Ohio Legislative Service Commission

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Fiscal Note & Local Impact Statement

Bill: Am. H.B. 81 of the 128th G.A. **Date**: December 15, 2009

Status: As Passed by the House **Sponsor**: Reps. Boyd and Gardner

Local Impact Statement Procedure Required: Yes

Contents: Requires certain health care plans and policies to provide benefits for equipment, supplies, and medication for the diagnosis and treatment of diabetes, and for diabetes self-management education, and creates the Small Business Health Care Affordability Task Force

State Fiscal Highlights

STATE FUND	FY 2010	FY 2011	FUTURE YEARS
General Revenue Fund			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	Potential minimal increase	Potential minimal increase	Potential minimal increase
Other State Funds			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	Potential minimal increase	Potential minimal increase	Potential minimal increase

Note: The state fiscal year is July 1 through June 30. For example, FY 2010 is July 1, 2009 – June 30, 2010.

- The state currently provides all required health benefits to state employees. Health insuring corporations (HICs) that cover state employees may experience an increase in administrative costs to comply with the bill. Any such potential cost increase is assumed to be passed through to the state in future rate negotiations. About half of any such potential cost increase may be paid (indirectly) from the GRF, with the remainder being paid from other state funds.

- The bill establishes the Small Business Health Care Affordability Task Force to study specified issues related to incentives for businesses to provide health benefits to workers. The Task Force is to include six members of the General Assembly, who may appoint up to five additional members. The bill does not specify whether members of the Task Force are to be compensated and it does not require any state agency to provide staff support.

Local Fiscal Highlights

LOCAL GOVERNMENT	FY 2010	FY 2011	FUTURE YEARS
Counties			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	Potential increase	Potential increase	Potential increase
Other Local Governments			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	Potential increase	Potential increase	Potential increase

Note: For most local governments, the fiscal year is the calendar year. The school district fiscal year is July 1 through June 30.

- Political subdivisions may be required to increase expenditures to provide health benefits to employees. While most of the required benefits may already be provided by several counties, not all counties provide the required amount of education in self-managing diabetes in full. HICs that cover employees of political subdivisions may experience an increase in administrative costs to comply with the bill's requirements. Any such increase is assumed to be passed on to the political subdivision that sponsors the plan eventually. The Legislative Service Commission does not have data necessary for estimating the statewide cost.

Detailed Fiscal Analysis

H.B. 81 requires health insuring corporations' contracts, sickness and accident insurance policies, public employee benefit plans, and multiple employer welfare arrangements to provide benefits for equipment, supplies, and medication for the diagnosis, treatment, and management of diabetes. The bill also requires all such contracts, policies, and benefit plans to provide benefits for "diabetes self-management education" and "medical nutrition therapy" when prescribed by a physician or other individual whose professional practice established by licensure under the Revised Code includes the authority to prescribe it. The bill states that the education benefits shall cover expenses for a minimum of ten hours of diabetes self-management education during the first twelve months and two hours of education in each subsequent year, and that education benefits must be covered whether provided during home visits, in a group setting, or by individual counseling (if medically necessary). The bill also requires copayments and deductible amounts to be no higher that they would be if provided through a supplemental benefit policy.

Coverage is not required for diabetes self-management education and medical nutrition therapy if health benefit plans are able to document that providing them has increased their costs by more than 1% and the increase in costs justifies an increase of more than 1% in premiums or rate charges, or the insured person is covered by an employer-provided supplemental benefit policy that provides comparable benefits. Exclusion from coverage would be determined by the Superintendant of Insurance based on actual claims experiences submitted by the providers.

Background information

Actuarial reports on the effects of implementing the provisions of similar bills introduced in the 124th General Assembly (H.B. 100 and S.B. 45) were produced during that General Assembly by Milliman USA.[1] The actuarial reports estimated that about 2.35% of Ohioans between the ages of 0 and 64 would be diagnosed with diabetes. Based on this estimate, the report projected that the provisions of H.B. 100 (and of S.B. 45) would increase health insurance premiums in Ohio by between 0.2% and 0.6% on average, and by up to 2% for plans that did not provide any of the required services at that time. The Milliman report acknowledged that the higher premiums predicted "would be expected" to lead to a reduction in the number of people covered by health insurance in the state, but did not provide an estimate of that reduction and described it as "minimal." The actuarial report did not take into account potential savings due to the possible avoidance of expensive complications associated with diabetes. Milliman actuaries studied the possibility of quantifying such savings and issued an opinion that

[1] Although the reports were produced in 2001 and may be dated, they are still believed to be relevant despite changes in the insurance and health care markets.

there were no existing studies at that time that could serve as a reliable basis for quantifying such potential savings.

State fiscal effects

The bill has the potential to increase costs to the state of providing health benefits to state employees. All health plans for state employees generally cover the costs of diabetes-related equipment, supplies, and medication. In addition, all plans offer a free diabetes disease management program. Enrollees in the disease management program do not have to pay a copayment for equipment, supplies, and medication, but plan members who are not enrolled have to pay a 20% copayment. In addition, enrollees in the disease management program are entitled to an unlimited number of hours of self-management education.

All the benefits that the bill requires are currently available to state workers, suggesting that the cost of the bill would be minimal. There may be some administrative costs for HICs, due to the requirement that all required coverage be provided as "basic health care services." It is not clear whether the current disease management program would satisfy this requirement. Medications are often covered under a pharmaceutical benefit "carve out" that is provided separately from the basic health care services covered by an HIC.[2] While there may be some administrative costs due to the bill, the Legislative Service Commission (LSC) staff expect that they would be minimal. Any such potential increase in administrative costs is expected to be passed along to the state. The state could either incur any such additional costs or pass on all, or a portion, of the costs to employees. The bill would have no direct fiscal effect on Ohio's Medicaid Program, since it is not a health insuring corporation, a sickness and accident insurer, or a public employee benefit plan. Moreover, Medicaid already covers equipment, supplies, and medication that are medically necessary to treat or diagnose diabetes. There could be an indirect fiscal effect due to the possibility of an increase in caseload due to the bill. This possibility is addressed in the section on indirect effects below.

Local government fiscal effects

The bill has the potential to increase costs to local governments of providing health benefits to their employees. LSC does not have data on health care expenditures by local governments in Ohio, nor does it have information on the details of benefit packages offered by local governments. Due to the lack of data, it is not possible to provide a complete and reliable estimate of the fiscal impact that the bill would have on counties, municipalities, townships, and school districts. Some of these local entities may already provide health care benefits that meet the bill's requirements. Others, however, may not, and for those that do not it is assumed that the cost of providing expanded benefits for the diagnosis and treatment of diabetes would increase costs.

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[2] Current law classifies prescription drug services as "supplemental" health care services rather than as basic services.

LSC previously gathered information about health benefits for workers from officials in Allen, Franklin, Hamilton, Lorain, Lucas, Montgomery, Muskingum, and Summit counties for a bill essentially similar to H.B. 81 (H.B. 137, 127th General Assembly). The information gathered provided insight into the potential cost to counties from implementing the bill. Based on those conversations, any increase in costs of providing health benefits that the bill might impose on these counties would apparently be small and would arise from two considerations. For counties where the education requirement is not met currently, the bill would require an increase in costs to provide the required education benefit. Second, like the state, some counties use "carve out" plans to provide prescription drug benefits, and some use disease management programs to provide comprehensive diabetes care benefits. As explained above, it is not clear whether these current features would comply with the requirement that HICs provide these benefits as "basic health care services." So there could be an increase in administrative costs for HICs to comply with the bill. These costs, like those associated with expanding the education benefit, are assumed to be passed on to the county involved.

Although LSC staff could not reliably project the impact of the bill to all 88 counties in the state, information from the sample of counties listed above suggests that most counties already cover equipment, supplies, and medications, so that the cost of the bill would be due primarily to the education requirement. LSC staff has not collected data from any Ohio municipalities, townships, or school districts, but we are not aware of any reason why the health benefit arrangements for those local governments would differ significantly from the arrangements made by counties. Nevertheless, although LSC cannot project the costs of the bill to these entities, we cannot rule out the possibility that the cost could be in the millions of dollars per year statewide. As stated earlier, the bill does not require an employer (i.e., state, counties, municipalities, and school districts) to assume any additional cost. Therefore, some (or all) of the increased costs could be passed on to the employee.

Indirect fiscal effects

Any direct fiscal effects of the bill would be limited to changes in costs to provide health benefits to workers. However, indirect fiscal effects could arise in a number of ways. For the state, early treatments provided because of the bill could reduce expenditures in the future for providing treatments for the expensive side effects of diabetes, such as kidney failure or eye disease, under Medicaid. Thus, some costs may be shifted from the state to insurers, and the bill could indirectly reduce state expenditures. On the other hand, if some Ohioans lose health insurance coverage and are eventually insured by the Medicaid Program as a result, the bill could increase state expenditures indirectly, offsetting part or all of the indirect decreases discussed above. Disability retirement costs and health insurance costs for the retirement systems may also decrease.

Regarding the possibility of shifting costs to insurers, LSC cannot quantify the savings that potentially would occur in employee benefits for the state and for political subdivisions, despite the existence of studies showing cost savings from preventive care. Determining the level of offsetting savings is difficult for several reasons. First of all, the savings associated with diabetes care often do not occur in the same year that the preventive care costs are incurred. Costly diabetic complications may occur after a lapse of several years, perhaps even after the patient is covered by Medicare. Thus, Medicare (or perhaps a state retirement system) may end up paying for complications that might have been prevented by more intensive treatment of the person's diabetes earlier in their lives.

Second, diabetes self management requires continuous self discipline in addition to equipment, education, and supplies. Financial assistance to purchase needed supplies cannot ensure that a person uses them in an ongoing self-management program that will successfully reduce or eliminate expensive complications. It is possible that research findings indicating that cost savings may occur were performed with highly motivated research program participants, and that the general population of people with diabetes would not employ the same degree of care in managing their disease.

LSC staff are not aware of any conclusive research about which of the above factors would have the greatest effect, and so LSC cannot predict whether the state's costs for covering an individual employee would be likely to increase or to decrease as a result of the combined effect of these indirect effects. Similarly, LSC is not aware of any conclusive estimates of the number of Ohioans who might lose their health insurance coverage due to the possibility of an increase in premiums. The actuarial report from Milliman USA did not provide such an estimate, but characterized the number as likely to be "minimal."

Small Business Health Care Affordability Task Force

The bill creates the Small Business Health Care Affordability Task Force which may have up to 11 members, six of which are members of the General Assembly (three from each chamber). The bill describes the tasks of the Task Force, which include:

- studying tax incentives for small businesses that provide employee health insurance coverage and health wellness and disease prevention programs;
- reviewing health insurance tax incentives and wellness programs in other states;
- examining the potential impact of the proposed federal "Healthy Workforce Act of 2009" and "Small Business Health Options Program Act of 2009" on Ohio's small businesses;
- studying the cost and feasibility of applying mandated health benefits as defined in section 3901.71 of the Revised Code to the Medicaid Program.

The Task Force is required to report its findings to the General Assembly and the Governor no later than six months following its initial organizational meeting, and will cease to exist after making the report. The bill does not specify if members of the Task Force are compensated, nor does it require any agency to provide staff support.

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