F I S C A L I M P A C T R E P O R T

SPONSOR SJC **ORIGINAL DATE** 03/02/11 **LAST UPDATED** 03/16/11 **HB**

SHORT TITLE Prescription Drug Price Controls **SB** 536/SJCS

ANALYST Hanika-Ortiz/Graeser

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY11	**FY12**		
	*See fiscal impact		

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From
Public School Insurance Authority (PSIA)
New Mexico Retiree Health Care Authority (NMRHCA)
Health Policy Commission (HPC)
Public Regulation Commission (PRC)

SUMMARY

Synopsis of Bill

Senate Judiciary Committee Substitute for Senate Bill 536 amends sections of the New Mexico Insurance Code, the Health Maintenance Organization Law, and the Nonprofit Health Care Plan Law to require health plans that are issued, delivered or renewed in New Mexico that provide prescription drug coverage with cost sharing, deductibles or co-insurance obligations based on a "tier" system be prohibited from reclassifying drugs that are tier 4 or tier 5 (specialty drugs) "during the term of the evidence of coverage." When drugs in tiers 2 or 3 are scheduled for reclassification, the administrator of the plan is required to notify the plan enrollees at least 60 days prior to the reclassification. A further 30 days may be provided to an enrollee who is unable to get an appointment with a prescribing practitioner. The substitute bill is properly titled as "PROVIDE NOTICE TO ENROLLEES" rather than "PRICING CONTROLS". The bill's provisions are contingent upon a federal requirement that requires the state to make payments on behalf of enrollees. The new notification requirements apply to individual or group health insurance policies (Chapter 59A, Article 22), to blanket and group health policies (Chapter 59A, Article 23), to Health Maintenance Organizations and to Nonprofit Health Care Plans.

The original bill proposed to limit any cost sharing to that of a non-preferred brand drug (usually tier 3) or a brand drug (usually tier 2) if there is no non-preferred brand category. It would have eliminated additional cost sharing for specialty drugs usually designated as tier 4.

FISCAL IMPLICATIONS

The notification provisions of this substitute bill are unlikely to result in reduced prescription drug costs. The notification requirements, however, will give individual enrollees the possibility of substituting a lower-priced drug for a higher-priced drug.

PSIA explains that each plan's formulary is organized into tiers, and each tier is associated with a set co-pay amount. Most formularies have between 3 and 5 tiers. The lower the tier, the lower the co-pay amount. For example, Tier 1 might include all of the Plan's preferred generic drugs, and each drug within this tier might have a co-pay of $5–10 per prescription. Tier 2 might include the Plan's preferred brand drugs with a co-pay of $20–$30, while Tier 3 may be reserved for non-preferred (non-formulary) brand drugs which are covered by the plan at a higher co-pay level - perhaps $40–$100. Tiers 4 and higher typically contain specialty drugs, which have the highest co-pays because they are generally expensive.

NMRHCA currently does not have any tiers of prescription coverage that require cost sharing beyond that of non-preferred brand drugs. As such, there would be no immediate fiscal impact.

SIGNIFICANT ISSUES

The bill does not provide any direct pricing controls. It does prohibit reclassifying specialty drugs to a higher tier of coverage during the term of the evidence of coverage. Any reclassification requires 60 days advance notice of the change to the covered members.

PERFORMANCE IMPLICATIONS

SB 536 provides that these requirements will not apply in the event that federal law requires the state to make payments on behalf of enrollees to cover the costs of implementing the prescription drug price controls.

ADMINISTRATIVE IMPLICATIONS

PRC reports that the Insurance Division currently does not have jurisdiction over cost-sharing, deductibles or coinsurance. Consequently, insurance carriers have the discretion of pricing prescription drugs at all levels of categories or tiers.

OTHER SUBSTANTIVE ISSUES

HPC reports that by 2008, the annual rate of increase in prescription spending was 3%, compared to 5% for hospital care and 5% for physician services. From 1998 to 2008, prescription drugs contributed 13% of the total growth in national health expenditures, compared to 30% for hospital care and 21% for physician and clinical services.

The U.S. Department of Health and Human Services projects U.S. prescription drug spending to increase from $234.1 billion in 2008 to $457.8 billion in 2019. Drug spending as a percent of

overall national health spending is projected to increase somewhat from 10.0% in 2008 to 10.2% in 2019.

Coverage and utilization of prescription drugs will be expanded by the Patient Protection and Affordable Care Act health insurance premium and cost-sharing subsidies; the designation of prescription drugs as an essential health benefit to be covered by private health plans; and Medicare's prescription drug rebate, cost-sharing, and catastrophic threshold changes.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Plans will retain the freedom to set copays and reclassify drug tiers to help control costs without notifying enrollees and allowing these enrollees to find an alternative, lower-priced formulary.

POSSIBLE QUESTIONS

AHO:LG/bym:mew