TENNESSEE GENERAL ASSEMBLY
FISCAL REVIEW COMMITTEE

FISCAL NOTE

SB 367 - HB 523

March 23, 2017

SUMMARY OF BILL: Create the *Cancer Patient Choice Act*. Requires any health insurance policy which covers intensity modulated radiation therapy (IMRT) for the delivery of a biological effective dose for a particular indication to cover the delivery of the same biological effective dose for an eligible adult patient for the same indication by a physician-prescribed hypofractionated proton therapy protocol, as defined in the legislation. Excludes from the provisions of this legislation TennCare or any successor program, and any state, local education, or local government group insurance plans. The legislation shall become effective on July 1, 2017; however, the provisions of the legislation shall be deleted on July 1, 2019.

ESTIMATED FISCAL IMPACT:

Increase State Expenditures - $1,802,400/FY17-18
$1,802,400/FY18-19

Potential Impact on Health Insurance Premiums (required by Tenn. Code Ann. § 3-2-111): Such legislation will result in an increase in the cost of health insurance premiums for hypofractionated proton therapy treatment being provided by plans that do not currently offer these benefits at the proposed mandated levels. It is estimated that the increase to each individual's total premium will be less than one percent. A one percent increase in premium rates could range between $50 (single coverage) and $140 (family coverage) depending on the type of plan.

Assumptions:

- This legislation explicitly exempts all TennCare plans, and any state, local education, or local government group insurance plans.
- Therefore, this legislation is estimated to have no significant impact on state or local government expenditures associated with those plans.
- The Department of Commerce and Insurance (DCI) is responsible for regulation of the provisions of the legislation. Any cost incurred due to regulation can be accommodated within existing resources without an increased appropriation or reduced reversion.
- Federal 45 C.F.R. §155.70 authorizes a state to require a qualified health plan (QHP) to offer benefits in addition to the essential health benefits. If the state-required benefits are in addition to the essential health benefits (EHB), then the state must make payments

to defray the cost of the additional required benefits to an enrollee or directly to the QHP issuer on behalf of the enrollee.

- According to DCI, the bill imposes a health insurance benefit mandate that exceeds the benefits provided under the Tennessee EHB plan.
- Pursuant to the Patient Protection and Affordable Care Act (PPACA), states are required to defray the cost of benefit mandates enacted after December 31, 2011, that require coverage of benefits by qualified health plans that exceed benefits included in the state's EHB benchmark plan.
- According to DCI, a state may defray the cost of a mandate by reimbursing the health insurance carrier for the amount of premium attributed to the new benefit, or for the insurance carrier's actual costs. DCI assumes the state will reimburse the health insurance carriers for the amount of premium attributed to the new benefit.
- In a census released by the U.S. Department of Health and Human Services, 250,500 Tennesseans have obtained health coverage on the federally facilitated exchange as of January 2016. Due to the trend of enrollment numbers increasing during the end of the enrollment period, it is estimated that 25,000 additional Tennesseans will obtain coverage on the exchange. In addition, based on data currently provided by carriers, the DCI estimates that approximately 100,000 individuals have obtained a QHP off the exchange. Therefore, the total QHP population is estimated to be 375,500 (250,500 + 25,000 + 100,000) for calendar year 2016.
- The QHP population is estimated to be approximately 375,500 for calendar years 2017 and 2018.
- The TDCI contacted one health insurance carrier currently offering QHPs in Tennessee. The carrier provided cost data estimates.
- According to the study, "Variation in the Cost of Radiation Therapy Among Medicare Patients with Cancer," (*Journal of Oncology Practice* 11, no. 5 (September 2015) 403-409.), which analyzed cost data of 55,200 patients from the National Cancer Institute's SEER program, the average cost increase per patient to provide a standard course of proton therapy relative to a course of IMRT was $11,000.
- Based on the number of individuals estimated to be enrolled in QHPs (375,500), this will result in an increase in costs to such plans estimated to be $4.80 per member per year, for a total of $1,802,400 ($4.80 x 375,500).
- An increase in state expenditures in each FY17-18 and FY18-19 estimated to be $1,802,400.

IMPACT TO COMMERCE:

Increase Business Revenue – Exceeds $1,802,400/FY17-18
$1,802,400/FY18-19

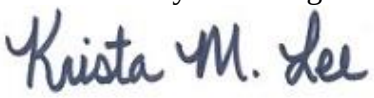
Increase Business Expenditures – Less than $1,802,400/FY17-18
Less than $1,802,400/FY18-19

Assumptions:

- Health care providers that provide hypofractionated proton therapy treatment will incur an increase in revenue to cover the cost of the increased coverage provided by insurance companies as a result of the proposed legislation.
- Insurance companies will realize an increase in premium revenue to cover the increased coverage.
- An exact impact to commerce cannot be determined due to a number of unknown factors, but the increase in business revenue is reasonably estimated to exceed the amount of increased state and federal expenditures resulting from the proposed legislation.
- For companies to retain solvency, any increased business expenditures are assumed to be less than the amount of revenue collected.

CERTIFICATION:

The information contained herein is true and correct to the best of my knowledge.



Krista M. Lee, Executive Director

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