Statement of the
Ohio State Medical Association
to the House Government Accountability and Oversight Committee

H.B. 450 – Requirements in relation to health insurance mandated benefits

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Chairman Blessing and members of the House Government Accountability and Oversight Committee, my name is Tim Maglione and I am the Senior Director of Government Relations for the Ohio State Medical Association (OSMA). On behalf of the 12,000 members of the OSMA, I offer testimony today in opposition to the introduced version of H.B. 450, legislation that would establish requirements in relation to mandated health insurance benefits already enacted in state law and requirements relating to any future legislation regarding mandated health insurance benefits.

Before discussing our specific concerns with H.B. 450, I would like to describe the process the OSMA has traditionally used when establishing a position on legislation that would require insurance coverage for certain benefits. Generally, our analysis will assess the following questions:

- Does the coverage requirement enhance the overall opportunities for a healthier Ohio?
- Are there studies that demonstrate there would be a minimal impact on insurance premiums if the coverage were mandated (or vice versa)?
- Is there data that show a long-term savings to the health care system if the coverage were required?
- Does the proposal address a unique or troublesome gap in existing insurance coverage?

Using the analysis above, the OSMA has previously supported legislatively enacted coverage requirements for services such as annual mammograms to detect breast cancer, mental health parity, hospital length of stay timeframes for mothers following the delivery of a baby and coverage for diabetes management, education and supplies. There have been others

where we have taken an “under advisement” position pending the attainment of data on the potential impact a mandate would have on premiums.

So, with that background, I would like to now comment on the specific provisions of H.B. 450.

ODI Actuarial Study & ODI Summary Report

The OSMA does not oppose this provision of the bill but would suggest that any actuarial study on existing mandated benefits include an analysis of the potential cost savings of the mandated benefit. In other words, what potential future insurance costs are avoided because an individual gets “upfront” coverage to potentially better manage an existing or future medical condition.

Mandate list to accompany insurance invoices

H.B. 450 requires every insurance invoice to include a statement that “the cost of health insurance may be *higher* due to mandated benefits required by the State of Ohio . . . regardless of whether plan participants need or use these benefits” and that “if you are concerned about how these mandated benefits *increase* the cost of your health insurance premium, please contact your state legislator.”

Like our comments on the actuarial study requirement, we are not necessarily opposed to this mandated statement to be included in insurance invoices, but we would suggest the statement also include a declaration “*that these mandates can also provide early detection opportunities for some diseases, may provide better care management opportunities for certain health conditions, may provide opportunities for better health outcomes and may actually lower overall health insurance premiums*.” As for the requirement to contact your state legislator regarding concerns, we might also suggest adding a provision that individuals might contact state legislators to express *thanks or support* for the coverage requirement.

Health Care Mandated Benefits Review Committee

We do not necessarily oppose this provision and appreciate the requirement that the committee consist of “experts in evidence-based medicine.” We would only suggest clarifying that that these experts be limited to actively practicing, Ohio-licensed physicians.

Criteria for new mandated benefits

The OSMA strongly opposes creating any statutory criteria that would limit a future General Assembly’s consideration of new health insurance coverage requirements. As many of you know from experience with these issues - and from my own personal 24-years of experience with the OSMA - no mandated benefit has ever been enacted without a thorough and deliberative process to assess its policy implications. Proponents, interested parties and opponents have weighed in on all of the various proposals through numerous legislative committee hearings, floor debates and eventually commenting to the executive branch. In short, these are not the types of issues that get done without considerable debate.

As such, we don’t believe future legislatures should be restricted by some arbitrary set of “qualifications” before new proposals can be enacted, i.e., medical expense inflation must be lower than CPI or whether any other state has enacted a similar proposal.

Conclusion

In summary and in conclusion, the OSMA has always reviewed each mandated health insurance benefit proposal on a case-by-case basis using criteria that weighs public health benefits and long-term cost savings v. potential for increased premiums. We believe the legislature has also always taken this approach and we see no need to change this thoughtful and deliberative process.

Thank you again, Mr. Chairman, and members of the committee, for the opportunity to comment on H.B. 450. I would welcome any questions or comments that you may have.