



May 19, 2015

The Honorable Bill Beagle  
Chairman of the Senate Finance Workforce Sub Committee  
Senate Building  
1 Capitol Square, 1st Floor  
Columbus, OH 43215 May 18, 2015

Chairman Beagle,

On behalf of the Ohio Association of Health Plans (OAHP), thank you for the opportunity to provide written comments to the Senate Finance Workforce Sub Committee about some of the health insurance-related provisions contained in the House-passed version of the State Budget, Sub H.B. 64.

OAHP is the statewide trade association representing 17 member companies that are commercial insurers, Medicare Advantage plans and Medicaid managed care plans. Collectively, OAHP member plans are dedicated and accountable to more than 8 million Ohio health care consumers. Our core mission is to promote and advocate for quality health care and access to a variety of affordable health benefits for all Ohioans.

The first part of my written comments will focus on amendments in the House-passed version of the Budget that would impose additional regulatory and reporting requirements on health insurance companies which are unnecessary given current regulatory and reporting requirements that already apply to health insurance companies. Specifically, my comments will focus on three specific provisions in the House-passed version of the Budget:

1. Amendments prohibiting the use of genetic information which are duplicative of current law,
2. Additional disclosures and reporting requirements related to health insurance plans sold on the federal exchange,
3. Establishment of an all payer claims database.

OAHP believes that these amendments are unnecessary and in many ways duplicative of current laws and regulations. They will impose additional requirements on health insurers which will raise the cost of compliance and also the state budget without clear evidence that they will provide additional consumer protections or benefits.

The second part of my written comments will focus on two additional provisions included in Sub H.B. 64 that relate to pharmacy benefit manager regulation and provisions that encourage the utilization of telemedicine.

## **Amendments Related to Genetic Information**

With regard to genetic information, Sub HB 64 amends ORC1739.05, 1751.18, 1751.65 and 3923.66 to prohibit Health Insuring Corporations from using genetic information to set premium rates and to prohibit sickness and accident insurers, public employee benefit plans, and multiple-employer welfare arrangements from using genetic information in connection with reviewing applications, determining insurability, cancelling or renewing a policy, limiting benefits, or setting premium rates. Although we believe that regulation of genetic information is appropriate for underwriting, rate setting, application and enrollment purposes, these amendments are duplicative of state and federal laws already in place to prohibit such conduct. Current law already provides appropriate limitations and safeguards, with appropriate exceptions to allow consumers and their physicians to use genetic tests and results to treat medical conditions. In this regard, the following laws already prohibit the conduct sought to be regulated by the Budget's genetic testing amendments:

- ORC 3901.491 prohibits sickness and accident insurers from considering genetic information in relation to processing applications, determining insurability, cancelling or renewing coverage, and limiting benefits. This law largely duplicates the new provisions applicable to sickness and accident insurers.
- The federal Genetic Information Nondiscrimination Act of 2008 (which is enforced by the Ohio Department of Insurance) also prevents insurers, HICs and group health plans (including Multiple Employer Welfare Arrangements or MEWAs) from requiring an individual to undergo genetic testing and from collecting genetic information for underwriting purposes. Under this federal law enforced by ODI, insurers and group health plans cannot use genetic information to determine eligibility for coverage or to compute premium or contribution rates for enrollees in both the individual and group markets. These restrictions are found at 42 U.S.C. 300gg-4(c-f).

Because the matters sought to be addressed by the genetic information amendments in the Budget Bill are already addressed by current law, we recommend the amendments be deleted from the Bill.

## **Disclosure of Additional Information Regarding Exchange Plans**

Sub HB 64 establishes a new section, ORC 3901.241, which requires insurers selling coverage on the exchange to make available certain information to individuals, including a list of the top 20% of services according to utilization and an enrollee's expected contribution for each service. These new requirements are unnecessary because of the broad transparency and disclosure requirements in current law applicable to insurers selling coverage on the federal exchange. In our view, the proposed amendment will only add unnecessary disclosure requirement on subjects

that have already been addressed by state and federal laws, creating additional costs with no consumer benefit.

In this regard, Federal law requires insurers selling coverage on the exchange to provide the following information in plain language to the exchange, HHS, and ODI, and also make it available to the general public:

- (1) Claims payment policies and practices;
- (2) Periodic financial disclosures;
- (3) Data on enrollment;
- (4) Data on disenrollment;
- (5) Data on the number of claims that are denied;
- (6) Data on rating practices;
- (7) Information on cost-sharing and payments with respect to any out-of-network coverage; and
- (8) Information on enrollee rights under title I of the Affordable Care Act. 42 U.S.C. 18031(e)(3)(A-C); 45 C.F.R. 156.220(a-c)

In addition, insurers selling on the exchange must disclose cost sharing amounts under plans as they relate to specific items and covered services in a timely manner upon the request of the consumer. At a minimum, such information must be made available to consumers through an Internet web site and other means for consumers without access to the Internet. See 42 U.S.C. 18031(e)(3)(D) and 45 C.F.R. 156.220(d).

It is also important to note that health insurers selling coverage on the exchange must also comply with accreditation requirements, including accreditation standards established by the National Committee for Quality Assurance (NCQA). For 2015, NCQA adopted an accreditation standard to require insurers to disclose benefit and financial responsibility information to members enrolled in exchange products. The information must include pricing information for all services available to members based on cost estimates, which must be disclosed on the insurer's web site and over the telephone as needed. Insurers must communicate to members the differences between network and out-of-network benefits and that members may be responsible for charges for out-of-network services. This standard is found in the 2015 NCQA Health Plan Guidelines, Member Connections Standard 5.

Also, Ohio Revised Code 3923.81(B) currently requires every sickness and accident insurer, health insuring corporation, or multiple-employer welfare arrangement to establish and maintain a system whereby a person covered by a health benefit plan may obtain information regarding potential out-of-pocket costs for services provided by in-network providers. Insurers have implemented this system of disclosure and already provide such information to consumers.

The provisions contained in the House-passed Budget that seek additional disclosures are simply not needed, would be duplicative of current laws and standards, and would subject insurers to multiple disclosure requirements that will raise the cost of compliance and coverage. Consumers

already have the right to learn about what they will be charged for covered services, and additional requirements on the subject at this point in time will not benefit consumers.

### **All-Payer Health Claims Database**

Sub HB 64 would enact into law proposed ORC 3728.01 to .08, which would create an All-Payer Health Claims Database to be a resource for continuous review of health care utilization, expenditures, quality and safety. It would also create an advisory committee to make recommendations to Office for Health Transformation for establishing the Database. The proposal also earmarks \$2 million each year for the creation of the Database.

OAHP is concerned with the creation of an All-Payer Claims Database, because there has been no showing that such a Database would be a benefit to the State of Ohio. We believe it would constitute simply another regulatory requirement that increases the cost of coverage and the state budget and reduces competition in the market. In this regard, our specific concerns are as follows.

- Before enacting into law a requirement to establish an All-Payer Claims Database, the purpose and scope of the Database should be clearly defined.
- The information to be collected by the Database is proprietary and competitively sensitive, and should not be shared with competitors or the public.
- Ohio currently has a competitive marketplace, with many insurance companies offering coverage. Onerous disclosure requirements could raise the administrative costs and, thus, premiums. A requirement that companies disclose proprietary and sensitive information could impact the competitive nature of Ohio's insurance marketplace.
- The dollars allocated to the Database are from a "money follows the person" approach, which we believe cannot be appropriated for this purpose.
- The funding for ongoing operations of an All-Payer Claims is significant, requiring both internal resources and outside vendors to make it work, which will be an ongoing burden on the State Budget.

OAHP recommends that the Database language be removed entirely from SB 64 because the idea has not been vetted. If this issue is to be pursued, OHT could convene an advisory group to discuss whether a Database is in the best interest of the State, to determine what is the appropriate purpose and scope of such a project, and to vet issues such as proprietary rights to competitively sensitive information, confidentiality and costs.

### **Pharmacy Benefit Manager**

OAHP is seeking an amendment to language included in Sub HB 64 regarding prescription cost transparency in pharmacists and the regulation of pharmacy benefit managers (PBMs). While

OAHP remains neutral on most of the provisions of this language, there are provisions that are unrelated to cost transparency to pharmacists or PBM regulation, but that interfere with the private right of contracting between a PBM and a plan sponsor or health plan. OAHP recommends that the Senate remove these offending sections of the language, so that the language reflects the goals of cost transparency to pharmacists and PBM regulation.

### **Telemedicine**

OAHP supports language the House added that establishes parameters around prescribing based on a telemedicine interaction. Telemedicine continues to evolve as an important tool and access point of care for those whose access to care may be limited due to geography or other life circumstances. The House language sets appropriate guidelines for when a prescriber may exercise his or her professional judgement to prescribe certain medicines (not controlled substances) based on a telemedicine interaction with a patient. OAHP encourages the Senate to support this language.

Again, thank you for the opportunity to provide the Committee some background related to provisions in the House-passed version of the Budget Bill. Should you or members of the committee have any questions please feel free to contact me.

Sincerely,



Miranda C. Motter  
President and CEO  
Ohio Association of Health Plans

CC: Members of the Senate Finance Workforce Subcommittee  
Senator Scott Oelslager, Chair of the Senate Finance Committee  
Senator Dave Burke, Chair of the Senate Medicaid Committee