



## Fiscal Highlights<sup>†</sup>

### 1. Health Insurance Credit Program and I-Ohio Reinsurance Program

STATE FUND	FY 2008	FY 2009	FUTURE YEARS
<b>General Revenue Fund</b>			
Revenues	- 0 -	Loss of \$433.8 million from domestic and foreign insurance taxes	Loss of \$453.6 million in FY 2010, growing by 4.5% per year
Expenditures	- 0 -	- 0 -	- 0 -
<b>Health Insurance Credit Fund (new)</b>			
Revenues	- 0 -	Gain of \$461 million	Gain of \$482 million in FY 2010, growing by 4.5% per year
Expenditures	- 0 -	- 0 -	Health Insurance Credit Program: \$176.5 million annual increase in FY 2010 and FY 2011 and \$354.0 million annual increase beginning in FY 2012
	- 0 -	- 0 -	I-Ohio Reinsurance Program: increase in the tens of millions in FY 2010, increasing to the limits imposed by the revenue to the fund within a few years

LOCAL GOVERNMENT	FY 2008	FY 2009	FUTURE YEARS
<b>Local Government Fund (LGF)</b>			
Revenues	- 0 -	Loss of \$17.0 million	Loss of \$17.7 million in FY 2010, growing by 4.5% per year
Expenditures	- 0 -	- 0 -	- 0 -
<b>Library and Local Government Support Fund (LLGSF)</b>			
Revenues	- 0 -	Loss of \$10.2 million	Loss of \$10.7 million in FY 2010, growing by 4.5% per year
Expenditures	- 0 -	- 0 -	- 0 -

- ***Diversion of receipts from GRF.*** The bill would change the destination for receipts from the domestic and foreign insurance taxes from the GRF to the newly established Health Insurance Credit Fund, with the change effective for taxable years beginning January 1, 2008. This provision would reduce GRF revenues by approximately \$461 million in FY 2009, of which \$17.0 million would have been transferred from the GRF to the Local Government Fund and \$10.2 million would have been transferred to the Library and Local Government Support Fund, leaving a net reduction of \$433.8 million in GRF revenues, and would increase

<sup>†</sup> Note: The state fiscal year is July 1 through June 30. For example, FY 2008 is July 1, 2007 – June 30, 2008. For most local governments, the fiscal year is the calendar year. The school district fiscal year is July 1 through June 30.

revenues to the Health Insurance Credit Fund by \$461 million. Based on historical experience, the revenues affected are likely to grow by approximately 4.5% per year thereafter.

- Health Insurance Credit Program.*** Up to 50% of the newly established Health Insurance Credit Fund, or up to about \$471.5 million in FY 2010 (the sum of receipts from FY 2009 and FY 2010), and up to an additional \$251.8 million in FY 2011 (plus any carryover from FY 2010) would be available to fund the Health Insurance Credit Program, which is established effective July 1, 2009. Expenditures are expected to be up to \$176.5 million in FY 2010 and FY 2011 and up to \$354.0 million per year beginning in FY 2012 based upon eligibility criteria for participating in the program.
- I-Ohio Reinsurance Program.*** Up to 40% of the newly established Health Insurance Credit Fund, or up to about \$377.2 million in FY 2010 (the sum of receipts from FY 2009 and FY 2010), and up to \$201.5 million in FY 2011 (plus any carryover from FY 2010) would be available to fund the I-Ohio Reinsurance Program, which is established effective July 1, 2009. Expenditures under the program are expected to be in the tens of millions of dollars in FY 2010, and to rise to the limits imposed by revenue to the fund within a few years.

**2. Insurance Coverage Changes**

STATE FUND	FY 2008	FY 2009	FUTURE YEARS
<b>General Revenue Fund</b>			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	- 0 -	Increase, potentially in the millions from providing health benefits to dependents up to age 29	Increase, up to \$4.5 million or more per year from providing health benefits to dependents up to age 29
	- 0 -	Potential increase, from requiring health insurance coverage for chronic care management	
	- 0 -	Potential increase, from prohibition against excluding health benefits when insured sustained injury under influence of alcohol or drugs	
<b>Highway Operating Fund, Highway Safety Fund, Other State Funds</b>			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	- 0 -	Increase, potentially in the millions from providing health benefits to dependents up to age 29	Increase, up to \$4.5 million or more per year from providing health benefits to dependents up to age 29
	- 0 -	Potential increase, from requiring health insurance coverage for chronic care management	
	- 0 -	Potential increase, from prohibition against excluding health benefits when insured sustained injury under influence of alcohol or drugs	

LOCAL GOVERNMENT	FY 2008	FY 2009	FUTURE YEARS
<b>Counties, Municipalities, Townships</b>			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	- 0 -	Increase, potentially up to \$30 million or more each year, for insurance costs of local governments	

LOCAL GOVERNMENT	FY 2008	FY 2009	FUTURE YEARS
<b>School Districts</b>			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	- 0 -	Increase, potentially up to \$38 million or more each year, for insurance costs of school districts	

- **Dependent coverage to age 29.** The provision that would require health insuring corporations, sickness and accident insurance policies, and public employee benefit plans to offer to cover certain dependent children of plan participants up to age 29 would likely increase costs to the state to provide health benefits to dependents. The increase in costs may be up to \$9 million or more per year. The cost would be split approximately equally between the GRF and other state funds. This requirement also would increase costs to local governments to provide health benefits to workers and their dependents. The increase in costs may be up to the amounts shown in the table or more.
- **Chronic care coverage.** The provision that would require public employee benefit plans to include coverage for chronic care management may increase costs for the state and for local governments to provide health benefits to their workers and the workers' dependents.
- **Certain exclusions prohibited.** The provision that would prohibit public employee benefit plans from excluding health benefits when the loss was sustained due to the insured individual being under the influence of alcohol or drugs may increase costs for state and local government health benefits for their workers and dependents.
- **Payment for 9-1-1 emergency services.** The bill specifies that the costs of 9-1-1 emergency services must be paid directly to the provider of the services or to the provider's billing agent, when paid by a health insuring corporation or a sickness and accident insurance policy. This would potentially accelerate reimbursements to local government service providers and decrease expenditures related to collecting insurance payments from patients who received payment and did not forward it.

### 3. Personal Income Tax Provisions Related to Health Care Premiums

STATE FUND	FY 2008	FY 2009	FUTURE YEARS
<b>General Revenue Fund</b>			
Revenues	- 0 -	Loss of up to \$61.4 million	Marginal increase in loss
Expenditures	- 0 -	- 0 -	- 0 -

LOCAL GOVERNMENT	FY 2008	FY 2009	FUTURE YEARS
<b>Local government funds (LGF, LLGSF)</b>			
Revenues	- 0 -	Loss of up to \$3.9 million	Marginal increase in loss
Expenditures	- 0 -	- 0 -	- 0 -
<b>School districts</b>			
Revenues	- 0 -	Gain of up to \$2.2 million	Marginal increase in gain
Expenditures	- 0 -	- 0 -	- 0 -

- **Replacement of a state income tax deduction with credit.** Provisions eliminating the income tax deduction for unsubsidized health insurance not claimed elsewhere, introducing a nonrefundable tax credit based on health insurance premiums, and extending the eligible age for certain dependent health insurance coverage

to age 29 are estimated to reduce state income tax revenue by up to \$65.3 million for FY 2009. The GRF will bear \$61.4 million (94.1%) of the loss.

- **Effect on local government funds.** The local government funds will share the other \$3.9 million (5.9%) of the \$65.3 million reduction in income tax revenue in FY 2009.
- **Effect on school district income tax revenue.** Eliminating the income tax deduction for unsubsidized health insurance not claimed elsewhere will increase the taxable base for school district income taxes, resulting in a potential increase of up to \$2.2 million in school district income tax revenue for FY 2009.

**4. Ohio Health Advantage Program**

STATE FUND	FY 2008	FY 2009	Future Years
<b>State Insurance Fund – Bureau of Workers' Compensation</b>			
Revenues	- 0 -	Potential loss in tens of millions of dollars per year, with reduced losses after FY 2011	
Expenditures	- 0 -	- 0 -	- 0 -
<b>Administrative Cost Fund (Fund 023) – Bureau of Workers' Compensation</b>			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	- 0 -	Potential annual increase of \$300,000-\$400,000 to administer OHAP	

- **Health and wellness premium discount.** The bill allows the Bureau of Workers' Compensation (BWC) to offer up to a 5% premium discount to eligible employers. BWC could lose tens of millions of dollars in premium revenue as a result. If all 217,891 employers covered by BWC were to qualify, and if this discount were applied to FY 2008 premiums paid by employers, it would amount to a maximum loss of \$92.2 million to the State Insurance Fund.
- **Qualifying health plan premium discount.** The bill allows BWC to offer eligible employers a 15% premium discount. BWC could lose tens of millions of dollars in premium revenue as a result. Based on BWC records, 124,539 employers could qualify for this discount; if all 124,539 employers were to participate, and if the discount were applied to FY 2008 premiums, it would amount to a maximum loss of \$67.0 million to the State Insurance Fund. As employers can only participate in the program for three years, losses would decline after FY 2011.
- **Administrative costs.** The Ohio Health Advantage Program (OHAP) would be housed within the BWC Customer Services Division. Based on the costs of administering a similar, existing employer discount program, the costs to operate OHAP are estimated to be \$300,000-\$400,000 annually. These expenses would be paid out of the Administrative Cost Fund (Fund 023).

## 5. Pharmacy Benefit Management (PBM)

STATE FUND	FY 2009	FY 2010	FUTURE YEARS
<b>Department of Administrative Services – General Services Fund (Fund 117) and Human Resource Fund (Fund 125)</b>			
Revenues	- 0 -		Potential annual gain or loss corresponding to charges assessed to state agencies for centralized pharmaceutical procurement services and oversight through the Office of Pharmaceutical Purchasing Coordination
Expenditures	- 0 -		Annual increase in PBM contract oversight costs and for the Office of Pharmaceutical Purchasing Coordination
	- 0 -		One-time increase in FY 2009 for review of pharmacy benefits programs, probably less than \$1 million

- **Centralized Pharmacy Benefits Management (PBM) oversight.** The bill would centralize, in the Department of Administrative Services, oversight of PBM services for state employees and their dependents, anyone covered by any of the five state retirement systems, workers' compensation claimants, and school district employees. This would cover approximately 980,000 persons. The cost of the current PBM contracts covering these persons is about \$1.2 billion. Including individuals enrolled in any of the Department of Job and Family Services' (ODJFS) Medicaid managed care programs would add a further 1.35 million people and unknown new costs.
- **Creating the Office of Pharmaceutical Purchasing Coordination.** New staff may be needed to review drug procurement policy and carry out the added oversight responsibilities. These operating expenses would be borne by the General Services Fund (Fund 117), and perhaps the Human Resources Fund (Fund 125). The fiscal effect would depend on new costs or savings derived from consolidating drug and PBM contract oversight in the new office.
- **Review of existing pharmacy benefits management programs.** The required study of existing PBM programs used by the participants would cost approximately \$750,000 to \$1 million, depending on the scope and contract terms, and would be paid from the General Services Fund (Fund 117).

## 6. Health Care Services and Prescription Drugs to Inmates of State Correctional Institutions

STATE FUND	FY 2008	FY 2009	FUTURE YEARS
<b>General Revenue Fund – Rehabilitation and Correction, Youth Services</b>			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	- 0 -		Potential savings of several million dollars per year as a result of purchasing drugs from FQHCs
<b>General Services Fund Group (Fund 151) – Mental Health</b>			
Revenues	- 0 -		Potential loss of millions of dollars per year related to the resale of drugs to DRC and DYS
Expenditures	- 0 -		Potential decrease of millions of dollars per year related to the purchase of drugs for DRC and DYS

- **Departments of Rehabilitation and Correction and Youth Services.** The Department of Rehabilitation and Correction (DRC) and the Department of Youth Services (DYS) could experience several million dollars in

GRF savings by purchasing prescriptions drugs from federally qualified health centers (FQHCs) through the federal 340B Drug Pricing Program.

- **Department of Mental Health.** The Office of Support Services (OSS) in the Department of Mental Health (DMH) would experience a decrease in expenditures as well as a corresponding loss of millions of dollars in revenue as a result of purchasing fewer prescription drugs for resale to DRC and DYS. Transactions for drug purchases and drug resale are conducted through Fund 151 in DMH.

**7. Medicaid Hospital Services, Charity Care Reporting, and Hospital Care Assurance Program (HCAP) Payments**

STATE FUND	FY 2008	FY 2009	FUTURE YEARS
<b>General Revenue Fund</b>			
Revenues	- 0 -	Loss in federal Medicaid reimbursement due to the decrease in payments to certain hospitals for providing service to a Medicaid managed care recipient	
Expenditures	- 0 -	Decrease in payments to certain hospitals for providing services to a Medicaid managed care recipient	

LOCAL GOVERNMENT	FY 2008	FY 2009	FUTURE YEARS
<b>Counties</b>			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	- 0 -	Potential minimal increase for counties to meet hospital reporting requirements	
<b>Public Hospitals</b>			
Revenues	- 0 -	Potential loss in HCAP payments received by county hospitals	
Expenditures	- 0 -	Potential minimal increase for public hospitals to meet hospital reporting requirements	

- **Hospital services to Medicaid recipients enrolled in managed care.** The state Medicaid program could experience a decrease in GRF expenditures as a result of reducing the payment a hospital is to receive for providing service to a Medicaid managed care recipient. Any such reduction in payments would result in a corresponding loss in federal Medicaid reimbursement.
- **Tax-exempt hospital charity care reporting.** County auditors' costs may increase as a result of the reporting requirements for property tax data related to certain tax-exempt hospitals. The County Auditors Association of Ohio estimates this increase to be minimal. Public hospitals could incur increased costs as a result of hospital reporting requirements.
- **Restriction on Hospital Care Assurance Program (HCAP) payments.** The bill could reduce the HCAP payment amount a county hospital receives if the hospital does not have a contract with a Medicaid managed care organization. These provisions of the bill could reallocate the funds received by hospitals but not change the total amount of funding under the HCAP program.

## 8. Nursing Instructor Salaries

STATE FUND	FY 2008	FY 2009	FUTURE YEARS
<b>General Funds of State Institutions of Higher Education</b>			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	- 0 -	Increase of approximately \$3.9 million statewide per year for five years for increased salaries for current nursing instructors	
	- 0 -	Increase of approximately \$200,000 statewide for increased starting salaries for nursing instructors	Increase of approximately \$225,000 per year statewide for increased starting salaries for nursing instructors

- **Salary increases for current nursing instructors.** The bill requires salary increases for all nursing instructors employed by institutions of higher education before the bill's effective date. The cost for these salary increases is approximately \$3.9 million statewide per year for five years.
- **Salary increases for new nursing instructors.** The bill requires institutions of higher education to increase the salaries of nursing instructors who begin teaching nursing classes in the first five fiscal years after the bill's effective date. Statewide, the annual costs for these salary increases would be approximately \$200,000 in the first fiscal year and \$225,000 in the subsequent four fiscal years.

## 9. Health Information Technology Pilot Program

STATE FUND	FY 2008	FY 2009	FUTURE YEARS
<b>General Revenue Fund</b>			
Revenues	- 0 -	- 0 -	Potential gain of federal Medicaid reimbursement beginning in FY 2010 for health information technology
Expenditures	- 0 -	- 0 -	Increase, possibly in the millions of dollars beginning in FY 2010 for health information technology

- **Health Information Technology pilot program.** The ODJFS Health Information Technology pilot program would increase state costs possibly in the millions of dollars, depending on how ODJFS develops and implements it. The pilot program might be eligible for 50% federal reimbursement or possibly more.

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# Detailed Fiscal Analysis

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### 1. Health Insurance Credit Program and I-Ohio Reinsurance Program

#### Diversion of receipts from GRF

To fund both the Health Insurance Credit Program and the I-Ohio Reinsurance Program, the bill changes the destination for receipts from the domestic and foreign insurance taxes from the GRF to the Health Insurance Credit Fund, with the change effective for taxable years beginning January 1, 2008. This would reduce revenue to the GRF by approximately \$461 million in FY 2009 and increase revenue to the new fund by a corresponding amount. Of the \$461 million revenue loss, \$17.0 million would have been transferred from the GRF to the Local Government Fund (LGF) and \$10.2 million would have been transferred to the Library and Local Government Support Fund (LLGSF). Hence, the final FY 2009 loss to the GRF would be \$433.8 million, to LGF \$17.0 million, and to LLGSF \$10.2 million. Revenue under the foreign insurance tax grew by an average of 4.5% per year from 1987 to 1997.<sup>1</sup> If that growth rate continues into the future, the Health Insurance Credit Fund would receive approximately \$482 million in FY 2010, \$503 million in FY 2011, and so on in future fiscal years.

#### Health Insurance Credit Program

The bill creates the Health Insurance Credit Program in the Department of Job and Family Services (ODJFS). This program will pay for private insurance for eligible low-income individuals and married couples.

The bill specifies some eligibility criteria based on income, marital status, and year of program implementation. Eligible populations include married couples age 18 or older with

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<sup>1</sup> Due to the phasing in of tax rate changes made by Am. Sub. H.B. 215 of the 122nd General Assembly and to recent interest rate volatility, this period was judged to be a more reliable basis for predicting long-term future experience with tax revenues than periods that include more recent fiscal years.

incomes 90%-100% of the federal poverty guideline (FPG) and unmarried individuals age 18 or older with incomes 65%-100% of the FPG for applications approved in FY 2010 and FY 2011. In FY 2012 and FY 2013 the bill increases the income ceiling for both groups to 125% of the FPG. The bill also specifies that to be considered eligible, an applicant must have been a resident of the state for at least six months, and have not been provided health insurance through an employer for six months.

At LSC's request the Ohio Department of Development Office of Policy Research and Strategic Planning determined estimates for each of these eligibility groups based on a three-year average of the U.S. 2005–2007 Current Population Surveys. According to their analysis, there are 1,000 uninsured married couples with incomes of 90%-100% of the FPG and 69,000 uninsured unmarried individuals with incomes of 65%-100% of the FPG. In addition, there are 10,000 uninsured married couples and 55,000 uninsured unmarried individuals with incomes of 101%-125% of the FPG. Based on these estimates there would be 70,000 eligibles in FY 2010 and FY 2011, and 135,000 eligibles in FYs 2012 and 2013.<sup>2</sup>

The bill mandates that ODJFS pay \$4,000 per year per eligible married couple and \$2,500 per year per eligible unmarried individual. If the total annual premium for the health plan chosen by each eligible couple or individual is less than the credit amounts, then the remaining balance will be deposited into a personal account managed by the private insurer to cover additional health costs such as copays and deductibles. Any amounts still remaining after 12 months will be redeposited into the Health Insurance Credit Fund. However, if the total annual premium for the health plan chosen by a couple or individual is more than the credit amount, then the eligible members are responsible for paying the balance to the health insuring organization.

Based on the estimates of the eligible populations and specific payment amounts mandated by the bill, this program could cost the state up to \$176.5 million  $((1,000 \times \$4,000) + (69,000 \times \$2,500))$  annually for FY 2010 and FY 2011, and \$354.0 million  $((11,000 \times \$4,000) + (124,000 \times \$2,500))$  for FY 2012 and annually thereafter.

These estimates are based upon a number of assumptions. The analysis assumes that the payment amounts (\$4,000 and \$2,500) remain flat over the analysis period (FY 2010 – FY 2013). However, it is possible that ODJFS or the Health Insurance Credit Program Advisory Board would at some point determine that payment amounts for either or both cohorts should increase or decrease, which would affect the costs of this program. The analysis also assumes that all eligible couples and individuals would participate in the program beginning in the first year of operation. This assumption is used to determine the highest potential costs of the program. It is probable that take-up in the program will occur gradually during the first year of operation and that participation will be less than 100%. Finally, the analysis does not include administrative or advertising costs in the estimates.

The bill mandates that if necessary ODJFS apply for a federal waiver to apply Medicaid funds to the Health Insurance Credit Program. ODJFS would likely need to apply for a Section

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<sup>2</sup> Both estimates for uninsured married couples are based upon statistically unreliable small sample sizes resulting mainly from the narrow income ranges specified for eligibility in the program. In this case, the U.S. Current Population Survey is the only known resource capable of producing an estimate for the specified cohorts.

1115 (a)(2) waiver, and would need to prove that the program would not increase costs to the federal government. If a waiver application is submitted and approved, then expenditures for the program would receive federal reimbursement. With federal reimbursement the program could cost the state \$67.1 million in FY 2010 and FY 2011 and \$134.5 million in FY 2012 and FY 2013 (based on Ohio's approximate 62% federal reimbursement for Medicaid expenditures in federal fiscal year 2009 and on the aforementioned cost estimate assumptions). However, it is uncertain if the Centers for Medicare and Medicaid would approve the waiver application.

The Health Insurance Credit Program would have access to up to 50% of the funds received by the Health Insurance Credit Fund, beginning July 1, 2009. Expenditures under the program would be limited to the moneys available in the fund. This would amount to approximately \$471.5 million in FY 2010 (50% x (\$461 million + \$482 million)). Thereafter, the expenditures would be limited to 50% of annual receipts, plus any unused carryover. Therefore, revenue to the fund available to the program would be approximately \$251.5 million (50% x \$503 million) in FY 2011, and that amount would grow by approximately 4.5% per year.

The bill creates the Health Insurance Credit Program Advisory Board. The Board will consist of seven members drawing from both the state government and private sectors and is required to meet at least four times each year. The bill mandates that Board members be reimbursed for actual expenses incurred for performing official duties and that ODJFS is to provide staff to support the Board. Therefore, this provision could result in a potential minimal increase in costs to ODJFS.

### **I-Ohio Reinsurance Program**

The bill repeals the Ohio Health Reinsurance Program and creates the I-Ohio Reinsurance Program effective July 1, 2009. The I-Ohio Reinsurance Program, to be administered by the Superintendent of Insurance, would provide reinsurance to certain insurance policies that cover individuals with certain high-risk health conditions. The Superintendent is required to establish a basic health policy that, when offered by an insurer to an eligible individual, would be eligible for reinsurance under the program. All sickness and accident insurers and health insuring corporations would be required to offer the basic health policy designed by the Superintendent. The bill provides some specifics that would govern eligibility under the program and levels of reinsurance provided, and leaves others to be determined by the Superintendent by rule.

The I-Ohio Reinsurance Program would have access to up to 40% of the funds received by the Health Insurance Credit Fund, beginning July 1, 2009. Expenditures under the program would be limited to the moneys available in the fund. This would amount to approximately \$377.2 million in FY 2010 (40% x (\$461 million + \$482 million)). Thereafter, the expenditures would be limited to 40% of annual receipts, plus any unused carryover. Therefore, revenue to the fund available to the program would be approximately \$201.5 million (40% x \$503 million) in FY 2011, and that amount would grow by approximately 4.5% per year.

Neither LSC staff nor the Department of Insurance has been able to estimate whether the amount needed to run the program would be less than the limit provided in the bill. The cost would depend on criteria adopted by the Superintendent by rule, so it would be uncertain until the rules are issued and finalized. However, it seems likely that the cost would be close to, if not at, the limit available, after the first two or three years of the program, based on the fact that the

target group for reinsurance is those with high-risk health conditions. The *State of Ohio High-Risk Pool Feasibility Study*, commissioned by the Department of Insurance, conducted by Leif Associates, Inc., and issued in June 2005, estimated the cost of a high-risk pool intended to cover a similar group of uninsured Ohioans. The I-Ohio Reinsurance Program differs from the high-risk pool concept, but given the similarity of the target groups, the costs may be of the same order of magnitude.<sup>3</sup>

Leif Associates estimated the cost to the state of a high-risk pool in Ohio would likely be between \$7,620 and \$17,172 per insured individual per year in FY 2010. They estimated that enrollment in the program would increase gradually, from between 1,182 and 4,605 in the first year of operation, to between 2,662 and 7,373 in the second year, and increasing eventually to about 17,250 Ohioans.<sup>4</sup> If these numbers are at all accurate and comparable to the cost of the reinsurance program, the cost of the latter would likely be in the tens of millions of dollars in the first year or two of the program, and would rise to hundreds of millions after that. Using numbers based on their "most conservative scenario," the cost could reach \$300 million by the third year of operation, or FY 2012. It is worth emphasizing that the reinsurance program has a different design than a high-risk pool, so the costs of the reinsurance program could be outside of any range that is based on the Leif Associates study. Even if they are only illustrative, the numbers presented here suggest that the cost of the reinsurance program may approach the limit of the available resources after a few years.

The I-Ohio Reinsurance Program could eventually reduce costs to local governments (and partially offset costs to the state) of providing health benefits to employees and their dependents. The potential exists for particularly high-risk individuals to be insured under the reinsurance program rather than a group plan operated by the state or a political subdivision. However, the reinsurance program is focused on the individual insurance market, not the group market, and its eligibility restrictions would require that some time elapse before people who are currently insured become eligible for reinsurance under the program. Therefore, these cost reductions and partial offsets are not likely to be realized for several years, and are probably best considered indirect effects of the bill rather than direct effects.

The bill creates the I-Ohio Reinsurance Advisory Board to oversee implementation of the program. The Board consists of seven members, selected according to criteria specified in the bill. The members serve without compensation, but are eligible for reimbursement for expenses. The bill does not specify the source of funding for any such reimbursements. The Department of Insurance is required to provide staff services to the Board. The Board is required to issue reports in January and July of each year to the Governor and to the General Assembly containing the Board's findings regarding the operation of the program and ways that it might be extended

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<sup>3</sup> Specifically, under the reinsurance program, private health insurers would bear some of the risk of covering high-risk insured individuals, and would receive premiums directly from those insured to compensate them for that risk. The state's role would be to bear some of the risk, at no cost to the insurer. Under the high-risk pool concept, the state would essentially be operating a health insurance company that would bear nearly all the risk, and recover only a part of the cost by collecting premiums.

<sup>4</sup> This estimate was based primarily on the experience of Illinois with its high-risk pool. Leif Associates explain on pages 19 and 20 of the study that they believe that the populations, proximity, and other relevant features of Ohio and Illinois are fairly similar. Considering that together with the fact that Illinois has had a relatively lengthy experience with its pool, the authors explain that they believed that Illinois was the best available basis for predicting Ohio's long-term experience with enrollment.

to the small group market. These provisions would increase costs for the Department of Insurance. The increase in costs may be minimal, however, the requirement that the Board issue reports twice a year may make it more significant. The bill does not specify the funding source for these costs.

## **2. Insurance Coverage Changes**

### **Offering coverage to dependents up to age 29**

The bill requires health insuring corporations (HICs), sickness and accident insurers, and public employee benefit plans to offer to provide health insurance coverage for dependent children up to the age of 29, subject to conditions specified in the bill.

These provisions are likely to increase costs to the state, political subdivisions, and school districts of providing health benefits to employees and their dependents. By increasing the pool of covered individuals, the bill would increase the cost of claims. In the case of self-insured plans, the increased cost of claims would directly increase state and local government expenditures; in the case of HIC contracts and traditional insurance policies, it would increase costs of the insurer, which are assumed to be passed through to the insured employer.

The Kaiser Commission on Medicaid and the Uninsured has issued estimates of the number of uninsured in the U.S. by age group in 2006. According to their estimates, 31.2% of adults aged 19 to 24 and 27.1% of adults aged 25 to 34 were uninsured that year. The percentage of nonelderly adults who are uninsured is higher for the U.S. as a whole than for Ohio. An affiliate of the Kaiser Family Foundation estimates that 12% of nonelderly Ohioans were uninsured during 2005-2006, and that 18% of all nonelderly Americans were uninsured in 2006.

Based on the estimated statistics described above, LSC fiscal staff estimate that up to 322,896 Ohio young adults would potentially be made newly eligible for insurance due to the bill's provisions.<sup>5</sup> Assuming these individuals would be covered by government employers in the proportions that government employees make up of overall Ohio employment, then up to 4,525 might be newly covered under a state plan, up to 14,814 might be covered by a plan provided by a county, township, or municipality, and up to 18,795 might be covered by a plan provided by a school district. These enrollment increases would be experienced gradually, likely over a period of years.

The Kaiser Family Foundation conducts an annual survey of employers, the results of which are published under the title *Employer Health Benefits*. The survey found that the average cost to employers of providing health benefits to employees increased by 7.7% from spring 2005 to spring 2006, and by 6.1% from spring 2006 to spring 2007. In addition, the Medical Expenditure Panel Survey<sup>6</sup> found that the average total<sup>7</sup> annual premium for employer-provided

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<sup>5</sup> This estimate includes an adjustment for the fact that a lower proportion of Ohioans are uninsured than are uninsured nationally.

<sup>6</sup> The Medical Expenditure Panel Survey is conducted by the Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services.

<sup>7</sup> The total includes premiums paid by both employers and employees.

health insurance for an individual in Ohio in 2005 was \$3,928. If this premium grew at the national growth rates for employer-provided health benefits found by Kaiser Family Foundation in its annual survey, this would correspond to a premium of \$4,489 in 2007.

The population that would receive insurance coverage due to the bill, consisting of individuals no older than 30, would be in relatively good health compared with the overall population below the age of 65. Therefore, health insurers' costs would certainly increase by less than \$4,489 for each individual newly enrolled in a plan. LSC staff are not aware of any research that provides the ratio of average health care costs for individuals in their twenties to costs for all individuals up to age 65. For illustrative purposes, a cost of \$2,000 per year for each additional individual enrolled is assumed in the cost estimates below. The cost increase estimates in the table below assume that no potentially eligible individuals are employed by an employer that offers health benefits to employees. In actuality, many of the potentially eligible individuals would be so employed, which means that actual enrollment is likely to be less than the enrollment assumed for the table.

<b>Governmental Unit</b>	<b>Estimated Increase in Number of Enrollees</b>	<b>Estimated Increase in Costs</b>
State	4,525	\$9.0 million
Counties, municipalities, and townships	14,814	\$29.6 million
School districts	18,795	\$37.6 million

**Prohibiting exclusion of coverage for losses involving alcohol or drug use**

The bill prohibits HICs, sickness and accident insurers, and public employee benefit plans from excluding coverage for a loss that is sustained due to the insured's use of alcohol or drugs (or both) if the loss would otherwise be covered under the plan. This provision is likely to increase costs to the state, political subdivisions, and school districts of providing health benefits to employees and their dependents. LSC staff have been unable to obtain data that would allow estimation of the magnitude of this increase in costs.

**Coverage for chronic care management**

The bill requires public employee benefit plans to include coverage for chronic care management, which is defined in the bill. This provision may increase costs to the state, political subdivisions, and school districts of providing health benefits to employees and their dependents. The requirements imposed on such plans may be subject to some interpretation; however, it is clear that the bill requires educational outreach to patients and coordination among health care providers, both of which require spending on the part of the plans.

It may be anticipated that this spending would result in reduced spending on acute health care for patients with chronic conditions, resulting in an overall reduction in costs. There is certainly some evidence that chronic care management (sometimes referred to as disease management), if practiced well, may reduce the amount of acute care that some patients need, for some types of conditions. However, the Congressional Budget Office (CBO) reviewed the literature on such savings and issued a report in October 2004 stating that "there is insufficient evidence to conclude that disease management programs can generally reduce overall health spending." A CBO official confirmed (in early February 2008) that this was still the agency's view. While there may be some potential for cost savings, it appears to be more likely, given the

CBO conclusion and the significant number of conditions for which management would be required by the bill, that the savings obtained for acute care that is avoided would be less than the required spending. Thus, this provision is expected to increase costs for public employee benefit plans.

### **Reimbursement for emergency 9-1-1 services**

The bill requires that policies of sickness and accident insurance that cover emergency services and HIC contracts provide for reimbursement for certain emergency services directly to the provider of the services. And it prohibits third-party payers from refusing to honor a validly executed assignment of benefits for claims regarding emergency physician services. These provisions apply only if the insurer already provides coverage of emergency services. Thus, it would affect who is paid, but not the amount paid. These provisions would have no fiscal effect on the state. They may accelerate the receipt of payments to local governments that provide emergency services (*e.g.*, ambulance services), and they may in some cases allow such governments to receive such payments that they would not have been able to collect from the individual served (who presumably received the payment instead of the provider).

### **3. Personal Income Tax Provisions Related to Health Care Premium**

Under current federal law, self-employed taxpayers may deduct unsubsidized health insurance premiums paid for themselves and their dependents on their federal income tax returns. Under current Ohio tax law a taxpayer may claim a deduction for unsubsidized health insurance premiums that are not already claimed on federal returns.

H.B. 456 proposes to eliminate this Ohio deduction and replaces it with a nonrefundable tax credit of up to \$1,000 for taxable years beginning on or after January 2008. The bill also extends, for purposes of claiming this nonrefundable tax credit, the eligible age for certain dependent children from the current 25 years to 29 years, subject to Ohio residency or full-time post-secondary student status of the dependent.

### **Revenue gain from elimination of current deduction for unsubsidized health premiums**

Based on the latest Tax Expenditure Report by the Ohio Department of Taxation, eliminating the health care premium deduction (including premiums for long-term care) will result in a revenue gain to the state of \$54.2 million in FY 2009.

Eliminating the deduction could also increase school district income tax revenue, because the tax base for school district income taxes could increase. Any actual revenue gain for a school district would depend on the amount of the deduction previously claimed by district resident taxpayers and the school district income tax rate for the district. If a taxpayer previously claiming the deduction were in a district without a school district income tax, there would be no revenue gain. To estimate the statewide school district income tax revenue gain, LSC first estimated the gain in federal adjusted gross income (FAGI) associated with eliminating the deduction. The \$54.2 million revenue gain from eliminating the deduction and the average effective income tax rate imply that statewide FAGI would increase by approximately \$2,191.9 million in FY 2009 as a result of eliminating the deduction. The FAGI of taxpayers in school districts with a school district income tax is approximately 10.5% of statewide FAGI and the weighted average school district income tax rate is approximately 0.94%. Applying this

percentage of income and average tax rate to the estimated amounts claimed as deductions yields an estimated statewide school district income tax gain of \$2.2 million in FY 2009.

### **Revenue loss from nonrefundable tax credit**

Using the federal tax data, the number of taxpayers eligible to claim this proposed nonrefundable tax credit for FY 2009 is estimated at 114,910. This estimate is derived from a projected trend based on the actual numbers of Ohio taxpayers claiming health care premium deductions from 1997 to 2001 (the latest year for which such data are available). The bill proposes a maximum of \$1,000 in nonrefundable tax credit for each eligible taxpayer. The maximum income tax revenue loss is thus estimated at \$114.9 million ( $\$1,000 \times 114,910$ ) in FY 2009.

### **Revenue impact of age extension for dependents**

According to a recent report published by the Employee Benefit Research Institute,<sup>8</sup> from 2004 to 2006, on average, approximately 600,000 Ohioans under age 65 were covered by individually purchased, or unsubsidized, health insurance. Assuming that the age distribution of these 600,000 individuals is the same as for all Ohioans under age 65, approximately 45,887 Ohioans age 25-29 might be covered by unsubsidized health insurance. Using the ratio of Ohio students enrolled in post-secondary institutions to the total population of the 25-29 age group (9.64%) and assuming the number grows at the population growth rate for this age group in Ohio,<sup>9</sup> LSC estimates the number of eligible dependents under the proposal at 4,562 for FY 2009. The revenue loss due to extension of the age limit for eligible dependents is then estimated at \$4.6 million for FY 2009, assuming that the maximum tax credit of \$1,000 is claimed for all eligible dependents. This loss could be higher if dependents of age 25-29 living in Ohio but not full-time post-secondary students are included. The bill defines this group also as eligible, but LSC could not find appropriate estimates for this group of eligible dependents.

### **Net effect**

The net state income tax revenue loss from combining the revenue gain from the elimination of the current deduction provision (\$54.2 million) with the revenue losses from the nonrefundable tax credit (\$114.9 million) and the age extension for eligible dependents (\$4.6 million) is thus estimated to be up to \$65.3 million for FY 2009, of which \$61.4 million (94.1%) will be borne by the GRF and \$3.9 million will be borne by local government funds.

## **4. Ohio Health Advantage Program**

The bill creates the Ohio Health Advantage Program (OHAP) in the Bureau of Workers' Compensation (BWC). The program would offer premium discounts to employers who offer health and wellness programs to their employees and/or participate in qualifying health plans. Certain employers may receive a total premium discount of up to 20% under the bill. A discount of up to 5% is available for all employers that establish and maintain one or more health and wellness programs. A discount of 15% is available for employers that meet certain criteria and participate in a qualifying health plan. The combined effect of these two discounts, if applied to

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<sup>8</sup> EBRI Issue Brief, No. 310, October 2007.

<sup>9</sup> Global Insight, February 2008 release.

FY 2008 premiums, could be a maximum initial loss of \$159.1 million, although the actual loss could be much lower than this maximum amount and future losses could be offset by decreased claims compensation costs if these programs lead to fewer workplace injuries.

### **Discounts for health and wellness programs**

Employers would be eligible for a premium discount of up to 5% if their health and wellness programs include: wellness, smoking cessation, diabetes management, physical fitness, and other similar features, as long as the programs meet accreditation criteria specified in the bill.

Although an employer may be eligible for a premium discount of up to 5%, the amount of the discount may not exceed the cost incurred by an employer for establishing and maintaining the program. BWC would set discounts based upon several factors: whether programs are offered at an employer's place of business, the number of programs an employer offers, the degree to which an employer facilitates access to fitness equipment and dietary options, and any other factors deemed relevant to the program.

Additionally, employers must participate in the program for six consecutive months before the discount is applied to premiums. For the first year of the program's existence, BWC will prorate the discount, but in subsequent years employers must participate for a full year to be eligible for a full year's discount. There is no limit on the amount of time that employers may participate in this discount program.

For FY 2008, BWC reports that it is covering approximately 217,891 policies and will collect about \$1.8 billion in premiums. Applying the 5% discount could result in a maximum loss of \$92.2 million ( $\$1,843,351,834 \times 0.05 = \$92,167,592$ ). As not all employers would participate in the premium discount program, and those that did would not all qualify for the full 5% discount, the actual dollar amount lost would most likely be less than the \$92.2 million.

### **Discounts for qualifying health plans**

The bill also establishes a premium discount program for employers that provide qualifying health plans to their employees. The bill sets the premium discount for these employers at a flat rate of 15%. A qualifying health plan is defined as a group sickness or accident insurance policy or a health insurance policy that meets specified criteria under which an employer must:

- offer its employees a qualifying health plan, but not have offered its employees such a plan for six consecutive months prior to applying for a discount;
- employ between two and 50 employees in Ohio;
- compensate its employees at an average rate of \$45,000 or below per year; and
- make its principal place of business in Ohio and have operated in the state for at least six months prior to applying for a discount.

An employer would only be eligible to participate in the qualifying health plan discount program for a period of up to three years.

According to currently available employer data, BWC estimates that 124,539 Ohio employers (or about 57% of 217,891) presently covered by BWC meet the basic criteria required for participation in the program, that is they (1) employ between 2 and 50 employees in this state, and (2) offer average compensation below \$45,000. However, BWC was not able to provide information on how many of these employers had not offered their employees a qualifying health plan during the last six months. Without this figure, it is difficult to accurately estimate the number of employers that would be eligible for the discount.

Supposing that all 124,539 employers were eligible, and knowing that total premium collections from these employers are estimated to be \$446.4 million in FY 2008, BWC could forgo up to \$67.0 million in premium collections that would otherwise be deposited into the State Insurance Fund ( $\$466,401,806 \times 0.15 = \$66,960,271$ ). However, as with the discount for health and wellness programs, the actual amount forgone would probably be considerably less as it is not likely that all of the 124,539 would be eligible or would participate.

**Cumulative fiscal effect of OHAP**

To summarize, based on employer premium data for FY 2008, 217,891 employers could qualify for a 5% BWC premium discount, and that 124,539 of those employers (about 57%) could qualify for an additional 15% discount. The potential cumulative cost of both discount programs with maximum employer participation is illustrated in the table below.

<b>Potential Impact of Premium Discount if Applied to FY 2008 Premiums</b>				
<b>Program</b>	<b>Applicable Discount</b>	<b>Qualifying Employers</b>	<b>Premium Eligible for Discount</b>	<b>Forgone Premium</b>
Health and Wellness	≤ 5%	217,891	\$1,843,351,834	\$92,167,591.7
Qualifying Health Plans	15%	124,539	\$446,401,806	\$66,960,270.9
<b>Potential Maximum Lost Premium</b>				<b>\$159,127,862.6</b>

The combined maximum revenue loss from both discounts could be \$159.1 million, or about 8.6% of BWC's total premium collections of \$1.84 billion for FY 2008. The actual loss will depend on the number of employers that participate in one or both of the available premium discount programs. Regardless, the amount of forgone premium revenue could still be in the tens of millions of dollars.

There are other factors that might tend to reduce the size of these premium losses in future years. First, there is a three-year limit on employer participation in the Qualifying Health Plans program. After the initial wave of employers who qualified for this program lapse out, beginning in FY 2012 premium losses would most likely be reduced. More speculatively, if employer participation in these programs reduces the number and cost of injury claims, this might offset at least some of the impact that the new premium discounts would have on BWC's overall premium revenue.

**Administration**

Presumably, OHAP would be housed in the Customer Services Division along with all other claims, risk, and safety operations, including BWC's group rating and other premium discount programs. BWC estimates that program administration costs could range between \$300,000 to \$400,000 annually. This figure is based on the estimated administrative costs for BWC's existing group rating program, which are approximately \$450,000. These costs would be paid for out of the BWC Administrative Cost Fund (Fund 023), which provides the majority of the agency's operating funds. New administrative functions could include reviewing applications, determining employer eligibility, monitoring employer compliance, and related activities. In all, the actual costs of administering OHAP are dependent upon the extent to which its operations can be integrated alongside existing programs with current staff and resources.

## 5. Pharmacy Benefit Management (PBM)

### Pharmaceuticals

The bill creates the Office of Pharmaceutical Purchasing Coordination within the Department of Administrative Services (DAS) and charges this new office with maximizing the purchasing power and value of pharmacy benefit management (PBM) programs to the participants covered in the bill. This section describes factors that might create (1) potential new costs or savings that might be expected from integrating the state's existing drug procurement and PBM services within this new office, and (2) potential new costs the new office would incur in performing the review of existing PBM contracts required by the bill.

### Integrating Drug Procurement and PBM Selection

The bill would require that the Office of Pharmaceutical Purchasing Coordination oversee PBM services provided to five groups: (1) state employees and their dependents, (2) retirees in all the state retirement systems, (3) workers' compensation claimants, (4) school employees, and (5) Medicaid recipients enrolled in any of ODJFS's managed care programs. The bill refers to these persons as "participants."

As the following table shows, if it were in place today, the office would be responsible for overseeing a centralized program in the \$1.20 billion range, encompassing about 980,000 participants. Not included in this total is the ODJFS managed care Medicaid population. If included, this group would account for another 1.35 million persons, making a total of about 2.3 million.

<b>Estimated Current Employee Coverage and PBM Contract Costs, FY 2008</b>					
	<b>State Employees and Dependents</b>	<b>State Retirement Systems</b>	<b>Bureau of Workers' Compensation</b>	<b>School Employees</b>	<b>Total</b>
<b>Participants</b>	130,000	520,000	130,000	200,000	980,000
<b>Cost</b>	\$74 million	\$773 million	\$150 million	\$200 million	\$1.20 billion

Source: Department of Administrative Services estimates, February 11, 2008.

Centralizing the PBM contracting process might reasonably be expected to yield economies of scale that increase the state's buying power and reduce its pharmaceutical costs. However, factors such as whether Medicaid recipients are included and the total number of people covered could potentially limit the savings that are realized. Adding Medicaid recipients,

who are subject to various federal and state laws, might introduce complexities in the procurement and oversight process that could offset some of the anticipated savings. Additionally, as the number of recipients grows, the pool of PBMs capable of managing contracts of this scope shrinks. To give some perspective, DAS obtained 14 bids from vendors before selecting a \$74 million proposal from CatalystRx to provide PBM services for state employees in FY 2008. DAS procurement officials have told LSC that if all 980,000 (excluding Medicaid recipients) participants were part of a single PBM contract, there are probably four vendors that could handle a contract of this size.

DAS would most likely fund the new office through the General Services Operating Fund (Fund 117), which pays for procurement services to state agencies and is funded by charges to those users. Presumably, DAS would adjust these charges to account for the additional costs of PBM contract oversight. DAS also indicated that some costs could be borne by the Human Resources Fund (Fund 125), which pays for state employee benefits administration and is funded by payroll assessments charged to agencies. Depending on implementation, the State Employee Health Benefits Fund (Fund 808), a pool of state employer premiums and employee payroll deductions that pays for health benefits, a portion of which is prescription drug coverage, may be affected by any increase or decrease in PBM costs.

#### **Start-up of Office of Pharmaceutical Purchasing Coordination**

There would be new costs for creating the Office of Pharmaceutical Purchasing Coordination, largely caused by expanding the scope of oversight and consolidating DAS's existing drug procurement processes. According to preliminary estimates, DAS officials foresee the need for perhaps ten additional staff: two or three to oversee PBM contract review and seven to handle the drug procurement process. There may not be any need for new office space, as the office staff could continue to work from their present locations at the General Services and the Human Resources divisions, or be reorganized as a unit within existing office space.

#### **PBM program review**

The bill requires the Office of Pharmaceutical Purchasing Coordination to conduct a review of any current PBM programs maintained by DAS, BWC, the state retirement systems, and school districts. This study would also examine the use of drug formularies, rebates, medication therapy, chronic disease management, and electronic prescribing among the participants. A recent study performed by Pharmaceutical Strategies Group (PSG) reviewed DAS's current pharmaceutical purchasing practices and recommended possible changes that could generate savings. That study cost approximately \$220,000.

It is reasonable to assume that a similar review of each of the individual groups mentioned in the bill would have a similar cost. DAS officials suggested that the cumulative cost for all of the studies would probably be less than \$1,000,000. Generally, consulting firms in the drug benefit area charge for their services in three different ways: by an hourly rate, by an agreed upon total service cost, or by a portion of the savings obtained from implementing the contractor's recommendations.

## **6. Health Care Services and Prescription Drugs to Inmates of State Correctional Institutions**

## *Departments of Rehabilitation and Correction and Youth Services*

The bill mandates that the Department of Rehabilitation and Correction (DRC) and the Department of Youth Services (DYS) receive health care services and prescription drug services from federally qualified health centers (FQHCs). FQHCs are nonprofit, consumer-directed corporations that provide care and treatment to the underserved and the uninsured. This provision only applies to DRC and DYS facilities that are located in a county where there is also an FQHC.

The bill could decrease prescription drug costs for DRC and DYS by several million dollars per year. FQHCs are permitted under federal law to purchase prescription drugs through the federal 340B Drug Pricing Program. The 340B program allows organizations to purchase prescription drugs at an average of 49% of Average Wholesale Price (AWP).<sup>10</sup> Currently, DRC and DYS purchase prescription drugs from the Department of Mental Health on average at a higher percentage of AWP than 49%; however, the exact average percentage is unknown.

There are other factors that will affect the fiscal impact of this provision. In addition to providing prescription drugs at lower prices, the bill also requires that any correctional facilities that receive such prescription drug benefits from an FQHC located in the same county must also receive health care services from the same FQHC. This provision of the bill will entail significant structural changes to the current healthcare delivery systems in place within the affected DRC and DYS facilities. These facilities currently contract with health care professionals and provider networks to deliver on-site health care services. There could be an increase in administrative costs in terminating current contracts with provider groups and developing new contracts with FQHCs. And, costs for contracting with FQHCs could be more or less than the costs of current health care contracts.

In addition to negotiating new contracts, FQHC capacity could affect costs as well as the scale and scope of the contracts themselves. According to a spokesperson for FQHCs, some FQHCs in the state may have capacity issues in meeting the requirements in the bill. Moreover, it is uncertain how the bill would affect the health care services provided at the DRC Corrections Medical Center (CMC) in Franklin County and the mental health services provided at Oakwood Correctional Facility (OCF) in Allen County. Both facilities are located in counties with an FQHC. Finally, approval from the federal Health Resources and Services Administration is necessary for DRC and DYS to contract with FQHCs for prescription drugs and health care services.

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<sup>10</sup> Information on 340B prices for specific prescription drugs is not available to the public.

### **Department of Mental Health**

The Office of Support Services (OSS) in the Department of Mental Health (DMH) would experience a decrease in expenditures as well as a corresponding loss of millions of dollars in revenue as a result of purchasing fewer prescription drugs for resale to DRC and DYS. Twenty-three of the thirty-two DRC facilities, four of the eight public DYS facilities and both private DYS facilities operate in counties where there is an FQHC. Currently DRC and public DYS facilities purchase about half of the volume of prescription drugs sold by the OSS in DMH. This provision could affect OSS's ability to purchase drugs at bulk rate prices in the future. Transactions for drug purchases and drug resale are conducted through Fund 151 in DMH.

## **7. Medicaid Hospital Services, Charity Care Reporting, and Hospital Care Assurance Program Payments**

### **Hospital services to Medicaid recipients enrolled in managed care**

The bill eliminates exceptions to a requirement in current law that a hospital that participates in Medicaid but is not under contract with a particular Medicaid managed care organization provide a service, other than an emergency service, for which the organization refers a Medicaid recipient to the hospital. Under current law, a Medicaid recipient turned down by the exempted hospitals may choose services from other hospitals or may receive no services until emergency services are required. This provision of the bill could result in savings to the state Medicaid program, presuming that Medicaid patients currently use emergency services and the emergency services have higher costs.

Current law also requires that a hospital must accept, as payment in full, the amount derived from the reimbursement rate ODJFS uses to reimburse other hospitals of the same type for providing the same service to a Medicaid recipient who is not enrolled in a Medicaid managed care organization. The bill reduces the amount a hospital is to accept from 100% to 95% of the amount derived from the reimbursement rate ODJFS uses to reimburse other hospitals. This provision of the bill will result in savings to the state Medicaid program. LSC is waiting for ODJFS to provide data on the amount the Department pays to these hospitals.

### **Tax-exempt hospital charity care reporting**

The bill requires each tax-exempt hospital whose Medicaid inpatient utilization rate is less than 35% in a given year to publish on its web sites the cost of charity care the hospital provided and the property tax and sales tax savings arising from the hospital's tax-exempt status. A tax-exempt hospital whose rate is greater than 35% must only report its Medicaid inpatient utilization rate to the Auditor of State. The bill requires the Auditor to adopt rules regarding the oversight and implementation of the bill's hospital reporting requirements. The Auditor must notify the Tax Commissioner and the Attorney General if a tax-exempt hospital fails to comply with the requirements.

According to the Auditor of State's Office, the requirement to adopt rules regarding the oversight and implementation of the bill's hospital reporting requirements should result in minimal increases in costs. LSC assumes that the costs to the Tax Commissioner and Attorney General would also be minimal, as the number of hospitals that fail to comply with this requirement is expected to be small.

There are currently 23 public hospitals in Ohio. A public hospital is government-owned, either by the state or county. According to the Ohio Hospital Association (OHA), tax-exempt hospitals, whose Medicaid inpatient utilization rate is less than 35%, should be able to publish the cost of charity care provided on their web sites with minimal increases in costs. Likewise, tax-exempt hospitals, whose rate is greater than 35%, should be able to report their Medicaid inpatient utilization rates to the Auditor of State with minimal increases in costs. Ultimately, though, this cost would be dependent upon the requirements established by the Auditor of State.

However, the provision requiring tax-exempt hospitals with Medicaid inpatient utilization rates less than 35% to publish on their web sites the property tax and sales tax savings arising from the hospital's tax-exempt status could result in increased costs. If hospitals would be responsible for collecting and calculating these property tax data on their own, then costs of public hospitals would increase. The full amount of this increase is unknown. However, OHA has stated that this provision may require the hiring of outside auditing consultants. According to the County Auditors Association of Ohio, it appears that county auditors could calculate the property tax savings for tax-exempt hospitals with minimal increases in costs. Currently, county auditors do appraisals on land parcels. County auditors could use these appraisals to calculate property tax information for tax-exempt hospitals. OHA has also stated that hospitals would incur additional costs to collect data on their sales and use taxes. Hospitals are huge purchasers of equipment and supplies. OHA believes that additional resources would be needed to collect these data. OHA is currently working on an estimate of the cost of these provisions.

#### **Restriction on Hospital Care Assurance Program payments**

The bill provides that a disproportionate share hospital may receive more funds under the Hospital Care Assurance Program (HCAP) than the minimum necessary to satisfy federal Medicaid law concerning disproportionate share hospitals only if the hospital has a contract with each Medicaid managed care organization that manages the health care of Medicaid recipients who reside in the region in which the hospital is located. The bill also provides that a hospital that is not a disproportionate share hospital may not receive any HCAP funds unless the hospital has a contract with each Medicaid managed care organization managing the health care of Medicaid recipients who reside in the region in which the hospital is located.

Current law requires ODJFS to adopt rules and to establish a methodology to pay hospitals that is sufficient to expend all money under the HCAP program. These provisions of the bill could reallocate the funds received by hospitals but not change the total amount of funding under the HCAP program. Thus, these provisions of the bill will not affect the total amount of the state's HCAP payments. However, these provisions of the bill could affect public hospitals such as state, county, or city hospitals if the hospitals do not have contracts with Medicaid managed care organizations. In FY 2006, the state made payments of approximately \$44 million to county and city hospitals, and approximately \$7 million to state hospitals. The total HCAP payment for FY 2006 was \$546 million. LSC does not know which hospital will not have a contract with a Medicaid managed care organization, and thus can not determine the amount of the loss to public hospitals under these provisions of the bill.

## **8. Nursing Instructor Salaries**

The bill requires that state institutions of higher education in Ohio with prelicensure nursing programs increase salaries for nursing instructors. Under the bill, current<sup>11</sup> nursing instructors will receive a salary in the first five fiscal years after the bill's effective date that is at least \$5,000 above the salary they received in the calendar year immediately prior to the bill's effective date. In FY 2006, 789 full-time instructors taught a majority of their classes in nursing.<sup>12</sup> Assuming approximately the same number are teaching when the bill becomes effective and these instructors continue teaching for five years, this requirement would cause a statewide increase in expenditures of approximately \$3.9 million (789 x \$5,000) in each of the five fiscal years after the bill's effective date.

In addition, the bill requires that state institutions pay an individual who begins teaching nursing classes in the first fiscal year after the bill's effective date a starting salary \$10,000 greater than the institution's average starting salary for nursing instructors in calendar year 2007. In the second, third, fourth, and fifth fiscal years after the bill's effective date, all individuals who begin teaching nursing classes must receive a starting salary \$15,000 greater than the institution's average starting salary for nursing instructors in calendar year 2007. In recent years, approximately 20 new nursing instructors were hired annually statewide. If 20 new instructors were hired in each of the first five fiscal years after the bill's effective date, the additional statewide expenditures would be \$200,000 (20 x \$10,000) in the first year and \$225,000 (20 x \$15,000) in each of the next four fiscal years.

These estimates do not take into account the probability that salaries may increase even without the bill. In this case, the additional costs resulting from the bill would be lower than those estimated.

Under the bill, state institutions are prohibited from reducing the number of nursing classes or nursing instructors from their 2007 levels for five fiscal years and thereby mitigating the cost of the increased salaries. A further consequence of this provision is that in the unlikely event that nursing enrollment falls, the institution may be forced to maintain inefficiently small class sizes. However, nursing enrollment is not likely to fall. In fact, according to the Ohio Board of Nursing, 7,414 academically qualified Ohio students were denied admission to a nursing program in FY 2006 because of lack of space.

## **9. Health Information Technology Pilot Program**

The bill mandates that ODJFS establish a Health Information Technology pilot program for Medicaid recipients and providers in Hamilton County beginning in FY 2010. The bill mandates that upon successful implementation of the program, ODJFS expand the program to include six additional counties by FY 2014 and then expand it further to a statewide level by FY 2016.

This provision would increase state costs, possibly in the millions of dollars, but a specific amount or reasonable range cannot be determined. The costs of such a program would depend entirely on how ODJFS would choose to go about developing and implementing it.

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<sup>11</sup> Nursing instructors who taught in the calendar year immediately prior to the bill's effective date.

<sup>12</sup> These instructors had an average annual salary of \$57,178 in FY 2006.

This pilot program might be eligible to receive federal reimbursement of 50% and possibly up to 90% of costs. Administrative expenditures related to Medicaid are generally eligible for 50% federal reimbursement, and expenditures on new information technology are usually eligible for higher reimbursement rates. For example, statewide Medicaid Management Information Systems (MMIS) programs are eligible to receive 90% federal reimbursement for up-front design and implementation costs and 75% federal reimbursement for ongoing operational costs. The Hamilton County pilot program might qualify for these higher reimbursement rates since the bill explicitly provides for a statewide program of which the pilot program is just the first phase. Without a clear mandate for an eventual statewide program, the Hamilton County pilot program might only be eligible for 50% federal reimbursement. Ultimately the federal Centers for Medicare and Medicaid would determine the federal reimbursement rates for this program.

It is possible that ODJFS could look beyond federal reimbursement to help fund the development of the pilot program as provided in the bill. Financial assistance in the form of grants is available at various times from a number of federal and nonprofit sources. For example, the United States Agency of Healthcare Research and Quality has awarded \$166 million in grants and contracts to support planning, implementation, and evaluation of health information technology, and to foster the development of state and regional health information exchanges since 2004. Also, the Health Foundation of Greater Cincinnati has awarded grants to multiple county governments and charities for health-related initiatives. It may be possible for ODJFS to seek out funding for the pilot program through these and/or other federal and nonprofit channels.

## **10. Other Provisions of the Bill**

### **School food**

Under current law, school districts must adopt standards governing the types of food that may be sold on school premises and specifying when and where those foods may be sold. In addition, the State Board of Education must adopt guidelines with respect to food sales that school districts may follow if they choose to do so. The bill makes the following changes to these requirements:

- Applies the requirements to community schools in addition to school districts;
- Requires the standards govern sales of beverages in addition to food;
- Requires the standards include prices in addition to types of food and beverages;
- Specifies that the standards cover food and beverages sold by school food service programs or vending machines;
- Requires the state board to adopt rules instead of guidelines;
- Requires that schools comply with the state board rules; and
- Bans the use of artificial trans fat in food or beverages sold in schools beginning one year after the bill's effective date.

The prohibition on the use of trans fat will require schools that are currently using trans fat in their food service program to substitute alternatives. These alternatives may be more

expensive, leading to a potential increase in costs, although schools may be able to recoup this cost through higher meal prices. It is also possible that the alternatives will *not* be more expensive. The general trend in school food service programs appears to already point toward a reduction in trans fat. The Ohio Department of Education issued a policy statement<sup>13</sup> effective February 4, 2008, advising schools to minimize trans fat in preparation for the incorporation of the 2005 update to the Dietary Guidelines for Americans into requirements for schools that receive federal funds for their school lunch and breakfast programs. As schools nationwide move toward using products that are free of trans fat, these products will likely become more readily available and at lower costs. According to the School Nutrition Association (SNA), companies that sell to the food service market are already producing a wide range of trans fat free products.

Under the bill, the state board, school districts, and community schools may incur minimal administrative costs in developing the new standards.

#### **Ambulatory surgical facility data reporting – Department of Health**

The bill requires ambulatory surgical facilities that serve at least ten patients per year to submit certain data to the Director of Health by May 1 of each year. The bill requires both the ambulatory surgical facilities and the Director to make the information available to the public and permits ambulatory surgical facilities to charge for copying the information. The Director must make the information available on a web site within 90 days of receiving it, if appropriations made by the Ohio General Assembly make this possible. The web site must (1) be available to the public without charge, (2) be organized in a manner that enables the public to use it easily, (3) exclude any information that compromises patient privacy, (4) include links to web sites pertaining to ambulatory surgical facilities for the purpose of allowing the public to obtain additional information about ambulatory surgical facilities, and (5) allow other Internet web sites to link to the web site for purposes of increasing the site's availability and encouraging ongoing improvement. The Director must update the web site as needed to include new information and correct errors. The bill allows the Director to contract with a vendor to create, maintain, and update the web site.

The bill does not appropriate funds for the Ohio Department of Health (ODH) to establish such a web site. ODH would be unlikely to be able to establish the web site until funds were appropriated for this purpose. The bill allows ODH to accept grants, gifts, or donations to pay for contracting with a vendor to establish the site. ODH may also sell information for a reasonable fee. What grant sources would be available, if any, for this purpose is unknown. Currently, ODH does not collect information from ambulatory surgical centers.

#### **Dental hygienist collaboration agreements with dentists**

The bill generally maintains current law governing the practice of dental hygienists but enacts new law to:

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<sup>13</sup> This statement is available on the Department's web site: [www.ode.state.oh.us](http://www.ode.state.oh.us) under Learning Conditions and Supports→Food and Nutrition→School Meal Programs→Guidance and Policy Memorandums.

- (1) Permit a dental hygienist to enter into a collaboration agreement with a dentist without the dentist being physically present at the facility where the services are provided and without prior examination by the dentist;
- (2) Govern the conditions under which a dental hygienist may practice under a collaboration agreement and the characteristics of a collaboration agreement; and
- (3) Provide an exception from the conditions in current law governing the practice of a dental hygienist when the dental hygienist practices under a collaboration agreement.

In effect, this means that if the bill is enacted, there will be two sets of laws governing the practice of dental hygienists: one that governs the practice of a dental hygienist when the hygienist practices under a collaboration agreement and another (the existing law) that governs the practice of a dental hygienist when the hygienist is not practicing under a collaboration agreement.

Although the bill expands the arena for dental hygienists to work, the State Dental Board does not expect any significant fiscal impact as a result of the changes. The bill also requires the board to adopt rules to implement certain requirements of the bill. There may be a one-time minimal increase in costs associated with rulemaking.

Lastly, it is unclear if the bill would have any impact on premium costs for liability insurance for public health clinics or public dental clinics. GRF appropriation line item 440-431, Free Clinic Liability Insurance, in the Department of Health provides this funding to free clinics.

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