LEGISLATIVE FISCAL ESTIMATE

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 1865

STATE OF NEW JERSEY
218th LEGISLATURE

DATED: NOVEMBER 22, 2019

SUMMARY

Synopsis:	Requires health insurers to provide plans that limit cost-sharing concerning certain prescription drug coverage.
Type of Impact:	Multiyear expenditure increase to the State General Fund, local boards of education, and local governments.
Agencies Affected:	Division of Pensions and Benefits, Department of the Treasury; local government entities; local boards of education.

Office of Legislative Services Estimate

Fiscal Impact	Year 1	Year 2	Year 3
State Cost Increase		Indeterminate	
Local Cost Increase		Indeterminate	

- The Office of Legislative Services (OLS) estimates that this bill will have an indeterminate fiscal impact on State and local employer costs, including from provisions that limit a member's cost-sharing for up to a 30-day supply for each prescription drug prescribed. The limits will apply at any point in the benefit design, including before and after any applicable deductible is reached, except for high deductible plans.

- Brand name prescription drugs with generic equivalents could increase prescription drug costs to the State and local employers if those prescription drug costs exceed the limits specified in the bill. In 2018, copays for brand name prescription drugs with generic equivalents were changed in some health insurance plans from specific dollar amounts to requiring the member to pay the generic copay amount as well as the difference in cost between a generic prescription drug and the brand name drug with a generic equivalent.

BILL DESCRIPTION

This bill includes provisions that, for example, require the State Health Benefits Program and the State Employees' Health Benefits Program to limit a covered person's cost-sharing, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than

$200 per month for each prescription drug for up to a 30-day supply of any single drug, and the limits must apply at any point in the benefit design, including before and after any applicable deductible is reached. For prescription drug benefits offered in conjunction with a high-deductible health plan, the programs will not provide prescription drug benefits until the expenditures applicable to the deductible under the plan have met the amount of the minimum annual deductibles in effect for self-only and family coverage under sections of the federal Internal Revenue Code. Once the expenditure amount has been met under the plan, coverage for prescription drug benefits will begin, and the limit on out-of-pocket expenditures for prescription drug benefits will be as specified in the bill.

The bill also requires insurers and other programs that provide coverage for prescription drugs to have at least 25 percent of all plans, or at least one plan if the insurer offers less than four plans, in each rating area and in each of the bronze, silver, gold, and platinum levels of coverage, that limit a covered person's cost-sharing financial responsibility under a silver, gold, or platinum level of coverage, including any copayment or coinsurance, for prescription drugs, including specialty drugs, to no more than $150 per month for each prescription drug for up to a 30-day supply of any single drug, and that limit a covered person's cost-sharing under a bronze level of coverage, including any copayment or coinsurance, to $250 per month for each prescription drug for up to a 30-day supply of any single drug.

In the case of high-deductible plans, these cost sharing limits apply after any applicable deductible is reached.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS estimates that this bill will have an indeterminate fiscal impact on State and local employer costs, including from provisions that limit a member's cost-sharing for up to a 30-day supply for each prescription drug prescribed. Those limits will apply at any point in the benefit design, including before and after any applicable deductible is reached, except for high deductible plans. Brand name prescription drugs with generic equivalents could increase prescription drug costs to the State and local employers if those prescription drug costs exceed the limits specified in the bill. In 2018, copays for brand name prescription drugs with generic equivalents were changed in some health insurance plans from specific dollar amounts to requiring the member to pay the generic copay amount as well as the difference in cost between a generic prescription drug and the brand name drug with a generic equivalent. The OLS has no basis for determining the number of prescriptions that may be filled for brand name drugs with a generic equivalent.

Section:	*State Government*
Analyst:	*Kimberly M. Clemmensen* *Lead Fiscal Analyst*
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This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).