

TENNESSEE GENERAL ASSEMBLY  
FISCAL REVIEW COMMITTEE



FISCAL MEMORANDUM

HB 1257 – SB 1312

March 25, 2013

**SUMMARY OF ORIGINAL BILL:** Requires court clerks to forward a copy of a judgment and date of birth of any person who is convicted of a methamphetamine-related offense to the Tennessee Bureau of Investigation (TBI) within 10 days of the clerk receiving the judgment and up to 45 days following the date of the judgment.

FISCAL IMPACT OF ORIGINAL BILL:

NOT SIGNIFICANT

**SUMMARY OF AMENDMENT (004464):** Deletes all language after the enacting clause. Requires a dispensing agent, prior to dispensing any prescription for buprenorphine combined with naloxone, to check the controlled substance database as required in Tenn. Code Ann. § 53-10-310(e)(3). Such combination is prohibited from being prescribed to anyone, except for patients diagnosed with opioid dependence, which are in the course of maintenance treatment. Limits the prescribing of buprenorphine to patients which are pregnant, have demonstrated hypersensitivity to naloxone, or as an injectable treatment in a physician's office or other healthcare facility. Any prescription for buprenorphine is required to be written out by a physician in accordance with the *Drug Addiction Treatment Act of 2000*. Requires a pharmacist, prior to dispensing a prescription for buprenorphine, to verify that the prescribing physician has received a waiver to prescribe the drug, provided, however, that a pharmacist may dispense buprenorphine if a seventy-two hour emergency prescription has been issued pursuant to federal regulations or law.

Prohibits any certified nurse practitioner or physician assistant from writing prescriptions for buprenorphine combined with naloxone. Sets maximum dosing limitations for the combination of buprenorphine and naloxone:

- No more than twenty-four milligrams buprenorphine and six milligrams naloxone shall be prescribed within the first six months of use.
- No more than sixteen milligrams buprenorphine and four milligrams naloxone shall be prescribed for the subsequent six months of use.

Requires any physician prescribing such buprenorphine to prescribe the lowest effective dose following the initial twelve months of the prescription for the maintenance treatment of opioid addiction to prevent patient relapse.

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Requires health insurance policies which are delivered executed, issued, amended, adjusted, or renewed in this state, or outside this state if insuring residents of this state, by January 1, 2014, to provide for a prescription in accordance with the limitations of this bill. States that coverage for such prescriptions shall not be subject to dollar limits, deductibles or coinsurance provisions that generally apply under health insurance policies. States that TennCare shall provide coverage for prescriptions of buprenorphine and naloxone.

Requires any prescribed combination of buprenorphine and naloxone to be in a uniquely numbered and 2D bar coded unit dose contained within a F2 child resistant package as determined by the federal food and drug administration (FDA). Requires any physician who prescribes such combination, to discontinue such treatment, if the patient tests positive for opioids in three or more urine tests. Requires, prior to prescribing such combination, that women who are fourteen years of age or older take a pregnancy test, and be counseled as to the risk of neonatal abstinence syndrome and offered means to prevent pregnancy. Such prescription shall not be fulfilled if the patient is found to be pregnant or breastfeeding unless the physician determines that the potential benefit of buprenorphine justifies the potential risk of use.

Requires physicians to quarterly evaluate patients whom are prescribed a combination of buprenorphine and naloxone and determine whether such patient's prescription should be reduced. If the patient's prescribed daily dosage is, after the first six months of treatment, found to exceed sixteen milligrams of buprenorphine or over four milligrams of naloxone, the physician is required to refer the patient to a physician certified in addiction treatment. If after two years of treatment, the patient's prescribed daily dosage is found to exceed four milligrams of buprenorphine or over one milligram of naloxone, the prescribing is required to refer the patient to a physician certified by the American Board of Medical Specialties (ABMS) in addiction treatment.

Authorizes the Board of Medical Examiners to impose disciplinary action against any physician who fails to comply with these requirements of the *Drug Treatment Act of 2000*.

## **FISCAL IMPACT OF BILL WITH PROPOSED AMENDMENT:**

**Increase State Expenditures - \$3,073,200/FY13-14**

**\$6,146,400/FY14-15 and Subsequent Years**

**Increase Federal Expenditures - \$5,834,600/FY13-14**

**\$11,669,300/FY14-15 and Subsequent Years**

**Potential Impact on Health Insurance Premiums (required by Tenn. Code Ann. § 3-2-111): Such legislation will result in an increase in the cost of health insurance premiums for prescription benefits being provided by plans that do not currently offer these benefits at the proposed mandated levels. It is estimated that the increase to each individual's total premium will be up to one percent. A one percent increase in premium rates could range between \$50 (single coverage) and \$140 (family coverage).**

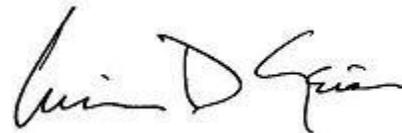
Assumptions for the bill as amended:

- According to the Bureau of TennCare, this bill will significantly impact the Bureau by increasing dosage limitations. Currently, TennCare covers buprenorphine with naloxone with a maximum dose of 16 mg buprenorphine of the first six months of treatment, then 8 mg buprenorphine per day thereafter.
- This bill would increase such limitations, from 16 to 24 mg in the first 6 months and, from 8 to 16 mg, in the next 6 months.
- This would result in a significant increase in TennCare expenditures.
- TennCare currently has 2,693 average monthly enrollees undergoing opiate addiction treatment.
- The current monthly average spent on such drugs is \$841,396.
- TennCare estimates that increased prescribed dosages of such drugs will increase expenditures by 263.79 percent or \$2,219,519 in monthly expenditures.
- This would increase the monthly expenditures for TennCare by \$1,378,123 (\$2,219,519 - \$841,396) or \$16,537,476 annually (\$1,378,123 x 12 months).
- There will be four urine drug administered annually to each patient undergoing opiate addiction treatment.
- A urine tests costs approximately \$113.89.
- This would increase annual TennCare expenditures by \$1,226,823 (2,693 x 4 x \$113.89).
- There will be four pregnancy tests administered annually to enrollees who are subject to pregnancy testing.
- According to TennCare, of the 2,693 who receive the drugs, there are 1,836 enrollees who would be subject to pregnancy testing.
- A pregnancy test costs approximately \$7.00.
- This would increase annual TennCare expenditures by \$51,408 (1,836 x 4 x \$7).
- The total increase in TennCare expenditures is estimated to be \$17,815,707 (\$16,537,476 + \$1,226,823 + \$51,408).
- This increase in expenditure will be covered through state and federal funds. Of the \$17,815,707, the recurring increase in state expenditures will be \$6,146,419 at a rate of 34.5 percent (\$17,815,707 x .345) and \$11,669,288 will be federal expenditures at a 65.5 percent match rate (\$17,815,707 x .655).
- Due to the effective date of January 1, 2014, there will be half the annual amount of expenditures in FY13-14, or \$3,073,209.50 in state funds and \$5,834,644. In FY14-15 and subsequent years, the full annual amount of expenditures will be incurred.
- Any costs incurred by the Board of Medical Examiners to impose necessary disciplinary actions will not result in a significant increase in expenditures for investigations or hearings and can be accommodated within existing resources of the Board.
- Pursuant to Tenn. Code Ann. § 4-3-1011, all regulatory boards are required to be self-supporting over a two-year period. The Board of Medical Examiners had closing balances of \$613,808 in FY10-11, \$687,808 in FY11-12, and a closing reserve balance of \$2,153,016 on June 30, 2012.

- According to the Division of Benefits Administration, there are no current dose limitations for members under any state, local education, or local government plan; therefore, there will be no significant increase in costs to the state to administer these plans.
- Federal 45 C.F.R. §155.70 authorizes a state to require a qualified health plan (QHP) to offer benefits in addition to the essential health benefits. If the state-required benefits are in addition to the essential health benefits, then the state must make payments to defray the cost of the additional required benefits to an enrollee or directly to the QHP issuer on behalf of the enrollee.
- It is assumed that the state will not be subject to an increase in expenditures related to the mandated benefits under this rule. *The Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, Final Rule* (Federal Register Vol. 78, No. 037, dated February 25, 2013) states that QHPs must offer at least the greater of one drug for each United States Pharmacopeia (USP) category and class or the number of drugs in the essential health benefit (EHB) benchmark plan, plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding EHB.
- Private sector health insurance premium impact: The provisions of the bill will result in an increase in covered individuals receiving specified dose amounts of buprenorphine and naloxone for a specific amount of time. Health insurance premiums will increase to cover the costs of the additional benefit.
- According to the *Health Insurance Mandates in the States 2010* report by the Council for Affordable Health Insurance (CAHI), the estimated cost to health insurance for drug abuse treatment is less than one percent of the total premiums nationwide. Based on a 2011 report by the Fiscal Review Committee staff, a one percent increase in premium rates will range between \$50 (single coverage) and \$140 (family coverage) on average depending on the type of plan.
- According to the Bureau, it is common medical practice to refer a patient to a specialist as necessary; therefore, any referrals to physicians specializing in drug addiction will have no significant impact to current claim reimbursements.

## **CERTIFICATION:**

The information contained herein is true and correct to the best of my knowledge.



Lucian D. Geise, Executive Director

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