OHIO LEGISLATIVE SERVICE COMMISSION

www.lsc.ohio.gov

Office of Research and Drafting

Legislative Budget Office

H.B. 177
135th General Assembly

Fiscal Note & Local Impact Statement

Click here for H.B. 177's Bill Analysis

Version: As Reported by House Public Health Policy

Primary Sponsor: Rep. Manchester

Local Impact Statement Procedure Required: No

Ruhaiza Ridzwan, Senior Economist, and other LBO staff

Highlights

- The bill may minimally increase administrative costs for the Department of Insurance to monitor health insurers' and pharmacy benefit managers' compliance with the bill's requirements. Any increase in such costs would be paid from the Department of Insurance Operating Fund (Fund 5540).
- The bill's requirements governing pharmacy benefit managers (PBMs) would likely result in a minimal increase in costs to the state to provide health benefits to employees and their dependents. Such costs are paid out of the Health Benefit Fund (Fund 8080), which receives transfers from the GRF and other state funds. There may also be a minimal increase in costs for the Medicaid Program, which contracts with a PBM that may be required to comply with the requirements. In both cases, LBO would classify the fiscal effects as indirect, as they depend on a manager passing through its cost increases in its contract with the state.
- Similarly, some local governments may experience an increase, likely minimal, in costs to provide health benefits to employees and their dependents. Any such increase may be direct or indirect for a particular local government, depending on whether it is self-insured or purchases a health insurance policy, and in either case whether a PBM is involved.

Detailed Analysis

The bill requires a health insurer to include all amounts paid by an insured person and on behalf of the insured person when calculating that person's contribution to any applicable cost-sharing requirement for a prescription drug. Examples of payments made on behalf of an insured person are manufacturer coupons and financial assistance. The bill specifies that the

requirement does not apply to cost sharing paid on behalf of an enrollee by another person, group, or organization for a brand prescription drug that has a medically appropriate generic equivalent,[1] unless the prescriber determines that the brand prescription drug is medically necessary.[2]

The bill's requirements apply to health benefit plans that are delivered, issued for delivery, modified, or renewed on or after January 1, 2025, by health insuring corporations (HICs) and sickness and accident insurers. The requirement applies also to a pharmacy benefit manager (PBM) that has a contract with a health insurer, managed care organization, employer, or other third party, to manage, either directly or indirectly, the entity's prescription drug benefit.

Under the bill's definition of a pharmacy benefit manager, it is likely that the single PBM which was selected by the Ohio Department of Medicaid (ODM), would be required to comply with the PBM components of the bill.

Fiscal effect

The bill's requirements may minimally increase administrative costs for the Department of Insurance, as the Department would have to monitor compliance by health insurers and PBMs. Any increase in such costs would be paid from the Department of Insurance Operating Fund (Fund 5540). Revenue to Fund 5540 is from various fees paid by insurance companies, primarily fees paid for appointing insurance agents.

The state health benefit plan uses a PBM for the prescription drug benefit under the plan and a Department of Administrative Services official reports that the PBM does not currently count manufacturer coupons toward a member's out-of-pocket maximum. So there would be a reduction in cost-sharing payments to the PBM under the bill, which would likely minimally increase the cost to the state of providing health benefits to employees and their dependents. Because the cost increase depends on whether the PBM cost increase is passed through to the state via contract, LBO would classify such a cost increase as indirect. Any increase in cost to the state plan would be paid from the Health Benefit Fund (Fund 8080). Fund 8080 receives funding through state employee payroll deductions and state agency contributions toward their employees' health benefits, which come out of the GRF and various other state funds.

[1] "Generic equivalent" means a drug that is designated to be therapeutically equivalent, as indicated by the U.S. Food and Drug Administration's publication *Approved Drug Products with Therapeutic Equivalence Evaluations*.

[2] The bill specifies that its requirements are not to be construed as requiring health insuring corporations, sickness and accident insurers, or pharmacy benefit managers to provide coverage for a prescription drug that is not included in the formulary or list of prescription drugs covered under the pharmaceutical or medical benefit being provided to a covered person under the plan. In addition, such insurers are not to be considered to violate the bill's requirements solely for removing a prescription drug from the formulary list if the removal would not violate any other existing state or federal laws or administrative rules. If, under federal law, application of the bill's cost-sharing requirement would result in an enrollee's health savings account (HSA) ineligibility for the purpose of federal income tax deduction for contributions, then such requirement applies only for HSA-qualified high deductible health plans (HDHPs) with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible.

Similarly, ODM may experience indirect fiscal effects from the bill, as the bill's requirements are likely to increase costs to ODM's single PBM, which in the long term may increase costs to ODM. Copay amounts for prescription drugs paid by Medicaid recipients are typically $2 per prescription refill for most brand name (nongeneric) medications and $3 per prescription or refill for medications for which a prior authorization is required. ODM also will not charge copays for Medicaid recipients who meet one of several exemption criteria, including being pregnant, being under the age of 21, or receiving the prescription as part of emergency services.

Similarly, local governments and school districts may also experience increases in costs to provide health benefits to employees and their dependents. Any local governments whose plans already comply with the bill's requirements would not experience such an increase in costs. LBO does not have information on the detailed provisions of local government health benefit plans, and so cannot quantify the effect on local government costs, but LBO staff believe that it is likely minimal, if there is an effect on costs. Whether a cost increase is a direct or indirect fiscal effect would depend on the specifics of a political subdivision's health benefit plan, i.e., whether it is self-insured, or uses an insurance policy, and whether a PBM is involved.

FNHB0177RH-135/lb