Fiscal Note

BILL # SB 1164

TITLE: ~~pharmacy benefits; coverage; exemptions~~ NOW: pharmacy benefits; coverage

SPONSOR: Shamp

STATUS: As Amended by House APPROP

PREPARED BY: Chandler Coiner

Description

The bill, as amended by the House Appropriations Committee, would prohibit pharmacy benefit managers (PBMs) from limiting prescription drug coverage for health plan members already medically stable on a specific prescription drug during the member's plan year if the prescribing provider gives notice that the member will continue on the medication. At the renewal of the plan year, the health insurer or PBM would be required to continue the member's coverage of the specific drug if requested by the prescribing provider and if the member meets certain criteria prescribed by the bill. This is referred to as a "formulary exception process."

Estimated Impact

We estimate the bill could increase costs to the state employee health plan by $240,000 annually beginning in Plan Year (PY) 2025. This cost would be borne by both General Fund and non-General Fund sources. This estimate assumes 85% of members will agree to substitute their medications each year despite not being required to by the PBM.

Additionally, the ongoing impact could be higher or lower than $240,000. We believe it could be lower if the formulary exception process reduces the potential secondary health care utilization impacts associated with switching medications. We also believe the cost could be higher due to future increases in brand name drug prices, which would compound the costs of fewer substitutions. We do not have the data or resources necessary to estimate the net impact of these factors.

ADOA has not yet responded to our request for its estimate of the fiscal impact of the current version of the bill.

Higher Health Insurance Trust Fund (HITF) costs are borne by either employer contributions in the form of increased state appropriations or higher employee contributions. The bill does not specify how any increased costs would be paid. If paid solely by the state agencies, the General Fund would be billed for 60% of the cost with non-General Fund monies covering the rest.

Analysis

The state employee health insurance plan is run by ADOA and is funded via HITF. The state uses a self-insured model, meaning that the state is responsible for the direct costs of health insurance claims. The state contracts with a PBM to manage prescription drug benefits for all of its members.

Currently, PBMs have the ability to limit or exclude coverage of specific prescription drugs from the members of a health plan. As part of this, a PBM may substitute a generic drug for a brand name drug within the health plan's formulary. This is likely to generate savings to the health plan and HITF as generic versions of drugs are often much less expensive than their brand name counterparts.

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ADOA estimates that in PY 2023, the health plan saved $1.6 million as a result of generic drug substitutions. Under this bill, if a provider were to give notice to the PBM that the member will continue on the medication, the member would continue on the brand name drug for the remainder of the current plan year. In this circumstance, we estimate the $1.6 million of savings would no longer accrue to the health plan every year given that new generic drugs are continually introduced to the market.

However, we anticipate that not all members would choose to continue on their current medication. This is because members share in the cost of prescription drug benefits. In addition to their deductible, members also pay a copay for prescription drug benefits. The copay for preferred brand name drugs is 2.7x larger than the copay for generic drugs, and the copay for non-preferred brand name drugs is 4x larger than the copay for generic drugs. Because of the different levels of cost sharing, we believe it is very likely that a portion of members would agree to substitute the generic drug for the brand name drug. To the extent that this occurs, the health plan would retain a portion of the $1.6 million in savings.

We assume that 85% of members will agree to substitute their medications each year despite having the option to continue on their current prescription. This is based on a National Institutes of Health study of consumer attitudes toward generic drugs and overall generic drug uptake in the U.S. If only the remaining 15% of members were to continue on their current medication, the loss of the $1.6 million of savings would be reduced to $240,000.

Additionally, the bill would require PBMs to continue coverage of a specific drug if requested by the prescribing provider and if the member meets certain criteria at the renewal of the plan year. These criteria include:

- The member has tried and failed to treat his or her condition using a formulary equivalent prescription drug.
- The member has experienced a positive therapeutic outcome on his or her current drug for more than 90 days.
- The formulary equivalent prescription drugs are contraindicated or will likely cause a serious adverse reaction to the member.

This formulary exception process could potentially result in additional costs as a portion of the $240,000 impact would accumulate every year. However, because the criteria prescribed by the bill only targets members that would be adversely affected by the substitution, we believe the more likely impact would be that certain potential secondary impacts on health care utilization would be reduced. Examples of these impacts include higher levels of physician or hospital visitation or increased use of services such as a lab tests. These added costs can be a result of re-emerging symptoms or side effects of the new medication.

We also believe that price increases for brand name drugs could further increase costs above $240,000 in future years. However, due to the volatility of the brand name drug market and several recent changes to federal law regulating prescription drug pricing, any estimate of the fiscal impact of future price increases would be highly speculative.

These factors could result in the overall impact of the bill being higher or lower than $240,000, but we do not have the data or resources necessary to estimate the net impact.

ADOA has provided its estimate of the fiscal impact for a previous version of the bill, but it has not yet responded to our request for an updated fiscal impact estimate for the bill as amended by the House Appropriations Committee.

Without a corresponding increase in member premiums, any additional HITF costs would potentially need to be paid for via additional employer contributions. These contributions would come from both General Fund and Other Fund sources.

Local Government Impact

The impact of the bill on local governments' health insurance costs cannot be determined in advance. The impact would depend on current levels of coverage, prescription drug utilization, and efforts to substitute members' use of generic drugs for brand name drugs.