

HB 214, INSURANCE COVERAGE MODIFICATIONS, (Ward, R)

Anticipated Fiscal Impact:

\$1,099,176 per year

This bill contains two provisions with a fiscal impact.

- 1) The bill requires the state health insurance pool to cover in-vitro fertilization (IVF) procedures, including genetic testing of an embryo, for an employee and partner who expect to have children, but have been diagnosed with a genetic trait for cystic fibrosis (CF), spinal muscular atrophy (SMA), Morquio Syndrome, or sickle cell anemia. The bill allows the couple to elect IVF in favor of natural conception to reduce the chances of a child born with the parents' disease.

Based on PEHP's claims experience, it would cost less for the state to pay for IVF than for a child born with CF, SMA, Morquio, or sickle cell anemia. PEHP currently pays an average of:

- a) \$89,717/person/year for those diagnosed with CF (this figure does not include coverage for the recent FDA approved Trikafta medication which can add \$310,000/person/year if indicated);
- b) \$17,604/person/year for those diagnosed with SMA (this figure does not include coverage for the recent FDA approved Zolgensma medication for Type I SMA which can add \$2,100,000/person if indicated);
- c) \$536,000/person/year for those diagnosed with Morquio; and
- d) \$14,077/person/year for those diagnosed with sickle cell anemia. While treatment for sickle cell anemia is lower than cost of one cycle of IVF,

treatment for sickle cell anemia occurs over many years and would ultimately cost significantly more than IVF.

IVF and genetic testing would cost about \$16,800 per cycle. For purposes of this fiscal analysis, PEHP assumes that: (1) anyone requesting to receive IVF under this bill would otherwise be able to successfully conceive; (2) IVF would result in a pregnancy of an individual without the genetic-related diseases listed; and (3) state coverage for a child with one of the genetic-related diseases would last for more than one year. Thus, treatment of IVF and genetic testing would not result in additional costs because the expensive nature of the treatments.

- 2) This bill requires an insurer, including PEHP, to count any cost sharing for a prescription drug without a drug alternative toward an enrollee's deductible or out-of-pocket maximum regardless of whether the enrollee actually paid the amount of the cost sharing or whether it was paid "on behalf of an enrollee" by a third party, such as a drug manufacturer. PEHP is currently able to obtain copay assistance amounts for some but not all drugs. For those that it can obtain, PEHP does not count the manufacturer's copay assistance toward cost sharing limits. This bill would reverse that at a cost to the state of at least \$1,099,176/year based on 2019 data: 1,838 claims with average of \$598.03/claim. The bill would result in additional \$850,000 in costs to the state if PEHP was able to obtain copay assistance amounts for all drugs.

In addition, for enrollees on a high deductible health plan with a qualified Health Savings Account, PEHP's reading of federal law does not allow a plan to cover non-preventive claims before the deductible is met without incurring tax penalties, including the enrollee receiving a 10% tax penalty on the HSA and the enrollee having to include the HSA amounts in gross income.

