future challenges and lessen the hidden tax on Wisconsin small businesses.

WEA TRUST

P.O. Box 7338, Madison, WI 53707-7338 \ 45 Nob Hill Road, Madison, WI 53713-3959 \ PHONE 608.276.4000 \ 800.279.4000 \ FAX 608.276.9119

February 19, 2004

The Honorable Carol Roessler
Chair, Senate Health Committee
Room 8 South
P.O. Box 8953
Madison, WI 53708

RE: Support for Senate Bill 466—HIRSP Reform Legislation

Dear Senator Roessler:

Thank you for your leadership and assistance in working to reform the Health Insurance Risk Sharing Plan (HIRSP). We write in support of Senate Bill 466.

We believe HIRSP is necessary and important to the citizens of this state, and we strongly support it. However, we also believe HIRSP is in desperate need of reform.

As you know, HIRSP is an insurance program of last resort for individuals—a safety net for people who, through no fault of their own, have lost or are no longer eligible for their private health insurance coverage. HIRSP was created by the Legislature in 1980 to make health insurance available to individuals who could not obtain coverage in the private marketplace. In 1997, the Legislature designated HIRSP as Wisconsin's Health Insurance Portability and Accountability Act (HIPAA) compliance program for individuals who lose their employer-sponsored group health insurance coverage.

We are all well aware of the fiscal constraints the state has been facing lately and the difficult funding choices before the Legislature. The Legislature made the decision during this last budget cycle to entirely eliminate all remaining state GPR support of HIRSP. Now it is time to let those of us who have a vested interest in HIRSP help to reform it.

The HIRSP program has experienced explosive growth since 1999 when enrollment was 7,904 individuals to the current enrollment of more than 17,000 individuals. During the same time period, the HIRSP program expenditures went from $47.2 million in 1999 to the current year budget of approximately $170 million. These numbers underscore the urgent need to reform this program. These increases not only negatively affect the insurers and providers in Wisconsin, but more acutely, they adversely affect the enrollees of the program that bear 60% of the program costs. These costs will continue to rise rapidly as the health care cost crisis causes the number of businesses, large and small, that cut back on or eliminate their employer-based health care coverage to increase.

One contributing factor to the skyrocketing costs of HIRSP is the dramatic increase in drug costs and utilization. Drug expenditures for HIRSP now represent approximately 35% of a near $170 million program. Ironically, the current funding formula for HIRSP does not include a required contribution from drug manufacturers, yet this industry reaps a direct benefit from the increased drug utilization in the program. In 2002, HIRSP received a modest supplemental rebate of $548,000—equal to approximately $1 per prescription. The time has arrived for a more equitable cost-sharing formula to alleviate some of the burden on Wisconsin businesses currently being assessed to fund the HIRSP program.

The proposal before you today makes several changes to the HIRSP program and is supported by a wide variety of Wisconsin employers including insurers, hospitals, physicians, and small businesses.

First, the proposal restores authority to the HIRSP Board of Governors to manage the program and transfers administrative responsibilities from DHFS to the Board. The Board selects the chair, and it continues to be attached to and staffed by DHFS for administrative purposes.

Second, it provides for an assessment of drug manufacturers to help pay for the costs of HIRSP. A representative of PhRMA would be added to the Board.

Third, the Board is granted full administrative rule-making authority. The proposal allows the Board to select the plan administrator through a competitive bid process, and they may also contract for professional services as needed.

Fourth, the proposal authorizes the Board to establish a premium rate schedule for enrollees with household income over $100,000. All additional premiums must be used to supplement the low-income subsidy for premium and deductibles.

Fifth, the bill requires that two or more insurers must reject an individual to establish eligibility. Current law requires only one rejection.

Sixth, the proposal requires DHFS to initially verify that a person is not eligible for employer-sponsored coverage and to periodically check on eligibility status. Additionally, the proposal requires DHFS to maintain a database of such information and to submit quarterly reports to the Board.

Lastly, the proposal requires that any federal grant money received by the state for a high-risk pool must be used to buy down HIRSP costs. Grant dollars are applied first before determination of premium, insurer and drug manufacturer assessment, and provider discounts.

HIRSP is an insurance program that should be allowed to operate as such—applying proven administrative efficiencies and utilizing cost-containment mechanisms. Current statutory constraints prevent the Board from making significant program design changes in order to positively affect the efficiency and cost effectiveness of this program. We strongly urge you and the Committee to support the proposal before you today.

Again, thank you for your leadership on this very important issue. Please feel free to contact either one of us if you have any questions or need additional information. We look forward to working with you and the Committee to reform this vital program.

Sincerely,

Alan J. Jacobs
Executive Director

Sandra Lonergan
External Relations Specialist

AJ/SL/sp

cc: Members, Senate Committee on Health

SB466

W.A.L.H.I.

Wisconsin Association of Life & Health Insurers

1995-97 Folder GPR 0

American Family Life Insurance Company

American Medical Security

Blue Cross & Blue Shield United Of Wisconsin

CUNA Mutual Group

Equitable Reserve Association

Fortis Health

Humana/ Employers Health Insurance Company

Midwest Security Life Insurance Company

Northwestern Mutual

The Old Line Life Insurance Company of America

Thrivent Financial For Lutherans

WEA Trust

Wisconsin Auto & Truck Dealers Insurance Corporation

WPS Health Insurance

Memorandum

DATE: February 19, 2004
TO: Members, Senate Health, Children, Families, Aging & Long Term Care Committee.
FROM: Pat Osborne, on behalf of WALHI
RE: WALHI Support for Senate Bill 466

The Wisconsin Association of Life and Health Insurers supports Senate Bill 466 and has been working on this legislation in an effort to help control costs in the HIRSP program and provide for a broader funding base.

BACKGROUND

The HIRSP Program serves as the insurer of last resort for state residents unable to obtain insurance in the individual market due to pre-existing medical conditions or other eligibility factors. It is an important component of the state's overall policy of promoting access to health care coverage. However, the current program is faced with significant increases in enrollment and costs that demand the attention of the Governor and the State Legislature. Since 1998 enrollment has grown from 7,200 to over 17,000 in 2003. Claim costs have nearly tripled in this same time period.

The program is currently funded by premiums paid by enrollees (60%), assessments levied on insurers (20%) and discounts provided by medical providers (20%). The State of Wisconsin provides no general-purpose revenue to support the program as a result of budget reductions of $10.2 million per year in the 2003-05 biennial budget.

The combination of cost increases and elimination of state GPR places a disproportionate burden on those insurers and providers who currently support 40% of total program costs. Insurer assessments alone have increased from $10 million in FY 2001 to $26.4 million in FY 2003 — and will significantly increase again in FY 2004, to an estimated $35.4 million. These costs end up being shifted to the private market, including the small group market, which is already facing premium cost pressures.

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SUPPORT SB 466

WALHI supports SB 466, particularly as it relates to the following key provisions.

- **Restore Governing Authority to the HIRSP Board of Governors**. The bill would transfer administrative and decision-making authority back to the Board of Governors and provide full rule-making authority to the Board including emergency rules. HIRSP is an insurance program and we feel this governance structure will enable it to operate more efficiently as an insurance program.

- **Eliminate Statutory Language Setting Benefits, Co-pays and Deductibles.** The bill authorizes the Board to set benefit design by rule. It also requires the Board to conduct a survey of existing standard plans and make adjustments to the HIRSP program at least every three years. This would allow for more flexibility in plan design and better utilization of contemporary cost saving plan features. The current benefit design has not been significantly updated since the program was established in 1979, while the health insurance market has changed dramatically since then.

- **Broaden the Assessment Base by Including an Assessment on Drug Manufacturers.** Increases in drug costs and utilization of drugs have contributed significantly to increases in overall program costs. Drug costs are currently estimated to comprise 1/3 of total claim costs in 2004. Accordingly, drug manufacturers should provide an equitable share of program funding. Under SB 466, an assessment on drug manufacturers would be collected equal to the rebate amount the drug manufacturers provide under Medical Assistance. Drug rebates under MA are approximately 21 percent of the amount paid for drugs in MA. Under the current HIRSP program, drug rebates are roughly three to four percent of total drug costs and 45% of that 3 to 4% goes to PBM administration rather than reducing program costs. In FY 2003, total drug rebate revenue in HIRSP was $1,084,409 or 3.3% of drug claims of $32.5 million. The HIRSP program received $596,425 of the $1,084,409 in total rebates for that year.

- **Means Test Premium Based on Household Income.** Enrollees with household income over $100,000 should pay more than a 60% share of premium. Under SB 466, additional premium revenue generated by high-income enrollees would be used to help fund additional premium subsidies for eligible low-income enrollees.

OTHER CONSIDERATIONS

In addition to the provisions in SB 466, we believe that other base broadening funding issues should be considered. Particularly the following:

- **Modify the Insurance Assessment to More Equitably Assess Stop-loss Carriers.** Roughly one-half of the insured in Wisconsin are covered under self-insured plans. Under the federal ERISA law, the state is restricted from directly assessing self-insured plans to support HIRSP. As a result, half of the insurance market is paying nearly 100% of the insurance assessment. In turn, the state's small group market is bearing the brunt of the HIRSP tax. A more equitable assessment on stop loss carriers could be adopted, which would provide for indirect contribution from the self-insured market.

- **Restore the State GPR Commitment to the Program.** The State should be an active partner in funding a portion of the HIRSP Program. GPR support should be restored, particularly as it relates to subsidizing the premium costs of low-income enrollees. In FY 1999 and FY 2000, GPR represented roughly 25% of program costs. State support decreased in each of the following years until it was totally eliminated in the 2003-05 biennial budget bill.

We appreciate your interest in these matters and look forward to working with you on this bill and the future of the HIRSP Program.