Ohio Legislative Service Commission

Ruhaiza Ridzwan

Fiscal Note & Local Impact Statement

Bill: Am. S.B. 99 of the 130th G.A. **Date**: May 23, 2014

Status: As Reported by House Health and Aging **Sponsor**: Sens. Oelslager and Tavares

Local Impact Statement Procedure Required: Yes

Contents: Insurance and Medicaid coverage for orally administered cancer medications

State Fiscal Highlights

- The bill may increase costs to the state of providing health benefits to its employees and their dependents. Officials at the Department of Administrative Services (DAS) are still analyzing the effects on state costs.
- The costs of state self-insured health benefits are paid out of the State Employee Health Benefit Fund (Fund 8080), of which somewhat less than half would be derived from GRF-supported payroll, with various state funds providing the rest.
- The bill exempts public employee benefit plans, like the state's, from its requirements if cost increases due to the requirements exceed 1% of health costs. The bill specifies procedures required to demonstrate this, which include a determination by the Superintendent of Insurance.
- The bill would increase the Department of Insurance's administrative expenses related to regulation and enforcement of requirements associated with coverage for cancer chemotherapy medications. Any such costs would be paid from the Department of Insurance Operating Fund (Fund 5540).
- The bill would increase Medicaid GRF spending by several thousand dollars annually.

Local Fiscal Highlights

- The requirement that the bill imposes on health insurers may increase insurance premiums of local governments' health benefit plans. Any increase in insurance premiums would increase costs to local governments to provide health benefits to employees and their dependents. Any such increase is unlikely to exceed $1 million per year statewide in total, for counties, municipalities, townships, and school districts. Any political subdivision that already provides the required benefit would experience no cost increase.

- The bill exempts public employee benefit plans and other health insurers from its requirements if cost increases related to the required coverage exceed 1% of the annual premiums or rates charged by local governments' health benefit plans.

Detailed Fiscal Analysis

Insurance coverage for orally administered cancer medications

The bill would prohibit health insurers that provide basic health care services or prescription drug services from: (1) providing coverage for or imposing cost sharing[1] for orally administered cancer chemotherapy treatments on a less favorable basis than coverage or cost sharing imposed for intravenously administered or injected cancer medications, or (2) imposing an increase in cost sharing solely for orally administered, intravenously administered, or injected cancer medications. The bill specifies that the prohibition does not preclude an insurer from requiring an enrollee to obtain prior authorization before orally administered cancer medication is dispensed to the enrollee. "Health insurers" in this bill include health insuring corporations (HICs), sickness and accident insurance policies for an individual or group, public employee benefit plans, and multiple employer welfare arrangements.[2] The bill applies to policies, contracts, agreements, or plans issued, delivered, renewed, established, or modified in Ohio on or after January 1, 2015.

The bill specifies that an insurer is deemed to be in compliance with the parity requirement, if the cost sharing imposed under its policy, contract, or agreement for orally administered cancer treatments does not exceed $100 per prescription fill. However, the bill does not specify the maximum quantity of oral cancer drugs (i.e., number of days supply) that must be dispensed for each prescription filled, relative to the cost sharing responsibility of up to $100.

Under the bill, an insurer is not required to comply with the chemotherapy treatments parity, if it is able to document, based on claims experience, that its costs increased by 1% or more due to the bill's requirements. The bill specifies a procedure for documenting such cost increases that includes a determination by the Superintendent of Insurance that the cost increase has been demonstrated by experience.

---

[1] The bill defines cost sharing as the cost to an individual insured according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement imposed by the policy, contract, or agreement.

[2] The bill specifies that the prohibitions do not apply to any individual or group policy of sickness and accident insurance that provides coverage for specific diseases or accidents only, or to any hospital indemnity, Medicare supplement, disability income, or other policy that offers only supplemental benefits.

Under current law, no mandated health benefits legislation enacted by the General Assembly may be applied to sickness and accident or other health benefits policies, contracts, plans, or other arrangements until the Superintendent of Insurance determines that the provision can be applied fully and equally in all respects to employee benefit plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA) and employee benefit plans established or modified by the state or any political subdivision of the state. The bill includes provisions that exempt its requirements from this restriction.

The bill specifies that the act be named the "Robert L. Schuler Act."

Fiscal effect

The bill would increase the Department of Insurance's administrative expenses related to regulation and enforcement of coverage for cancer chemotherapy medications. LSC staff believe that any increase in such expenditures would likely be minimal. Currently, the Department's administrative costs are paid from Fund 5540.

According to a Department of Administrative Services (DAS) official, the state's health benefit plans are currently providing coverage for a prescribed and orally administered cancer medication for cancer chemotherapy treatments. In addition, officials at DAS have expressed a concern that the bill would increase costs to the state, due to future cancer patients beginning to take a brand name version of a drug instead of a generic version. They attribute this result to the effective elimination of a cost incentive for patients to take the generic version. Department officials believe that it is not currently possible to attach a precise estimate to the increase in future costs but are still analyzing the effect on state costs.

Currently, the state administers a self-insured health benefits plan in which the state pays all benefit costs directly while contracting with private insurers to administer the benefits. The costs are paid from the Health Benefit Fund (Fund 8080). Fund 8080 receives funding through employee payroll deductions and state agency contributions toward their employees' health benefits.[3] Approximately half of the contributions come out of the GRF while various other state funds provide the rest. In FY 2013, state spending from Fund 8080 was $585.3 million.[4]

The requirement under the bill may increase insurance premiums for local governments' health benefit plans. Any increase in insurance premiums would increase costs to local governments to provide health benefits to employees and their dependents. If some of the local government plans already included both treatments, those plans would experience no fiscal impact of the requirement. LSC staff is unable to quantify the bill's fiscal impact on local governments due to lack of information on the

---

[3] Currently, full-time employees pay 15% of the premium cost, with state agencies paying the remainder. Part-time employees pay a larger percentage, dependent upon hours worked each week.

[4] Including expenditures related to dental and vision benefits.

specific benefits offered under their employee health benefit plans. Despite the uncertainties caused by data limitations, though, LSC staff consider it unlikely that the costs to local governments would exceed $1 million per year statewide. That figure is derived from an estimate for the state of California by the California Health Benefits Review Program (CHBRP), and is thereby dependent upon both the accuracy of the CHBRP estimate and on the validity of adjustments made to that estimate to arrive at a figure applicable to Ohio's public employers. Generally, orally administered cancer chemotherapy treatments are included under a prescription plan.

Due to the coverage exception under the bill, any increase in insurance costs that would be incurred by the plans due to the requirements under this bill would be limited to 1% per year.

Background information

According to data from the National Program of Cancer Registries,[5] in 2010 25,784 new cases of cancer were diagnosed and reported among Ohioans who are under 65 years old. Based on data derived from the Annual Social and Economic Supplement of the Current Population Survey (CPS), published by the U.S. Census Bureau, in 2012, approximately 58.4% of Ohioans received their health insurance coverage through their employers. In addition, according to U.S. Bureau of Labor Statistics (BLS) annual average nonagricultural employment data for Ohio in 2012, 1.1% of the Ohio nonfarm workforce was employed by state government, 4.7% was employed by local government, and 5.3% was employed in local government education. Using the number of cancer cases and the percentage of Ohioans that received their health insurance coverage through their employers as stated above, approximately 15,058 new cancer patients each year may be covered by an employer's health plan. Assuming 4.7% of those individuals were employed by local government, and 5.3% were employed in local government education, the estimated number of new cancer patients that may be covered under a county, municipality, or township health plan is approximately 708, and the number of cancer patients that may be covered by a school district-sponsored health plan is about 798. At a cost between $10 and hundreds of dollars for a 30-day supply of anticancer pills, the estimated costs to provide coverage for a prescribed oral anticancer medication for all new cancer patients covered by a local government's health benefit plan would likely be over $180,720 and could be up to tens of millions of dollars in each year statewide, depending on the type of anticancer drugs used and the number of people being treated for cancer. The requirement would shift some of the estimated cost from an insurance beneficiary to an insurer.

---

[5] Source: National Program of Cancer Registries: 1999 – 2010 Incidence, WONDER On-line Database, United States Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2013. Accessed at http://wonder.cdc.gov/cancernpcr.html on November 18, 2013.

In 2009, California enacted a law similar to S.B. 99.[6] According to a study conducted by the CHBRP dated April 17, 2009, the California bill would increase insurance premiums paid by both employers and employees by almost $19.7 million. The study concluded that the average portion of the premium paid by an employer would increase between $0.03 and $0.24 per member per month (PMPM), and the average portion of the premium paid by employees would increase between $0.01 and $0.04 PMPM.

Although the study was based on data for California, the estimates could be a good indicator of how much an insurance premium paid by both employers and employees in Ohio may increase if S.B. 99 were enacted. Based on the study, approximately 18.5 million Californians under age 65 were covered under an employer's health insurance plan in 2007. Using data from the U.S. Census Bureau, about 6.0 million people under age 65 were covered under an employer plan in Ohio in 2012. Adjusting the $19.7 million cost estimate for the difference in insured populations, the CHBRP estimate implies that the bill's requirement would raise costs for all Ohio employers by approximately $6.4 million per year. Based on their shares of Ohio employment in 2012, local government and school district employers would see cost increases of roughly $0.6 million of that $6.4 million. The accuracy of the $0.6 million figure depends on the accuracy of the CHBRP estimate and on a number of assumptions about the comparability of Ohio's and California's health care markets. Thus, the most that LSC staff can say about the bill's cost is that it is unlikely to increase costs for local governments statewide by more than $1 million per year.

Medicaid coverage for orally administered cancer medications

The bill requires that the Medicaid Program cover prescribed, orally administered cancer medications on at least the same basis as the coverage for intravenously administered or injected cancer medications. The bill also prohibits the Department of Medicaid from instituting cost sharing requirements for prescribed, orally administered cancer medications that are greater than any cost sharing requirements instituted for intravenously administered or injected cancer medications. The bill specifies that the Department is not precluded from requiring a Medicaid recipient to obtain prior authorization before a prescribed, orally administered cancer medication is dispensed to the recipient. The bill specifies that the Medicaid Program must not implement the coverage related to oral cancer medications during a fiscal year if the Medicaid Director determines that the implementation would cause the costs of the Medicaid Program's coverage of prescribed drugs to increase by more than 1% over such costs for the most recent previous fiscal year for which the amount of such costs is known.

[6] S.B. 161 for the 2009-2010 California State legislature.

Fiscal effect

According to an official at the Department of Medicaid, the bill would have a minimal fiscal impact to the Medicaid Program, approximately $3,000 per year for the Medicaid fee-for-service program and perhaps a similar amount for the Medicaid managed care program.

SB0099HR.docx / lb