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

SPONSOR Trujillo, CH **ORIGINAL DATE / LAST UPDATED** _____ **HB** 58

SHORT TITLE Health Insurance for Artery Screening **SB** _____

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY19	FY20	FY21	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		Up to $3,400.0, but see Fiscal Impact; may be cost saving	Up to $3,400.0, but see Fiscal Impact; may be cost saving	Up to $6,800, but see Fiscal Impact; may be cost saving	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to 2017 HB 11

SOURCES OF INFORMATION
LFC Files

Responses Received From
Retiree Health care Authority (RHCA)
Office of the Superintendent of Insurance (OSI)
Public School Insurance Authority (PSIA)

SUMMARY

Synopsis of Bill

House Bill 58 adds new sections to the Health Care Purchasing Act, the Public Assistance Act, the New Mexico Insurance Code, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law to require coverage of artery calcification screening for early detection of cardiovascular disease in certain individuals.

HB58 would require Medicaid coverage of an artery calcification screening for an eligible recipient once every five years. The bill defines "artery calcification screening" as a computed tomography scan measuring coronary artery calcification for atherosclerosis and abnormal artery structure and function. The bill defines “eligible recipient" as the following:

1. a male older than thirty years of age and younger than seventy-six years of age
2. a female older than forty years of age and younger than seventy-six years of age; and
3. who has a risk of developing coronary heart disease based on at least one of the following:

a. hypertension
b. hyperlipidemia
c. diabetes
d. smoking
e. family history of heart disease

The three sections of the bill refer to different types of health insurance, but make the same requirement for each. They are as follows: Section 1: Health Care Purchasing Act (group health insurance and any form of self-insurance under the Health Care Purchasing Act); Section 2: Public Assistance Act (Medicaid), Section 3: Other forms of insurance offered within New Mexico.

FISCAL IMPLICATIONS

While the bill contains no appropriation, HSD, in analyzing 2017 House Bill 11, which is essentially the same as current House Bill 58, anticipated additional operating budget impact. HSD at that time estimated the additional impact by multiplying the Medicare reimbursement rate for this procedure by the estimated number of Medicaid enrollees eligible for this procedure, as follows:

> The estimated additional operating budget impact was calculated by multiplying the Medicare reimbursement rate for this procedure by the estimated number of Medicaid enrollees eligible for this procedure. HSD provided cost impact to the categories of eligibility that would be applicable, which are the full Medicaid eligibility categories. CMS would not approve for limited benefit categories, such as family planning and categories for which we contribute Medicare premiums. To calculate the financial impact HSD had 79,615 Medicaid members with full Medicaid benefits in the age range of this test. Approximately 75 percent (59,712) of members would meet the risk factor criteria to qualify for the test. The frequency of the test is every 5 years therefore HSD allocated 1/5 of the expenses per year for a cost of $3,400,000 per year.

HSD's analysis did not and cannot take into account the likely cost savings that might take place from making coronary artery calcium screening available to Medicaid recipients at increased risk. According to an article written by University of New Mexico internists, specialists, and researchers R. Philip Eaton MD, Mark R. Burge MD, George Comerci MD, Brendan Cavanaugh MD, Barry Ramo MD and David S. Schade MD in the American Journal of Medicine, April 2017, "Studies have repeatedly shown that CAC scores are the best predictor of future cardiovascular events in asymptomatic individuals—even more sensitive than coronary angiography." Finding an abnormal coronary artery screen result would allow for intensive medical treatment, which would be very likely to lead to economic benefits to the patient and to the health care system that would be greater than the cost of the test.

DOH stated in response to 2017 House Bill 11 that "Self-insured entities, such as state agencies, will realize costs related to CAC [coronary artery calcium] scans for its covered employees and their family members. In the Albuquerque area, a recent estimate of charges for CAC scans ranged from $150 to $300. Additional testing or medical interventions that may result from

CAC scan results could also significantly add to healthcare costs."
In analysis of this year's House Bill 58, OSI calculates the cost of the mandate to state government as lower than the HSD analysis from 2017. Its analysis is reproduced as follows:

> To mandate coverage for artery calcification screening, OSI projects that the state will be forced to offset the costs of approximately $540,000 a year in premium increases through premium tax credit payments for this mandate.
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> Conservatively estimated based on 2018 enrollment data, there are approximately 30,000 individuals enrolled in individual coverage in the health insurance marketplace in the age ranges impacted by the proposed legislation. The estimated cost, based on a survey of insurance carriers, for artery calcification screening is approximately $150 per screening. Although this legislation prohibits the costs for this service applying to the deductible, there are no prohibitions on insurance companies charging cost-sharing for this procedure. Conservatively estimated for a bronze plan that requires a consumer to share 40% of the cost of this testing, the carrier will be responsible for indemnifying consumers for $90 per test. If the entire population of 30,000 eligible Exchange enrollees received this screening over a five-year period, this cost of this mandate over a five-year span would be $2,700,000, or $540,000 per year.
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> Seventy-eight percent of New Mexicans with health insurance coverage through the Exchange in 2018 received advance premium tax credits to assist with purchasing insurance. As a rough estimate, the state would have to offset 78% of the costs associated with mandating this screening for individuals receiving premium tax credits, which is approximately $421,200 per year. These are very rough estimates of the impact of cost-offsets for this mandated service.
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> Additionally, this piece of legislation would create a mandate screening coverage for individuals receiving insurance regulated through the Health Care Purchasing Act. The Health Care Purchasing Act regulates the health insurance coverage provided to public employees, public school employees, and retirees of public employment and public schools across the state. While OSI does not regulate the insurance covered by this population, it can roughly state that if this mandate is enacted, impacting approximately 20,000 covered lives. The cost for providing this service for eligible state employees and their covered family members would be approximately $3,000,000 over a five-year period or an additional $600,000 per year.
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> The total cost for mandating this service for these two populations would be approximately $1,021,200 per year.
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> Additionally, OSI projects the need for additional actuarial services and staff to implement this and account for this new mandate. OSI projects to require $100,000 a year for a contract actuary to perform and audit these mandate cost defrayment requirements and $20,000 for a half-time FTE (salary plus benefits) to perform analysis and administrative functions.

Furthermore, costs of a diagnostic test are not limited just to the test itself – they also include the costs of follow-up tests, especially where the test is "non-specific," meaning that many people without actual real increased risk of disease undergo further testing to assure that they are in the category of "false positives", rather than "true positives," the ones truly at increased risk. For

many tests with low specificity, the costs of the initial test itself are dwarfed by the follow-up tests.
As noted below under "Significant Issues", coronary artery testing has been analyzed as having low specificity, meaning that a large proportion of those an abnormal test will not have a truly increased risk of coronary artery disease. The cost of procedures to follow up on those with falsely positive screening using this test cannot be easily calculated.

SIGNIFICANT ISSUES

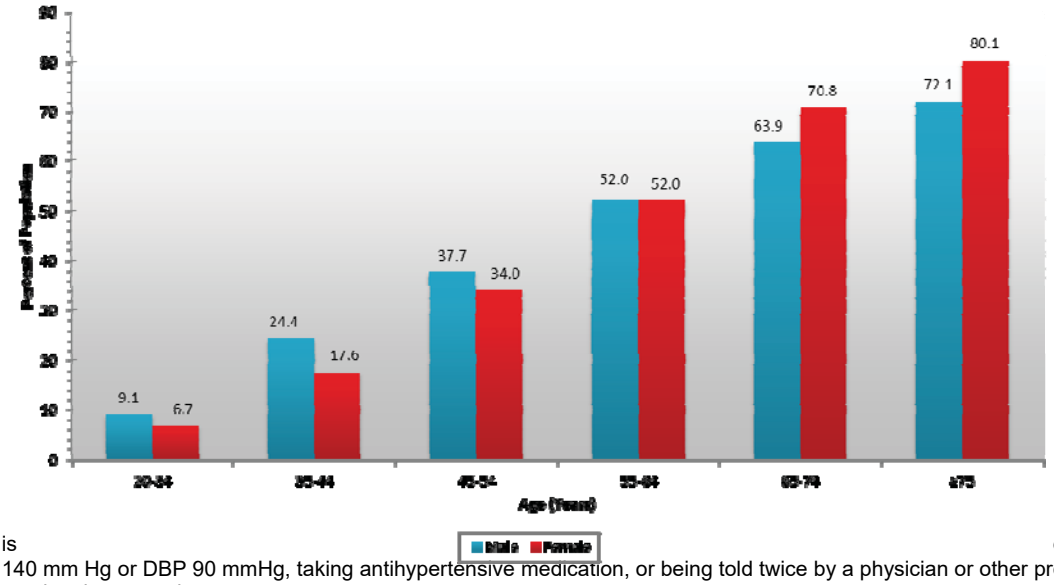
HSD pointed out with respect to 2017 House Bill 11 that the managed care programs through Centennial Care are not currently required to provide the specific services identified in this bill to cover artery calcification screening; however, passage of this bill would require the coverage specified. Consequently, by adding coverage of these services under the Medicaid benefit package, the Medicaid program would experience increased costs for these services and the additional service would be considered an expansion of the Medicaid Program.

The bill defines eligible enrollees as anyone between 30 and 75 years of age and being of increased risk of developing heart disease "based on at least one the following: hypertension, hyperlipidemia, diabetes, smoking, or family history of heart disease." Depending especially on the unspecified definitions of "hypertension" and of "family history of heart disease," a very large proportion of American adults would fit into the description of being at increased risk.

One of the most common of the disorders listed in House Bill 58 as causing a "risk of developing heart disease" is hypertension. As defined by the National Heart Lung and Brain Institute, a large proportion of American adults can be defined as having hypertension:

Prevalence of High Blood Pressure in Adults Age 20 and Older
NHANES: 2007–2010

Source: NCHS and NHLBI. Hypertension



is defined as SBP 140 mm Hg or DBP 90 mmHg, taking antihypertensive medication, or being told twice by a physician or other professional that one has hypertension.

The United States Preventive Services Task Force (USPSTF), the American Academy of Family Physicians, the American College of Cardiology and the American Heart Association do not support coronary artery calcium screening for the general public, although the USPSTF is considering the issue again in light of new data.

As stated in the current USPSTF report,
"The consequences of false-positive tests potentially may outweigh the benefits of screening. False-positive tests are common among asymptomatic adults, especially women, and may lead to unnecessary diagnostic testing, overtreatment, and labeling. Because the sensitivity of these tests is limited, screening also could result in false-negative results. A negative test does not rule out the presence of severe CAS or a future CHD event. The USPSTF recommends against routine screening with resting electrocardiography (ECG), exercise treadmill test (ETT), or electron-beam computerized tomography (EBCT) scanning for coronary calcium for either the presence of severe coronary artery stenosis (CAS) or the prediction of coronary heart disease (CHD) events in adults at low risk for CHD events.**"** **(**http://www.aafp.org/afp/2004/0615/p2891.html), although the statement does not address the use of the procedure in patients at intermediate or high risk.

"The majority of the members of the Writing Group would not recommend EBCT for diagnosing obstructive CAD because of its low specificity (high percentage of false-positive results), which can result in additional expensive and unnecessary testing to rule out a diagnosis of CAD."

Current American Heart Association guidance was published in 2010 and is available at https://www.ahajournals.org/circ/doi/10.1161/CIR.0b013e3182051bab. It includes the following:

As discussed by the Department of Health, the most recent statement from the American Heart Association on the subject, dated March 7, 2012, does not support coronary artery calcium screening, as follows:

> **20. Recommendations for Calcium Scoring Methods**
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> **2. Measurement of CAC is reasonable for cardiovascular risk assessment in asymptomatic adults at intermediate risk (10% to 20% 10-year risk). *(Level of Evidence: B)***
>
> *Class IIb*
>
> **1. Measurement of CAC may be reasonable for cardiovascular risk assessment in persons at low to intermediate risk (6% to 10% 10-year risk). *(Level of Evidence: B)***
>
> *Class III: No Benefit*
>
> **1. Persons at low risk (<6% 10-year risk) should not undergo CAC measurement for cardiovascular risk assessment. *(Level of Evidence: B)***

PSIA notes that it "supports this effort to improve early detection of cardiovascular disease. The earlier cardiovascular disease is diagnosed and treated, it provides for future cost savings to the patient and to the plan**."**

RHCA indicates that it "is unable to estimate the demand for this service and impact to its membership, as the average cost of provide this services ranges from $100 to $400 per episode."

OTHER SUBSTANTIVE ISSUES

OSI points out that House Bill 58 "does not address coverage provided by self-funded multiple-employer welfare arrangements regulated by the state under permissible ERISA exemptions."

LAC/al/gb