LEGISLATIVE FISCAL OFFICE
Fiscal Note

Fiscal Note On: **SB 48** SLS 24RS 178
Bill Text Version: **ORIGINAL**
Opp. Chamb. Action:
Proposed Amd.:
Sub. Bill For.:

Date: March 27, 2024 8:13 AM
Author: TALBOT
Dept./Agy.: Insurance and Office of Group Benefits
Subject: Consensus Statements for Biomarker Testing, Penalties
Analyst: Patrice Thomas

GENETICS OR INCREASE GF EX See Note

Provides for health insurance coverage of genetic testing for diseases and other medical conditions. (gov sig)

Present law requires health plans to cover biomarker testing for diagnosis, treatment, appropriate management, or ongoing monitoring. Present law provides a list of items demonstrated by medical and scientific evidence that biomarker testing provides clinical utility. Proposed law adds "Consensus Statements" to that list of medical and scientific evidence and provides for a definition. When a health insurer is not in compliance, proposed law authorizes the Commissioner of Insurance may do the following: (1) assess penalties including non-renew/suspend/revoke certificate of authority to operate, or issue a fine of $1,000 per violation, not to exceed $250,000; and (2) issue and serve a cease and desist order. If a health insurer violates the cease and desist order, proposed law provides the Commissioner shall, at his discretion, do one or more of the following: (1) issue a penalty of $25,000 per violation per day, not to exceed $250,000 for any six (6) months; (2) suspend or revoke insurer's certificate of authority; or (3) pursue injunctive relief in district court. Proposed law provides aggrieved insurers may appeal and demand a hearing with the Division of Administrative Law.

EXPENDITURES	2024-25	2025-26	2026-27	2027-28	2028-29	5 -YEAR TOTAL
State Gen. Fd.	**INCREASE**	**INCREASE**	**INCREASE**	**INCREASE**	**INCREASE**	
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	$0	$0	$0	$0	$0	**$0**
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total						

REVENUES	2024-25	2025-26	2026-27	2027-28	2028-29	5 -YEAR TOTAL
State Gen. Fd.	$0	$0	$0	$0	$0	**$0**
Agy. Self-Gen.	**INCREASE**	**INCREASE**	**INCREASE**	**INCREASE**	**INCREASE**	
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	$0	$0	$0	$0	$0	**$0**
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total						

EXPENDITURE EXPLANATION

Proposed law is anticipated to increase SGF expenditures in the health care exchanges by $1.5 M to $2.4 M beginning in FY 25 and subsequent fiscal years according to an analysis provided by the LA Department of Insurance (LDI) actuary. Under the Affordable Care Act (ACA), any state benefit mandate, through legislative or regulatory action, that exceeds what is considered an essential health benefit (EHB) would subject the state to defrayal costs. The proposed law would be considered a state benefit mandate; therefore, the state may be required to make payments to defray the cost of additional required benefits specified under this proposed law. The Office of Group Benefits (OGB) reports no impact.

Office of Group Benefits Impact (Self-Generated Revenue Impact)
OGB reports that through its contracted third-party administrator, Blue Cross and Blue Shield of Louisiana (BCBSLA), all of its five self-funded health plans already comply with the provisions of existing law (Act 324 of 2023), and the proposed law adding "consensus statements" is not anticipated to increase biomarker testing claims. Therefore, OGB does not anticipate any increased medical claims or non-compliance penalties as a result of this measure.

Insurance Exchanges Impact (State General Fund Defrayal Impact)
Proposed law may increase SGF expenditures beginning in FY 25 and subsequent fiscal years according to an analysis provided by the LDI health actuary. The state would be required to refund health claims expenditures associated with including consensus statements to the existing list of items that can be used to demonstrate medical or scientific evidence for the clinical utility of biomarker testing for diagnosis, treatment, appropriate management, and ongoing monitoring as required in the proposed law for policies issued by qualified health plans through the health insurance exchange beginning in FY 25 with estimated costs totaling approximately $1.5 M to $2.4 M SGF and a potential phase-up of $2 M to $3.2 M SGF by FY 29 and beyond. Claims expenses associated with the proposed law would be paid out by the State Treasury Department. LDI bases this analysis on the following assumptions: the calculations are on a fiscal year basis; the exchange population is approximately 200,000 and the insured population is assumed to be stationary; medical cost inflation (MI) is 8%; the premium loss ratio is 85%; and the estimated cost for genetic testing is between $0.63 PMPM (low) and $1.00 (high) PMPM over the entire insured population based on research and analysis.

See EXPENDITURE EXPLANATION on Page 2

REVENUE EXPLANATION

Proposed law may increase SGR by an indeterminable amount in LDI as a result of fines authorized by this measure. The proposed law provides for civil fines of up to $1,000 per violation, not to exceed $250,000, if a health insurer violates provisions of this measure. Furthermore, if a health insurer violates a cease and desist order, the Commissioner of Insurance may issue fines of $25,000 per violation per day until compliant, not to exceed $250,000 for any six months. The number of individuals that may violate the proposed law and be assessed civil fines by the Commissioner of Insurance is speculative and indeterminable.

Senate Dual Referral Rules

[x] 13.5.1 >= $100,000 Annual Fiscal Cost {S & H}

[ ] 13.5.2 >= $500,000 Annual Tax or Fee Change {S & H}

House

[x] 6.8(F)(1) >= $100,000 SGF Fiscal Cost {H & S}

[ ] 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease {S}

Alan M. Boxberger

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CONTINUED EXPLANATION from page one:

EXPENDITURE EXPLANATION Continued from Page 1

Based upon the aforementioned assumptions on page 1, the estimated annual cost increases for insurance providers associated with claims are as follows:

Aggregate Cost Determination*
Aggregate cost = exchange population x PMPM cost x 12 months.
FY 25 (Low) - 200,000 x $0.63 PMPM x 12 months = $1,512,000
FY 25 (High) - 200,000 x $1.00 PMPM x 12 months = $2,400,000

FY 26 (Low) - $1,512,000 x 8% MI = $1,633,000
FY 26 (High) - $2,400,000 x 8% MI = $2,592,000

FY 27 (Low) - $1,633,000 x 8% MI = $1,764,000
FY 27 (High) - $2,592,000 x 8% MI = $2,799,000

FY 28 (Low) - $1,764,000 x 8% MI = $1,905,000
FY 28 (High) - $2,799,000 x 8% MI = $3,023,000

FY 29 (Low) - $1,905,000 x 8% MI = $2,057,000
FY 29 (High) - $3,023,000 x 8% MI = $3,265,000

Premium Increase Determination*
Premium = exchange population x PMPM cost x 12 / loss ratio
FY 25 (Low) - 200,000 x $0.63 PMPM x 12 / 85% = $1,779,000
FY 25 (High) - 200,000 x $1.00 PMPM x 12 / 85% = $2,824,000

FY 26 (Low) - $1,779,000 x 8% MI / 85% = $1,921,000
FY 26 (High) - $2,824,000 x 8% MI / 85% = $3,049,000

Aggregate Extra Premium Determination*
Premium cost = PMPM x 12 months / loss ratio

FY 25 (Low) - $0.63 x 12 / 85% = $8.89
FY 25 (High) - $1.00 x 12 / 85% = $14.12

FY 26 (Low) - $ 8.89 x 8% MI = $ 9.61
FY 26 (High) - $14.12 x 8% MI = $15.25

*Estimated claims expenditures and premium increases are rounded to the nearest thousand.

PRIVATE INSURANCE IMPACT
Pursuant to R.S. 24:603.1, the information below is the projected private insurance impact of the proposed law. Based upon an actuarial analysis prepared by LDI, the proposed law is anticipated to increase expenditures associated with claims by $5.1 M - $8.1 M and premium increases by $6 M - $9.5 M for private insurers and the insured in FY 25 with phase-up costs of an estimated $5.5 M -$8.7 M claims and $6.4 M - $10.3 M premiums by second year, FY 26. LDI bases this analysis on the following assumptions: the calculations are on a fiscal year basis; the exchange population is approximately 675,000 and the insured population is assumed to be stationary; medical cost inflation (MI) is 8%; the premium loss ratio is 85%; and the **estimated cost is between $8.89 PMPM and $14.12 PMPM over the entire insured population, which represents a 0.10% to 0.15% annual premium increase**. Based upon the aforementioned assumptions, the estimated annual cost increases for insurance providers associated with claims are as follows:

Aggregate Cost Determination*
(exchange population x PMPM cost x 12 months)
FY 25 (Low) - 675,000 x $0.63 PMPM x 12 months = $5,103,000
FY 25 (High) - 675,000 x $1.00 PMPM x 12 months = $8,100,000

FY 26 (Low) - $5,103,000 x 8% MI = $5,511,000
FY 26 (High) - $8,100,000 x 8% MI = $8,748,000

Premium Increase Determination*
(exchange population x PMPM cost x 12 months)/ loss ratio
FY 25 (Low) - (675,000 x $0.63 PMPM x 12) / 85% = $6,004,000
FY 25 (High) - (675,000 x $1.00 PMPM x 12) / 85% = $9,529,000

FY 26 (Low) - $6,004,000 x 8% MI = $ 6,484,000
FY 26 (High) - $9,529,000 x 8% MI = $10,292,000

*Estimated claims expenditures and premium increases are rounded to the nearest thousand.

Division of Administrative Law
The proposed law allows an insurer to appeal any penalties assessed by the Commissioner of Insurance under this measure through the Division of Administrative Law (DAL). The DAL does not anticipate this proposed law to impact the number or scope of administrative hearings it conducts. For all work performed by DAL, the standard billing rate is $142.35 per judicial hour and $79.23 per clerical hour. The number of administrative hearings that may arise as a result of the provisions of proposed law is speculative and indeterminable.

Senate Dual Referral Rules
[x] 13.5.1 >= $100,000 Annual Fiscal Cost {S & H}
[ ] 13.5.2 >= $500,000 Annual Tax or Fee Change {S & H}

House
[x] 6.8(F)(1) >= $100,000 SGF Fiscal Cost {H & S}
[ ] 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease {S}

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