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FISCAL IMPACT REPORT

ORIGINAL DATE 1/28/2020
 SPONSOR Trujillo, C. LAST UPDATED 2/15/2020 HB 126/aHHHC/aHFI#1/aSPAC
 SHORT TITLE Coverage for Health Artery Calcium Scan SB _____
 ANALYST Chilton/Esquibel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY20	FY21	FY22	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
State-funded medical insurance		Uncertain	Uncertain	Uncertain	Recurring	General Fund
Office of the Superintendent of Insurance	\$40.0			\$40.0	Nonrecurring	General Fund
Office of the Superintendent of Insurance	\$10.0	\$10.0	\$10.0	\$30.0	Recurring	General Fund
Total	\$50.0	\$10.0	\$10.0	\$70.0	Recurring	General Fund

(Parenthesis () Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From

Retiree Health Care Authority (RHCA)
 University of New Mexico Health Sciences Center (UNM HSC)
 Public Schools Insurance Authority (PSIA)
 Office of the Superintendent of Insurance (OSI)
 Department of Health (DOH)
 Human Services Department (HSD)

SUMMARY

Synopsis of SPAC Amendments

The Senate Public Affairs Committee (SPAC) amendments to House Bill 126 as amended by the House Floor and the House Health and Human Services Committee (HHHC) strike the HHHC amendments which specified that insurance coverage for coronary artery calcium scans would apply to insurance policies going into effect, or new policies beginning on, January 1, 2021.

The SPAC amendments also strike Section 3 of the bill which provided coverage for heart artery calcium scans under certain conditions for individual health insurance policies.

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The SPAC amendments add that coronary artery calcium scans shall be covered under group health plans excluding small group health plans.

The SPAC amendments exclude individual and small group health maintenance organization (HMO) coverage from requiring coronary artery calcium scans.

The SPAC amendments exclude individual and small group health care plan nonprofit coverage from requiring coronary artery calcium scans.

The SPAC amendments clarify the effective date of the legislation is applicable to group health insurance policies, health care plans or certificates of health insurance, other than small group health plans, that are delivered, issued for delivery or renewed on or after January 1, 2021.

Synopsis of House Floor #1 Amendment

The House floor amendment adds a word to Section 5C to make it grammatically correct. The meaning is not changed.

Synopsis of HHHC Amendment

The House Health and Human Services Committee amendment replaces the previous Section 7 of the bill, which simply stated that the act would go into effect January 1, 2021, with a new Section 7 indicating that the provisions of the bill and the requirement that insurance products cover the cost of coronary artery calcium scans for all policies, plans, and certificates of insurance that would become effective or be renewed on or after January 1, 2021.

Synopsis of Original Bill

House Bill 126, Coverage for Health Artery Calcium Scan, would require all types of health insurance plans sold in New Mexico to provide coverage for certain insured patients for a coronary artery (heart) calcium scan (CAC), used to predict the likelihood of myocardial infarction (heart attack, abbreviated as MI). Those who would be eligible for the coverage would be between the ages of 45 and 65 and have intermediate risk of coronary artery disease based on a score using an algorithm to determine the given patient's ten-year risk of MI. Such patients would be eligible for repeat scanning every ten years as long as the CAC score remained zero; those with a higher (abnormal) score would not receive mandated coverage for further CAC tests.

As noted, the requirement for coverage would be made of each type of insurance, as indicated in the following sections of the bill:

Bill Section	Type of Insurance Product	Reference to statute
1	Group health plans	Chapter 59A, Article 23E NMSA 1978
2	Medical assistance plans	Public Assistance Act, Chapter 27, Article 2, NMSA 1978
3	Individual health policies, health care plans, or certificates of health insurance	Chapter 59A, Article 22, NMSA 1978
4	Group or blanket health insurance policy, health care plan or certificate of insurance	Chapter 59A, Article 23 NMSA 1978
5	Individual or group health maintenance organization contract	Health Maintenance Organization Law, Chapter 59A, Article 46 NMSA 1978
6	Non-profit health care plans	Nonprofit health care plan law, Chapter 59A Article 47 NMSA 1978

The act would become effective on January 1, 2021.

FISCAL IMPLICATIONS

There are no appropriations in this bill. OSI estimates its costs for actuarial services to set up the program as \$40 thousand (nonrecurring, before the effective date of the requirement) and \$10 thousand of recurring costs annually for program review and enforcement.

PSIA estimates costs (but not costs averted) to that agency if this bill is passed. Because costs averted may be substantial and may indeed result in the test being cost-saving, the costs indicated below have not been included in the table above.

NMPSIA has approximately 18,500 members within the age range indicated in HB 126, with approximately 57.6 percent of these members being women. Based on data from the National Center for Health Statistics, 51.6 percent of men and 41.2 percent of women are expected to have at least one of the three risk factors for cardiovascular disease.

Based on the effective date of January 1, 2021, there is no estimated impact in FY20 and the impact in FY21 is expected to be lower than in future years. However, we assume that a larger share of the applicable population would have a claim for this service during the first year than during subsequent years due to the reduced likelihood that they had the scan during the prior five years. The fiscal implication calculation uses the assumption that 1 in 3 applicable individuals would have a claim in the first year (CY 2021) with 1 in 5 having a claim during subsequent years.

Finally, the fiscal implication calculation is based on the assumption that cost sharing for the health artery calcium scan is consistent with the average over all NMPSIA coverage (85.2 percent plan paid on average across all plans and services).

The fiscal impact is estimated to be \$360.2 thousand in FY2021, \$576.4 thousand in FY2022, and \$432.3 thousand in subsequent years.

There are much larger costs or avoidance of costs involved, depending on the assertions of proponents and detractors of the test (see Significant Issues). Proponents of the test's use would indicate that the cost of the test, which ranges from \$50 to \$400 in cost for individual tests, would be more than offset by the avoidance of costs associated with heart attacks averted – the estimated cost of each heart attack is \$94 thousand, so (at a median cost per CAC test of \$200), if more than one in every 470 heart attacks were prevented, use of the procedure would be cost-saving.

Detractors of use of the test would point out that costs of the test are not limited just to the amount charged for the procedure. They also include the costs of follow-up tests, especially on “false positives”: those later found to have no additional risk of MI. As noted under Significant Issues below, the United States Preventive Services Task Force believes that the evidence is insufficient to recommend the procedure at this point largely because of the question of these downstream costs. Since costs and benefits of the procedure's use would enure to all of the state agencies providing health care insurance to past and present employees and to Medicaid recipients, these considerations are vital to calculating the effect of CAC testing on the state budget. OSI has indicated that it has contracted with an actuarial firm to calculate costs and benefits of requiring this benefit.

DOH notes that the cost to state government of DOH's and all other state employees' health insurance might increase if the CAC were required, although if CAC testing prevents cardiac disease, the opposite may be the case.

SIGNIFICANT ISSUES

There is considerable difference of opinion as to the advisability and applicability of the coronary artery calcium scan (CAC) to the prevention of myocardial infarctions (heart attacks).

On the one hand, researchers at the University of New Mexico, in an article in press (Schade, Obenshain et al, American Journal of Medicine, 2020) state that the evidence suggests that CAC screening could prevent all or most myocardial infarctions, which they estimate would save \$538 billion per year in the US and 600,000 annual deaths from myocardial infarctions. They cite a 2016 review of studies, published in the Annals of Internal Medicine, as indicating little agreement among 21 organizations that have published guidelines for prevention of myocardial infarction. The article (Khanji, Bicalho et al, Annals of Internal Medicine, 2016; attached to this FIR), comes to the following conclusion:

Of the 21 guidelines [on screening for cardiovascular risk factors], 17 showed considerable rigor of development. These recommendations address assessment of total cardiovascular risk (5 guidelines), dysglycemia (7 guidelines), dyslipidemia (2 guidelines), and hypertension (3 guidelines). All but 1 recommendation advocates for screening, and most include prediction models integrating several relatively simple risk factors for either deciding on further screening or guiding subsequent management. No consensus on the strategy for screening, recommended target population, screening tests, or treatment thresholds exists.

The United States Preventive Services Taskforce in 2018 issued a revised statement regarding CAC and two other screening tests proposed for use in detecting an increased risk of myocardial infarction. Its conclusions, published in the Journal of the American Medical Association at

(<https://jamanetwork.com/journals/jama/fullarticle/2687225>) include the following:

A systematic review that addressed the effect of screening with CAC score on risk perception, adherence to medication, and behavioral therapies found only 2 studies comparing traditional CVD risk assessment vs CAC score. Neither of these studies found that screening with CAC score was superior to traditional CVD risk assessment for preventive medication use or risk factor management.⁵

Potential Harms of Screening and Treatment

The main potential harm of adding nontraditional risk factors to CVD risk assessment is radiation exposure from CAC score testing, although the dosage (0.4 to 2.1 mSv) is relatively low.⁷ More general potential harms are false-positive test results and subsequent invasive diagnostic procedures (such as coronary angiography). Three studies assessing the effect of CAC score on health care utilization found conflicting results. The Early Identification of Subclinical Atherosclerosis by Noninvasive Imaging Research (EISNER) study, an RCT of CAC score use in an academic setting, found no statistically significant increase in downstream cardiac testing and procedures.²⁹ In contrast, a retrospective study of Medicare data found that use of CAC score increased downstream cardiac testing and procedures compared with use of hsCRP and lipid screening,³⁴ while a second smaller observational study found no difference.³⁵ A systematic review of 7 studies found that the prevalence of incidental findings on computed tomography for CAC score ranged from 8% to 58%. The ultimate outcomes of subsequent diagnostic procedures for these incidental findings, whether positive or negative, are not known.³⁶ Two studies found no short-term psychological harms from use of CAC score in CVD risk assessment...

Recommendations of Others

The American Association of Clinical Endocrinologists' 2017 guidelines include hsCRP level, as part of the Reynolds Risk Score, as a possible CVD risk assessment tool and to stratify borderline cases, and also states that CAC score can be useful in refining risk stratification.⁴⁰ The American College of Cardiology and American Heart Association encourage using the Pooled Cohort Equations to assess 10-year risk of an initial hard CVD event (defined as stroke, nonfatal myocardial infarction, or CVD death). If risk-based treatment is still uncertain, they recommend using 1 or more of the nontraditional risk factors (including the ABI, hsCRP level, or CAC score) or family history to help clarify treatment decisions.⁴ The Canadian Cardiovascular Society encourages use of a modified Framingham Risk Score risk assessment tool in asymptomatic persons to assess 10-year risk of any CVD event. It recommends judicious use of secondary testing among patients for whom the need for statin therapy is unclear.⁴¹ The European Society of Cardiology uses the Systemic Coronary Risk Evaluation (SCORE) risk charts, which do not include the ABI, hsCRP level, or CAC score, to determine 10-year risk of a fatal CVD event.⁴² The UK National Institute for Health and Care Excellence uses the QRISK3 risk tool, which does not include the ABI, hsCRP level, or CAC score, to estimate 10-year risk of a CVD event.⁴³ The Scottish Intercollegiate Guidelines Network (SIGN) uses the ASSIGN risk score to determine the 10-year risk of a CVD event, which does not include the ABI, hsCRP level, or CAC score.⁴⁴

OSI indicates that the cost of adding coverage for this procedure to plans under the Affordable Care Act would likely fall to the state:

Under the Affordable Care Act, states are required to establish a benchmark for required benefits in each category. States can select their benchmark from a menu of options of already existing plans. The state then uses that benchmark to ensure that coverage offered in the individual and small group market will meet certain actuarial values prescribed to the ACA's metal level system (bronze, silver, gold). The actuarial value of these plans 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.

In an effort to limit the amount the federal government would be required to pay for premium tax credits in any given state, the Affordable Care Act requires states to defray the costs of any mandated benefits in excess of the essential health benefits that were not required by the state prior to the passage of the ACA. See 45 CFR §155.170 and <https://www.cms.gov/CCIIO/Resources/Files/Downloads/eHB-faq-508.pdf>. The amount the state is required to defray for the cost for any new mandated benefits is based on the actuarial value of the benefit.

The federal government is enforcing this requirement for states to defray the cost of new mandates. Massachusetts recently had to use state funding to defray the cost of a new benefit offered in its individual and small group markets.

Currently, New Mexico's essential health benchmark plan does not require coverage for artery calcification screening services. As a result, this would be a new mandate for which the state would have to offset the cost. Unlike previous versions of this bill requiring screening for all persons, this bill establishes eligibility based on medical algorithms; while appropriate, this provision make it less predictable to estimate the cost to the state. OSI would need to rely upon actuarial analysis to estimate the cost to the state. OSI has not calculated the impact on the state of the cost of this legislation on taxpayer funded health insurance plans.

TECHNICAL ISSUES

DOH notes that "the test is not universally recommended, but it is most helpful for those who are at an intermediate risk of developing coronary artery disease based on a calculated score and risk factors, such as diabetes and high blood pressure." DOH continues, noting that the bill would appear to require coverage of the CAC scan itself, but not necessarily of follow-up tests or procedures. "This could leave patients uncovered for appropriate cardiac care for a wide variety of conditions based on a single screening test for coronary artery disease. Adjusting the wording may help to make the intent of this section more clear."

HSD, in noting that Medicaid already pays for coronary artery calcium scans, makes the following suggestion:

Since the HB126 proposes to use the heart artery calcium scan as a clinical management tool with some limitations and in certain "eligible enrollees" who has an intermediate risk of developing coronary heart disease as determined by a health care provider based on an evidence-based algorithm widely used as well as the bill allows a managed care organization providing medical assistance to offer or refuse coverage for further cardiac testing or procedures, the bill could be enacted in a manner that is in alignment with the Medicaid principal requirement of offering services that are "medically necessary."

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Patients would not have mandated health insurance coverage for coronary artery calcium testing. Medical care providers would have to decide whether to order the test, not necessarily based solely on a given patient's likelihood of benefiting from the test, but rather on his/her ability to pay for the test, creating a discrepancy among those of greater and lesser economic means.

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