



**Testimony of
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House Insurance Committee**

Chairwoman Sears, Vice Chair Brinkman, Ranking Minority Member Bishoff, and members of the House Insurance Committee, on behalf of the Ohio Association of Health Plans (OAHP), thank you for the opportunity to testify before you today on Substitute Senate Bill 129 (SB 129). I am Miranda Motter, President and CEO of OAHP.

OAHP is the leading state trade association representing the health insurance industry. OAHP members provide health benefits to more than 9 million Ohioans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare, Medicaid and the Health Insurance Exchange marketplace. Our members offer a broad range of health insurance products to Ohioans in the commercial marketplace and are committed partners in public programs.

At the outset of my testimony, it is important that I reiterate OAHP's position on the bill that is currently pending before this Committee -- OAHP is an interested party with very serious concerns with the as passed by the Senate version of SB 129.

On November 17, 2015, OAHP testified before the Senate Insurance Committee as an opponent to this bill. Over the past year, OAHP has worked extensively with Senators Gardner and Cafaro and the stakeholders to address numerous challenges that existed in the as introduced version of the bill. The Senators led an open and transparent interested party process and OAHP commends the work that has been done to date on the most comprehensive piece of legislation any state has passed regulating prior authorization.

However, OAHP was very clear in the Senate that there are three critical areas of concern that the industry would continue to raise in the House deliberations on SB 129.

I would like to spend the remainder of my time before you outlining those concerns; but first, I think it is important that I provide this Committee an understanding of the health insurance industry's perspective on utilization management tools, such as prior authorizations.

Health plans continue to innovate with ongoing efforts in Ohio and across the country that are transforming the health care delivery system, providing integrated care with collaborative provider partnerships, and providing tools and data to help consumers make informed decisions.

Over the past thirty plus years, the health insurance industry has incrementally transformed from a payer of health insurance claims to an *active participant* working with health care providers to improve the quality of health care in a cost-effective manner. ***Innovation and continued transformation is not an option anymore for our industry. Today, it is expected.*** Purchasers of health insurance coverage – from employers, individuals and states – are demanding it. And, Ohio has been at the forefront in terms of setting policy agendas that insist on improved quality of health care in a cost-effective manner.

In Ohio, examples of this transformation have been the creation of the Governor's Office of Health Transformation (OHT) and later the Joint Medicaid Oversight Committee (JMOC) under Senate Bill 206. As you know, OHT has been at the forefront of developing new innovative models of care to be used in both Ohio's commercial and Medicaid markets through Episode-Based Payments and Patient Centered Medical Homes that go to the heart of balancing costs and quality. These new models are intended to move away from a fee for service purchasing system to a value based purchasing system.

In addition, JMOC was established by this legislative body to provide ongoing oversight of the costs and quality being provided in Ohio's Medicaid program with the goal of keeping the annual per member per month growth at no more than 3%.

Most recently, the Ohio General Assembly approved a provision in the state's biennial budget (ORC 5167.33) that will require the Medicaid health plans, by a date certain, to tie at last 50% of their aggregate net payments to providers to the value of the providers' services.

All of these state initiatives:

- Place a higher demand on both health insurers and providers alike to provide better health care outcomes in a cost effective-manner.
- Will require a closer, interdependent working relationship between providers, insurers and consumers of health care.
- Ultimately will have a profound effect on the continued transformation that is taking place in Ohio's health care system.

It is important to remember that utilization management tools, such as prior authorizations, are aligned with and support these state initiatives. They are designed for health care consumers and providers to ensure optimal, cost effective outcomes while maintaining a focus on quality care for services and medications. The core purpose of prior authorization is to ensure appropriateness of care based upon national clinical guidelines – of either a medical service or medication – and the existence of coverage for that care.

It is through the context of these state initiatives and expectations, that health insurers are reviewing this bill's restrictions on prior authorization.

Last spring, the health insurance industry came to the table with the Ohio State Medical Association and a number of providers to discuss providers' concerns relative to the prior authorization process, the goal was (and continues to be) – ***how do we work better with our provider partners to provide medically necessary services to those patients they treat and those members we provide health insurance coverage.***

As you know, interested parties have participated in extensive and intense discussions on this bill. I am here to tell you, these are difficult and challenging issues – because of the substance and the comprehensive nature of this bill. And, for OAHP member plans, our guiding principles for these discussions have been:

- Ensuring that patients continue to receive appropriate care that aligns with their health care coverage.
- Considering potential opportunities for better coordination and collaboration with our provider partners through an improved prior authorization process.
- Ultimately, improving health care outcomes and affordable health insurance coverage.

Today, this bill includes a number of provisions that OAHP member plans believe will have a significant impact on the prior authorization process for providers while ensuring appropriate care for patients. These include:

- Allowing providers to utilize a web-based system for prior authorization requests.
- Providing advance notice of new prior authorization requirements.
- Indicating prior authorization requirements on issuers' website.
- Allowing retrospective reviews of claims, in certain circumstances, where the provider should have submitted a prior authorization.

Please understand that work continues and our discussions with the proponents are still underway. OAHP's goal is to address the remaining three key areas of concern:

- 1. Turn-around times and Duplicative Appeals Process for Prior Authorization Process.** SB 129 utilizes turn-around times and associated definitions that are inconsistent with current law that accepts nationally recognized best practices as the standard for operating in Ohio. In fact, SB 129 creates a separate process JUST for certain prior authorization decisions. Creating a separate system for some prior authorization decisions that is different than other authorized decisions will likely cause confusion for both patients and providers. Also, SB 129 requires a duplicative appeals process for prior authorization appeals. Current Ohio law already provides patients with internal and external appeals processes when there are disputes about prior authorization determinations. If SB 129 passes as written, providers and health plans to build separate and distinct systems to accommodate the different, yet duplicative system requirement.

To address this concern, OAHP recommends that the bill's turn-around times, definitions and approach align with those utilized by National Committee for Quality Assurance (NCQA). Additionally, OAHP recommends that the duplicative process be eliminated and in its place insert any needed cross references to Ohio's current internal and external review process.

2. **Retroactive Denials/60 Day Binding Decisions.** As currently drafted, SB 129 includes very problematic language relative to retroactive denials. The bill prohibits retroactive denials for coverage decisions and medical necessity decisions for 60 days. OAHP has repeatedly requested specific examples from providers in order to better understand the issues this language is intended to resolve. In addition, OAHP would like to understand the rationale relative to the 60 days – many times non-urgent services are not scheduled for a period of time due largely to the provider’s schedule. In these instances, it should remain the provider and patient’s responsibility to ensure that nothing has changed that might impact the original information provided that the prior authorization approval was based off of.

Until OAHP is able to review specific examples brought forward by the providers relative to this issue, OAHP will continue to recommend language that would address the issue proponents raised in interested party meetings last year which would prohibit a retroactive denial where:

- The health plan reviews a prior authorization request for patient eligibility, patient coverage and medical necessity;
- The health plan issues a prior authorization approval because eligibility, coverage and medical necessity are all met;
- Provider renders the medical service/drug to the patient and submits a “clean” claim – all of the information matches (correct codes were used by the provider, and eligibility met on the day the service was rendered/medication received, coverage is met and nothing has changed to change the original medical necessity determination.)

OAHP has also submitted draft legislative language that aligns with this concept.

3. **Year-Long Prior Authorization for Drugs.** As currently drafted, SB 129 would permit year-long prior authorization approvals for certain drugs to treat chronic conditions. In an environment where Ohio continues to deal with an overprescribing problem of opioids, OAHP continues to advocate that additional guardrails are needed to ensure patient safety, quality of care and affordability.

During the Senate process, OAHP advocated that additional guardrails be incorporated into this year long approval that would require the patient be stable on the prescribed drug for 60 days, to clarify that the drug(s) for which a year-long prior approval could be obtained was a maintenance drug, that the year-long approval was consistent with FDA prescribing guidelines and that drugs that are controlled substances be specifically excluded from this provision. Also, given recent releases of several new, astonishingly expensive, specialty medications, OAHP believes it is critically important to exclude specialty drugs entirely from being able to qualify for a year-long prior approval.

This does not mean that extended prior authorizations will not be available for these types of drugs. In fact, most health plans currently provide an extended prior authorization

based upon clinical guidelines. These types of state mandated measures relative to prescription drugs limit the ability of health plans to utilize innovative solutions to prescription drug costs for Ohio's health care consumers.

OAHP has also submitted draft legislative language that aligns with this concept.

These are the three areas that OAHP will continue to work on with the bill sponsors and stakeholders. It is important to note that there are some areas of clarification and technical change that are needed to ensure the final language meets the intent of bill. OAHP has provided a list of these recommended changes.

Our work, discussions, and efforts of bringing solutions to the proponents will continue with the goal of consensus on the three key areas of concern.

Again, it has been challenging – these discussions have been long and laborious. It has been a learning experience for all involved. We will continue to work diligently with our provider partners on issues that align with the guiding principles I previously outlined.

In light of where we are in this process, I will conclude my testimony with a note that I need to reserve the right to come back before this Committee to testify again as this bill continues to evolve and the various issues discussed.

Thank you for the opportunity to present on Sub. SB 129 and I am happy to answer any questions you might have.