SENATE BILL NO. 130

INTRODUCED BY KENNEDY, PIPINICH, THAYER, CONNELLY, WANZENRIED, MEASURE, COHEN, O'KEEFE, T. BECK, VAN VALKENBURG, DOHERTY, HARPER, BECKER, BRUSKI, HOCKETT, GROSFIELD, JERGESON, CRIPPEN, SVRCEK, DEVLIN, MAZUREK

IN THE SENATE

JANUARY 18, 1991	INTRODUCED AND REFERRED TO COMMITTEE ON LABOR & EMPLOYMENT RELATIONS.
	FIRST READING.
FEBRUARY 4, 1991	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
FEBRUARY 5, 1991	PRINTING REPORT.
FEBRUARY 12, 1991	SECOND READING, DO PASS.
FEBRUARY 13, 1991	ENGROSSING REPORT.
	THIRD READING, PASSED. AYES, 49; NOES, 0.
	TRANSMITTED TO HOUSE.

IN THE HOUSE

FEBRUARY 14, 1991	INTRODUCED AND REFERRED TO COMMITTEE ON LABOR & EMPLOYMENT RELATIONS.
	FIRST READING.
MARCH 8, 1991	COMMITTEE RECOMMEND BILL BE CONCURRED IN. REPORT ADOPTED.
MARCH 11, 1991	SECOND READING, CONCURRED IN.
MARCH 12, 1991	THIRD READING, CONCURRED IN. AYES, 92; NOES, 5.
	RETURNED TO SENATE.

IN THE SENATE

MARCH 13, 1991	RECEIVED FROM HOUSE.
	SENT TO ENROLLING.

REPORTED CORRECTLY ENROLLED.

Senate BILL NO. 130

INTRODUCED BY

A BILL FOR AN ACT ENTITLED: "AN ACT LIMITING WORKERS' COMPENSATION PAYMENTS FOR PRESCRIPTION DRUGS TO THE PURCHASE OF GENERIC-NAME PRODUCTS UNLESS A PRESCRIBED BRAND-NAME DRUG IS MEDICALLY NECESSARY OR THE INJURED WORKER AGREES TO PAY THE DIFFERENCE IN THE COST FOR THE BRAND-NAME PRODUCT; AMENDING SECTION 39-71-704, MCA; AND PROVIDING AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 39-71-704, MCA, is amended to read:

"39-71-704. **Payment of medical, hospital, and related services -- fee schedules and hospital rates.** (1) In addition to the compensation provided by under this chapter and as an additional benefit separate and apart from compensation benefits actually provided, the following must be furnished:

(a) After the happening of the injury, the insurer shall furnish, without limitation as to length of time or dollar amount, reasonable services by a physician or surgeon, reasonable hospital services and medicines when needed, and such other treatment as may be approved by the department for the injuries sustained, subject to the

requirements of [section 2].

(b) The insurer shall replace or repair prescription eyeglasses, prescription contact lenses, prescription hearing aids, and dentures that are damaged or lost as a result of an injury, as defined in 39-71-119, arising out of and in the course of employment.

(c) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury pursuant to rules adopted by the department. Reimbursement must be at the rates allowed for reimbursement of travel by state employees.

(2) A relative value fee schedule for medical, chiropractic, and paramedical services provided for in this chapter, excluding hospital services, must be established annually by the department and become effective in January of each year. The maximum fee schedule must be adopted as a relative value fee schedule of medical, chiropractic, and paramedical services, with unit values to indicate the relative relationship within each grouping of specialties. Medical fees must be based on the median fees as billed to the state fund during the year preceding the adoption of the schedule. The state fund shall report fees billed in the form and at the times required by the department. The department shall adopt rules establishing relative unit values, groups of specialties, the procedures insurers must

INTRODUCED BILL
SB 130

use to pay for services under the schedule, and the method of determining the median of billed medical fees. These rules must be modeled on the 1974 revision of the 1969 California Relative Value Studies.

(3) Beginning January 1, 1988, the department shall establish rates for hospital services necessary for the treatment of injured workers. Approved rates must be in effect for a period of 12 months from the date of approval. The department may coordinate this ratesetting function with other public agencies that have similar responsibilities.

(4) Notwithstanding subsection (2), beginning January 1, 1988, through December 31, 1991, the maximum fees payable by insurers must be limited to the relative value fee schedule established in January 1987. Notwithstanding subsection (3), beginning January 1, 1988, through December 31, 1991, the hospital rates payable by insurers must be limited to those set in January 1988."

NEW SECTION. **Section 2.** **Payment for prescription drugs -- limitations.** (1) The department shall limit payments for prescription drugs to the purchase of less expensive drug products with the same generic name if the generic-name product is the therapeutic equivalent of the specific brand-name drug prescribed by the physician unless:

(a) the physician certifies that, in his professional opinion, the prescribed brand-name drug is medically

necessary; or

(b) the injured worker agrees to pay the difference in the cost between the drug prescribed and the generic-name drug product.

(2) For purposes of this section, the terms "brand name", "drug product", and "generic name" have the same meaning as provided in 37-7-502.

NEW SECTION. **Section 3.** **Codification instruction.** [Section 2] is intended to be codified as an integral part of Title 39, chapter 71, part 7, and the provisions of Title 39, chapter 71, part 7, apply to [section 2].

NEW SECTION. **Section 4.** **Effective date.** [This act] is effective July 1, 1991.

-End-

STATE OF MONTANA - FISCAL NOTE
Form BD-15
In compliance with a written request, there is hereby submitted a Fiscal Note for SB0130, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION:

An act limiting workers compensation payments for prescription drugs to the purchase of generic-name produces unless a prescribed brand-name drug is medically necessary or the injured worker agrees to pay the difference in the cost for the brand-name product; amending section 39-71-704, MCA; and providing an effective date.

ASSUMPTIONS:

1. The Department of Labor will maintain and distribute to carriers a fee schedule for prescription drugs which limits reimbursements for brand-name drugs based on the "book" price for generic equivalents. The Department of Labor would contract with a private vendor to receive, in an electronic format which is updated quarterly, the FDA list of generic equivalents and the appropriate "book" prices.
2. The fee schedule created by the Department of Labor will be converted to the State Fund computer system. A cross-reference listing of generic-name versus brand-name prices for each drug code will be created.
3. Claims forms, statement forms, and computerized databases will be modified to enable the indication of non-generic brand drugs authorized by the physician or chosen by the claimant.
4. The State Fund will pay the full cost of the prescription and bill the claimant for the price difference between the generic-name prescription and the brand-name prescription if the brand-name prescription was not authorized by the physician. A billing statement will be developed to notify claimants of the amount to remit to the State Fund for the purchase of brand-name prescription drugs which were not physician approved.
5. The State Fund would add 0.50 FTE to bill, receipt, and account for the amount due from claimants; 1.00 FTE to administer the provisions of the bill including reviewing copies of the prescription if a brand-name drug is purchased in order to determine if the physician specifically ordered the brand-name drug of if the claimant agreed to pay the difference; and 0.50 FTE to maintain and enhance the modifications made to the State Fund computer system associated with limitations on prescription drug payments.
6. The State Fund currently pays approximately $2 million per year in benefits for prescribed drug claims. Generic equivalents generally cost 50% less than brand-name prescription drugs. However: 1) not all brand-name prescriptions have generic equivalents; 2) some generic substitution is already occurring; and 3) physicians will determine that some brand-name drugs are medically necessary. Therefore, a 6.25% savings, or $125,000 per year, is a preliminary estimate of the impact of SB0130 on drug claims.
7. The State Fund and the Department of Labor and Industries will absorb the cost to implement the program within FY91 appropriation authority in order to make the program operational by the July 1, 1991, effective date.

FISCAL IMPACT:

see next page.

1-25-91

ROD SUNDSTED, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

1/29/91

JOHN "ED" KENNEDY, JR., PRIMARY SPONSOR DATE
Fiscal Note for SB0130, as introduced.

SB 130

FISCAL IMPACT:

State Fund:	FY 92			FY 93		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
Expenditures:						
FTE	0.00	2.00	2.00	0.00	2.00	2.00
Personal Services	0	50,532	50,532	0	52,937	52,937
Operating Costs	0	1,620	1,620	0	1,620	1,620
Equipment	0	23,916	23,916	0	0	0
Total	0	76,068	76,068	0	54,557	54,557
Funding:						
Proprietary Fund	0	76,068	76,068	0	54,557	54,557
Potential Drug Claims Savings:	2,000,000	1,875,000	(125,000)	2,000,000	1,875,000	(125,000)
Labor & Industries:						
Expenditures:						
Operating Costs	0	10,000	10,000	0	10,000	10,000
Funding:						
State Special (02)	0	10,000	10,000	0	10,000	10,000

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:

Likely decrease in drug claims payments.

SB 130

STATE OF MONTANA - FISCAL NOTE
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In compliance with a written request, there is hereby submitted a Fiscal Note for SB0130, as amended.

DESCRIPTION OF PROPOSED LEGISLATION:

An act limiting workers compensation payments for prescription drugs to the purchase of generic-name produces unless a physician specifies no substitutions or the generic equivalent is unavailable, allowing an injured worker to pay the difference in the cost for the brand-name product; amending section 39-71-704, MCA; and providing an effective date.

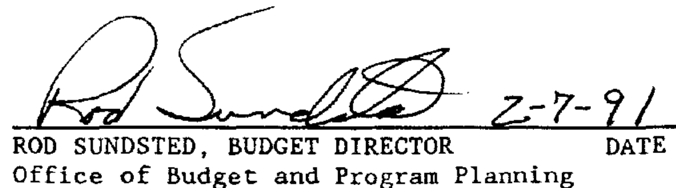
ASSUMPTIONS:

1. Pharmacists will identify which brand-name prescriptions have generic equivalents and will determine maximum reimbursements based on general guidance from insurance carriers.
2. The State Fund currently pays approximately $2 million per year in benefits for prescribed drug claims. Based on a survey conducted by the bill sponsor, 29% of prescriptions were for a brand name having a generic equivalent. If all of the brand-name prescriptions having generic equivalents in the survey sample were substituted with generic equivalents, the savings would have been 21%.
3. Physicians would, in certain instances, proscribe substitution of brand-name pharmaceuticals with generic equivalents.

FISCAL IMPACT:

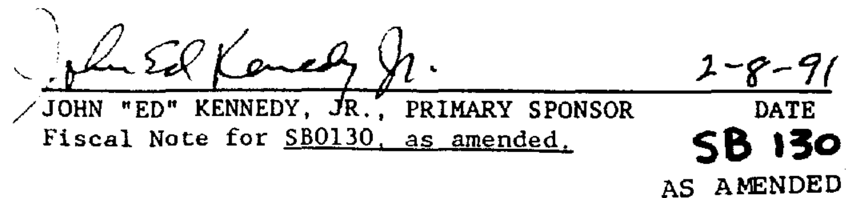
State Compensation Mutual Insurance Fund:

	FY 92			FY 93		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
Potential Drug Claims Savings:						
a. All brand names substituted with generic equivalents when available:	2,000,000	1,580,000	(420,000)	2,000,000	1,580,000	(420,000)
b. One-third of currently prescribed brand names substituted with generic equivalents when available:	2,000,000	1,860,000	(140,000)	2,000,000	1,860,000	(140,000)



2-7-91

ROD SUNDSTED, BUDGET DIRECTOR DATE
Office of Budget and Program Planning



2-8-91

JOHN "ED" KENNEDY, JR., PRIMARY SPONSOR DATE
Fiscal Note for SB0130, as amended.

SB 130
AS AMENDED

APPROVED BY COMMITTEE
ON LABOR & EMPLOYMENT
RELATIONS

SENATE BILL NO. 130

INTRODUCED BY KENNEDY, PIPINICH, THAYER, CONNELLY,
WANZENRIED, MEASURE, COHEN, O'KEEFE, T. BECK,
VAN VALKENBURG, DOHERTY, HARPER, BECKER, BRUSKI,
HOCKETT, GROSFIELD, JERGESON, CRIPPEN, SVRCEK,
DEVLIN, MAZUREK

A BILL FOR AN ACT ENTITLED: "AN ACT LIMITING WORKERS' COMPENSATION PAYMENTS FOR PRESCRIPTION DRUGS TO THE PURCHASE OF GENERIC-NAME PRODUCTS UNLESS ~~A-PRESCRIBED-BRAND-NAME-DRUG IS--MEDICALLY--NECESSARY--OR--THE~~ A PHYSICIAN SPECIFIES NO SUBSTITUTIONS OR THE GENERIC-NAME DRUG IS UNAVAILABLE; ALLOWING AN INJURED WORKER ~~AGREES~~ TO PAY THE DIFFERENCE IN THE COST FOR THE BRAND-NAME PRODUCT; REQUIRING PHARMACISTS TO BILL ONLY FOR THE COST OF THE GENERIC-NAME PRODUCT, EXCEPT WHEN PURCHASE OF THE BRAND-NAME DRUG IS OTHERWISE ALLOWED; AMENDING SECTION 39-71-704, MCA; AND PROVIDING AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 39-71-704, MCA, is amended to read:

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compensation benefits actually provided, the following must be furnished:

(a) After the happening of the injury, the insurer shall furnish, without limitation as to length of time or dollar amount, reasonable services by a physician or surgeon, reasonable hospital services and medicines when needed, and such other treatment as may be approved by the department for the injuries sustained, subject to the requirements of [section 2].

(b) The insurer shall replace or repair prescription eyeglasses, prescription contact lenses, prescription hearing aids, and dentures that are damaged or lost as a result of an injury, as defined in 39-71-119, arising out of and in the course of employment.

(c) The insurer shall reimburse a worker for reasonable travel expenses incurred in travel to a medical provider for treatment of an injury pursuant to rules adopted by the department. Reimbursement must be at the rates allowed for reimbursement of travel by state employees.

(2) A relative value fee schedule for medical, chiropractic, and paramedical services provided for in this chapter, excluding hospital services, must be established annually by the department and become effective in January of each year. The maximum fee schedule must be adopted as a relative value fee schedule of medical, chiropractic, and

SECOND READING

paramedical services, with unit values to indicate the relative relationship within each grouping of specialties. Medical fees must be based on the median fees as billed to the state fund during the year preceding the adoption of the schedule. The state fund shall report fees billed in the form and at the times required by the department. The department shall adopt rules establishing relative unit values, groups of specialties, the procedures insurers must use to pay for services under the schedule, and the method of determining the median of billed medical fees. These rules must be modeled on the 1974 revision of the 1969 California Relative Value Studies.

(3) Beginning January 1, 1988, the department shall establish rates for hospital services necessary for the treatment of injured workers. Approved rates must be in effect for a period of 12 months from the date of approval. The department may coordinate this ratesetting function with other public agencies that have similar responsibilities.

(4) Notwithstanding subsection (2), beginning January 1, 1988, through December 31, 1991, the maximum fees payable by insurers must be limited to the relative value fee schedule established in January 1987. Notwithstanding subsection (3), beginning January 1, 1988, through December 31, 1991, the hospital rates payable by insurers must be limited to those set in January 1988."

NEW SECTION. **Section 2. Payment for prescription drugs -- limitations.** ~~(1)-The-department-shall-limit-payments-for prescription-drugs-to-the-purchase-of--less--expensive--drug products--with--the--same--generic--name-if-the-generic-name product--is--the--therapeutic--equivalent--of--the--specific brand-name-drug-prescribed-by-the-physician-unless:~~

~~(a)--the-physician-certifies-that,-in--his--professional opinion,---the---prescribed--brand-name--drug--is--medically necessary,-or~~

~~(b)--the-injured-worker-agrees-to-pay-the-difference--in the--cost--between--the-drug-prescribed-and-the-generic-name drug-product.~~ (1) FOR PAYMENT OF PRESCRIPTION DRUGS, AN INSURER IS LIABLE ONLY FOR THE PURCHASE OF GENERIC-NAME DRUGS IF THE GENERIC-NAME PRODUCT IS THE THERAPEUTIC EQUIVALENT OF THE BRAND-NAME DRUG PRESCRIBED BY THE PHYSICIAN, UNLESS THE PHYSICIAN SPECIFIES NO SUBSTITUTIONS OR THE GENERIC-NAME DRUG IS UNAVAILABLE.

(2) IF AN INJURED WORKER PREFERS A BRAND-NAME DRUG, THE WORKER MAY PAY DIRECTLY TO THE PHARMACIST THE DIFFERENCE IN THE COST BETWEEN THE BRAND-NAME DRUG AND THE GENERIC-NAME PRODUCT, AND THE PHARMACIST MAY ONLY BILL THE INSURER FOR THE COST OF THE GENERIC-NAME DRUG.

(3) THE PHARMACIST MAY BILL ONLY FOR THE COST OF THE GENERIC-NAME PRODUCT ON A SIGNED ITEMIZED BILLING, EXCEPT IF PURCHASE OF THE BRAND-NAME DRUG IS ALLOWED AS PROVIDED IN

1 SUBSCTION (1).
2 (4) WHEN BILLING FOR A BRAND-NAME DRUG, THE PHARMACIST
3 SHALL CERTIFY THAT THE PHYSICIAN SPECIFIED NO SUBSTITUTIONS
4 OR THAT THE GENERIC-NAME DRUG WAS UNAVAILABLE.
5 ~~(2)~~(5) For purposes of this section, the terms "brand
6 name", "drug product", and "generic name" have the same
7 meaning as provided in 37-7-502.
8 NEW SECTION. **Section 3. Codification instruction.**
9 [Section 2] is intended to be codified as an integral part
10 of Title 39, chapter 71, part 7, and the provisions of Title
11 39, chapter 71, part 7, apply to [section 2].
12 NEW SECTION. **Section 4. Effective date.** [This act] is
13 effective July 1, 1991.

-End-

SENATE BILL NO. 130

INTRODUCED BY KENNEDY, PIPINICH, THAYER, CONNELLY, WANZENRIED, MEASURE, COHEN, O'KEEFE, T. BECK, VAN VALKENBURG, DOHERTY, HARPER, BECKER, BRUSKI, HOCKETT, GROSFIELD, JERGESON, CRIPPEN, SVRCEK, DEVLIN, MAZUREK

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Section 1. Section 39-71-704, MCA, is amended to read:

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(2) A relative value fee schedule for medical, chiropractic, and paramedical services provided for in this chapter, excluding hospital services, must be established annually by the department and become effective in January of each year. The maximum fee schedule must be adopted as a relative value fee schedule of medical, chiropractic, and

THIRD READING

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(2) IF AN INJURED WORKER PREFERS A BRAND-NAME DRUG, THE WORKER MAY PAY DIRECTLY TO THE PHARMACIST THE DIFFERENCE IN THE COST BETWEEN THE BRAND-NAME DRUG AND THE GENERIC-NAME PRODUCT, AND THE PHARMACIST MAY ONLY BILL THE INSURER FOR THE COST OF THE GENERIC-NAME DRUG.

(3) THE PHARMACIST MAY BILL ONLY FOR THE COST OF THE GENERIC-NAME PRODUCT ON A SIGNED ITEMIZED BILLING, EXCEPT IF PURCHASE OF THE BRAND-NAME DRUG IS ALLOWED AS PROVIDED IN

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Montana Legislative Council

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REFERENCE BILL

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9 [Section 2] is intended to be codified as an integral part
10 of Title 39, chapter 71, part 7, and the provisions of Title
11 39, chapter 71, part 7, apply to [section 2].
12 NEW SECTION. **Section 4.** Effective date. [This act] is
13 effective July 1, 1991.

-End-