GOVERNOR'S OFFICE OF BUDGET AND PROGRAM PLANNING

Fiscal Note 2025 Biennium

Bill information:	
HB0758 - Require insurance coverage of continuous glucose monitoring supplies (Nave, Fiona)	
Status:	As Amended in Senate Committee

☐Significant Local Gov Impact ☒Needs to be included in HB 2 ☐Technical Concerns

☐Included in the Executive Budget ☐Significant Long-Term Impacts ☐Dedicated Revenue Form Attached

FISCAL SUMMARY

	FY 2024 Difference	FY 2025 Difference	FY 2026 Difference	FY 2027 Difference
Expenditures:				
General Fund	$9,704,160	$9,704,160	$9,849,722	$9,997,468
Other - Proprietary	$51,946	$111,436	$119,551	$128,281
Revenue:				
General Fund	$0	$0	$0	$0
Other - Proprietary	$0	$0	$0	$0
Net Impact-General Fund Balance:	($9,704,160)	($9,704,160)	($9,849,722)	($9,997,468)

Description of fiscal impact: Under the Affordable Care Act, the state of Montana is required to pay the costs of certain state benefit mandates (mandates) enacted after December 31, 2011, that (1) apply to Qualified Health Plans (QHPs) sold in the individual and small group markets, on and off-exchange; and (2) are in addition to the essential health benefits and which relate to specific care, treatment, or services.

Applying the framework of the Affordable Care Act, the Commissioner of Securities and Insurance, Office of the State Auditor (CSI or SAO) conclude the mandate in HB 758, as amended, requires the state of Montana to defray the associated costs of the benefit for QHPs sold in the individual and small group market based on Section 33-22-129, MCA, and Montana's EHB-benchmark plan.

There is also a fiscal impact to the Department of Administration since the amended bill shifts the authority for determining what is medically necessary from the health insurance carrier to the health care provider. This revision negates the health insurance carrier's ability to follow their internal policies resulting in an increased cost to the state.

FISCAL ANALYSIS

Assumptions:

State Auditor's Office

1. HB 758, as amended, goes into effect on January 1, 2024, resulting in only six months of the revised cost being used in fiscal year 2024.

2. In drafting its initial fiscal note, the State Auditor's Office sought cost estimates from the three issuers that offer Qualified Health Plans (QHPs) in the individual and/or small group market based on their respective membership, claims data, allowable costs, and other pertinent information in their possession. To ensure a direct comparison of the cost estimates, the office requested each issuer to submit a cost estimate based on the following assumptions:
    - The bill would apply to members with a diagnosis of Type 1 or Type 2 diabetes.
    - The bill would not preclude the use of an issuer's formulary or other preferred providers.
    - The bill would require that a healthcare provider, acting within the course and scope of the provider's license, prescribe (versus recommend) a CGM.
    - An issuer's estimated cost should not include costs that the issuer already covers and reimburses for CGMs.
    - An issuer's estimated cost should account for applicable copayments, deductibles, and limitations.
3. In addition to the cost estimate described above, an issuer was given the option of submitting a second cost estimate if the issuer disagreed with the assumptions stated by the office. The issuers varied in their compliance with the office's request for cost estimates based on the above-stated assumptions. See the chart below identifying each issuer's initial cost estimate forming the basis for the office's initial fiscal note.
4. Subsequently, the bill was amended. The amendment confirmed the bill only required coverage of CGMs for members diagnosed with Type I or Type II diabetes based upon the individual's health care provider (acting within the scope of the provider's license) determining a CGM was medically necessary and prescribing the same.
5. In drafting the Revised Fiscal Note based on the amendment of HB 758, CSI again requested each issuer to submit a cost estimate based on the same assumptions as CSI communicated in its request for the Initial Fiscal Note. Further, CSI clarified that issuers should also calculate what percentage of uptake it estimated with respect to impacted members. See the chart below identifying each issuer's revised cost estimate forming the basis for CSI's Revised Fiscal Note.

Issuer	Individual QHP Membership	Small Group QHP Membership	Total QHP Individual and Small Group Membership	Initial Fiscal Note Annual Cost Estimate	Revised Fiscal Note Annual Cost Estimate
Issuer #1	26,000	25,000	52,000	$100,148,360	**$4,632,160**
Issuer #2	11,176	15,851	27,027	$15,264,000	**$ 672,000**
Issuer #3	22,672	3,978	26,650	$8,184,000	**$4,400,000**
TOTAL ANNUALIZED COST ESTIMATE TO STATE:				(Initial) $123,596,360	**(Revised) $9,704,160**

6. These costs have been inflated by 1.5% for fiscal years 2026 and 2027.

Department of Administration

7. HB 758 would provide coverage of continuous glucose monitors (CGMs) and monitor supplies to persons diagnosed with type-I or type-II diabetes, regardless of disease state. The CGM would be determined as medically necessary when ordered by the treating physician. This would eliminate the current usage of the State Plan's medical necessity policies and the use of prior authorizations when determining if a member is eligible for CGM coverage.
8. Removal of current medical necessity policies and prior authorizations will commence on January 1, 2024, which will increase the historical approval rating from 76% to 100%.
9. The basis for this analysis is calendar year 2022 where 167 members utilized CGMs and related supplies.

MEDICAL PLAN COSTS

10. 2022 expenses of CGMs and related supplies was $173,489.
11. The adjustment factor for claims incurred by not reported (IBNR) is 1.007 for all 4 fiscal years based on a 1.5 month claim lag for medical claims.
12. Estimated claims trend factors using a low trend scenario of medical at 6% from 2022 to each respective fiscal year is as follows:
    a. FY 2024 is 1.091 based on 18 months from December 2022 through June 2024
    b. FY 2025 is 1.157 based on 30 months from December 2022 through June 2025
    c. FY 2026 is 1.226 based on 42 months from December 2022 through June 2026
    d. FY 2027 is 1.300 based on 54 months from December 2022 through June 2027
13. Estimated Medical Plan Costs ($173,489 x 1.007 x [FY trend factor]):

FY 2024	FY 2025	FY 2026	FY 2027
$190,660	$202,100	$214,226	$227,079

PRESCRIPTION DRUG PLAN COSTS

14. 2022 expenses of CGMs and related supplies was $121,073.
15. The adjustment factor for claims incurred by not reported (IBNR) is 1.004 for all 4 fiscal years based on a 0.5 month claim lag for prescription drugs.
16. Estimated claims trend factors using a low trend scenario of prescription drugs at 9% from 2022 to each respective fiscal year is as follows:
    a. FY 2024 is 1.138 based on 18 months from December 2022 through June 2024
    b. FY 2025 is 1.240 based on 30 months from December 2022 through June 2025
    c. FY 2026 is 1.352 based on 42 months from December 2022 through June 2026
    d. FY 2027 is 1.474 based on 54 months from December 2022 through June 2027
17. Estimated Prescription Drug Plan Costs ($121,073 x 1.004 x [FY trend factor]):

FY 2024	FY 2025	FY 2026	FY 2027
$138,331	$150,781	$164,352	$179,143

TOTAL COSTS

18. Estimated Total Plan Costs ([medical plan costs] + [prescription drug plan costs]):

FY 2024	FY 2025	FY 2026	FY 2027
$328,992	$352,881	$378,577	$406,223

19. Adjusted Total Plan Costs covering all medically necessary diabetics ([estimated total plan costs]/0.76):

FY 2024	FY 2025	FY 2026	FY 2027
$432,884	$464,317	$498,128	$534,503

20. Net cost to the State Plan ([adjusted total plan costs] – [estimated total plan costs]) with FY 2024 halved due to HB758 start date of January 1, 2024:

FY 2024	FY 2025	FY 2026	FY 2027
$51,946	$111,436	$119,551	$128,281

Montana University System

21. The Montana University System's Group Insurance Plan currently provides coverage for continuous glucose monitors and supplies. There is no fiscal impact to the MUS from HB 758, as amended.

	Difference	Difference	Difference	Difference
Fiscal Impact:				
FTE	0.00	0.00	0.00	0.00
Expenditures:				
Benefits - Insurer 1	$4,632,160	$4,632,160	$4,701,642	$4,772,167
Benefits - Insurer 2	$672,000	$672,000	$682,080	$692,311
Benefits - Insurer 3	$4,400,000	$4,400,000	$4,466,000	$4,532,990
Benefits DOA SOM Plan	$51,946	$111,436	$119,551	$128,281
TOTAL Expenditures	$9,756,106	$9,815,596	$9,969,273	$10,125,749
Funding of Expenditures:				
General Fund (01)	$9,704,160	$9,704,160	$9,849,722	$9,997,468
Other - Proprietary	$51,946	$111,436	$119,551	$128,281
TOTAL Funding of Exp.	$9,756,106	$9,815,596	$9,969,273	$10,125,749
Revenues:				
General Fund (01)	$0	$0	$0	$0
Other	$0	$0	$0	$0
TOTAL Revenues	$0	$0	$0	$0
Net Impact to Fund Balance (Revenue minus Funding of Expenditures):				
General Fund (01)	($9,704,160)	($9,704,160)	($9,849,722)	($9,997,468)
Other	($51,946)	($111,436)	($119,551)	($128,281)

Effect on County or Other Local Revenues or Expenditures:

Montana Association of Counties

1. The Montana Association of Counties does not expect any fiscal impact to Montana counties from HB 758, as amended. The Health Care Trust, which covers 39 counties, already provides this coverage.

Montana League of Cities and Towns/Montana Municipal Interlocal Authority

2. There is no fiscal impact from HB 758, as amended, for the Montana League of Cities and Towns or the Montana Municipal Local Authority.

Sponsor's Initials	*Date*	*Budget Director's Initials*	*Date*
			4-11-23