OHIO LEGISLATIVE SERVICE COMMISSION

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Office of Research and Drafting

Legislative Budget Office

S.B. 207
136th General Assembly

Fiscal Note & Local Impact Statement

Click here for S.B. 207's Bill Analysis

Version: As Introduced

Primary Sponsors: Sens. Manchester and Liston

Local Impact Statement Procedure Required: Yes

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Highlights

- The bill may minimally increase administrative costs for the Department of Insurance to monitor health insurers' and pharmacy benefit managers' compliance with the bill's requirements. Any increase in such costs would be paid from the Department of Insurance Operating Fund (Fund 5540).
- The bill's requirements would likely result in an increase in costs to the state to provide health benefits to employees and their dependents. Such costs are paid out of the Health Benefit Fund (Fund 8080), which receives transfers from the GRF and other state funds. There may also be a potential increase in costs for the Medicaid Program, which contracts with a pharmacy benefit manager (PBM) that may be required to comply with the requirements.
- Similarly, some local governments would likely experience an increase in costs to provide health benefits to employees and their dependents. Any local governments that have already complied with the bill's requirements would experience no fiscal effect.

Detailed Analysis

The bill requires a health insurer to include all amounts paid by an enrollee and on behalf of the enrollee by another person when calculating that enrollee's contribution to any applicable copayment charges, coinsurance, cost sharing, deductibles, or other similar charges for a prescription drug. Examples of payments made on behalf of an enrollee are manufacturer coupons and financial assistance. The bill specifies that the requirement does not apply to copayment charges, coinsurance, cost sharing, deductible, or similar charges paid on behalf of an enrollee by another person, group, or organization for a brand prescription drug for which there is a medically appropriate generic equivalent, unless the prescriber determines that the brand

prescription drug is medically necessary.[1] Under the bill, a health insurer and a pharmacy benefit manager (PBM) cannot directly or indirectly set, alter, implement, or condition the terms of coverage, including benefit design, based in full or in part on the availability or amount of financial or product assistance for a prescription drug.

The bill's requirements apply to health benefit plans that are delivered, issued for delivery, modified, or renewed on or after January 1, 2027, by health insuring corporations (HICs) and sickness and accident insurers. The requirement applies also to a PBM that has a contract with an insurer, managed care organization, employer, or other third party, to manage, either directly or indirectly, the entity's prescription drug benefit.

Under the bill's definition of a pharmacy benefit manager, it is likely that the single PBM which was selected by the Ohio Department of Medicaid (ODM), would be required to comply with the PBM components of the bill.

Fiscal effect

The bill's requirements may minimally increase administrative costs for the Department of Insurance, as the Department would have to monitor compliance by health insurers and PBMs. Any increase in such costs would be paid from the Department of Insurance Operating Fund (Fund 5540). Revenue to Fund 5540 is from various fees paid by insurance companies, primarily fees paid for appointing insurance agents.

The state health benefit plan uses a PBM for the prescription drug benefit under the plan, and a Department of Administrative Services' official reports that the PBM does not currently count manufacturer coupons toward a member's out-of-pocket maximum. Consequently, there would be a reduction in cost-sharing payments to the PBM under the bill, which would likely increase the cost to the state for providing health benefits to employees and their dependents. Any increase in cost to the state plan would be 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.

Similarly, ODM may experience indirect fiscal effects from the bill, as the bill's requirements are likely to increase costs to ODM's single PBM, which in the long term may increase costs to ODM. Copay amounts for prescription drugs paid by Medicaid recipients are typically $2 per prescription refill for most brand name (nongeneric) medications and $3 per prescription or refill for medications for which a prior authorization is required. ODM also will

[1] The bill specifies that its requirements are not to be construed as requiring health insuring corporations, sickness and accident insurers, or pharmacy benefit managers to provide coverage for a prescription drug that is not included in the formulary or list of prescription drugs covered under the pharmaceutical or medical benefit being provided to a covered person under the plan. In addition, such insurers are not to be considered to violate the bill's requirements solely for removing a prescription drug from the formulary list if the removal would not violate any other existing state or federal laws or administrative rules. If, under federal law, application of the bill's cost-sharing requirement would result in an enrollee's health savings account (HSA) ineligibility for the purpose of federal income tax deduction for contributions, then such requirement applies only for HSA-qualified high deductible health plans (HDHPs) with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible.

not charge copays for Medicaid recipients who meet one of several exemption criteria, including being pregnant, being under the age of 21, or receiving the prescription as part of emergency services.

Similarly, local governments and school districts would likely also experience increases in costs to provide health benefits to employees and their dependents. Any local governments whose plans already comply with the bill's requirements would not experience such an increase in costs. LBO does not have information on the detailed provisions of local government health benefit plans and therefore cannot quantify the effect on local government expenditures, but LBO staff believe that it is likely there is an effect on costs.

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