

Fiscal Note & Local Impact Statement

127th General Assembly of Ohio

Ohio Legislative Service Commission
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BILL: **Sub. H.B. 125** DATE: **March 11, 2008**

STATUS: **As Reported by Senate Judiciary--Civil Justice** SPONSOR: **Rep. Huffman**

LOCAL IMPACT STATEMENT REQUIRED: **No — Offsetting savings**

CONTENTS: **Establishes certain uniform contract provisions between health care providers and third party payers, creates a Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts, and creates an Advisory Committee on Eligibility and Real Time Claim Adjudication**

State Fiscal Highlights

STATE FUND	FY 2008	FY 2009	FUTURE YEARS
General Revenue Fund			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	Minimal increase	Minimal increase	Minimal increase
Other State Funds			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	- 0 -	Potential minimal increase	Potential minimal increase
Department of Insurance Operating Fund (Fund 5540)			
Revenues	Potential minimal gain	Potential minimal gain	Potential minimal gain
Expenditures	Potential minimal increase	Potential increase up to \$490,000 or more	Potential increase up to \$140,000 or more

Note: The state fiscal year is July 1 through June 30. For example, FY 2008 is July 1, 2007 – June 30, 2008.

- The provision that requires the Department of Job and Family Services to allow managed care plans that provide services to Medicaid enrollees to use medical providers to render care upon completion of the plan's credentialing process would require the Department to change administrative processes. This change in administrative processes would increase costs minimally to the state, with the increase paid from the GRF.
- The prohibition against third party payers selling or renting out the rights to a participating medical provider's services (with certain exceptions) may reduce revenue to some health insurers, which has the potential to increase the costs to the state of providing health benefits to employees. Any such increase is expected to be minimal. About half of any such increase would be paid by the GRF, with the remainder being paid by other state funds.
- The Department of Insurance is required to perform several new duties under the bill, including providing staff support to the newly formed Joint Legislative Study Commission and the Advisory Committee. A Department official reports that the Department expects its expenses to increase by approximately \$130,000 per year due to



these provisions, with one-time costs of an additional approximately \$370,000. This increase in departmental costs would be paid from Fund 5540. The numbers in the table split \$20,000 in one-time costs for supporting the two new committees between FY 2009 and future fiscal years.

- The market conduct examinations of insurers regarding compliance with the provisions of the bill may increase departmental expenditures to conduct such examinations and increase revenue to Fund 5540. The revenue may result from assessments or fines authorized by the bill.
- The provision increasing statutory maximum charges that a health care provider or medical records company may charge for copies of medical records may increase costs to any state agency that would request such records. Any such increase in costs is expected to be minimal.

Local Fiscal Highlights

LOCAL GOVERNMENT	FY 2008	FY 2009	FUTURE YEARS
Counties, municipalities, townships, school districts			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	Potential minimal increase	Potential minimal increase	Potential minimal increase
Counties, municipalities			
Revenues	Potential loss	Potential loss	Potential loss
Expenditures	Potential decrease	Potential decrease	Potential decrease

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

- The prohibition against third party payers selling or renting out the rights to a participating medical provider's services may reduce revenue to some health insurers, which has the potential to increase the costs to political subdivisions of providing health benefits to employees. Any such increase is expected to be minimal.
- The provision requiring mandatory arbitration of contract disputes related to the bill's provisions may reduce caseload in county courts of common pleas and in municipal courts. This would reduce both administrative costs to the courts and fee revenue that accompanies the filing of cases.
- The provision increasing statutory maximum charges that a health care provider or medical records company may charge for copies of medical records may increase costs to any political subdivision that would request such records. Any such increase in costs is expected to be minimal.

Detailed Fiscal Analysis

H.B. 125 would establish several provisions in the Revised Code governing contracts between health care providers and third party payers (who would typically be health insurance corporations or sickness and accident insurers). Most of the provisions govern the contents of such contracts, required accompanying documents, and the process of credentialing a medical provider. Some of these provisions may affect the relative bargaining power of one of the parties to a contract, but LSC is not aware of any research that would reliably allow prediction of the outcomes of negotiations between the parties before and after the changes to relative bargaining power, and the consequent effect on health insurance premiums.

The bill has several provisions that may have predictable fiscal effects. First, the bill prohibits third party payers from selling, renting, or giving away their rights to a participating medical provider's services except under specified conditions. Second, the bill establishes a mandatory arbitration procedure for contract disputes related to the provisions of the bill. Third, the bill requires the Superintendent of Insurance to adopt rules necessary for implementation of the bill's provisions, and to produce forms to be used by insurers statewide to credential medical providers. Fourth, the bill authorizes the Department of Insurance to conduct market conduct examinations of insurers to ensure compliance with the provisions of the bill, and authorizes the Department to assess the insurers that are examined for the costs of the examination. The amount assessed, as well as any fines that may result from the examination, are to be deposited into the Department of Insurance Operating Fund. Fifth, the bill requires the Department of Job and Family Services (JFS) to allow managed care plans that provide services to Medicaid enrollees to use medical providers to render care upon completion of the managed care plan's credentialing process. Sixth, the bill increases the statutory maximum that a health care provider or medical records company may charge for copies of medical records. These increases are between 8.8% and 15%.

The seventh such provision creates the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts. The Commission is to have 17 members, including the Superintendent of Insurance, 4 legislators, and 12 members chosen jointly by the Speaker of the House and the Senate President that represent interested parties according to criteria set in the bill. The Commission is to study the issue of the use of these clauses¹ in health care contracts during a two-year moratorium on the use of such clauses and issue a report to the General Assembly on its findings and recommendations. The two-year moratorium may be extended to a third year if the Commission recommends an extension and it is granted by the General Assembly. After issuing its final report the Commission is to cease to exist. The bill would require the Department of Insurance to provide office space and staff support for the work of the Commission. The bill does not provide for compensation or reimbursement of travel expenses for members of the Commission. Also, the bill includes codified law that would go into effect three years after the effective date of the bill, that would prohibit the use of

¹ The term "most favored nation clause" is defined by the bill. The bill lists four different types of such a clause. One type, for example, is a clause that prohibits the medical provider from contracting with another insurer at a lower rate. A second type is a clause that would require the provider to accept a lower reimbursement rate if that provider does charge another insurer a lower rate.

most favored nation (MFN) clauses in health care contracts with any medical providers other than hospitals.

The eighth such provision creates the Advisory Committee on Eligibility and Real Time Claim Adjudication. The Committee is to include the Superintendent of Insurance and at least one person, appointed by the Superintendent, to represent each of ten groups specified in the bill. The Committee is to study technical issues related to third-party payers making available to health care providers sufficient information regarding a patient to determine that patient's insurance eligibility at the time of the patient visit. The bill specifies that Committee members are to serve without compensation, and it requires the Department of Insurance to provide office space and staff support for the Committee. The Committee is to report its recommendations to the General Assembly by January 1, 2009, after which it will cease to exist.

Fiscal effects

The provision prohibiting third party payers from selling the rights to the services of medical providers on its network, except under certain circumstances, could reduce revenue for some health insurers, and it could increase costs for others. Insurers who are affected by this provision may respond by reducing costs or by increasing revenues from another source in an attempt to maintain profits. LSC fiscal staff has no information as of this writing regarding how widespread this practice is and how large the amounts of money involved may be. It is possible that this provision could result in an increase in premiums, thus increasing the costs for the state and for political subdivisions to provide health benefits for workers. It has been assumed that the revenues and costs involved are minimal, in part due to the bill's exemptions from the prohibition. If it should emerge with further study that the revenue amounts involved are more than minimal, and that qualifications to the prohibition have a relatively minor impact, the local impact determination may be changed.

The provision regarding mandatory arbitration for contract disputes related to the bill's provisions may reduce caseload that would otherwise go to county or municipal courts. This would reduce costs related to processing cases and revenue from fees that accompany filing of cases.

Provisions affecting the Department of Insurance (ODI) may increase administrative costs that would be paid by the Department of Insurance Operating Fund (Fund 5540). An ODI official reports that the Department expects that it would need to hire an Attorney 5 in order to review contracts affected by the bill's provisions. The salary range for such a position is between \$76,250 and \$99,973. Allowing for fringe benefits, the increase in costs to the Department could be up to \$130,000 or more. Market conduct examinations authorized by the bill may also increase expenditures from Fund 5540, but the costs of any such examinations are paid for by the authorization to assess the cost against the insurer examined, thus raising an equivalent amount of revenue to Fund 5540. Since the revenue from any fines that are levied as a result of an examination is also deposited into Fund 5540, the increase in revenue to the fund may exceed the increase in expenditures.

An ODI official reports that the provisions requiring ODI to provide office space and staff support to the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts and to the Advisory Committee on Eligibility and Real Time Claim Adjudication are expected

to create a significant increase in costs to the Department. The official reports that the Department does not currently have in-house expertise on the subject of the use of MFN clauses in contracts, meaning that providing support for the Joint Legislative Study Commission would require commissioning a study on the subject. Such a study is expected to cost approximately \$350,000. In addition, the Department expects expenses related to providing office space and staff support to amount to (a one-time cost of) an additional \$20,000. As with the ongoing costs described above, these costs would be paid from Fund 5540.

According to a JFS official, the provision that requires JFS to allow managed care plans to use providers upon completion of the plan's credentialing process would require JFS to make a minor change in its administrative process in dealing with managed care companies. This would increase costs to the state minimally, with the increase in costs being paid from the GRF.

The provision increasing statutory maximum charges that a health care provider or medical records company may charge for copies of medical records may increase costs to any state agency or political subdivision that would request such records. Continuing law exempts the Bureau of Workers' Compensation (BWC), the Industrial Commission, JFS, and county departments of job and family services from paying for such records. The increases in maximum charges are between 8.8% and 15.0%. Any such increase in costs is expected to be minimal.

Potential indirect fiscal effects

As noted above, the bill has provisions that may affect the relative bargaining power between medical providers and insurers. These provisions have the potential to affect health insurance premiums paid by employers, including the state and local governments, to provide health benefits to workers and their dependents. Again, as noted above, LSC is not aware of any research that would reliably allow prediction of the outcomes of negotiations between the parties before and after the changes to relative bargaining power. However, two of these provisions require further discussion.

First, the bill imposes a moratorium on the use of MFN clauses in contracts for at least two years. LSC is not aware of how widespread the use of such clauses is currently in Ohio,² and certainly the magnitude of any indirect fiscal effect would depend on that. The bill describes as an MFN provision four different types of contract provisions, including ones that (1) prohibit a provider from offering a competitor a lower reimbursement rate than the provider offers to the insurer (*i.e.*, the counterparty to the contract), and (2) require that the provider accept that lower reimbursement rate in cases when the provider does offer a lower rate to a competitor. Note that provisions like the first one have the direct effect of preventing reimbursement rates from falling, which would tend to keep health insurance premiums higher than they otherwise would be, while provisions like the second have the direct effect of requiring a provider to accept a lower reimbursement rate (leading to lower premiums). The U.S. Federal Trade Commission (FTC) has held hearings on the use of MFN provisions in health care contracts, and concluded that "there is no need for a counterintuitive blanket rule against MFNs.

² The Committee did receive some testimony on this subject on December 11, 2007, given by Lisa G. Han, appearing on behalf of the Ohio State Medical Association. LSC has not verified the accuracy of this testimony.

There may be situations, however, where an MFN has an anticompetitive effect . . . ³ Based on the FTC conclusion it would appear that the moratorium could prevent an anticompetitive practice, or not, depending on circumstances in the particular market.

Second, the bill prohibits clauses that require, as a condition of contracting with the insurer, that the provider provide services for all of the products offered by the insurer. Again, LSC is unaware of how widely employed such clauses are currently, and the indirect fiscal effect would depend upon that. However, the Committee heard testimony that such clauses may make it more difficult or expensive for insurers to assemble a complete panel of medical providers, especially for Workers' Compensation and Medicaid products. LSC staff contacted officials with BWC, JFS, and ODI to discuss the possible implications of such a prohibition. A BWC official reported no concern about the provision, while an ODI official reported that this may be a provision whose effects will not be discernable for months (or even years).

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³ This quotation is found on page 21 of the FTC publication (dated July 2004) *Improving Health Care: A Dose of Competition*. The publication is available at the FTC web site at the web address www.ftc.gov/bc/healthcare/research/healthcarehearingreports.