Ohio Legislative Service Commission

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Fiscal Note & Local Impact Statement

Bill: S.B. 135 of the 131st G.A. **Date**: November 25, 2015

Status: As Introduced **Sponsor**: Sens. Cafaro and Jones

Local Impact Statement Procedure Required: Yes

Contents: To limit the out-of-pocket cost to an individual covered by a health plan for drugs used to treat rare diseases and complex or chronic medical conditions

State Fiscal Highlights

- The bill would increase costs to the state of providing health benefits to its employees and their dependents. However, the magnitude of the fiscal impact is undetermined. The costs of such benefits are paid out of the State Employee Health Benefit Fund (Fund 8080). Fund 8080 is funded by employer contributions derived from GRF and various state funds and state employee payroll deductions.

Local Fiscal Highlights

- The requirements under this bill would increase costs to local governments to provide health benefits to employees and their dependents. However, the magnitude of the fiscal impact is undetermined. Any local government that already provides the required benefit would experience no cost increase.

Detailed Fiscal Analysis

The bill would prohibit health insurers that provide prescription drug services from imposing cost sharing of more than $150 for a one-month supply of specialty drugs. It would prohibit health insurers from placing all drugs in a given class on a specialty tier. The bill also requires health insurers to establish a process by which a covered individual may request that a specialty drug that is not listed on a preferred drug formulary may be covered and subject to cost-sharing requirements as if it were listed on the formulary. The bill specifies that the denial of such a request must be treated as an adverse benefit determination, subject to internal appeal and external review under existing law, Chapter 3922. of the Revised Code.

The bill defines a "specialty drug" as a prescription drug that meets all of the following: (1) the drug is prescribed for an individual with a complex or chronic medical condition or a rare medical condition, (2) the drug costs $600 or more for up to a 30-day supply, (3) the drug is not typically stocked at retail pharmacies, and (4) the drug has at least one of the following characteristics: (a) it requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug or (b) it requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug. "Specialty drug tier" is defined as a tier of a preferred drug formulary that imposes cost-sharing requirements for specialty drugs that are higher than for nonspecialty drugs. The bill specifies that health insurers, for these purposes, include health insuring corporations, sickness and accident insurers, multiple welfare arrangements, and public employee benefit plans.

The bill provides that its requirements related to specialty drugs are not intended to require health insurers (1) to provide coverage for any additional drugs, (2) to implement specific utilization management techniques, such as prior authorization or step therapy, (3) to stop the use of any cost-sharing requirements, policies, or procedures that are not otherwise prohibited under this bill or existing law, including those strategies used to incentivize the use of preventative services, disease management, and low-cost treatment options.

The bill includes provisions that exempt the current requirement that the Superintendent of Insurance must determine that the mandated provision under the bill 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. 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 makes such determination.

Fiscal effect

The bill may minimally increase the Department of Insurance's administrative costs related to internal appeal and external review requirements. Any such increase would be paid from the Department of Insurance Operating Fund (Fund 5540).

The bill would increase costs to the state health benefit plan. However, LSC staff could not determine the magnitude of the fiscal impact due to lack of information on the number of individuals that have been diagnosed with a rare disease, or a complex or chronic medical condition, and who are covered under the state plan. Any increase in costs would be paid from the Health Benefit Fund (Fund 8080), used by the Department of Administrative Services (DAS). 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] A DAS official confirmed the opinion of LSC staff that the bill would increase these costs, but was also unable to quantify the increase.

The bill's requirements would also increase costs to local governments to provide health benefits to employees and their dependents, though any political subdivision that already complies with the bill's requirements would experience no cost increase. LSC staff is not able to estimate the magnitude of the bill's fiscal impact on local governments due to data limitations on specific prescription benefits provided by local governments' health benefits plans and the number of individuals who have been diagnosed with a rare disease, or a complex or chronic medical condition, and who are covered under the plans.

Background information

According to *Frequently Asked Questions*, published on the Genetic and Rare Diseases Information Center of the National Institutes of Health, there are over 6,800 rare diseases in the United States.[2] In addition, the U.S. Food and Drug Administration (FDA) has approved more than 340 treatments for rare diseases. The bill does not define "complex or chronic medical conditions," and LSC does not have an estimate of the number of individuals covered by the state health plan or a local health plan who might have such conditions.

The bill's requirements clearly indicate that a health plan must pick up at least $450 per month of cost for any patient that did fit either category, where $450 equals $600 (the minimum cost to qualify as a specialty drug) minus $150 (the maximum amount that the bill allows the patient to be charged). Thus, for any individual patient, the cost to the employer, in the case of self-insured plans, or the employer's insurer

[1] Currently, full-time state employees pay 15% of the premium cost, while state agencies pay the remaining amount.

[2] The publication is posted at https://rarediseases.info.nih.gov/about-gard/pages/31/frequently-asked-questions.

would be a minimum of $5,400 annually, assuming a full year of treatment, and could be considerably more because the $600 is just a minimum cost.

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