Department of Legislative Services
Maryland General Assembly
2006 Session

FISCAL AND POLICY NOTE

House Bill 863 (Delegate Gilleland, *et al.*)
Health and Government Operations

Prescription Drugs - Preferred Drug List - Price

This bill requires a health insurer, nonprofit health service plan, or HMO (carrier) that provides coverage for prescription drugs through a pharmacy benefit manager (PBM) and uses a preferred drug list to permit an enrollee to purchase a preferred brand named drug at the drug price or copayment the carrier requires for a generic drug, if there is no equivalent generic drug available on the preferred drug list.

Fiscal Summary

State Effect: Minimal special fund revenue increase in FY 2007 only for the Maryland Insurance Administration from the $125 rate and form filing fee. No effect on the State Employee and Retiree Health and Welfare Benefits Program or Medicaid, which are not carriers. No effect on revenues.

Local Effect: Local jurisdiction prescription drug expenditures could increase to the extent their employees purchase more expensive drugs.

Small Business Effect: Potential meaningful. To the extent small businesses purchase health insurance from a carrier that uses a PBM and preferred drug list to manage drug costs, prescription drug expenditures could increase.

Analysis

Current Law: A carrier that limits coverage of prescription drugs to those in a formulary must permit an enrollee to receive a prescription drug that is not on the entity's formulary if: (1) there is no equivalent prescription drug on the formulary; or (2) an equivalent has been ineffective, or has caused or is likely to cause an adverse reaction or

other harm to the enrollee. There is no provision specifying prices that may be charged for coverage.

Background: In an effort to stem rapidly increasing prescription drug costs, many carriers have implemented preferred formularies with tiered copayments. About two-thirds of employees with employer-sponsored prescription drug coverage are subject to tiered copayments, designed to encourage the use of generic and other lower-priced drugs. Under many such arrangements, an enrollee pays the smallest copayment for a generic drug, a higher copayment for a preferred brand named drug, and an even higher copayment for a nonpreferred brand named drug. In addition, many prescription drug coverage policies require the automatic substitution of a generic, if available, when an enrollee has been prescribed a brand named drug.

A tiered copayment policy may be inadequate to contain costs for some of the latest high-cost drugs, including injectable and oral agents such as certain cancer treatments. Biologics, such as antitoxins or vaccines, are of special concern because of their expense (often $1,000 or more per month), the large number of biologics under development, and the lack of generic competition. As the number of high-cost drugs increases, health benefit plans are likely to require consumers to share the costs of high-cost drugs through coinsurance rather than copayments. A plan might, for example, require enrollees to pay 25%-50% coinsurance for high-cost drugs.

According to the U.S. Food and Drug Administration, about half of all brand named drugs have generic counterparts.

Additional Information

Prior Introductions: An identical bill, HB 953 of 2005, was withdrawn.

Cross File: None.

Information Source(s): "Moving Toward Better Formulary Management" (January 2005), *American Journal of Managed Care*; U.S. Food and Drug Administration; Department of Health and Mental Hygiene (Medicaid, Board of Pharmacy); Department of Budget and Management (Employee Benefits Division); Department of Legislative Services

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