F I S C A L I M P A C T R E P O R T

SPONSOR Gentry **ORIGINAL DATE** 2/14/18 **LAST UPDATED** **HB** 301

SHORT TITLE Cancer-Related Health Coverage **SB**

ANALYST Esquibel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY18	FY19	FY20	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		$240.0	$240.0	$720.0	Recurring	Health Insurance Marketplace, Public School Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
Office of Superintendent of Insurance (OSI)
Public School Insurance Authority (PSIA)
Retiree Health Care Authority (RHCA)
University of New Mexico Cancer Center (UNCC)

SUMMARY

Synopsis of Bill

House Bill 301 (HB301) amends the Health Care Purchasing Act, Public Assistance Act, Insurance Code and Health Maintenance Organization Law and Nonprofit Health Care Plan Law to provide for cancer-related coverage in requiring the Secretary of Health on September 1, 2018 and each September 1 thereafter to provide annual recommendations to the superintendent of insurance and secretary of human services for the establishment of health coverage requirements related to cancer-related coverage based on a review of best practices in the prevention and detection of cancer in women and girls.

Guidelines for group health cancer-related coverage are:

1. Low-dose screening mammograms for determining the presence of breast cancer that include one baseline mammogram to enrollees 35-39, one mammogram biennially to enrollees 40-49 and one mammogram annually to enrollees 50 and older. Participating

facilities must meet American college of radiology accreditation standards for mammography;

2. At least 48 hours of inpatient care following a mastectomy and 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer (unless the attending physician and patient determine a shorter stay is appropriate;

3. Cytologic and human papillomavirus screening for determining the presence of precancerous or cancerous conditions and other health problems; provided that the coverage shall make available:

(a) cytologic screening, as determined by the health care provider in accordance with national medical standards, for female enrollees who are 18 or older and for female enrollees who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening; and

(b) human papillomavirus screening once every three years for female enrollees 30 and older;

4. The human papillomavirus vaccine to female enrollees 9 to 14 years of age;
5. Screening for cervical cancer every three years for female enrollees 21 to 65;

6. For female enrollees who are at increased risk for breast cancer and at low risk for adverse medication effects, prescription drugs that reduce the risk of cancer; and

7. Any other screening for the prevention or detection of cancer in women that the secretary of health recommends.

The coverage won't involve:

1. Enrollee cost-sharing;
2. Utilization review;
3. Prior authorization or step therapy requirements; or
4. Any other restrictions or delays on the coverage.

By November 1, 2018 and each November 1 thereafter, a group health plan administrator shall consult with the office of superintendent of insurance to learn current coverage guidelines for screening for the prevention or detection of cancer in women and girls adopted pursuant to the recommendations the secretary of health has issued.

A group health plan administrator shall grant an enrollee an expedited hearing to appeal any adverse determination made relating to the coverage provisions of this section. The process for requesting an expedited hearing pursuant to this subsection shall:

1. Be easily accessible, transparent, sufficiently expedient and not unduly burdensome on an enrollee, the enrollee's representative or the enrollee's health care provider;
2. Defer to the determination of the enrollee's health care provider; and
3. Provide for a determination of the claim according to a time frame and in a manner that takes into account the nature of the claim and the medical exigencies involved for a claim

involving an urgent health care need.
The provisions of this section shall not apply to short-term travel, accident-only or limited or disease-specific group health plans.

By November 1, 2018, and each November 1 thereafter, the secretary of HSD shall adopt and promulgate any rules necessary to implement the coverage guidelines for screening for the prevention or detection of cancer in women and girls per the recommendations of the secretary of DOH.

For any adverse action made relating to the coverage provisions of this section, a medical assistance plan is required to grant a recipient an expedited hearing for an appeal. Requirements to assure the appeal process is expedient are stated in the bill.

FISCAL IMPLICATIONS

The Retiree Health Care Authority (RHCA) notes it already provides screenings for a variety of diseases as outlined by the United States Preventative Services Task Force. Also, many of the screenings outlined in the bill pertain to age groups outside RHCA purview.

The Medicaid program reports it already meets the coverage requirements of HB 301. Medicaid costs could increase in the future based on any changes that might occur to the coverage guidelines for screening for the prevention or detection of cancer in women and girls per the annual recommendations of the secretary of DOH. While a small number of changes to regulatory language may be needed to clarify coverage requirements, no major changes are required. Medical economic studies indicate that early detection and treatment of cancer and precancerous conditions are cost effective.

The Office of Superintendent of Insurance (OSI) reports the Affordable Care Act currently mandates cost-sharing free cancer screening and prevention services for women. These mandates apply to fully-insured coverage sold in the individual and small group markets, Medicaid coverage, and non-grandfathered fully-insured and self-insured (Health Care Purchasing Act) plans. This legislation's mandates do not completely overlap with the ACA's current cost-sharing free preventive care requires. As a result, it will create new mandates that will have a fiscal impact on the state. First, mandates impacting individual plan coverage purchased using financial assistance through the health insurance marketplace require the state to offset any additional costs to the market place's financial assistance program. The proposed legislation's mandates for cost-sharing free hospitalization stays for mastectomies and lymph node dissection would need to be offset by state funds. For example, if the average cost of overnight hospitalizations for these newly mandated services is $15 thousand and approximately 20 women of the women in this 50 thousand person risk pool use these services, there would be a cost to insurance companies of $300 thousand per year. (Estimates of cancer rates based upon market share and incidence rates as determined by data from DOH's IBIS system). The state would be responsible for offsetting the costs of the increase in premiums to cover this $300 thousand amount for the percentage of women who receive financial assistance. Currently approximately 80 percent of enrollees in the marketplace receive financial assistance. As a result, the state would be required to offset the cost of approximately $240,000 yearly for these services.

The Public School Insurance Authority (PSIA) indicates under the provisions of the bill there would be additional costs to the PSIA self-insured Medical/Rx Plan.:

It is unclear whether coverage available to public employees currently incorporates ACA cost-sharing free preventive care mandates for services such as cytologic and human papillomavirus screening for female enrollees ages eighteen years of age or older, cervical cancer screening every three years for female enrollees age twenty-one to sixty-five years of age, prescription drugs that reduce the risk of cancer. There may be additional costs related to covering those mandates for that population.

SIGNIFICANT ISSUES

The UNM Cancer Center indicates the provisions in the bill for cancer-related health care are virtually all aligned with national recommendations and represent an actual reduction in prevention efforts specified by former guidelines and therefore in effect are cost-savings. It is without question that the inclusions of HB301 embody the minimum necessary cancer preventive care that must be made available to all women and girls.

The UNM Cancer Center writes:

HB301 designates providing HPV vaccine provision to females 9 to 14 years of age. New Mexico has aligned its immunization practices in general with the recommendations of the ACIP (Advisory Committee on Immunization Practices) which currently recommends catch-up vaccination with 3 doses after age 14 for females up to age 26. Recently a cost savings but effective 2 dose regimen was recommended for 9-14 year olds which enables more HPV vaccine doses to be provided across the state. It might be prudent for New Mexico to consider additional provision of coverage for HPV vaccines up to age 18 years (or until the 19th birthday) given federal coverages available up to this age. The US Centers for Disease Control and national recommendations for HPV vaccination target both 9-14 year old boys and girls for completion of a two dose series and the inclusion of males though not the focus of this bill remains essential for the state of New Mexico.

Cytologic screening for women and girls for any reason under the age of 21 years is not currently recommended by any official body in the United States (including the USPSTF). These changes in national guidelines were established in 2012 and any cervical cancer screening (e.g. Pap test also known as cytology) for girls under the age of 21 years is specifically NOT recommended given medical evidence supporting that the potential harms outweigh the benefits of screening younger women/girls. Harms include that excisional treatments can cause adverse pregnancy outcomes including preterm delivery, that cervical cancer is rare under the age of 25 and even more rare under the age of 21 and finally that most HPV-related abnormalities resolve on their own with time especially in the young. Finally, HEDIS measures for cervical screening by cytology or any method incorporate national recommendations to NOT screen women less than 21 years of age or women with prior hysterectomy. Women over the age of 65 with a history of up to date normal cervical screening results should also not be screened.

The Public School Insurance Authority (PSIA) indicates under the provisions of the bill coverage appears to be required with no enrollee cost sharing for both in-network and out-of-network services. With requiring no enrollee cost sharing for out-of-network services, it exposes the PSIA Medical/Rx Group Plan to potentially abusive billing practices by the provider community.

Most, if not all, mastectomy patients likely already receive 24 hours of inpatient care while

lumpectomy procedures are regularly performed on an outpatient basis. Most doctors can justify and receive approval for longer stays if circumstances warrant it. However, unnecessary hospitalizations expose patients to potential medication errors and acquired infections during the course of their hospital stay.

Although PSIA is in support of increasing measures for preventive care and advocating for members to seek the best cancer-related care possible, adding additional services and prescription drugs that eliminate enrollee cost-sharing, prior authorization and step therapy rules come with a cost that can be offset through increased medical premiums. The PSIA Medical/Rx Group Plan is self-insured and medical/Rx claims are paid by premiums collected from school employees and the school districts/charter schools/educational entities. Any additional projected claims expense to the NMPSIA self-insured plan will need to be considered when determining medical/Rx premiums for FY 19 and moving forward.

ADMINISTRATIVE IMPLICATIONS

Under the provisions of the bill, the NM secretary of Health would be required to be current with breast and cervical cancer prevention recommendations as well as other cancer prevention guidelines at a national level updating the provisions annually for New Mexico. Enabling the implementation as HM301 intends, also requires regular review of prevention measure health care provision by health plans, insurers, and medical assistance programs to insure requirements are being met on an ongoing basis.

TECHNICAL ISSUES

The UNM Cancer Center reports although some girls/women 18 to 21 years of age may have had prior cervical abnormalities or HPV detected which could have resulted in continuation of their cervical screening and management after the USPSTF changed/issued its recommendations in 2012, it has been more than five years since the issue of the recommendations and all or the vast majority of such individuals of young age where their screening was being continued are now age 21 years of age or older. The underlined portion of the statements in HB302 will be provided to female enrollees who are eighteen years of age or older and for female enrollees who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening' is the only portion of the HB301 that could benefit by removal through amendment by deletion or by striking the age of 18 with replacement with age 21 years. Deletion of the information underlined above would seem most appropriate since throughout the HB301 detailed sub-specifications cervical screening for all females aged 21-65 years every 3 years is already incorporated fully.

Section 2 (7) defines broad powers for the secretary of Health to recommend full coverage of "any other screening for the prevention or detection of cancer in women". This language is overly broad and exposes the PSIA Medical/Rx Group Plan to unknown financial risks.

OTHER SUBSTANTIVE ISSUES

OSI notes the legislation creates mandates that do not overlap with ACA required mandates. For coverage under the Health Care Purchasing Act, Non-Profit Health Care Law, and Public Assistance Act, the legislation requires additional services, such as cost-sharing free inpatient care for mastectomies and lymph-node dissection. For commercial insurance available through

Health Maintenance Organizations, Group and Blanket Health Insurance Contracts, the legislation mandates fewer cost-sharing free preventive care services than currently mandated through the ACA. As a result, this section is currently pre-empted by federal requirements under the ACA.

The legislation also carves out application of the additional cost-sharing free services provisions to non-profit health plans, but not other forms of fully-insured commercial health plan coverage. This may provide an unfair premium cost advantage to commercial health insurance carriers that are not non-profit health plans.

The Office of the Superintendent of Insurance does not regulate coverage of benefits for health plans provided to public employees through the Health Care Purchasing Act or benefits in medical assistance plans through Medicaid.

The Office of the Superintendent has federally approved grievance and appeals procedures in regulation for denials of benefits or services, including, currently, preventive care benefits. Any amendments to these grievance and appeals procedures as mandated by this act would require an additional federal approval process.

RAE/al