



**Testimony of
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Senate Insurance and Financial Institutions Committee**

Chairman Hottinger, Vice Chair Bacon, Ranking Minority Member Brown, and members of the Senate Insurance Committee, on behalf of the Ohio Association of Health Plans (OAHP), thank you for the opportunity to testify before you today on 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 8 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 in the commercial marketplace and are committed partners in public programs.

At the outset of my testimony, it is important that I make two points:

- First, OAHP opposes the version of SB 129 that is currently pending before this Committee.
- Second, I am disappointed in the tenor of some of the proponent testimony presented during last week's hearing given the extent of work has taken place between the providers and the plans to date on this bill.

However, rather than focus on the current version of SB 129 and the challenges we experience with providers relative to the prior authorization process, today I am going to describe for you:

- The efforts that have been underway with the bill's proponents since early April,
- The concepts where there may be potential for emerging consensus, and
- What we believe are next steps in this process.

To provide some context for the work that has been done, I need to 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.

Examples of this transformation in Ohio are the creation of the Governor's Office of Health Transformation (OHT) and the creation of the Joint Medicaid Oversight Committee (JMOC) under Senate Bill 206. As you know, OHT has been at the forefront of helping to develop 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. 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 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 – of either a medical service or medication – and the existence of coverage.

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

In the 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 has been 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.

Interested party meetings began in April and we've met, I believe, at least a half a dozen times since then. I am here to tell you, these are difficult and challenging issues. 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 affordability health insurance coverage.

To date, there are a number of concepts where there is potential for emerging consensus. Please understand that work continues and our discussions with the proponents are still underway with the goal of consensus on a limited number of issues via a substitute version of the bill.

Again, it has been challenging – these discussions have been long and laborious. It is 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 on a substitute version of the bill.

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