Ohio Legislative Service Commission

Jim Ramey and other LSC staff

Fiscal Note & Local Impact Statement

Bill: H.B. 93 of the 129th G.A. **Date**: February 16, 2011

Status: As Introduced **Sponsor**: Reps. Burke and Johnson

Local Impact Statement Procedure Required: No

Contents: Establishes and modifies the laws regarding the prevention of prescription drug abuse, development of information programs by the State Medical Board, and Medicaid coverage of prescription drugs

State Fiscal Highlights

- **Prescription drug carve-in to Medicaid managed care.** LSC staff estimates that including coverage of prescription drugs in Medicaid managed care could result in potential net savings of between $19.8 million to $41.7 million in FY 2012 and $51.0 million to $92.5 million in FY 2013. Including coverage of prescription drugs in Medicaid managed care would affect program costs, state and local tax revenue, federal Medicaid reimbursement, and drug rebates. Net savings to the state in future years could vary based on the amount of actual savings managed care organizations (MCOs) are able to achieve. Including coverage of prescription drugs in Medicaid managed care would impact the GRF, the Health Care Federal Fund (Fund 3F00), and the Prescription Drug Rebate Fund (Fund 5P50).
- **Pain management clinics and the Ohio Automated Rx Reporting System (OARRS)**. The State Board of Pharmacy will gain a minimal annual amount from the licensing of pain management clinics and likely experience significant one-time costs related to modifying OARRS, up to several hundreds of thousands of dollars. The Board will also experience an ongoing increase in expenses related to licensing and overseeing additional terminal distributors of dangerous drugs, and enforcing new criminal prohibitions. Additional staff will likely be needed to perform these duties and responsibilities. The licensing revenues would be credited to, and the expenditures charged against, the Occupational Licensing and Regulatory Fund (Fund 4K90). The bill also allows the Board to accept grants, gifts, or donations to operate the database, and establishes the Drug Database Fund for this purpose.
- **Enforcement of terminal distributors.** GRF-funded annual incarceration costs may increase as additional felony offenders could be convicted and sentenced to prison. The state may gain a minimal amount of locally collected state court cost revenues that would be divided between the Indigent Defense Support Fund (Fund 5DY0) and the Victims of Crime/Reparations Fund (Fund 4020).

- **Drug Take-Back Program.** The State Board of Pharmacy, the Attorney General, and the Department of Alcohol and Drug Addiction Services would likely experience an increase in expenditures to operate the Drug Take-Back Program.
- **Criminal records checks**. The Attorney General's Bureau of Criminal Identification and Investigation would likely experience an increase in the number of requests for criminal background checks. Presumably the revenues generated will offset any expenditures incurred. The revenues would be credited to, and the expenditures charged against, the General Reimbursement Fund (Fund 1060).
- **Standards for physicians regarding pain management.** The State Medical Board would experience a one-time increase in costs to adopt rules specified under the bill and ongoing costs to summarily suspend licenses in accordance with the bill. The Board may also experience a gain in fine revenue for violations of the rules of operation or standards for pain management clinics. Operating expenditures of the Board are paid from, and fine revenue is deposited into, the State Medical Board Operating Fund (Fund 5C60). The bill also establishes the Education and Patient Safety Fund, which is to consist of grants solicited and accepted by the Board. Expenditures from the fund will be limited to the amount of grants deposited into the fund.

Local Fiscal Highlights

- **Prescription drug carve-in to Medicaid managed care.** Counties would gain new revenue from the local sales tax. Counties, along with public libraries, would further gain revenue from a small portion of the state sales tax and the Health Insuring Corporation tax receipts that are deposited in the Local Government Fund and the Public Libraries Fund. Total tax revenues to counties and public libraries are estimated at $7.4 million to $9.3 million in FY 2012 and $15.4 million to $19.2 million in FY 2013. Tax revenue to counties and public libraries in future years could vary based on the amount of actual savings MCOs are able to achieve.
- **Enforcement and criminal investigations of terminal distributors and misuse of OARRS.** As a result of violations of the bill's prohibited conduct, additional misdemeanor and felony criminal cases may be generated for county and municipal criminal justice systems to process, potentially increasing the costs to investigate, prosecute, adjudicate, and sanction violators. The court would generally impose court costs and fines to be paid by violators.

Detailed Fiscal Analysis

Prescription drug carve-in to Medicaid managed care

The bill requires the Medicaid managed care system to include coverage of prescription drugs, including drugs prescribed for mental illness. LSC staff estimates that including coverage of prescription drugs in Medicaid managed care could result in potential net savings of $19.8 million to $41.7 million in FY 2012[1] and $51.0 million to $92.5 million in FY 2013.

In addition, counties would gain new revenue from the local sales tax. Counties, along with public libraries, would further gain revenue from a small portion of the state sales tax and the Health Insuring Corporation (HIC) tax receipts that are deposited in the Local Government Fund and the Public Libraries Fund. Total tax revenues to counties and public libraries are estimated at $7.4 million to $9.3 million in FY 2012 and $15.4 million to $19.2 million in FY 2013. In future years, the managed care capitated rates will be based on actual costs submitted to the state actuary by the managed care organization (MCOs). Therefore, future savings to the state could vary based on the amount of actual savings MCOs are able to achieve.

Assumptions

This analysis is based on a number of assumptions. The bill requires that mandatory coverage of prescription drugs be included in contracts between the Ohio Department of Job and Family Services (ODJFS) and MCOs not later than one year after the implementation date of the bill. State contracts with MCOs are renewed on a fiscal year basis; managed care rates are set on a calendar year basis. Before the contracts can be amended, the state must receive approval from the federal Centers for Medicare and Medicaid Services and consumers must be notified of the change. As such, LSC staff assumes that ODJFS would likely amend the current managed care contracts to include prescription drug coverage and adjust the capitated rate payments beginning on January 1, 2012. Therefore, cost savings estimates provided are for the second half of FY 2012 (January through June 2012) and all of FY 2013.

All estimates are based on a calculated FY 2011 fee-for-service prescription drug cost of $1.15 billion for the Medicaid managed care population.[2] The assumed federal Medicaid reimbursement rate is 64% for FY 2012 and FY 2013. LSC staff assumed a total tax rate of 7.7% (5.5% state sales tax, 1.2% average local sales tax, and 1.0% HIC tax). This analysis assumes the state would receive the same federal drug rebate

[1] Estimates for FY 2012 assume managed care prescription drug coverage would begin on January 1, 2012 for the second half of FY 2012 (January through June 2012).

[2] FY 2011 estimated costs were calculated by summing March through September 2010 prescription drug carve-out disbursements, and then dividing by 0.58333 to annualize the costs (i.e., $671.2 million ÷ 0.58333 = $1.15 billion).

percentage, assumed to be 35%, as it does under fee-for-service.[3] The state supplemental drug rebate, which would be retained by the state, is assumed to be 2.5% and the manufacturer rebate, sent directly to MCOs, is assumed to be 2.5%.[4] In addition, it is assumed that the state would continue to receive supplemental rebates under managed care.

LSC staff assumes a range of cost savings of 0% to 20% as compared to fee-for-service. According to an October 8, 2010 ODJFS Medicaid Cost Management report, as a result of the carve-out of prescription drugs on February 1, 2010, the state saved about $15.6 million during the first quarter of FY 2011. This implies that carving-out prescription drugs from managed care has reduced costs. Conversely, according to an October 13, 2010 Wakely Consulting Group analysis done for the Ohio Association of Health Plans, managed care could achieve a 19.35% cost savings over fee-for-service for the managed care eligible population. Given this differing information, LSC staff presents scenarios that assume no cost savings, 10% cost savings, and 20% cost savings.

Summary of potential savings

Tables 1 and 2 below show costs under fee-for-service and managed care, the impact of managed care on revenues, and potential cost savings of managed care for prescription drugs for FY 2012 and FY 2013, respectively.

Table 1. FY 2012 (January through June 2012)
Estimated Costs and Revenues for Medicaid Rx Drug Carve-In (in millions)

Assumed Cost Savings Provided by MCOs:	**0%**	**10%**	**20%**
Baseline – Estimated FFS FY 2011 Rx Drug Cost	$575.0	$575.0	$575.0
Costs			
Adjusted Drug Cost to Reflect MC Savings	$575.0	$517.5	$460.0
Manufacturer Rebates (Direct to MCOs)	($14.4)	($12.9)	($11.5)
Cost of Taxes	$46.8	$42.1	$37.4
Managed Care (Adj. Drug Cost – Mfg. Rebates + Tax)	**$607.4**	**$546.7**	**$485.9**
Cost Difference (Baseline FFS – MC)	**($32.4)**	**$28.3**	**$89.1**
Revenues			
Loss of Federal Rebates (to State)	$0	($7.2)	($14.5)
Loss of State Supplemental Rebates (to State)	$0	($0.5)	($1.0)
Loss of FFP from Cost Savings and Mfg. Rebates	($9.2)	($45.1)	($81.0)
Gain of State Tax Revenue	$31.5	$28.3	$25.2
Gain of FFP from Taxes	$29.9	$26.9	$23.9
Total Revenues	**$52.2**	**$2.4**	**($47.4)**
Potential Savings of Managed Care	**$19.8**	**$30.7**	**$41.7**

[3] A September 28, 2010 letter from the federal Centers for Medicare and Medicaid Services clarified that the state could receive the same federal prescription drug rebates for individuals enrolled in managed care plans as it could for individuals enrolled in fee-for-service. This change resulted from a provision of the Affordable Care Act of 2010. https://www.cms.gov/smdl/downloads/SMD10019.pdf.

[4] Wakely Consulting Group analysis for the Ohio Association of Health Plans, October 13, 2010.

Table 2. FY 2013 Estimated Costs and Revenues for Medicaid Rx Drug Carve-In (in millions)			
Assumed Cost Savings Provided by MCOs:	**0%**	**10%**	**20%**
Baseline − Estimated FFS FY 2011 Rx Drug Cost	$1,150.0	$1,150.0	$1,150.0
Costs			
Adjusted Drug Cost to Reflect MC Savings	$1,150.0	$1,035.0	$920.0
Manufacturer Rebates (Direct to MCOs)	($28.7)	($25.9)	($23.0)
Cost of Taxes	$93.5	$84.2	$74.8
Managed Care (Adj. Drug Cost – Mfg. Rebates + Tax)	$1,214.8	$1,093.3	$971.8
Cost Difference (Baseline FFS – MC)	**($64.8)**	**$56.7**	**$178.2**
Revenues			
Loss of Federal Rebates (to State)	$0	($14.5)	($29.0)
Loss of State Supplemental Rebates (to State)	$0	($1.0)	($2.0)
Loss of FFP from Cost Savings and Mfg. Rebates	($18.4)	($90.2)	($161.9)
Gain of State Tax Revenue	$74.3	$66.9	$59.4
Gain of FFP from Taxes	$59.9	$53.9	$47.9
Total Revenues	**$115.8**	**$15.1**	**($85.6)**
Potential Savings of Managed Care	**$51.0**	**$71.8**	**$92.5**

As shown in the tables above, the potential savings vary depending on the amount of cost savings managed care can achieve. However, as a result of the state recovering most of the tax costs through the gain of new tax revenue and the gain in federal Medicaid reimbursement, including prescription drugs in managed care would produce net cost savings even if managed care is unable to achieve prescription drug and administrative cost savings over fee-for-service.

Costs

Under current law, MCOs must pay state and local sales tax, as well as the HIC tax, on Medicaid payments received from the state. The state compensates MCOs for the cost of the taxes by including the cost in the monthly capitated rate. The tax cost is considered an allowable cost under the Medicaid Program and is therefore eligible to earn federal Medicaid reimbursement. Under the bill, the capitated rate paid to MCOs would be adjusted to include both the cost of providing prescription drugs through managed care and the cost of the taxes to be paid.

LSC staff assumes MCOs would be able to collect 2.5% of the total prescription drugs cost in rebates directly from drug manufacturers and the state contracted actuary would subtract this 2.5% manufacturer rebate from the amount to be included in the capitated rate. As such, the manufacturer rebate amount is expressed as a negative number (i.e., a decrease in costs) in the tables above.

As shown in the tables above, under the no cost savings scenario, managed care costs more than fee-for-service by about $32.4 million in FY 2012 and $64.8 million in FY 2013, because of the added cost of the tax. However, if managed care is able to achieve cost savings (greater than the total tax rate), the cost of providing prescription

drugs under managed care would be less than providing prescription drugs under fee-for-service by $28.3 million to $89.1 million in FY 2012 and $56.7 million to $178.2 million in FY 2013, depending on the rate of savings.

Revenues

Under the bill, the state would receive tax revenue from the MCOs and federal Medicaid reimbursement on the cost of the taxes, as described above. Once the program is fully implemented, about 81% of the tax revenue would be retained by the state, and about 19% would be disbursed to counties and local libraries. Furthermore, the cost of the tax included in the capitated rate would be eligible for federal Medicaid reimbursement. Thus, state revenue in the form of federal Medicaid reimbursement would increase under the bill. LSC staff estimates that the state would collect $49.1 million to $61.4 million in both tax revenue and federal Medicaid reimbursement in FY 2012 and $107.3 million to $134.2 million in FY 2013.

However, to the extent that MCOs are able to achieve cost savings on the provision of prescription drug, the state would lose some revenue in the form of federal Medicaid reimbursement.[5] If MCOs achieve 10% to 20% cost savings, the state would lose between $45.1 million and $81.0 million in federal Medicaid reimbursement in FY 2012, and between $90.2 million and $161.9 million in FY 2013.

Counties and public libraries would gain new revenue if prescription drugs were covered by MCOs. Collectively, counties and public libraries would gain $7.4 million to $9.3 million in FY 2012 and $15.4 million to $19.2 million in FY 2013. When the state collects taxes from the MCOs, it deposits most of the state sales and HIC tax receipts into the GRF. A small portion (5.9%) of the state sales and HIC tax revenues are diverted to the Local Government Fund (3.68%) and the Public Libraries Fund (2.22%), and then disbursed to counties and public libraries. Counties receive the local sales tax revenue based on the residence of Medicaid clients covered by the MCOs. Additionally, because the HIC tax is paid on a fiscal year basis, but collected each March for the preceding calendar year, there will be a slight lag in HIC tax collection.

Drug rebates

Ohio currently receives two types of drug rebates under Medicaid: rebates under federal law and state supplemental rebates under state law. Federal law requires that pharmaceutical manufacturers enter into rebate agreements with the federal government in order for their products to be eligible for outpatient drug coverage by state Medicaid programs. The federal rebates and state supplemental rebates are separate from the manufacturer rebates that go directly to MCOs.

---

[5] Under the no cost savings scenario, the state would lose some federal Medicaid reimbursement due to the decreased cost of managed care that results from manufacturer rebates that go directly to MCOs; LSC staff estimates the state could lose about $9.2 million in FY 2012 and about $18.4 million in FY 2013.

If MCOs are able to achieve cost savings under the bill, the state would lose some federal drug rebate revenue and state supplemental drug rebate revenue. If MCOs are able to achieve 10% or 20% savings, LSC staff estimates the state would lose $7.7 million to $15.5 million in combined federal drug rebate and state supplemental rebate revenue in FY 2012 and $15.5 million to $31.0 million in FY 2013.

Coordinated Services Program

Currently, ODJFS has a program that identifies individuals who overuse pharmacy benefits. The bill requires MCOs to establish a coordinated services program (also referred to as Lock-in) under which a Medicaid recipient who overuses the prescription drug benefit is required to use a single pharmacy. If the program established under the bill results in an increase in the number of individuals identified as overusing pharmacy benefits, additional program savings could be achieved. If the program created by the bill essentially codifies existing practice, there would be no fiscal impact.

Pain management and controlled substances

Licensure of pain management clinics

The bill requires the State Board of Pharmacy to license pain management clinics[6] as terminal distributors of dangerous drugs subject to the same requirements as other terminal distributors[7] of dangerous drugs and establishes a "pain management clinic" classification within that licensing category. The number of new licenses that will be issued annually will likely be minimal. The fee for a new license is $150 per year. Some current holders of terminal distributor licenses will likely have their licenses converted to the new classification. There would be no charge for these reclassifications. Annual licensing fees would be deposited to the credit of the Occupational Licensing and Regulatory Fund (Fund 4K90).

Enforcement and criminal investigations of terminal distributors

As a result of requiring pain management clinics to obtain a terminal distributor license, the Board will likely incur some additional expenses related to the deliberation and issuance of such licenses, oversight of compliance with state law and administrative rules, and future criminal investigations if cases are brought to the Board's attention. Such investigations may be costly, with a recent case reaching $400,000 to adjudicate, according to Board representatives.

---

[6] Pain management clinics are facilities in which the treatment of pain is the primary component of practice and the majority of chronic pain patients are treated with narcotics or tramadol. This definition of pain management clinic does not include certain hospitals, certain medical or dental schools, and licensed hospice programs.

[7] "Terminal distributor of dangerous drugs" means a person who is engaged in the sale of dangerous drugs at retail, or any person, other than a wholesale distributor or a pharmacist, who has possession, custody, or control of dangerous drugs for any purpose other than for that person's own use and consumption.

Penalties for violating any of the provisions related to licensed terminal distributors as well as operating a pain management clinic without a license will range from a misdemeanor of the first degree (punishable by up to six months in jail and a maximum fine of $1,000) to a felony of the third degree (punishable by 1, 2, 3, 4, or 5 years in prison and a maximum fine of $10,000). In some of these cases, multiple charges could be stacked against an individual. There will likely be a number of successful prosecutions related to violations of the bill's prohibited conduct. As such, some individuals could be sentenced to a term of incarceration in a local jail or in state prison. Dependent upon the number of successful prosecutions, the state could realize a gain in court cost revenues for the Indigent Defense Support Fund (Fund 5DY0) and the Victims of Crime/Reparations Fund (Fund 4020). In certain criminal investigations, the lead investigating law enforcement agency may retain a portion of the fine revenue.

The bill also authorizes the State Board of Pharmacy to impose administrative fines of no more than $5,000 for two types of violations as follows:

- If a person is found to be operating a facility that is required to be licensed as a pain management clinic and has failed to do so, or if currently licensed, has failed to remain in compliance with that license, that individual could be subject to a fine of no more than $5,000 per incident; and
- The Board may impose a no more than $5,000 fine, per incident, on prescribers who do either of the following: (a) in any 30-day period, personally furnish an amount of all controlled substances combined that exceeds a total of 2,500 dosage units, or (b) in any 24-hour period, personally furnish to or for a patient an amount of a controlled substance that exceeds the amount necessary for the patient's use in that time period.

Any fine revenue would be deposited to the credit of the Occupational Licensing and Regulatory Fund (Fund 4K90).

Drug Take-Back Program

The bill requires the State Board of Pharmacy, in conjunction with the Attorney General and Department of Alcohol and Drug Addiction Services, to develop a program under which drugs are collected from the community for destruction or disposal. The bill specifies that the costs of the program are to be equally divided among the participating agencies and authorizes the participating agencies to obtain grants to fund the program. Costs to operate the program would likely include personnel, advertising, and disposal.

Ohio Automated Rx Reporting System (OARRS)

System modifications

The bill modifies the operation of OARRS[8] and establishes criminal penalties for failing to comply with certain requirements of the system. In addition to these changes, the bill allows the State Board of Pharmacy to accept grants, gifts, or donations to operate the database, and establishes the Drug Database Fund for this purpose.

The bill requires the Board to consider improvements to Ohio's method of monitoring the misuse and diversion of controlled substances through OARRS. The Board is to submit a report not later than six months after the bill's effective date.

These modifications and expansions will require the Board to make hardware and software updates to the existing database. These one-time costs, as well as those associated with new programming, could be several hundreds of thousands of dollars. The Board also anticipates that additional staff would be required to help assist in the increased workload.

Criminal prohibitions

The bill establishes several criminal prohibitions and penalties for the misuse of the information contained within OARRS. The number of possible criminal cases that could be generated annually would likely be small. Therefore, any related fiscal effect on local criminal justice systems would be minimal at most. Dependent upon the number of successful prosecutions, the state could realize a gain in court cost revenues generated annually to the credit of the Indigent Defense Support Fund (Fund 5DY0) and the Victims of Crime/Reparations Fund (Fund 4020).

Criminal records checks

The bill requires that all employees of pain management clinics seeking licensure submit to a criminal records check. No employee may have been previously convicted of, or pleaded guilty to, any felony in this state or another state. The Attorney General's Bureau of Criminal Identification and Investigation charges $22 to perform a state criminal records check and an additional $24 to obtain information from the FBI to perform a federal criminal records check. Presumably, these charges would offset the cost of performing the background checks required by the bill. The revenue would be deposited to the credit of the General Reimbursement Fund (Fund 1060). Presumably the revenues generated will offset any expenditures incurred.

[8] OARRS was first authorized by Sub. H.B. 377 of the 125th General Assembly. The Act, which became effective May 2005, permitted the Board to establish and maintain an electronic database to monitor the misuse and diversion of controlled substances and certain dangerous drugs. The program began full operation in October 2006.

Standards for physicians regarding pain management

The bill requires the State Medical Board to adopt rules regarding all of the following:

- Standards for physician operation of pain management clinics and standards to be followed by physicians who provide care in such clinics;
- Physician review of OARRS; and
- Physician treatment and diagnosis of patients with "chronic pain" (currently "intractable pain" in Medical Board rules).

The rule-making process would increase expenditures for the Medical Board. The Board's staff would consult with and compensate physicians acting as clinical advisors in developing the rules. The Board would also have to pay a court reporter to document the public hearing prior to the rules being adopted.

Summary suspension of medical licenses

The Medical Board currently has summary suspension authority, and the bill extends this authority to physicians who hold a terminal distributor license with a pain management classification. The Board may incur additional costs due to the larger pool of licenses subject to suspension. The bill authorizes the Board to hold a telephone conference call with at least six members present to vote on the suspension of the medical license. Members would be compensated at the usual per diem rate of $157.50 to $204.96 for telephone conference calls.

Fines

The Board is authorized to impose fines of up to $20,000 on any physician who fails to comply with the rules of operation or standards for pain management clinics. Fine revenue is to be deposited into the State Medical Board Operating Fund (Fund 5C60).

Medical Board Education and Patient Safety Fund

The bill creates the Medical Board Education and Patient Safety Fund, which is to be used to develop and maintain programs that address patient safety and education, supply and demand of healthcare professionals, and information sharing with the public and individuals regulated by the Board. Fund revenue will consist of grants solicited and accepted by the Board from public and private sources. Expenditures would be limited to amounts deposited into the fund.