HB 691 Opponent Testimony
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House Insurance Committee
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Chairman Brinkman, Vice Chair Antani, Ranking Member Boggs and Members of the House Insurance Committee:

Thank you for the opportunity to submit written opponent testimony on HB 691. 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.

Before commenting on specific provisions of the legislation, OAHP would like to provide background on prompt pay laws and their general intent. Prompt pay laws represent a "checks and balance" system that is intended to ensure that providers are paid in a timely manner, while also allowing health plans the opportunity to receive and review information related to a claim to verify that it is eligible for payment according to the terms of the insurance contract, as well as any applicable laws or regulations. Health plans have a duty to comply with contractual terms and to mitigate the potential for fraud, waste, and abuse in the healthcare system.

The current prompt pay law was built upon this notion of checks and balances on all parties. Currently, the Ohio Department of Insurance (ODI) enforces prompt pay laws for the commercial and exchange plans they regulate. Plans must file prompt pay reports to ODI on a bi-annual basis. Further, if plans do not comply with prompt pay standards, they are subject to penalties in the form of interest on the amount of the unpaid claim. ODI can also impose fines starting with $100,000 and initiate market conduct exams. To put this in perspective, Ohio has some of the most stringent prompt pay penalties in the country, with the second highest interest rate at 18% and being one of only seventeen states that allow the appropriate regulator (ODI) to impose further administrative fines.

The Department of Medicaid (ODM) follows federal prompt pay standards (42 CFR 447.46) put in place by the Centers for Medicare and Medicaid Services (CMS), as Medicaid is a

joint federal and state program. States must comply with federal requirements set forth by CMS. In addition to federal standards, the Ohio Department of Medicaid sets forth requirements within the provider agreement. If Managed Care Plans (MCPs) are not complying with prompt pay standards, they can be fined by ODM through provisions in the provider agreement.

During the IP meeting on HB 691 earlier this year, OAHP asked for data and studies of the current system to support the contention that the current law is not working. We look forward to receiving such data and studies so that we can understand the proposed need for such drastic changes.

While OAHP has concerns about many parts of the legislation, below are some provisions we would like to highlight.

Timelines/Penalties

The legislation shortens many of the timelines, including for penalties as follows:

- Shortens the timeline for a health plan to request supporting documentation from 15 days to 10 days (lines 71- 73)
- Shortens the timeline for payment upon receipt of supporting documentation from 45 days to 5 days (lines 88 - 94)
    - This is 15 days in total to pay an "unclean claim", as opposed to the current 60 days.
- Increase the penalty for late processing/payment from 18% to 50% - 100% of the claim (lines 342 - 361) depending on the claim/situation.
    - This includes if the provider fails to provide supporting documentation or if just one claim is not processed in accordance with the timelines specified.

Information to verify claims

There are many lines in the legislation that limit a health plans ability to gather information and verify claims. Some examples include:

- Lines 86-87 prohibit a health plan from denying a claim for lack of supporting documentation. Supporting documentation is requested to verify a claim for factors such as medical necessity.
    - A provider could refuse to provide supporting documentation and then a plan would be liable to pay the penalties detailed above because the claim was not paid.
- Lines 117-124 prohibit a health plan from requesting medical documentation as to whether services are documented in the record or concerning the amount of a claim. o This does not allow a health plan to verify that services were rendered, which opens a health plan to paying fraudulent claims.
- Lines 125-132 do not allow a plan to request medical records if services are prior authorized or if the plan was notified of a hospital admission within 48 hours.

- This would not allow a health plan to confirm that services were rendered, confirm items on an invoice to ensure nothing was added to what was previously authorized and could lead to fraud. Health plans are charged with being good stewards of taxpayer, employer, and individual's health care dollars and using said dollars for medically necessary services. This language directly undermines a health plan's ability to do this and opens the healthcare system up to fraud, waste, and abuse.

Medicaid Managed Care

It is worth noting that this legislation would require ODM to adopt the same prompt pay standards as ODI as revised in this legislation. As stated above, MCPs are required to comply with federal prompt pay standards and the requirements set forth in the ODM provider agreement. In order for this to occur ODM would have to receive approval from CMS of a state plan amendment or waiver to impose different prompt pay requirements. A state law applied MCPs that deviates from federal prompt pay requirements, without CMS approval, is contrary to federal law and puts federal funding for Ohio's Medicaid program at risk.

OAHP is opposed to HB 691. We believe this legislation does not strike an appropriate balance between paying medical providers in a timely manner while allowing health plans the proper ability to ensure claims are eligible for payment. Furthermore, no compelling data or studies have been provided to show the need for the changes proposed in the legislation. Thank you for the opportunity to submit testimony on HB 691.