LEGISLATIVE FISCAL ESTIMATE TO

[First Reprint]
ASSEMBLY, No. 2926

STATE OF NEW JERSEY

DATED: JULY 3, 1997

Bill Summary

The Assembly Bill No. 2926 (1R) of 1997 exempts designated narrow therapeutic range (NTR) drugs from mandatory substitution pursuant to the "Prescription Drug Price and Quality Stabilization Act, " but allows substitution if the prescriber gives informed consent for the substitution. NTR drugs are widely used for the treatment of a number of acute or chronic medical conditions. According to the Senate Health Committee Statement, among the drugs that may qualify for NTR designation are: carbamazepine (Tegretol), conjugated estrogens (Premarin), digoxin (Lanoxin), levothyroxine sodium (Synthroid), phenytoin sodium (Dilantin), cyclosporine (Neoral), theophylline (Theo-Dur) and warfarin sodium (Coumadin).

The substitute authorizes the Drug Utilization Review Council in the Department of Health and Senior Services (DHSS) to establish a list of NTR drugs pursuant to criteria specified in the legislation.

Penalties for violating the provisions of the substitute are at least $100 for the first offense and $200 for each subsequent offense.

Agency Comments

The DHSS, the Division of Pensions and Benefits and the Office of Management and Budget have not provided fiscal information on this bill.

Office of Legislative Services Comments

Medicaid and PAAD Programs

The Office of Legislative Services (OLS) is not able to determine the impact the NTR designation will have on pharmaceutical expenditures in the Medicaid or PAAD programs, since future prescribing patterns that may result due to a drug's receiving an NTR designation cannot be determined and generic equivalents for at least two of the frequently dispensed drugs that may be designated as NTR, i.e., Coumadin and Premarin, are not yet available for substitution.

Data from the State's Medicaid and PAAD programs indicate that in those cases in which a generic equivalent is available for a drug that potentially may be designated as NTR and for which more than 100,000 claims were processed in 1996, the brand name drug is

prescribed significantly more frequently than its generic equivalent. For example, an estimated 106,500 claims were processed for Dilantin in 1996 as compared to 4,600 claims for its generic equivalent, Phenytoin Sodium. Similarly, an estimated 199,600 claims were processed for Lanoxin compared to 30,600 claims for Digoxin, its generic equivalent. In these cases, an NTR designation may have little impact on dispensing patterns and expenditures.

It is noted that if the committee substitute has any impact on prescribing and dispensing practices, State expenditures and rebates received from pharmaceutical manufacturers may be affected. If the brand name drug is prescribed more frequently than its generic counterpart because of an NTR designation:

- the NTR Designation could result in higher Medicaid and PAAD costs since generic drugs are generally less expensive than brand name drugs; and
- the State would receive an increase in pharmaceutical manufacturers' rebates because the State receives a greater rebate from manufacturers for the brand name (the greater of 15 percent of the average manufacturer price of the drug or the manufacturers' "best price") compared to a rebate of 11 percent of the average manufacturers' price on generic drugs.

State Prescription Drug Program

The Office of Legislative Services is not able to determine the impact the NTR designation will have on the pharmaceutical expenditures in the State Prescription Drug Program, since future prescribing patterns that may result due to a drug's receiving an NTR designation cannot be determined.

The State Prescription Drug Program currently substitutes generic for non-generic (brand) drugs, unless the patient or the doctor request no substitution. The State has taken several steps to encourage the use of generic drugs. In mid-1993, the State Health Benefits Program (SHBP) reduced the copay for generic drugs from $3.50 to $1.00 to encourage the patient to request generic substitution. To further encourage generic dispensing, by retail and mail order pharmacies, Blue Cross increased the generic dispensing fee (the fee paid to pharmacists) from $2.50 to $2.75 and lowered the brand dispensing fee to $2.25.

During the past year, approximately 56 percent of the drugs dispensed under the Prescription Drug Program, through the retail program (versus mail order), are long term care drugs. More than 60 percent of these prescriptions were for brand name drugs for which there is no generic substitute and approximately one-third of the prescriptions dispensed were for generic drugs. No information is available on individual drugs.

If the committee substitute has any impact on prescribing and

dispensing practices in the Prescription Drug Program that results in brand drugs being prescribed more frequently than generic drugs, the cost to State employees, through higher co-payments, will increase. Furthermore, the NTR designation could result in higher State Prescription Drug Program costs since generic drugs are generally less expensive than brand name drugs. However, such increased costs would be partially offset because the brand name dispensary fee is 50 cents less than the fee for generic drugs.

Finally, it is noted that a physician who consents to the substitution of an NTR drug may require additional medical monitoring or blood testing to assure that the patient does not have an adverse reaction to the newly prescribed medication or to adjust the dosage of the medication. Additional medical monitoring or blood testing would entail an additional cost to the State Medicaid and State Health Benefits programs, with the exception of patients at State institutions where additional monitoring and testing do not necessarily increase institutional costs. The PAAD program does not pay for medical monitoring or blood testing, and any additional medical costs would be paid for by the PAAD recipients' health insurance. However, the extent to which additional medical monitoring or blood testing will be required by physicians cannot be determined as it involves physician judgment as to whether a particular patient requires additional medical monitoring or blood testing.

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67.