FISCAL IMPACT REPORT

SPONSOR HHHC **LAST UPDATED** 2/25/2023
ORIGINAL DATE 1/24/2023
BILL NUMBER CS/House Bill 53/HHHCS/aHAFC
SHORT TITLE Delivery of Necessary Diabetic Resources
HHHC Substitute
ANALYST Esquibel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

	FY23	FY24	FY25	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
OSI Actuarial Analyses	No fiscal impact	$150.0			Nonrecurring	General Fund
OSI recurring data and compliance officers		$155.0	$155.0	$310.0	Recurring	General Fund
NMPSIA		$637.0	$1,356.0	$1,993.0	Recurring	General Fund
Total		**$942.0**	**$1,511.0**	**$2,453.0**	**Recurring**	**General Fund**

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.
** GSD was not sent a request for analysis in time for the first hearing of HB53, LFC analysis uses agency analysis from similar legislation

Sources of Information

LFC Files

Responses Received From
Office of Superintendent of Insurance (OSI)
New Mexico Attorney General (NMAG)
Human Services Department (HSD)
Department of Health (DOH)
NM Public Schools Insurance Agency (NMPSIA)

SUMMARY

Synopsis of HAFC Amendment

The HAFC amendment to the House Health and Human Services Committee substitute for House Bill 53 removes the proposed appropriation of $350 thousand to the Office of Superintendent of Insurance.

Synopsis of Original Bill

The House Health and Human Services Committee substitute for House Bill 53 would

appropriate $350 thousand from the general fund to the Office of Superintendent of Insurance (OSI) to hire additional personnel to conduct or contract for annual compliance audits of health care insurers and enforce compliance with the act.

The House Health and Human Services Committee substitute for House Bill 53 would amend the Health Care Purchasing Act to require coverage of diabetes and diabetes durable medical equipment (DME) for different types of group health insurance coverage that is traditionally regulated under the Insurance Code. The legislation updates terminology and increases the scope and coverage of diabetes benefits to be provided by insurance providers. Section 2 includes new mandates including requiring insurers to maintain a network of providers for diabetic patients, requiring insurers to reimburse covered patients who incur out of pocket expenses in certain circumstances, implementing an 18 percent interest rate for reimbursements delayed beyond 30 days, and requiring quarterly reporting to the Superintendent of Insurance.

The legislation gives OSI the authority to determine whether or not insurers have contracted with a sufficient number of providers or suppliers. The bill gives the Superintendent of Insurance the authority to issue corrective action or use other compliance mechanisms to enforce the act.

Specifically in the HHHC substitute,

- the proposed changes to Section 2(J) have been replaced with specific references to glucose monitor test strips, lancets, injection aids, and pen-like insulin;
- the definitions that were proposed to be deleted in Section 2(J) have been restored;
- Section 3 no longer amends NMSA 1978, Section 59A-23-11, but instead creates a new section in Chapter 59A-23 titled "Coverage for Individuals with Diabetes;"
- Section 5 amends the Nonprofit Health Plan Law with a new section titled "Coverage for Individuals with Diabetes" which requires plans to guarantee reimbursement within 30 days to a covered person who pays out of pocket for diabetic supplies or insulin and pay interest at the rate of 18 percent per year if the covered person is not paid within 30 days; and
- Section 6 creates a "Diabetes Coverage Work Group" lead by the Office of Superintendent of Insurance.

The HHHC substitute to HB53 would require insurance plans to submit a written report to OSI each quarter on a number of performance related metrics, and requires OSI to annually audit all health insurers for compliance with the requirements of the bill.

The effective date of this bill is January 1, 2024.

FISCAL IMPLICATIONS

The federal Affordable Care Act (ACA) requires all major medical health commercial insurance and small groups to cover a standard group of benefits, called a "benchmark" plan. The ACA requires states set this benchmark plan based on popular existing health plans. The actuarial value of this benchmark plan is then used to calculate the premium tax credits consumers will receive from the federal government to help subsidize purchasing coverage through the health insurance marketplace.

The Affordable Care Act requires states to defray the costs of any newly mandated benefits as a way to limit the amount the federal government would be required to pay for premium tax credits in any given state. This applies to any newly mandated benefits legislatively or administratively required in excess of the benchmark plan not mandated after the passage of the ACA. According

to OSI, the current benchmark plan does not reflect definitions provided by the legislation, leaving the state liable to pay defrayment costs. OSI notes:

> OSI's current benchmark plan reflects the previously mandated, pre-ACA diabetes coverage requirements of blood glucose monitors, including those for the legally blind; test strips for glucose monitors; visual reading urine and ketone strips; lancets and lancet devices; insulin; injection aids, including those adaptable to meet the needs of the legally blind; syringes; prescriptive oral agents for controlling blood sugar levels; medically necessary podiatric appliances; and glucagon emergency kits. The benchmark further, generally states that "Coverage includes equipment, appliances, prescription drug medications, insulin or supplies that meet the United States Food and Drug (FDA) approval and are the generally medically accepted standards for diabetes treatment, supplies and education."

OSI did not project the amount of defrayment possibly required by the legislation, using analyses from similar legislation expanding benefits for breast exams, LFC projects the potential cost to be indeterminate but substantial, depending on utilization.

OSI projects that it would need to hire at least one compliance officer and one data analyst, a total recurring cost of $155 thousand, to fulfill the reporting requirements of the legislation. OSI also predicts that it would need $150 thousand in one-time appropriations to contract a firm to project defrayal costs for the new benefits.

NMPSIA notes that, under the bill, member cost-share in excess of $25 per 30-day fill would shift to NMPSIA. This would include costs for preferred-brand oral diabetes medications and certain diabetic supplies purchased through PSIA's Durable Medical Equipment (DME) benefit. NMPSIA's estimated impact in FY24 represents a partial year impact of approximately $637 thousand with the impact in FY25 and beyond increasing to roughly $1,356,000 annually. There is no proposed appropriation to NMPSIA in the bill.

SIGNIFICANT ISSUES

OSI notes that health insurance plans are treated as contracts, and are not typically changed mid-policy year because premium rates for the year have already been approved pursuant to ACA timelines. Data will likely not be available to audit for the first six months of FY24, and it is unclear how the agency will complete its audit on the program with the existing effective date of January 1, 2024.

OSI also has concerns with the volume and frequency of reports being submitted to OSI, and obligation to monitor new plans:

> While the proposed legislation has an initial appropriation, this appropriation is not recurring. OSI does not currently review IBAC plans for compliance with the provisions of the Health Care Purchasing Act.

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