



Fiscal Note 2021 Biennium

Bill #	SB0280
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Title:	Establish requirements for providing and covering medication-assisted treatment
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Primary Sponsor:	Olszewski, Albert
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Status:	As Introduced
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- Significant Local Gov Impact
 Needs to be included in HB 2
 Technical Concerns
 Included in the Executive Budget
 Significant Long-Term Impacts
 Dedicated Revenue Form Attached

FISCAL SUMMARY

	<u>FY 2020</u> <u>Difference</u>	<u>FY 2021</u> <u>Difference</u>	<u>FY 2022</u> <u>Difference</u>	<u>FY 2023</u> <u>Difference</u>
Expenditures:				
General Fund	\$217,114	\$470,306	\$513,480	\$560,617
State Special Revenue	\$13,811	\$19,368	\$19,609	\$19,687
Federal Special Revenue	\$460,645	\$956,972	\$1,038,650	\$1,127,085
Other	\$0	\$0	\$0	\$0
Revenue:				
General Fund	\$0	\$0	\$0	\$0
State Special Revenue	\$0	\$0	\$0	\$0
Federal Special Revenue	\$460,645	\$956,972	\$1,038,650	\$1,127,085
Other - Rebates	(\$29,055)	(\$31,670)	(\$34,520)	(\$37,627)
Net Impact-General Fund Balance:	<u>(\$217,114)</u>	<u>(\$470,306)</u>	<u>(\$513,480)</u>	<u>(\$560,617)</u>

Description of fiscal impact: SB 280 implements the “Ensuring Access to High-Quality Care for the Treatment of Substance Use Disorders Act” and requires health insurance and Medicaid coverage of medication-assisted treatment. Additionally, requirements for the Commissioner of Insurance include developing standards, reporting and rules.

FISCAL ANALYSIS

Assumptions:

Department of Public Health and Human Services:

- Section 4 requires health insurers including Medicaid to cover Medication Assisted Treatment (MAT) and requires all MAT medications to have a preferred status on the preferred drug list. The implementation of

- these requirements is estimated to increase the PMPM costs of outpatient pharmacy by \$216.85 for FY 2020 with an estimated growth rate of 1% per year thereafter. The PMPM cost is based on members utilizing MAT.
2. Based on current utilization, 1,900 members are accessing MAT. The department assumes an annual growth rate of eligible members at 6%.
 3. The department estimates 25% of MAT are reimbursable under regular HB 2 Medicaid and 75% are reimbursable under Medicaid Expansion.
 4. Fiscal Year 2020 impact reflects six months of increase as the bill has an effective date of January 1, 2020. The remaining years represent 12 months of activity.
 5. The following table shows the estimated expenditures by fiscal year and estimated impacts by funding source.

	FY 2020	FY 2021	FY 2022	FY 2023
Estimated Members Utilizing MAT	1,900	2,014	2,135	2,263
Estimated Increase PMPM	\$ 216.85	\$ 223.36	\$ 230.06	\$ 236.96
Estimated Expenditure	\$ 2,472,090	\$ 5,398,056	\$ 5,893,597	\$ 6,434,629
FMAP				
	FY 2020	FY 2021	FY 2022	FY 2023
Standard Medicaid				
State Share	35.07%	34.85%	34.85%	34.85%
Federal Share	64.93%	65.15%	65.15%	65.15%
Medicaid Expansion				
State Share	8.74%	10.00%	10.00%	10.00%
Federal Share	91.26%	90.00%	90.00%	90.00%
FUNDING				
	FY 2020	FY 2021	FY 2022	FY 2023
Medicaid - 25%				
State - Medicaid	\$ 216,740	\$ 470,306	\$ 513,480	\$ 560,617
Federal - Medicaid	\$ 401,282	\$ 879,208	\$ 959,920	\$ 1,048,040
TOTAL Medicaid	\$ 618,023	\$ 1,349,514	\$ 1,473,399	\$ 1,608,657
Medicaid Expansion - 75%				
State	\$ 162,045	\$ 404,854	\$ 442,020	\$ 482,597
Federal	\$ 1,692,022	\$ 3,643,688	\$ 3,978,178	\$ 4,343,375
TOTAL Medicaid Expansion	\$ 1,854,068	\$ 4,048,542	\$ 4,420,198	\$ 4,825,972

6. Section 5 of SB 280 requires insurance companies disclose all providers offering MAT. To implement this requirement, the department would need to maintain a list of current waiver providers and the level of care they provide.
7. The department anticipates hiring a 1.00 FTE Medicaid Program Officer to develop and monitor MAT programs and services for adults.
8. Salary and Benefits for the 0.50 FTE is estimated at \$37,443 in FY 2020, and 1.00 FTE at \$74,885 in FY 2021, \$76,058 in FY 2022 and \$76,439 in FY 2023.
9. Operating costs are 3% of personal service costs.
10. There will be a one-time expense of \$2,800 in FY 2020 for computer and office set-up.

11. The department estimates 722 hours of one-time only changes to the Medicaid Management Information System (MMIS) to include MAT as a required expense. The cost in FY 2020 would be \$83,000 (722 hours x \$115 an hour).
12. Section 6 of the bill requires the department to submit a detailed substance use disorder and mental health parity report to the insurance commissioner for review annually.
13. SB 280 requires a parity (evidentiary) report to the insurance commissioner on an annual basis, which would require the department to contract with an actuary. Based on data received from other states, the department estimates the cost of the contract would be \$50,000 each year to produce and finalize the report. Costs would be incurred beginning in FY 2021.
14. The department estimates that 40% of MAT services are reimbursable under regular HB2 Medicaid, and 60% are reimbursable under Medicaid Expansion. Federal matching percentages are detailed below:

	FY 2020	FY 2021	FY 2022	FY 2023
Standard Medicaid				
State Funds	35.07%	34.85%	34.85%	34.85%
Federal Funds	64.93%	65.15%	65.15%	65.15%
Medicaid Expansion				
State Funds	8.74%	10.00%	10.00%	10.00%
Federal Funds	91.26%	90.00%	90.00%	90.00%

State Auditor’s Office:

15. The State Auditor’s Office (CSI) will contract with a program consultant to support CSI staff efforts in setting network requirements, insurer reporting requirements, and mental health parity reporting requirements. Costs for the consultant in FY 2020 are estimated at \$25,000.
16. The CSI shall adopt rules necessary to implement and enforce the necessary requirements of the bill. The cost of the rules is expected to be \$1,200 in FY 2020 (20 pages at \$60 per page).

Department of Administration:

17. SB 280 Section 4 requires all current and new formulations and medications must be covered by the Pharmacy Benefit Manager (PBM) formulary at the lowest cost-sharing tier. Five medications specifically listed are buprenorphine, including extended-release injectable buprenorphine; methadone; naloxone; extended-release injectable naltrexone; and buprenorphine and naloxone in combination. The State of Montana Employee Group Benefits Plan (plan) utilization through the pharmacy benefit of these medications during plan year 2018 was as follows:

Drug Name	SOM Coverage	SOM 2018 Utilization	SOM Plan Paid	SOM Net Plan Paid
buprenorphine and ER buprenorphine inj products	NC	1	\$0	\$0
methadone products	1	95	\$300	\$300
naloxone products	2 or NC	10	\$548	\$486
ER naltrexone inj products	1 or NC	110	\$2,178	\$2,178
buprenorphine/naloxone combo products	2 or NC	250	\$68,498	\$44,111

18. Assuming the same utilization, if the naloxone products and buprenorphine/naloxone combo products were moved to the lowest cost-sharing tier (\$0-member copay), there would be an additional cost to the plan of \$9,100 (260 scripts at Tier 2 * \$35 copay previously paid by the member = \$9,100).

19. The plan’s contract with the PBM includes direct passthrough of any rebate dollars received on the pharmacy member utilization. Some of the rebate agreements held by the PBM include placement location on a formulary in relation to similar alternative medications. Assuming the same utilization, if all the noted medications were placed at the lowest cost-sharing tier, the plan would lose an estimated \$24,455 in rebates dollars each year.
20. Three additional injectable medications noted by the plan’s current PBM include Sublocade, Vivitrol, and Evzio. These medications are traditionally administered and billed under the medical benefit. Under this bill, these medications would be covered at the lowest cost-sharing tier (\$0-member copay) on the pharmacy formulary. The per fill and annual cost for these injectable medications would be as follows:

Drug Name	Total Net Cost per Fill	Total Net Cost per Year per Utilizing Member
*SUBLOCADE	\$1,539	\$18,468
*VIVITROL	\$1,258	\$15,096
EVZIO	\$3,012	\$3,012

- The plan is unable to project how many utilizers would be prescribed these injectable medications at this time.
21. The plan’s actuary uses a low pharmacy trend rate of 9% per year when completing claims projections. Applying this 9% trend per year to the pharmacy utilization outlined in item 1, as well as rebate reductions outlined in item 3, provides the following annual impact:

	2018	2019	2020	2021	2022	2023
Pharmacy Claims	9,100	9,919	10,812	11,785	12,845	14,001
Rebate Reduction	24,455	26,656	29,055	31,670	34,520	37,627

22. The medical plan currently provides coverage for the outlined services. There is a potential the Montana provider network will not be sufficient to provide the needed care for all patients. In this case, as outlined in SB 280, the member would have the ability to obtain the needed treatment at or from an out-of-network facility or provider with the health plan applying the in-network benefits. The plan does not anticipate a significant new volume of patients requiring the outlined care. The plan believes the potential cost impact to be minimal.
23. SB 280 outlines additional required plan disclosures relating to the provider network and level of care available to the members. These additional plan administration requirements would be completed with current staff and resources.

	<u>FY 2020</u> <u>Difference</u>	<u>FY 2021</u> <u>Difference</u>	<u>FY 2022</u> <u>Difference</u>	<u>FY 2023</u> <u>Difference</u>
<u>Fiscal Impact:</u>				
FTE	0.50	1.00	1.00	1.00
<u>Expenditures:</u>				
Personal Services	\$37,443	\$74,885	\$76,058	\$76,439
Operating Expenses	\$62,303	\$22,247	\$22,282	\$22,293
Benefits	\$607,211	\$1,361,299	\$1,486,244	\$1,622,658
TOTAL Expenditures	\$706,957	\$1,458,431	\$1,584,584	\$1,721,390
<u>Funding of Expenditures:</u>				
General Fund (01)	\$217,114	\$470,306	\$513,480	\$560,617
State Special Revenue (02)	\$13,811	\$19,368	\$19,609	\$19,687
Federal Special Revenue (03)	\$460,645	\$956,972	\$1,038,650	\$1,127,085
Other	\$0	\$0	\$0	\$0
TOTAL Funding of Exp.	\$691,569	\$1,446,646	\$1,571,739	\$1,707,389
<u>Revenues:</u>				
General Fund (01)	\$0	\$0	\$0	\$0
State Special Revenue (02)	\$0	\$0	\$0	\$0
Federal Special Revenue (03)	\$460,645	\$956,972	\$1,038,650	\$1,127,085
Other - Rebate Revenue	(\$29,055)	(\$31,670)	(\$34,520)	(\$37,627)
TOTAL Revenues	\$431,590	\$925,302	\$1,004,130	\$1,089,458
<u>Net Impact to Fund Balance (Revenue minus Funding of Expenditures):</u>				
General Fund (01)	(\$217,114)	(\$470,306)	(\$513,480)	(\$560,617)
State Special Revenue (02)	(\$13,811)	(\$19,368)	(\$19,609)	(\$19,687)
Federal Special Revenue (03)	\$0	\$0	\$0	\$0
Other - Rebate Revenue	(\$29,055)	(\$31,670)	(\$34,520)	(\$37,627)

Technical Notes:

Department of Public Health and Human Services:

1. Methadone cannot be included on the Preferred Drug List for medication assisted treatment because methadone can only be dispensed at an outpatient pharmacy for a pain diagnosis and not for medication assisted treatment. Methadone dispensing for medication assisted treatment is restricted to clinics/facilities in accordance with 42 CFR 8.12. It is further explained in the DEA practitioner’s manual-section VI <https://www.dea diversion.usdoj.gov/pubs/manuals/pract/section6.htm>
2. A state plan amendment adding the additional fee must be written and sent to the Centers for Medicare and Medicaid Services (CMS) for approval. It must be approved in order to receive federal matching funds for this service.
3. Costs for this service for the Medicaid Expansion population are outlined in the table on page 2, but not included in the fiscal summary as the current program ends June 30, 2019. To the extent that a Medicaid Expansion program is renewed, these costs, as outlined, will need to be included in the budget for the department.

Department of Administration:

- 4. SB 280 Section 4(2) and (3) requires a pharmacy benefit manager (PBM) to include all current and new formulations and medications approved by the U.S. food and drug administration for the treatment of substance use disorder on the lowest cost-sharing tier of the formulary. Section 4(4) states coverage may not be subject to annual or lifetime dollar limitations; limitations to a predesignated facility, specific number of visits, days of coverage, days in a waiting period, scope or duration of treatment, or other similar limits; financial requirements and quantitative treatment limitations that do not comply with the federal Mental Health Parity and Addiction Equity Act of 2008 and 45 CFR 146.136(c)(3); step therapy or other similar drug utilization strategies or policies when they conflict or interfere with a prescribed or recommended course of treatment by a health care provider; or prior authorization. The pharmaceutical industry is continually obtaining approval for new formulations and medications, some of which can be high cost. The requirement to cover all formulations and medications at the lowest cost-sharing tier places financial risk and uncertainty on the plan.

NO SPONSOR SIGNATURE

Sponsor's Initials

Date

TL

Budget Director's Initials

3/26/19

Date