
Detailed Fiscal Analysis

S.B. 99 requires health insuring corporations' contracts, sickness and accident insurance policies, and public employee benefit plans to provide benefits for equipment, supplies, and medication for the diagnosis, treatment, and management of diabetes. The bill also requires all such contracts, policies, and benefit plans to provide benefits for "diabetes self-management education" and "medical nutrition therapy" when prescribed by a physician or other individual whose professional practice established by licensure under the Revised Code includes the authority to prescribe it. The bill states that the education benefits shall cover expenses for a minimum of ten hours of diabetes self-management education during the first twelve months and two hours of education in each subsequent year, and that education benefits must be covered whether provided during home visits, in a group setting, or by individual counseling (if medically necessary).

Health insuring corporations (HICs) are not required to continue to provide the above-described benefits if they are able to document that providing them has increased their costs by more than 1%. Documenting such a cost increase would require a letter to the Superintendent of Insurance signed by an independent member of the American Academy of Actuaries certifying that the increase reflects actual claims experience. The approval of the Superintendent would be required before the requirement could be dropped.

Background information

Diabetes is a disease that prevents a patient's pancreas from producing the correct amount of insulin, with the direct result that the amount of sugar in the patient's blood is not properly regulated. An untreated patient, or a patient whose diabetes is not well controlled, typically suffers from abnormally high levels of blood sugar, which leads over time to serious damage to the body's cells. As the cellular damage progresses, the patient will very likely suffer organ damage and serious complications. Having diabetes increases one's risk of suffering heart disease or stroke by a factor of two to four. It is the leading cause of both blindness and kidney disease in adults, and it increases the risk of nerve disease that can lead to amputation of a leg or some other extremity.¹ There is no known cure for diabetes as of this writing. In order to avoid the serious complications described above, diabetes patients must carefully plan their meals, and regularly exercise and monitor their blood sugar level. In addition, patients with insulin-dependent diabetes, and about 40% of patients with Type II diabetes,² require daily (or even more frequent) injections of insulin. The frequency of diabetes and diabetic complications increases with the age of the cohort.

¹ A number of basic facts about diabetes are available online at www.niddk.nih.gov; just click on diabetes on that page.

² There are two types of diabetes. Type I is juvenile onset diabetes and is insulin dependent. Type II is adult onset and is often associated with overweight people. Usually Type II diabetes can be controlled by pills, diet, and exercise. Insulin dependent Type II is often associated with advanced stages of the disease, the elderly, or acute cases.

The complications that can arise due to diabetes are very expensive to treat, often requiring hospitalization. The preventive treatment mandated by this bill, by reducing the frequency of occurrence of such complications, may produce future savings from treating such complications. The Diabetes Control and Complications Trial, conducted by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)³ from 1983 to 1993, found that intensive management of diabetes (as defined by that study) reduced the risk of eye disease by 76%, the risk of kidney disease by 50%, and the risk of nerve disease by 60%.

Actuarial reports on the effects of implementing the provisions of similar bills introduced in the 124th General Assembly (H.B. 100 and S.B. 45) were produced during that General Assembly by Milliman USA. Such actuarial reports were required at that time under the provisions of H.B. 221 of the 123rd General Assembly for any bills that mandate health insurance benefits and that receive a second hearing. The actuarial reports estimated that about 2.35% of Ohioans between the ages of 0 and 64 would be diagnosed with diabetes. Based on this estimate, the report went on to estimate that the provisions of H.B. 100 (and of S.B. 45) would increase health insurance premiums in Ohio by between 0.2% and 0.6% on average, and by up to 2% for plans that did not provide any of the required services at that time. The Milliman report acknowledged that the higher premiums predicted "would be expected" to lead to a reduction in the number of people covered by health insurance in the state, but did not provide an estimate of that reduction and described it as "minimal."

The state of Wisconsin conducted a study, which was primarily concerned with assessing the costs of mandated diabetes education, equipment, and supplies coverage. After Wisconsin passed its diabetes mandate in 1987, its Insurance Commission studied the costs of a standard benefits package on five insurers. Of the total medical benefits paid in 1987, \$762,666,109, the dollar amount spent on required diabetes-related coverage was \$624,460 or less than 1%. In 1988 the percent of the total was 1.1% (\$835,240 out of a total \$752,563,830). The Commission concluded that directing the five insurers to offer diabetes supplies and education coverage did not increase claims filed, disbursements, costs, or premiums, when compared to nonmandated benefits. In 1990 Wisconsin stopped surveying for the costs of diabetes, home health care, skilled nursing care, and kidney disease treatment mandates, because they were small dollar figures. In addition, the cost of these four mandates added together was less than 1% of the total medical benefits.

Neither the Milliman actuarial report nor the Wisconsin study took into account potential savings due to the possible avoidance of expensive complications associated with diabetes. Milliman actuaries have studied the possibility of quantifying such savings and have issued an opinion that there are no existing studies that could serve as a reliable basis for quantifying such potential savings.

State fiscal effects

The bill has the potential to increase costs to the state of providing health benefits to state employees. According to an official with the Department of Administrative Services, all health plans for state employees cover the costs of diabetes-related equipment, supplies, and medication. In addition, all plans offer a free diabetes disease management program. Enrollees in the disease management

³ One of the institutes making up the National Institutes of Health (NIH).

program do not have to pay a copayment for equipment, supplies, and medication, but plan members who are not enrolled have to pay a 20% copayment. In addition, enrollees in the disease management program are entitled to an unlimited number of hours of self-management education. All the benefits that the bill requires are currently available to state workers (and their covered dependents), suggesting that the bill would not increase costs to the state to provide health benefits to workers.

The bill would have no direct fiscal effect on Ohio's Medicaid program, since it is not a health insuring corporation, a sickness and accident insurer, or a public employee benefit plan. Medicaid managed care could be affected by the requirement, since Medicaid participants covered by managed care are covered by an HIC which is subject to the bill's provision. Medicaid currently covers equipment, supplies, and medication that are medically necessary to treat or diagnose diabetes though. There could be an indirect fiscal effect due to the possibility of an increase in caseload due to the bill. This possibility is addressed in the section on indirect effects below.

Local government fiscal effects

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

LSC staff members called selected counties to gather information about health benefits for workers in those counties. The information gathered was not derived from a random sample, and so cannot serve as a statistically reliable basis for estimating the costs to counties or other local governments of implementing the bill. It does provide information on the impact on the counties selected, however, and to the extent that these counties are representative of other counties in the state (which they may or may not be) could provide insight into the cost to counties from implementing the bill.

LSC staff contacted officials of eight counties: Allen, Franklin, Hamilton, Lorain, Lucas, Montgomery, Muskingum, and Summit. These counties are currently spending a combined approximately \$230 million to provide health benefits to employees and their dependents in FY 2007. All eight counties provide benefits for equipment, supplies, and medication for treatment of diabetes. Six of the eight provide education benefits at a level that meets or exceeds the bill's requirements, but the other two counties do not. A Franklin County official reports that, while the education benefit may not be in accordance with the bill's requirements currently, they expect to implement a disease management program within a year or so that would provide a level of benefits that is compliant with the bill. A Summit County official reports that there is no formal education benefit, but that it is expected that patients will receive the needed education from office visits with physicians. Three of the counties report providing the benefits using a disease management program for diabetes.

Any increase in costs of providing health benefits that the bill might impose on these counties would apparently be small and would arise from two considerations. First, the education requirement is apparently not met currently in two of the counties, so the bill would require an increase in costs to provide the required education benefit. Second, like the state, some counties use carve-out plans to provide prescription drug benefits, and some use disease management programs to provide comprehensive diabetes care benefits. It is not clear whether these current features would comply with the requirement that HICs provide these benefits as "basic health care services." So there could be an increase in administrative costs for HICs to comply with the bill. These costs, like those associated with expanding the education benefit, are assumed to be passed on to the county involved.

LSC staff cannot reliably project the cost to all 88 counties in the state from this sample. However, the sample does seem to suggest that most counties already cover equipment, supplies, and medications, so that the cost of the bill would be due primarily to the education requirement. LSC has not collected data from any Ohio municipalities, townships, or school districts, but we are not aware of any reason why the health benefit arrangements for those local governments would differ significantly from the arrangements made by counties. Nevertheless, although LSC cannot project the costs of the bill to these entities, we cannot rule out the possibility that the cost could be in the millions of dollars per year statewide.

The bill does not require an employer (i.e., state, counties, municipalities, and school districts) to assume any additional cost. Therefore, some (or all) of the increased costs could be passed on to the employee.

Indirect fiscal effects

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

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

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

LSC staff is not aware of any conclusive research about which of the above factors would have the greatest effect, and so LSC cannot predict whether the state's costs for covering an individual employee would be likely to increase or to decrease as a result of the combined effect of these indirect effects.

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