LEGISLATIVE FISCAL OFFICE
Fiscal Note

Fiscal Note On: **SB 100** SLS 24RS 79
Bill Text Version: **ORIGINAL**
Opp. Chamb. Action:
Proposed Amd.: **w/ PROP SEN COMM AMD**
Sub. Bill For.:

Date: April 16, 2024 8:03 PM
Author: DUPLESSIS
Dept./Agy.: Insurance and Office of Group Benefits
Subject: Mandates Coverage of Injectable Drugs
Analyst: Patrice Thomas

INSURANCE POLICIES OR INCREASE GF EX See Note

Provides health insurance coverage for certain injectable drugs. (gov sig)

Proposed law requires a health coverage plan to provide coverage for United States Food and Drug Administration (FDA) approved drugs to lower glucose levels or for weight reduction (subject to cost share and prior authorization) if all of the following apply: (1) The drug is approved by the FDA for lowering glucose levels or for weight reduction; (2) The covered person is diagnosed or previously diagnosed, the drug is prescribed by a licensed healthcare provider, and the drug is medically necessary for the treatment of prediabetes, gestational diabetes, or overweight/obesity; (3) The drug is on the insurer's formulary or preferred drug list. Proposed law requires treatment for prediabetes, gestational diabetes, or obesity to be medically necessary as certified by a healthcare provider. Proposed law authorizes a health coverage plan to require participation in a lifestyle management plan administered by the health coverage plan after granting access to the drug. Proposed law prohibits coverage for anti-obesity medication to be more restrictive than the FDA indications. Proposed law is effective January 1, 2025 (new health coverage plans) and January 1, 2026 (existing health coverage plans).

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.	**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						

REVENUES	2024-25	2025-26	2026-27	2027-28	2028-29	5 -YEAR TOTAL
State Gen. Fd.	**SEE BELOW**	**SEE BELOW**	**SEE BELOW**	**SEE BELOW**	**SEE BELOW**	
Agy. Self-Gen.	**SEE BELOW**	**SEE BELOW**	**SEE BELOW**	**SEE BELOW**	**SEE BELOW**	
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 will result in a significant increase in Self-Generated Revenue expenditures within the Office of Group Benefits (OGB) beginning in FY 25. Also, the proposed law would be considered a state benefit mandate; therefore, the state may be required to make payments, assumed to be SGF, to defray the cost of the additional required benefits specified under this proposed law. Note: Proposed Senate Insurance Committee amendment expands coverage to all FDA-approved drugs to lower glucose levels or for weight reduction. OGB reports the proposed amendment does not significantly impact projections. The LFO will work with OGB to include anti-obesity drugs in pills or other forms in future fiscal notes as necessary.

Office of Group Benefits Impact (Self-Generated Revenue Impact)

Proposed law increases pharmacy claims expenditures within the Office of Group Benefits (OGB). Proposed law requires OGB to provide coverage for injectable drugs to lower glucose levels or weight loss (Saxenda, Wegovy, Zepbound). Based upon the assumptions listed below and a tiered utilization rate (uptake), the expenditures to cover this benefit range are as follows:

Utilization

Rate	FY 24-25*	FY 25-26	FY 26-27	FY 27-28	FY 28-29	Total
10%	$ 27,313,300	$ 56,265,399	$ 57,953,361	$ 59,691,962	$ 61,482,721	$ 262,706,743
20%	$ 54,626,601	$ 112,530,798	$ 115,906,722	$ 119,383,924	$ 122,965,441	$ 525,413,486
50%	$ 136,566,502	$ 281,326,994	$ 289,766,804	$ 298,459,808	$ 307,413,602	$ 1,313,533,710

*FY 24-25 represents 6 months of estimated claims expenditures based on an implementation date of January 1, 2025.

Unless OGB Fund Balance is utilized, an appropriation will be required to cover the state portion of the increase in premium costs, which is generally approximately 40% SGF and 60% other means of finance. As of March 2024, OGB reports a $346 M fund balance.

The expenditure estimate is based upon the following assumptions: (1) As of 4/01/2024, the current OGB member population in the five self-funded health plans is 213,770 (170,139 on Commercial Plan and 43,631 on Employer Group Waiver Plan, EGWP) and membership will remain constant. No change in OGB self-funded health plan membership in future fiscal years from current levels. (2) The coverage will become effective on 1/01/2025. (3) Based solely on claims experience, OGB's medical third-party administrator, Blue Cross Blue Shield of LA estimates pre-diabetes (13.1%), gestational diabetes (0.1%), and obesity - BMI over 30 (29.2%). (4) In future fiscal years,a medical inflation (MI) factor of 3% is applied, based on Consumer Price Index data for medical care in the Southern United States through the end of FY 23.

See EXPENDITURE EXPLANATION on page 2

REVENUE EXPLANATION

To the extent, the projected increase in pharmacy claims expenditures mandated by the proposed law (along with increases associated with other legislative instruments that are enacted to expand covered medical and pharmacy benefits) cannot be absorbed by OGB's fund balance, the cumulative impact may be material and require OGB to do the following: (1) decrease or eliminate benefits; or (2) seek additional revenue authority, either a direct SGF appropriation or increase SGR collections from premium rate increases. OGB must maintain an actuarially sound fund balance of $276 M. For FY 2024 plan year, a 1% premium increase generates approximately $15.5 M.

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:

Projected costs

Injectable Drug	Members	Commercial	EGWP	Projected Costs
Saxenda	9,285	$23,608,779	$10,969,200	$34,577,979
Wegovy	75,574	$399,968,913	$94,785,492	$494,754,405
Zepbound	863	$396,648	$626,317	$1,022,965
Base Cost	85,722	$423,974,340	$106,381,008	**$530,355,348**

	10%	20%	50%
% of Base Cost	$53,035,535	$106,071,070	$265,177,674
3% MI	$1,591,066	$3,182,132	$7,955,330
FY 24-25*	**$54,626,601**	**$109,253,202**	**$273,133,004**
3% MI	$1,638,798	$3,277,596	$8,193,990
FY 25-26	**$56,265,399**	**$112,530,798**	**$281,326,994**
3% MI	$1,687,962	$3,375,924	$8,439,810
FY 26-27	**$57,953,361**	**$115,906,722**	**$289,766,804**
3% MI	$1,738,601	$3,477,202	$8,693,004
FY 27-28	**$59,691,962**	**$119,383,924**	**$298,459,808**
3% MI	$1,790,759	$3,581,518	$8,953,794
FY 28-29	**$61,482,721**	**$122,965,442**	**$307,413,602**
Total	**$290,020,043**	**$580,040,086**	**$1,450,100,212**

*FY 24-25 represents 6 months costs

10%	20%	50%
($27,313,300	$54,626,601	$136,566,502)

Insurance Exchanges Impact (State General Fund Defrayal Impact)
Proposed law will 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 providing coverage for injectable drugs to lower glucose levels or weight loss as required in the proposed law for policies issued by qualified health plans through the health insurance exchange beginning in FY 25 with estimated claims costs totaling approximately $43.2 M to $57.6 M SGF and a potential phase-up of $54 M to $72 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% in FY 26, then 5% in subsequent years; the premium loss ratio is 85%; and the estimated cost for genetic testing is between $18 PMPM (low) and $24 PMPM (high) over the entire insured population based on research and analysis.

Aggregate Cost Determination**
Aggregate cost = exchange population x PMPM cost x 12 months.
FY 25 (Low) - 200,000 x $18 PMPM x 12 months = $43,200,000
FY 25 (High) - 200,000 x $24 PMPM x 12 months = $57,600,000
FY 26 (Low) - $43,200,000 x 8% MI = $46,656,000
FY 26 (High) - $57,600,000 x 8% MI = $62,208,000
FY 27 (Low) - $46,656,000 x 5% MI = $48,988,800
FY 27 (High) - $62,208,000 x 5% MI = $65,318,400
FY 28 (Low) - $48,988,800 x 5% MI = $51,438,240
FY 28 (High) - $65,318,400 x 5% MI = $68,584,320
FY 29 (Low) - $51,438,240 x 5% MI = $54,010,150
FY 29 (High) - $68,584,320 x 5% MI = $72,013,540
**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 impact of the proposed law on the private insurance market. Based upon an actuarial analysis prepared by LDI, the proposed law is anticipated to increase expenditures associated with claims by $145.8 M - $194.4 M and premium increases by $171.4 M - $228.8 M for private insurers and the insured in FY 25 with phase-up costs of an estimated $182.3 M - $243 M claims and $214 M - $285.5 M premiums by FY 29. LDI bases this analysis on the following assumptions: the calculations are on a fiscal year basis; the exchange population is approximately 675,000 (including 200,000 population in health exchanges) and the insured population is assumed to be stationary, entries equal exits; medical cost inflation (MI) is 8% in FY 26, then 5% in subsequent years; the premium loss ratio is 85%; and the **estimated cost is between $18 PMPM and $24 PMPM over the entire insured population, which represents an annual premium increase between 2.8% (low) to 3.7% (high) on an average monthly premium/PMPM of $650**. Based upon the aforementioned assumptions, the estimated annual cost increases for insurance providers associated with claims are as follows:

Aggregate Cost Determination**
(insured population x PMPM cost x 12 months x MI)
FY 25 (Low) - 675,000 x $18 x 12 months = $145,800,000
FY 25 (High) - 675,000 x $24 x 12 months = $194,400,000
FY 26 (Low) - $145,800,000 x 8% MI = $157,464,000
FY 26 (High) - $194,400,000 x 8% MI = $209,952,000
FY 27 (Low) - $157,464,000 x 5% MI = $165,337,200
FY 27 (High) - $209,952,000 x 5% MI = $220,449,600
FY 28 (Low) - $165,337,200 x 5% MI = $173,604,060
FY 28 (High) - $220,449,600 x 5% MI = $231,472,080
FY 29 (Low) - $173,604,060 x 5% MI = $182,284,263
FY 29 (High) - $231,472,080 x 5% MI = $243,045,684

Aggregate Extra Premium Determination*
(PMPM cost x 12 months)/medical loss ratio x MI
FY 25 (Low) - ($18 x 12 months)/85% = $254
FY 25 (High) - ($24 x 12 months)/85% = $339
FY 26 (Low) - $254 x 8% MI = $274
FY 26 (High) - $339 x 8% MI = $366
FY 27 (Low) - $274 x 5% MI = $288
FY 27 (High) - $366 x 5% MI = $384
FY 28 (Low) - $288 x 5% MI = $302
FY 28 (High) - $384 x 5% MI = $403
FY 29 (Low) - $302 x 5% MI = $317
FY 29 (High) - $403 x 5% MI = $423
**Estimated claims expenditures are rounded to the nearest thousand and premium increases are rounded to whole dollars.

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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