OHIO LEGISLATIVE SERVICE COMMISSION

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Office of Research and Drafting

Legislative Budget Office

H.B. 418
133rd General Assembly

Fiscal Note & Local Impact Statement

Click here for H.B. 418's Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Clites and Carruthers

Local Impact Statement Procedure Required: Yes

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Highlights

- The bill's prohibitions are likely to increase costs to the state employee health benefit plans. The state's costs to provide health benefits to employees and their dependents are paid from the Health Benefit Fund (Fund 8080). Fund 8080 receives funding through state employee payroll deductions and state agency contributions toward their employees' health benefits, which come out of the GRF and various other state funds.
- The bill's prohibitions are likely to increase costs to counties, municipalities, townships, and school districts statewide of providing health benefits to employees and their dependents. However, LBO staff could not determine the magnitude of the fiscal impact due to lack of information on the number of local government employers that will be affected by the prohibitions.

Detailed Analysis

Health plan issuers

The bill prohibits a health plan issuer to do any of the following during a plan year: (1) increase a covered person's burden of cost-sharing with respect to a drug, (2) move a drug to a more restrictive tier of the plan's formulary, (3) remove a drug from the plan's formulary unless one of the following occurred: (a) the United States Food and Drug Administration (USFDA) issued a statement about the drug calling into question the clinical safety of the drug, (b) the drug manufacturer notified the USFDA of a permanent discontinuance or interruption of the manufacture of the drug as required by federal law, or (c) the drug manufacturer has removed the drug from sale in the United States, (4) limit or reduce coverage of a drug with respect to a covered person in any other way, including subjecting it to a prior authorization requirement. Despite these prohibitions, the bill explicitly permits a health plan issuer to add a

drug to its formulary, or remove a drug from its formulary if the drug manufacturer has removed the drug from sale in the United States.[1]

The bill specifies that a violation of its provisions is considered an unfair and deceptive practice in the business of insurance for the purposes of existing section 3901.21 of the Revised Code. The bill also includes a provision that exempts its provisions from the mandated health benefits application under existing law. Under current law, no mandated health benefits legislation enacted by the General Assembly may be applied to sickness and accident or other health benefits policies, contracts, plans, or other arrangements until the Superintendent of Insurance determines that the provision can be applied fully and equally in all respects to employee benefit plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA) and employee benefit plans established or modified by the state or any political subdivision of the state.

The bill applies to all health benefit plans under section 3922.01 of the Revised Code, including a nonfederal government health plan, delivered, issued for delivery, modified, or renewed on or after the bill's effective date.

Fiscal effect

The bill may minimally increase the Department of Insurance's administrative costs for regulating health insurers. Any increase in the Department's administrative costs would be offset by any civil penalties that may arise from failure to comply with the bill's requirements. Any penalties would be deposited into the Department of Insurance Operating Fund (Fund 5540) and any increase in administrative costs would also be paid from Fund 5540.

The prohibitions related to prescription drug coverage during a plan year could restrict health plan issuers' ability to control any increase in costs of prescription coverage during a plan year. Thus, the prohibitions are likely to increase costs to the state employee health benefit plans. The state's costs to provide health benefits to employees and their dependents are paid from the Health Benefit Fund (Fund 8080). Fund 8080 receives funding through state employee payroll deductions and state agency contributions toward their employees' health benefits, which come out of the GRF and various other state funds. In addition, the bill is likely to increase costs to counties, municipalities, townships, and school districts statewide of providing health benefits to employees and their dependents. However, LBO staff could not determine the magnitude of the fiscal impact due to lack of information on the number of local government employers that will be affected by the bill's provisions.

[1] Also, the bill specifies that it does not prevent: (1) a health care provider from prescribing another drug covered by the health benefit plan that the provider considers medically appropriate for the covered person, (2) a pharmacist from substituting for the prescribed drug a generically equivalent drug or interchangeable biological product in accordance with section 4729.38 of the Revised Code, or (3) a pharmacist from substituting for a prescribed epinephrine autoinjector another epinephrine autoinjector pursuant to section 4729.382 of the Revised Code.

Medicaid

The bill prohibits Medicaid and Medicaid managed care organizations (MCOs) from removing a drug from their formularies, unless there is a warning regarding the clinical safety of the drug, the drug has been discontinued by the manufacturer, or the drug has been removed from sale in the United States by the manufacturer.

Fiscal effect

According to the Ohio Department of Medicaid (ODM), Medicaid and its MCOs are currently disallowed by federal law from removing drugs from their formulary under almost all circumstances except for significant changes in drug safety or availability, which generally align with the exceptions in H.B. 418. The bill is therefore expected to have minimal fiscal impacts for Medicaid.