Ohio Legislative Service Commission

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Fiscal Note & Local Impact Statement

Bill: H.B. 157 of the 131st G.A.

Date: May 8, 2015

Status: As Introduced

Sponsor: Reps. Butler and T. Johnson

Local Impact Statement Procedure Required: Yes

Contents: To revise the laws governing health insurance coverage, medical malpractice claims, the Medicaid Program, health care provider discipline, and required and permitted health care provider disclosures; and to create the Nonstandard Multiple Employer Welfare Arrangement

State Fiscal Highlights

Department of Medicaid

- **Agreement with the United States Secretary of Health and Human Services**. The Ohio Department of Medicaid (ODM) would be required to request the United States Secretary of Health and Human Services to enter into an enforceable agreement regarding certain provisions within the bill. Certain provisions are not to be implemented or would not apply to Medicaid recipients unless this agreement was in effect; thus, some of the costs and savings outlined in the Fiscal Note would depend on this agreement.
- **Healthy Ohio Program**. The establishment of a Healthy Ohio Program and the associated Buckeye accounts would likely be operated under a Medicaid waiver. While the program could produce savings from a decrease in utilization by program participants due to cost sharing, the cost of the provision requiring health professional services provided under the program to be reimbursed at the Medicare rate would lead to costs that would outweigh the potential savings. There would also be some start-up and administrative costs for the program.
- **Emergency room diversion**. The bill requires each operator of an emergency department to designate a space within or adjacent to the emergency department, where services may be provided 24 hours a day, seven days a week, to patients who have a nonemergency condition or to authorize a federally qualified health center (FQHC) to operate in the same manner in a space within the hospital or adjacent to the hospital. However, if emergency room usage was reduced, there would be savings to the Medicaid Program.
- **Nonemergency services**. Prior to dispensing a prescription or providing a medical product or service, health care providers are required to provide information to the patient about certain charges and out-of-pocket expenses. If a

Medicaid recipient has access to price information prior to receiving a drug, medical product, or service, the patient could choose the best and lowest price or could choose to forego the prescription, medical product, or service altogether. As a result, this could reduce state Medicaid costs for those prescriptions, products, or services for which the price is readily available.

- **Hospital outpatient services**. Payment rates for hospital outpatient services that may also be provided by a noninstitutional provider cannot exceed the rate charged by the noninstitutional provider by more than 10%. As a result, the Medicaid Program could experience some savings if payments for hospital outpatient services currently exceed the limits established in the bill.
- **Nursing facility value-based purchasing payment**. ODM is required to reduce a portion of nursing facilities' Medicaid rates by specified amounts and these funds will be used to pay for a value-based purchasing payment. There could be reduction in nursing facility costs if the program incentivizes greater care and/or efficiencies.
- **Nursing facility costs**. If a Medicaid recipient receiving nursing facility services has resided in this state for less than one year, ODM must seek to have the state in which the recipient resided immediately before coming to this state pay for the services. Thus, ODM would experience an increase in Medicaid administrative costs and a potential reduction in nursing facility service costs.
- **Regional hospital networks**. A regional network consisting of hospitals is authorized to serve as a Medicaid Managed Care Organization (MCO) if it accepts a capitated payment from ODM that is not more than 90% of the lowest capitated payment made to a Medicaid MCO that is a health insuring corporation.
- **Hospital value-based purchasing program**. Medicaid MCOs are required to implement a hospital value-based purchasing program. The amount to be used as incentive is to equal the amount of savings due to reductions for participating hospitals' base operating Diagnosis-Related Group payments. There could be reduction in hospital costs if the program incentivizes greater care and/or efficiencies.
- **Medicaid Managed Care Performance Payment Program**. The bill revises the Medicaid Managed Care Performance Payment Program by, among other things, requiring, instead of permitting, payments to Medicaid MCOs and increasing the percentage withheld for premium payments. There could be reduction in costs if the program incentivizes greater care and/or efficiencies.
- **Medicaid MCOs' shared saving bonus**. ODM is required to pay a Medicaid MCO a shared saving bonus if its three-year average per recipient capitated payment rate is less than the three-year average per recipient cost to the Medicaid programs in Illinois, Indiana, Michigan, Ohio, Pennsylvania, and West Virginia for the populations served by the Ohio Medicaid managed care

program. There could be reduction in Medicaid costs if the program incentivizes greater care and/or efficiencies.

- **Medicaid Donations Fund**. The Medicaid Donations Fund is created whereby grants and donations, to help fund certain Medicaid payments, services, and coverage, are to be deposited.
- **Medicaid managed care service coordination pilot program**. A two-year pilot program is established whereby a Medicaid MCO(s) would be selected to help coordinate certain services. ODM and other agencies that are required to participate would have an increase in administrative costs. The program could result in better coordination of services, which would reduce costs.

Medical Injury Compensation System

- **Medical Injury Compensation Center**. The bill creates the Medical Injury Compensation Center (MICC), which would be responsible for the administration of medical malpractice claims.
- **Medical Injury Compensation Panel**. The bill establishes the Medical Injury Compensation Panel (MICP) to hear appeals related to malpractice claims, and creates a new fund, the Medical Injury Compensation Center Operating Fund (MICCOF), in the state treasury to pay for costs attributable to the activities of the Center and the Panel. Such costs could be in the tens of millions of dollars annually.
- **Annual assessments on providers**. The bill allows the Administrator to impose an annual assessment on each provider subject to the requirements related to medical malpractice claims. All assessments will be deposited into the MICCOF to pay for the operations of the Center and related activities.

Health Care Professional Standards Board

- **Creation of Board**. The Board is established to discipline medical, dental, optometric, and chiropractic providers who are required to obtain liability insurance under the bill relating to malpractice. The Board would incur operating costs in order to fulfill these duties.

Department of Insurance

- **Malpractice claims**. The provisions in the bill related to requirements associated with liability insurers and malpractice claims would increase the Department of Insurance (DOI) administrative costs. Any increase in such costs would be paid from the Department of Insurance Operating Fund (Fund 5540).
- **Nonstandard Multiple Employer Welfare Arrangement**. The bill requires DOI to establish a nonstandard multiple employer welfare arrangement (MEWA) Program for certain employer groups, to provide reinsurance coverage for nonstandard MEWAs, to provide reinsurance coverage to insurers that provide stop-loss insurance coverage to nonstandard MEWAs, and to guarantee the

liabilities of program participants. These requirements would increase the Department's administrative costs, which would be paid from two new funds created, in the state treasury.

- **MEWA-related funds**. The bill allows DOI to impose fees for these programs. Any revenue collected by DOI, would be deposited into two funds, the Nonstandard Multiple Employer Welfare Arrangement Reinsurance Fund and the Nonstandard Multiple Employer Welfare Arrangement Guarantee Fund, and the bill prescribes the use of fee revenue and other transfers into the funds.
- **Cash transfer from the GRF**. The bill requires the Director of Budget and Management to transfer cash from the GRF to the Reinsurance and Guarantee Funds, in amounts determined by the Superintendent of Insurance, sufficient to start the reinsurance and guarantee portions of the Nonstandard MEWA Program. The GRF will be reimbursed by the Reinsurance and Guarantee Funds.

Department of Administrative Services

- **Office of Medical Purchasing**. The Department of Administrative Services (DAS) would incur costs to operate the Office of Medical Purchasing if it is created. This includes hiring a manager as required by the bill and additional staff that may be needed, as well as office space, equipment, and other expenses. At a minimum, these costs would be several hundred thousand dollars annually.
- **Multi-state and provincial purchasing compacts**. The bill requires DAS to seek to enter multi-state negotiated purchasing compacts for drugs and medical equipment. This is likely to reduce the cost of drug and medical equipment purchases for the Department of Medicaid, the Bureau of Workers' Compensation, the Department of Health, and the Department of Rehabilitation and Correction, among others.

Local Fiscal Highlights

- **Hospital emergency room diversion**. A hospital that has an emergency department is required to: designate a space within the hospital that is separate from the emergency department, or adjacent to the hospital, where services may be provided to patients who have a nonemergency condition or authorize a FQHC to operate in a space within the hospital or adjacent to the hospital. It is unknown if public hospitals already have sufficient space and/or the resources to establish this space. Providing separate space could result in increased costs for public hospitals. Treatment provided in nonemergency settings is generally less expensive than treatment provided in an emergency department. Thus, if public hospitals divert patients to these nonemergency settings, it is possible that the public hospitals could experience a loss of revenue.

- **Hospital value-based purchasing program**. The implementation of a hospital value-based program described above would result in a reduction to each participating hospital's base operating Diagnosis-Related Group (DRG) payment amount for each discharge as specified under the bill. However, the savings achieved with this reduction would be made available as incentive payments to hospitals, including public hospitals.
- **Hospital outpatient services**. Payment rates for hospital outpatient services that could also be provided by a noninstitutional provider cannot exceed the rate charged by the noninstitutional provider by more than 10%. As a result, public hospitals might realize a loss in revenue related to Medicaid patients receiving outpatient services.
- **Nonemergency services**. Prior to dispensing a prescription or providing a medical product or service, health care providers are required to provide information to the patient about the following: the usual and customary charges, the amount to be paid through health insurance or Medicaid, and the amount of any out-of-pocket expenses the patient must pay. Public hospitals might experience an increase in administrative costs as a result of this requirement. Additionally, public hospitals might experience a loss of revenue if the notification results in patients foregoing these services, products, or prescriptions or seeking these items at another less expensive location.
- **Medicaid managed care service coordination pilot program**. A two-year pilot program whereby a Medicaid MCO(s) would be selected to help coordinate certain specified services is established. Local government agencies that coordinate these services might have an increase in costs to provide assistance to the organization under the pilot program. The program could result in better coordination of services, which might lead to a reduction in unnecessary services.
- **Courts of common pleas**. A potential savings effect may be created for courts of common pleas, as certain medical malpractice claims will be diverted into and resolved by the bill's Medical Injury Compensation System.

Detailed Fiscal Analysis

Agreement with the United States Secretary of Health and Human Services

The bill requires the Medicaid Director to request that the United States Secretary of Health and Human Services enter into an enforceable agreement that provides for many health and Medicaid provisions in the bill to be implemented without loss of federal funds and for the federal government to pay Ohio a penalty if the federal government fails to comply in full with the agreement. The bill specifies that certain provisions are not to be implemented or are not to apply when a patient is a Medicaid recipient, unless the agreement is in effect.

Healthy Ohio Program

The bill requires the Medicaid Director to establish the Healthy Ohio Medicaid Program. Furthermore, it requires the following individuals, other than wards of the state, to participate in the program as a condition of Medicaid eligibility: (1) individuals who qualify for Medicaid on the basis of being included in the Covered Families and Children (CFC) category, or (2) individuals who meet all of the following (or a prioritized portion of these individuals): are under age 65, are not pregnant, are not entitled to or enrolled in Medicare Part A, are not entitled to Medicare Part B, are not otherwise eligible for Medicaid, and have family countable incomes equal to at least 50% of the federal poverty line (FPL), but no more than 100% FPL. As of March 2015, the average monthly caseload in the CFC category was approximately 1.8 million individuals. The other population required to participate could include several hundred thousand individuals. This population is currently covered under Medicaid expansion authorized through the federal Affordable Care Act (ACA).

Health plan

Healthy Ohio Program participants are to enroll in a comprehensive, high deductible, health plan offered by a managed care organization (MCO) under contract with the Ohio Department of Medicaid (ODM). If a health professional service is covered under Medicare, the bill requires the health plan to pay the same payment rate. The health plan is also to require copayments for services as long as there are funds in the core portion of the participant's Buckeye account (the core portion consists of contributions made by or on behalf of the participant and awards – see below for more information). The health plan cannot pay for services until the noncore portion of the participant's Buckeye account is $0. Lastly, the plan has a $300,000 annual payout limit and a $1 million lifetime payout limit. If annual or lifetime limits are exhausted, then participants are to be transferred to a catastrophic health care plan.

Buckeye accounts

Under the bill, a Buckeye account is established for each participant in the Healthy Ohio Program. The account is to consist of Medicaid funds and individual contributions. The bill requires, with certain exceptions, that Medicaid funds totaling $1,000 be deposited annually for an adult and $500 be deposited annually for a minor. Additionally, the bill requires, with certain exceptions, that a participant annually contribute at least the greater of $1 or the lesser of (1) 2% of the participant's annual countable family income and (2) $99 if the participant is an adult nonsmoker, $49 if the participant is a minor nonsmoker, and $149 if the participant is a smoker of any age. The bill permits certain individuals to make contributions on an individual's behalf. A Buckeye account may not have more than $10,000 in it at any one time.

The bill provides for all or part of the amount remaining in a Buckeye account at the end of a year to carry forward for the next year and for the amount that the participant must contribute to the account that next year to be reduced by the amount that carries forward. The bill requires that each participant receive a monthly statement showing the current amount in the participant's account and the previous month's expenditures from the account. These statements may be provided electronically.

The bill specifies under which circumstances that a participant's participation could be terminated.

Debit card

Under the bill, a Medicaid MCO that offers health plans to Healthy Ohio participants must issue a debit swipe card. The card can only be used for specified services and requires that the noncore portion of the account be used to pay covered health care services and the core portion be used to pay copayments and noncovered, medically necessary services. Lastly, the card is to (1) verify the participant's eligibility, (2) determine whether a service is covered, (3) determine whether the provider is a participating provider, and (4) be linked to the participant's Buckeye account.

Award system

The bill requires the Medicaid Director to establish an award system in which up to 200 points may be awarded annually for satisfying health care goals and up to 100 points may be awarded annually for satisfying benchmarks. Additionally, the Director is to provide a one-time award of 20 points to a participant whose contributions are made by electronic funds transfers from the participant's checking or savings account. One dollar of Medicaid funds is to be deposited into a participant's Buckeye account for each point awarded.

Bridge accounts

The bill transfers to a bridge account the entire amount remaining in a participant's Buckeye account if the participant ceases to qualify for Medicaid due to increased family countable income and the participant purchases a health insurance policy or obtains health care coverage under an eligible employer-sponsored health

plan. The bill specifies what the bridge account may be used for and closes an account once the transferred amount is exhausted.

Workforce referral

The bill requires county departments of job and family services to offer to refer to a workforce development agency each Healthy Ohio Program participant who is an adult and either unemployed or employed for less than an average of 20 hours per week. The participant is allowed to refuse to accept the referral without any effect on the participant's eligibility or participation in the program.

Fiscal effect

The Healthy Ohio Program would likely be operated as a Medicaid waiver program. As such, it must be budget neutral in order for the federal government to approve the waiver request. This means that, over the waiver period, the state's program cannot cost the federal government more than would have been spent without the waiver. However, while the program must be budget neutral, there are some provisions that would lead to additional costs and some that could result in savings. These are discussed below.

LSC staff spoke with an actuary with Milliman, the actuarial firm that sets rates for the Healthy Indiana Plan (HIP), a similar plan to the proposed Healthy Ohio Program. According to the actuary, Indiana realized cost savings of approximately 2% to 4% in overall costs for the population served under HIP. The savings came from efficiencies relating to managed care, as well as from a decrease in utilization by program participants. The decrease in utilization was largely attributed to the fact there is cost sharing. The actuary also stated that since program participants would have access to Buckeye accounts with funds dedicated to health care, this could decrease some risk to MCOs and result in a lower capitation rate. Estimated Medicaid managed care costs are $5.8 billion ($2.2 billion state share) in FY 2017 for the CFC population and $2.2 billion ($55 million state share[1]) for individuals from 50% FPL to 100% FPL.[2] Assuming that Ohio received the same savings as Indiana, the estimated savings for the Healthy Ohio Program could be approximately $160 million to $320 million ($45 million to $90 million state share). However, the actuary cautioned that Ohio might realize less savings than Indiana since the populations in Ohio that would be served under the Healthy Ohio Program are already receiving services under managed care. HIP participants in the original program were previously uninsured. In addition, since Ohio currently charges copays for certain services, it is unclear how much deductibles would influence utilization for Healthy Ohio Program participants.

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[1] Assumes 5% state share for half of FY 2017 based on federal reimbursement rate for the Medicaid expansion population.

[2] Total estimated managed care costs for the population 0% FPL to 138% FPL (the Medicaid expansion population) are $4.4 billion in FY 2017. For the purposes of this analysis, LSC assumed that 50% of these individuals would be eligible under the Healthy Ohio Program.

The bill also requires that the state pay health professional providers at the Medicare rate. According to ODM, professional services account for about 20% of the capitated rate which equates to approximately $1.6 billion in FY 2017 for the population that would be served under the Healthy Ohio Program. Ohio Medicaid currently pays about 60% of the Medicare rates for professional services.[3] Increasing these rates would result in costs for the Medicaid Program of approximately $1.1 billion ($298 million state share) per year.[4] These costs would outweigh the estimated savings described above that might be achieved. Costs would also be incurred for the award incentives given to program participants. However, these award incentives could lead to lower capitated rates since an individual would have access to more funds in their Buckeye account to pay for health care. The award incentives could also lead to indirect savings in future years if they result in better health outcomes. Costs would also be incurred for collections of individual contributions. In addition, there would be administrative costs associated with implementing the program and establishing the debit cards; some of these costs would continue beyond the first years of program implementation.

Hospital referrals for nonemergency medical conditions

The bill requires each operator of an emergency department, including a hospital or a facility operated as a freestanding emergency department, to do either of the following: (1) designate a space within or adjacent to the emergency department, where services may be provided 24 hours a day, seven days a week, to patients who have a nonemergency condition, or (2) authorize a federally qualified health center (FQHC) to operate 24 hours a day, seven days a week, in a space within the hospital or adjacent to the hospital. If treatment is sought by an individual at an emergency department, a qualified hospital staff member is required to ask the individual to describe the individual's symptoms. If the symptoms are associated with a nonemergency condition, the staff member is to refer the individual to the designated space or the FQHC. The bill specifies that there is a rebuttable presumption that a referral made is not negligent.

The bill prohibits a service provided to a Medicaid recipient in such a space to be billed as an emergency service if, at the time the service was provided, the individual had a nonemergency condition. In addition, the bill prohibits charges for treatment of a nonemergency condition in the emergency room department to exceed the usual and customary charges for that treatment had it been provided in the designated space or FQHC.

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[3] For example, according to the Office of Health Transformation, Ohio Medicaid currently pays about 59% of the Medicare physician fee schedule.

[4] The bill does not define "health professional service." For purposes of this analysis, LSC assumes health professional service does not include hospital services. If hospital services were included, the cost impact would be larger.

State Medical Board of Ohio rules

The bill requires the State Medical Board of Ohio to specify a list of nonemergency medical conditions and to identify symptoms that are associated with the nonemergency condition.

Fiscal effect

LSC staff found that the percentage of nonemergency emergency department visits varies depending on what study is cited. According to the United States Government Accountability Office (GAO),[5] in 2007, there were approximately 117 million visits to emergency departments; of these visits, approximately 8% were classified as nonurgent. In addition, a report on the National Center for Biotechnology Information's website indicates that between 14% and 27% of all emergency room visits could actually be treated at another location, such as an urgent care.[6]

Ohio's state and federal costs for emergency department visits under the Medicaid Program are estimated to be approximately $690 million in calendar year (CY) 2015.[7] Assuming these costs could be reduced by 8% to 27%, the state and federal Medicaid emergency department costs could be reduced by $55 million to $186 million per year. Assuming these individuals are diverted to a less costly setting to receive care, state and federal Medicaid costs could decrease by tens of millions of dollars.

As mentioned above, treatment provided in nonemergency settings is generally less expensive than treatment provided in an emergency department. If a public hospital diverted patients to a nonemergency setting, it is possible that public hospitals could experience a loss of revenue since the patient would be treated at the less expensive setting and billed accordingly. In addition, the hospital would have to designate a space or authorize an FQHC to operate within or adjacent to the hospital. It is possible that some hospitals would lack the space and/or resources to establish this and might incur capital costs.

There is currently a $3 copay under the Medicaid Program for nonemergency services for nonpregnant individuals age 21 and older who are not residing in a nursing facility or an intermediate care facility for individuals with intellectual disabilities.

Nonemergency service conditioned on paying out-of-pocket charge

The bill requires, unless an emergency exists, that a health care provider do the following prior to dispensing a prescription or providing a medical product or service: (1) provide to the patient or the patient's representative certain cost information, including the provider's usual and customary charge, the amount to be paid through

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[5] http://www.gao.gov/assets/100/97416.pdf.

[6] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3412873/.

[7] Emergency room per member per month cost is based on Mercer 2015 draft rate book. Number of enrollees is based on all enrollees (both fee-for-service and managed care plans) from ODM's March 2015 caseload report.

health insurance or Medicaid, and the patient's out-of-pocket charges, and (2) obtain that person's consent to the out-of-pocket charges. The Department of Health is to constitute in rules what qualifies as an emergency.

Fiscal effect

If a Medicaid recipient has access to price information prior to receiving a prescription, medical products, or services, the recipient could choose the best and lowest price or to forego the drug, medical products, or services altogether. As a result, this could reduce state Medicaid costs for those prescriptions, products, or services for which the price is readily available. However, according to GAO, there are several health care and legal factors that make obtaining accurate price information for health services difficult. The health care factors include the "difficulty of predicting health care services, in advance, billing from multiple providers, and the variety of insurance benefit structures." The legal factors include the prohibition of insurance companies sharing negotiated rates due to the proprietary nature of this information and antitrust laws.[8]

Public hospitals will realize an increase in administrative costs as a result of this requirement. Hospital employees that dispense drugs, or provide medical products or services would have to provide information to patients about the costs and out-of-pocket amounts. As mentioned above, providing accurate price information might prove difficult. Additionally, if public hospitals provide this information and patients choose to either forego the drug, medical product, or service, or choose to receive these items at another less expensive location, then it is possible that some public hospitals might experience a loss of revenue. Conversely, some public hospitals might actually realize a gain in revenue if patients choose to receive these items at their facility rather than at a more expensive location.

Limit on payment for hospital outpatient services

The bill prohibits the Medicaid fee-for-service (FFS) payment rate for an outpatient service provided by a hospital, hospital-owned provider, or institutional provider from exceeding by more than 10% a noninstitutional provider's Medicaid FFS payment rate for the service if a noninstutional provider also may provide the service. Additionally, the bill requires ODM to penalize a contracted Medicaid MCO if the organization pays a rate that is more than 10% higher.

Fiscal effect

The Medicaid Program could experience some savings if payments for a hospital outpatient service currently exceed the limits established in the bill. On the other hand, public hospitals might experience a loss of revenue if payments for hospital outpatient services are limited.

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[8] United States Government Accountability Office, GAO-11-791, Health Care Price Transparency, September 23, 2011.

Nursing facility value-based purchasing payment

ODM is required to reduce a portion of nursing facilities' Medicaid rates by 2% for fiscal year (FY) 2016, 4% for FY 2017, and 6% for each subsequent fiscal year. The funds made available are to be used to pay nursing facilities a value-based purchasing payment based on their ranking regarding quality indicators. The bill establishes certain quality indicators.

Fiscal effect

This provision could incentivize nursing facilities to provide better care and greater efficiencies, which could result in savings for the Medicaid Program. However, Ohio currently has a quality incentive program whereby nursing facilities receive incentives for meeting quality indicators. It is unknown how these programs would interact.

Billing other states for nursing facility services

ODM is required to seek to have another state pay for nursing facility services provided under the Medicaid Program to a recipient who has resided in Ohio for less than one year.

Fiscal effect

ODM could realize an increase in administrative expenses as a result of seeking payment from other states. Conversely, ODM could realize a gain in nursing facility revenues if the other states reimbursed Ohio for these expenses.

Regional hospital network as a Medicaid MCO

The bill authorizes a regional network consisting of hospitals to serve as a Medicaid MCO if it accepts a capitated payment from ODM that is not more than 90% of the lowest capitated payment made to a Medicaid MCO that is a health insuring corporation.

Fiscal effect

If regional networks of hospitals can and are willing to provide care management at a lower capitated rate, savings to the Medicaid managed care program would result.

Hospital value-based purchasing programs

The bill requires MCOs under contract with ODM to implement a hospital value-based purchasing program that is largely identical to the Medicare Hospital Value-Based Purchasing Program. Under the program, a Medicaid MCO is required to make incentive payments to participating hospitals based on their success in meeting the clinical process of care measures used for the Medicare Hospital Value-Based Purchasing Program. The total amount of money available as incentive payments for a year must equal the total amount of the savings achieved for that year due to reductions the organization must make under the program to participating hospitals' base operating Diagnosis-Related Group (DRG) payments.

Fiscal effect

The implementation of a hospital value-based program in Ohio could result in savings for the Medicaid Program if the program resulted in better quality care for Medicaid patients and thus caused a reduction in hospital readmissions or better health outcomes.

Medicaid Managed Care Performance Payment Program

The bill revises the Medicaid Managed Care Performance Payment Program by (1) requiring, instead of permitting, ODM to make payments to Medicaid MCOs under the program, (2) specifying the amounts that are to be withheld from the organizations' premiums, and (3) requiring ODM to establish the amount of each performance payment in an equitable manner that results in the total amount withheld from the premiums being spent on the performance payments.

Fiscal effect

ODM currently implements a managed care pay for performance program. During the last program year, ODM did not pay out all of the withheld funds because managed care plans did not meet all of the quality measures. The bill revises the Medicaid Managed Care Performance Payment Program by, among other things, requiring, instead of permitting, payments to Medicaid MCOs and increasing the percentage withheld for premium payments. There could be reduction in costs if the program incentivizes greater care and/or efficiencies.

Medicaid MCOs' shared saving bonus

ODM is required to determine the average of the per recipient capitated payment rate for each Medicaid MCO for the three fiscal years immediately preceding the fiscal year for which the determination is made and the average per recipient cost to the Medicaid programs in certain specified states for certain eligibility groups for the same time periods. If the organization's three-year average for a fiscal year is less than the three-year average determined for that fiscal year, ODM is to pay a shared savings bonus. The bonus equals 20% of the difference between the organization's three-year average per recipient capitated payment rate and three-year average per recipient cost determined for the states specified.

Fiscal effect

State costs could be reduced if the potential bonus incentivizes Medicaid MCOs to contain their costs.

Use of certain Medicaid funds and Medicaid Donations Fund

The bill requires the Medicaid Director to seek grants and donations to help fund certain Medicaid payments, services, and coverage and creates the Medicaid Donations Fund into which these are to be deposited.

The bill requires the Medicaid Director, for FY 2018 and each fiscal year thereafter, to (1) adjust the total amount of the Medicaid Program's FY 2016 actual

expenditures by the cumulative rate of core inflation for the period beginning July 1, 2016, and ending the last day of the most recent month for which the rate of core inflation is known preceding the first month of the fiscal year for which the determination is being made, and (2) subtract, from that adjusted amount, the total amount of the Medicaid Program's estimated expenditures for the fiscal year immediately preceding the fiscal year for which the determination is being made.

The bill requires the Medicaid Director to use the amount determined above for a fiscal year and the amount in the Medicaid Donations Fund to fund certain specified services, payments, and coverage, unless the HHS Secretary refuses to enter into an enforceable agreement regarding many of the bill's Medicaid provisions.

Medicaid managed care service coordination pilot program

The bill requires ODM to establish a two-year pilot program under which one or more Medicaid MCOs help coordinate certain services that Medicaid recipients who enroll in the organizations receive. The bill specifies who is to assist ODM in establishing the pilot program. ODM is to select organizations for participation through a request for proposals.

A Medicaid MCO participating in the pilot program is to receive a bonus payment if the organization succeeds in coordinating services in an efficient and effective manner that prevents Medicaid and other programs from incurring costs that would have been incurred if not for the coordination. The bill specifies that a service is to be coordinated with other services for a Medicaid recipient only to the extent, if any, that the recipient is eligible for and receiving the service. The bill is not to be construed as making an individual eligible for a service that he or she is not. All persons and government entities overseeing or operating programs offering any services are to cooperate with the Medicaid MCOs.

ODM is to complete a report regarding the pilot program 90 days after the program ends.

Fiscal effect

This provision could result in administrative costs to ODM to implement the program and any other state or local government entity that was called upon to provide assistance or cooperation. There could be state and local savings if the pilot program resulted in better service coordination and thus, greater efficiencies and a reduction in unnecessary or duplicative services.

Medical Injury Compensation System

The bill creates the Medical Injury Compensation Center (MICC), under the direction of an administrator appointed by the Governor, that will be the exclusive state agency to resolve medical, dental, optometric, or chiropractic malpractice claims, except for claims involving intentional misconduct, brought against providers who are required to obtain liability insurance under this bill or providers' liability insurers for any injury, death, or derivative claims. The bill specifies requirements related to the

operation of the Center, health care providers, and assignment procedures for claims. The Administrator is to assign each malpractice claim filed with the Center to a reviewing health care provider employed by the Center. The bill requires the Administrator to appoint a Medical Injury Compensation Panel (MICP) for purposes of hearing an appeal of a claim filed under the System, and allows a claimant or a provider's liability insurer to appeal an order issued by a reviewing health care provider to an MICP.

The bill creates a new fund, the Medical Injury Compensation Center Operating Fund, in the state treasury to pay the costs attributable to the activities of the Administrator, the Center, and MICP. The bill requires the Administrator to assess each provider for the costs attributable to the activities of the Administrator and Center. The bill requires the Administrator allocate the administrative assessment in a fair and equitable manner among the providers based upon the number of patients seen by each of those providers during the preceding year.

The bill requires all providers[9] to obtain liability insurance, and provides that they could be penalized for not obtaining such insurance. An insurer providing liability insurance for purposes of the requirements under this bill is required to pay compensation in any claim determined to be compensable in accordance with the amount calculated by the MICC. The bill specifies that if an individual files a claim for compensation to MICC that lists a provider who did not obtain liability insurance, as required, at the time the claim arose, and it is determined that the individual is entitled to compensation, the Administrator is required to make and file an affidavit, including certain information for record in the office of the county recorder in the counties where the provider's real or tangible personal property is located. The bill requires county recorders to accept and file such affidavits as lien against the provider's real or tangible personal property. The bill prohibits county recorders from charging any fees for the services provided related to malpractice claim provisions.

Finally, the bill creates the offense of medical injury compensation fraud, which is similar to workers' compensation fraud. The offense is a misdemeanor of the first degree, but escalates to a felony of the fifth, fourth, or third degree based upon the value of the goods, services, property, or money stolen.

Fiscal effect

Medical Injury Compensation Center and its activities

The bill would increase both state revenue and expenditures. The bill would increase state expenditures to operate the MICC and to pay for administrative costs related to the MICP and health care providers. The precise magnitude of such increase

[9] The bill defines a "provider" as a dentist, chiropractor, emergency medical technician-basic, emergency medical technician-intermediate, emergency medical technician-paramedic, hospital, licensed practical nurse, optometrist, pharmacist, physician, physician assistant, physical therapist, podiatrist, registered nurse, and registered facility (in a drafting error, this should probably be "residential facility").

is very uncertain, but could be in the tens of millions of dollars, due to the number of highly skilled employees that the Center must employ, including an administrator, actuaries, hearing examiners and staff members who would be specially trained in medical-legal analysis, to perform complex administrative duties as specified under the bill. The Center is also required to hire a pool of providers, who specialized in various medical fields, to serve as health care providers and on the MICP to hear claims and appeals process. The Ohio 2013 Medical Professional Liability Closed Claim Report,[10] which summarized the Ohio medical professional liability closed claim data received by the Department of Insurance in 2013, reported a total of 3,019 malpractice claims, an increase of 246 claims compared to 2012. In 2012, total claims were 2,773. Of the claims closed over the period 2005 through 2013, over 48 different medical specialties were represented.[11] Because the bill requires each claim to be assigned to a medical provider that specializes in the relevant field, this experience suggests that the Center will need to employ medical providers in dozens of specialties. The bill would increase revenue to the Medical Injury Compensation Center Operating Fund from an annual assessment the Administrator imposes on each provider that is subject to the requirements related to medical malpractice claims under this bill. Presumably, the assessment should cover the costs of the Center and its operations.

Insurance premiums

The bill could potentially lower medical malpractice insurance premiums, due to the prohibition against punitive damages. Any decrease in such premiums could decrease insurance premium tax revenue. Potentially, the decrease could be made up by the bill's requirement that all medical providers carry malpractice insurance. Currently, all insurance tax revenues are deposited into the GRF.

The bill could also have an indirect effect on costs of defensive medicine (precautionary treatment decisions made by a medical provider that generally have minimal medical benefits, but an option to protect the provider against future legal liability). According to various studies,[12] decreases in the use of defensive medicine would reduce health care spending by between 0.5% and 9% of health care spending. Generally, the costs of defensive medicine are passed on to consumers through health insurance premiums. Any reduction in costs of defensive medicine, which typically depending on a medical provider's decision to practice defensive medicine, would

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[10] The report was prepared by the Department of Insurance in March 2015.

[11] Of the 14,141 claims closed involving various medical specialties, 57 were against "other" specialties, and 53 were against an unknown specialty.

[12] Estimated costs of defensive medicine to health care spending are derived from the following publications: Congressional Budget Office letter to Representative Bruce Braley, dated December 29, 2009; Restoring Fiscal Sanity 2007: The Health Spending Challenge, edited by Alice M. Rivlin and Joseph R. Antos, Brookings Institution Press, 2007; Daniel P. Kessler, "Evaluating the Medical Malpractice System and Options for Reform," Journal of Economic Perspectives, Spring 2011; and Medical Malpractice, by Frank A. Sloan and Lindsey M. Chepke, MIT Press, 2009.

lower health insurance premiums. Any decrease in such premiums could decrease insurance premium tax revenue. As noted above, all insurance tax revenues are deposited into the GRF.

Courts of common pleas

The creation of the Medical Injury Compensation System will have the effect of diverting certain cases filed for medical malpractice claims out of the jurisdiction of the common pleas courts. The bill requires the Administrator of the MICC to appoint an MICP to hear appeals of orders issued by the reviewing health care providers. When a decision on a medical claim is rendered, the bill allows a claimant or a provider's liability insurer to appeal certain orders issued by an MICP to the court. Thus, the bill will initially divert certain cases from the court, with some number of those matters subsequently filed with the court as appeals from the Medical Injury Compensation System. As it seems unlikely that all of the medical claim decisions will be appealed, a potential savings effect will be created for the courts by reducing certain filings and the related adjudicatory costs.

Offense of "medical injury compensation fraud"

Data from the Department of Rehabilitation and Correction (DRC) indicates that very few are incarcerated for convictions stemming from similar fraud offenses such as insurance fraud, Medicaid fraud and workers' compensation fraud. Over the course of calendar years 2013 and 2014, there were a total of ten offenders sent to prison for these related fraud offenses. This would suggest that the number of offenders likely to be convicted of this new offense and sentenced to prison will be extremely small, especially in the context of a prison system housing 50,000-plus offenders. The average cost for DRC to incarcerate an offender is currently $24,870 per year, with the marginal cost of adding an offender estimated at between $3,000 and $4,000. The fiscal effects on the new offense on county and municipal criminal justice systems are expected to be minimal as well.

Health Care Professional Standards Board

The Health Care Professional Standards Board (HCPSB) will consist of nine members appointed by the boards within the HCPSB's scope of regulatory authority. Board members will be compensated for time spent performing official duties and any necessary expenses incurred in the performance of those duties. The HCPSB would likely require staff including an executive director or secretary to oversee daily Board activities, investigators, hearing examiners, and administrative support staff. The Board will also require human resources and IT services. Smaller professional licensing boards utilize services available through the Central Service Agency (CSA) of the Department of Administrative Services (DAS) to meet this need, but larger boards, such as the State Medical Board, carry out these functions internally. Depending on the size of the HCPSB, the Board may need to hire additional staff to carry out these functions.

The HCPSB is required to create and maintain a database of all claims and any reports or complaints about which the HCPSB receives notice and also maintain a public website. Other costs associated with the HCPSB will include office space, supplies, maintenance, and equipment. The total cost of the HCPSB will likely depend on its size and volume of activity. Collectively, the boards under the regulatory authority of the HCPSB conducted about 17,000 investigations in FY 2014 with the number of investigations per board ranging from 22 (State Board of Optometry) to 9,790 (State Board of Nursing). The bill does not specify what funding source will be used to fund the HCPSB's operating expenses.

Department of Administrative Services

Office of Medical Purchasing

The bill creates a contingency by which the Office of Medical Purchasing, within DAS would be created subsequent to the establishment of an enforceable agreement between the Director of Medicaid and the United States Secretary of Health and Human Services which, among other things, would provide for the establishment of the Office. Under the bill, the Office, if established, would be required to seek to enter into a pact with other states and Canadian provinces to negotiate discounted prices for drugs and medical equipment from suppliers of those items. Once prices have been negotiated, the bill requires that purchases of drugs or medical equipment be made with suppliers that have agreed to discounted prices if those purchases will be made or reimbursed using money provided by the state or counties.

Fiscal effect

Costs to administer

If the Office is created, DAS would incur new costs to fund its operations. The largest portion of which would likely be personnel costs. The bill specifically requires the Director of Administrative Services to appoint a manager to supervise the Office. It is likely that additional employees would also be needed, although the number that might be needed is currently unknown. DAS would also bear expenses for any necessary equipment, office space, travel, and other miscellaneous costs associated with carrying out the Office's duties. Depending upon how the Office is organized and the workload that the Office would undertake, DAS could incur new costs ranging from a few hundred thousand dollars to several million dollars per year to operate the Office.

Reduction in costs for pharmaceuticals and medical equipment

Multi-state/province negotiations with suppliers of drugs and medical equipment for discounted prices could result in a reduction of costs paid by public insurers or public health care providers, including the Department of Medicaid, the Bureau or Workers' Compensation, the Department of Health, and the Department of Rehabilitation and Correction, or any other public entity that provides funding for these items. As of 2014, five multi-state consortiums to reduce prices for drugs and medical equipment were in operation. One such arrangement is the Minnesota Multistate

Contracting Alliance for Pharmacy (MMCAP). Forty-seven states, including Ohio, are members of this voluntary purchasing arrangement overseen by the Minnesota Department of Administration. According to MMCAP, it achieves average savings of about 23.7% below wholesale price for brand named drugs and 65% below wholesale for generics. In Canada, the Pan-Canadian Pharmaceutical Alliance (PCPA) serves a similar purpose for its member provinces and territories. PCPA estimates that its efforts result in savings in excess of C$230 million per year.

Department of Insurance

Nonstandard Multiple Employer Welfare Arrangement Program

The bill requires the Department of Insurance (DOI) to establish a Nonstandard Multiple Employer Welfare Arrangement (MEWA) Program for certain employer groups,[13] and specifies the amount of surplus that must be maintained by a program participant. The bill allows DOI to impose fees, through rules, at an amount necessary to ensure the continued operation of the program. The bill specifies that a nonstandard MEWA is allowed to participate in the program for a period of up to five years. The bill also specifies requirements related to program participants, including reimbursements to health care providers using reference-based pricing.

The bill requires DOI to provide reinsurance coverage for program participants and to insurers that provide stop-loss insurance coverage to program participants, as required under existing law, with the intent of reducing the cost of such coverage. The bill requires DOI to guarantee the liabilities of program participants. The bill requires DOI, upon default by a program participant on liabilities assumed under this bill, to guarantee a nonstandard MEWA's liabilities and limits the amount that can be paid out on such liabilities to be no more than the surplus amount required for MEWAs under existing law for standard MEWAs.

The bill creates two new funds, the Nonstandard Multiple Employer Welfare Arrangement Reinsurance Fund (Reinsurance Fund) and the Nonstandard Multiple Employer Welfare Arrangement Guarantee Fund (Guarantee Fund), in the state treasury. The Reinsurance Fund will be used to reduce the cost of purchasing stop-loss insurance coverage for program participants in the Nonstandard MEWA Program and pay any related expenses. The Guarantee Fund will be used to guarantee the liabilities of participants in the program and pay any related expenses.

The bill requires, 30 days after the effective date of this bill, or as soon as possible thereafter, the Director of Budget and Management to transfer cash from the GRF to the Reinsurance and Guarantee funds in amounts determined by the Superintendent sufficient to fund the reinsurance and guarantee portions of the Nonstandard MEWA Program. Five years after the effective date of this bill, or as soon as possible thereafter,

[13] The bill provides that the purpose of the program is to enable a group of employers that is a bona fide association under existing federal law to form a self-insured MEWA that does not meet the criteria or standards necessary for a certification by DOI under existing law.

the Director of Budget and Management is required to transfer all cash credited to the two funds back to the GRF and abolish the funds.

Fiscal effect

The bill would increase Department of Insurance administrative costs to establish a Nonstandard MEWA Program, to provide reinsurance coverage, and to guarantee the liabilities of program participants. All fees and costs related to the reinsurance coverage and guaranteed requirements under this bill will be deposited into and paid out of the newly created funds, the Nonstandard Multiple Employer Welfare Arrangement Reinsurance Fund and the Nonstandard Multiple Employer Welfare Arrangement Guarantee Fund, respectively. In addition, there would be startup costs associated with the program in order to determine premiums, deductibles, and benefit options for the program and provisions related to reinsurance coverage and guaranteed issues. LSC staff assume any startup may be paid out of cash transferred to the two funds, as required above.

The magnitude of the fiscal impact associated with nonstandard MEWAs requirements is uncertain because it would depend on the number of employer groups that choose to participate in the program, characteristics of the participants in the program, and other requirements of the program. The requirements related to nonstandard MEWAs would have no direct fiscal effect on local governments.

The requirement that the Department provide reinsurance coverage could potentially be self-financed, through the fees the Department is permitted to charge on insurers providing stop-loss insurance. The nature of reinsurance, though, implies that it is possible for one or more participating MEWAs to be hit by exceptionally large claims that are very infrequent. In statistical jargon such events are known as "long-tail" events, in reference to the statistical likelihood of the event with respect to a normal (bell-curve) distribution. The reinsurance requirement may subject the state to the possibility of a large liability from such a long-tail event. If any potential long-tail events are to be financed through the fees levied on insurers, it is not clear how state provision of reinsurance would reduce the costs to MEWAs of reinsurance.

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