House Health Committee
April 11, 2018
Comments of Miranda Creviston Motter
President and CEO, Ohio Association of Health Plans

Chairman Huffman, Vice Chair Gavarone, Ranking Member Antonio, and members of the House Health Committee, thank you for the opportunity to provide comments on House Bill 72, a measure which, as currently drafted:

- strays from the original intent of the bill;
- mandates a certain step therapy protocol; and
- put upwards pressure on health care costs – by ushering in higher drug costs – for employers, individual consumers and the state as the purchaser of Medicaid benefits and state employee health care benefits.

The Ohio Association of Health Plans (OAHP) is the state's leading trade association representing the health insurance industry. OAHP's member plans 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 Federal Insurance Marketplace. Our members offer a broad range of health insurance products to Ohioans in the commercial marketplace and are committed partners in public programs.

Health insurers utilize step therapy processes to protect the Ohioans they cover. Step therapy programs are valuable tools used by insurers to ensure that the safest, most cost-effective drugs are used before having to turn to riskier and more costly pharmaceuticals. These tools are especially important in today's health care landscape.

For more than a year, stories of pharmaceutical companies increasing prices for both new and old, brand and generic drugs, have become mainstays in news cycles across the country. From EpiPens and naloxone to insulin and muscular dystrophy drugs and many more, rising and erratic drug pricing is adding to the overall cost of health care in the United States and placing undue burden and uncertainty on purchasers of health insurance. Unfortunately, these stories of overnight, astronomical drug increases are becoming the norm rather than the exemption.

One of HB 72's primary objectives is to allow patients the ability to access more expensive drugs. OAHP agrees that something must be done about the unsustainable cost of drugs that eases the unpredictable financial burdens placed on Ohio's health care consumers. Many Ohioans would not be able to afford the price of their prescription drugs without their health insurance coverage. And, for many, even with their health insurance, they cannot afford the drugs they need.

Aside from relieving individuals and families of the full financial burden associated with certain drug

regiments, step therapy also ensures patient safety. Health plans use accredited step therapy protocols that comply with state and federal laws, are developed in alignment with FDA guidelines and clinical evidence and adhere to utilization management (UM) accreditation standards from organizations such as the National Committee for Quality Assurance (NCQA) and URAC.

These standards are developed with multi-stakeholder participation, including clinical input, with the opportunity for public comment. Step therapy programs encourage providers and patients alike to pursue evidence-based treatments that gauge a patient's response to less dangerous drugs before transitioning them to more potent - and potentially harmful - medications.

HB 72 strays from the original intent of the bill. As we understand it, the original intent of this policy measure was not to significantly diminish the step therapy process; but rather ensure that a patient – who has gone through step therapy and switches health plans – does not have to go through the step therapy process again with the new plan. OAHP supports that goal and is supportive of language to fix that issue.

Unfortunately, the most recent version of the bill (-2 version) does not accomplish this goal. In fact, the current version of the bill widens the applicability, scope and impact. Further, the effect of those changes will eliminate the step therapy process and jeopardize the safety of patients and the affordability of health care for Ohio's purchasers of healthcare.

OAHP has developed a proposal that addresses original problem presented. *As a result, OAHP cannot support the -2 version of HB 72 and would respectfully request that the bill be narrowed to address the original concept.* OAHP has drafted language that addresses the original intent of the legislation regarding "switching plans," and is based off a Maryland statute that was agreed to by both the provider and health plan community. OAHP's proposal is attached for your review.

HB 72 is subject to the two-year moratorium on mandates, established by Section 6 of Ohio HB 463 from the 131st General Assembly. OAHP does not agree with the LSC memorandum dated April 2, 2018 from Yosef Schiff, Attorney indicating Sub. H.B. 72 does not require insurers to cover specified services or expand coverage. Rather, HB 72 is subject to the HB 463 moratorium. If passed, HB 72:

- will be a law "impacting" health care and insurance plans;
- requires insurers to adopt specific "practices" to determine if health care is covered;
- requires insurers to cover prescription drugs in specific situations; and
- expands coverage of prescription drugs by limiting step therapy in comparison to existing coverage.

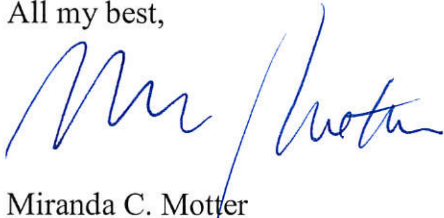
It is important to note that HB 72 is not only subject to the moratorium, but it also constitutes a "mandated health benefit" that should undergo an actuarial review as required by Ohio Rev. Code § 103.145 and is subject to the prohibition contained in Ohio Rev. Code § 3901.71.

I have attached a memorandum prepared by Doug Anderson, of Squire Patton Boggs that provides a fuller analysis on this issue.

I ask that as you deliberate on this bill, that you thoughtfully consider the many ways in which step therapy programs benefit Ohioans regarding their overall health and health care costs. **And, ultimately, we urge you to vote against this bill.**

The Ohio Association of Health Plans and its member plans stand ready to work with state policymakers to achieve the shared goal of enacting health care reforms that lower costs and improve quality for all Ohioans.

All my best,



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

OAHP Step Therapy Proposal
March 2018

Background: The original goal of SB 56 was not to significantly diminish the step therapy process; but rather to ensure that a patient -- who has gone through step therapy and switches health plans – does not have to go through the step therapy process again with the new plan. OAHP supports that goal and is supportive of language to fix that issue.

SB 56/-4 Version: The most recent version of the bill (-4 version) does not accomplish this goal. In fact, the various versions of the bill have widened the applicability, scope and impact and the effect of those changes will eliminate the step therapy process and jeopardize the safety of patients and the affordability of health care for Ohio's purchasers of healthcare.

OAHP Request and Position: As a result, OAHP cannot support the -4 version and would respectfully request that the bill be narrowed to address the original concept.

OAHP supports addressing this "switching plan" issue and OAHP would like to offer language that provides a solution for "switching plan" issue. OAHP's solution provides a step therapy exemption for patients switching plans and is based off a Maryland statute that addresses this issue and was agreed to by both the provider and health plan community.

Note, Divisions (C) and (D) were added to the Maryland language to ensure that the insured/enrollee receives information about lower cost/clinically effective alternative medications.

Legislative Proposal:

As used in 3901.82 of the Revised Code:

(A) "Health Benefit Plan" or "Health plan issuer" have the same meaning as section 3922.01 of the Revised Code.

(B) "Step therapy protocol" means a protocol established by a health plan issuer that requires a prescription drug or sequence of prescription drugs used by an insured or enrollee before a prescription drug ordered aby a prescriber for the insured or the enrollee is covered.

As used in 3901.821 of the Revised Code:

(A) A health plan issuer may not impose a step therapy protocol on an insured or an enrollee if a prescriber provides supporting medical information to the health plan issuer that a prescription drug covered by the health plan issuer:

(1) was ordered by a prescriber for the insured or enrollee within the past 180 days; and

(2) based on the professional judgment of the prescriber, was effective in treating the insured's or enrollee's disease or medical condition and where the prescriber provided documentation in the patient's medical record the specific reason for the step therapy exemption, consistent with national treatment guidelines or package inserts.

(B) Division (A) of this section may not be construed to require coverage for a prescription drug that is not:

(1) covered by the policy or contract of a health plan issuer subject to this section; or

(2) otherwise required by law to be covered.

(C) Nothing in this section shall be constructed from prohibiting a health plan issuer from notifying the insured or enrollee of a lower cost alternative drug that could be clinically effective for their condition and is available for a lower co-payment to the insured or enrollee.

(D) Where Division (A) applies, a prescriber shall notify the insured or enrollee of a lower cost alternative drug that could be clinically effective for his or her condition and is available for a lower co-pay to the insured or enrollee.

SQUIRE
PATTON BOGGS

Memorandum

To: Miranda Motter
Ohio Association of Health Plans

From: Doug Anderson

Date: April 10, 2018

Subject: Ohio HB 72 and the Moratorium on Health Care Mandates

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At your request, I reviewed the current sub-bill version of Ohio HB 72 ("HB 72") pending in the Ohio General Assembly to determine whether it: (1) contains a "health care mandate" subject to the two-year moratorium on mandates established by Section 6 of Ohio HB 463 from the 131st General Assembly ("HB 463"); (2) should undergo an actuarial review pursuant to Ohio Rev. Code § 103.145; and (3) is subject to Ohio Rev. Code § 3901.71 which prohibits mandated health benefits from taking effect if they cannot be applied equally in all respects to plans subject to ERISA.

As you know, Section 6 of HB 463 states that the General Assembly intends to impose a two-year moratorium on "any new health care mandate impacting individual and group health insurance plans" not subject to ERISA. This two-year moratorium extends until April 6, 2019. Further, Ohio Rev. Code § 103.145 provides that if a bill includes a "mandated benefit", the bill should undergo an actuarial review as part of its consideration by the General Assembly. In addition, Ohio Rev. Code § 3901.71 provides that a "mandated health benefit" should not take effect unless the Ohio Department of Insurance determines that it can be applied equally in all respects to employee benefits plans subject to ERISA.

The term "health care mandate" as related to the HB 463 moratorium is not defined. However, the term "mandate" is commonly defined as an "official order", and synonyms include "directive", "order", "law", "statute", and "requirement". *See* Oxford Dictionary, definition of "mandate".

In the context of Ohio Rev. Code §§ 103.145 and 3901.71, the term "mandate" is defined as follows:

- Ohio Rev. Code § 103.144 defines "mandated benefit" to include:
  - "Any requirement that an insurer . . . offer specific medical or health-related services, treatment, medications or practices to . . . enrollees"; and
  - "[A]ny expansion of . . . existing coverage".
- Ohio Rev. Code § 3901.71 defines "mandated health benefit" to include "any required coverage".

Although these two statutory definitions do not directly apply to the HB 463 moratorium, they are consistent with the common definition of mandate as being a "requirement."

HB 72 is subject to the HB 463 moratorium because:

- If passed, HB 72 will be a law "impacting" health care and insurance plans.
- HB 72 requires insurers to adopt specific "practices" to determine if health care is covered.
- HB 72 requires insurers to cover prescription drugs in specific situations. In this regard, HB 72 states:
  - "A health plan issuer . . . shall grant a step therapy exemption if any of the following are met . . . ."
  - "Upon granting a step therapy exemption, the health plan issuer . . . shall authorize coverage for the prescription drug . . . ."
- HB expands coverage of prescription drugs by limiting step therapy in comparison to existing coverage.

As to the last two bullet points, HB 72 "requires" and "expands" coverage of prescription drugs and, thus, is a health care mandate. Consequently, not only is HB 72 subject to the moratorium, but it also constitutes a "mandated health benefit" that should undergo an actuarial review as required by Ohio Rev. Code § 103.145 and is subject to the prohibition contained in Ohio Rev. Code § 3901.71.

Thank you for opportunity to review this matter. If you have any questions or follow up, please do not hesitate to contact me at (614) 365-2717 or doug.anderson@squirepb.com.