



Substitute House Bill 49 – Interested Party Testimony
Senate Small Business & Economic Opportunity Committee
Wesley Wolfe, Vice President, Market & Network Services, Cleveland Clinic
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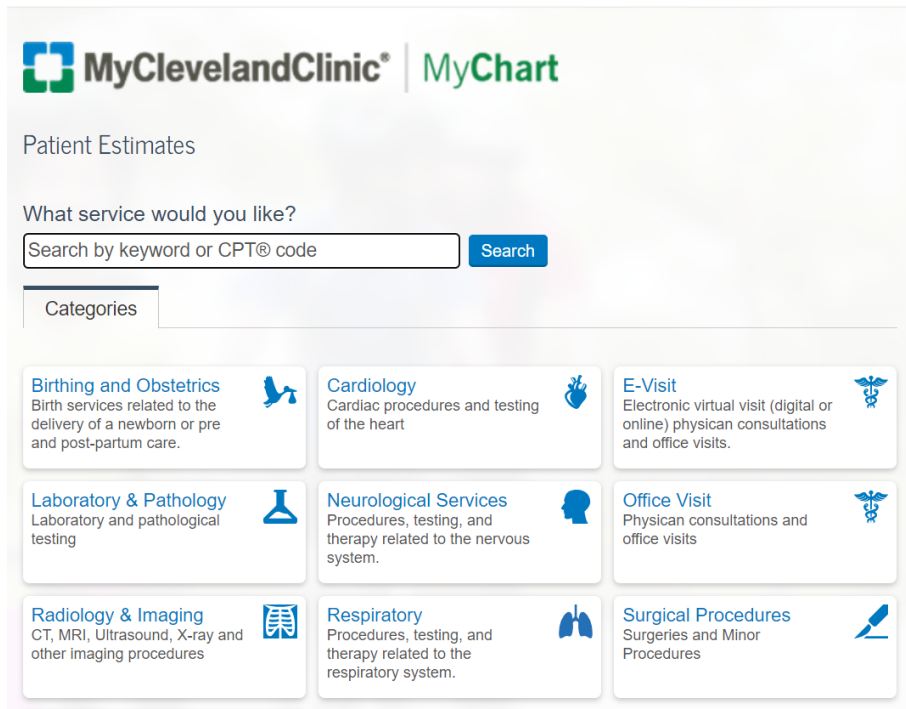
Chair Lang, Vice Chair Wilkin, Ranking Member Sykes, and members of the Ohio Senate Small Business & Economic Opportunity Committee, thank you for allowing me to provide interested party testimony for Substitute House Bill 49, legislation regarding hospital price transparency and site neutral payments. My name is Wesley Wolfe, and I am Vice President of Market & Network Services at Cleveland Clinic.

As described in more detail below, Cleveland Clinic is committed to price transparency and provides tools and support for patients seeking to understand their potential health care costs. We are pleased with the substitute bill's approach to price transparency, which provides an appropriate balance between state-level accountability and alignment with existing federal requirements. However, we have significant concerns with the proposed provisions that restrict the ability of hospitals and health systems to bill for hospital services provided at facilities that may have been acquired from physicians at any time in the past.

Cleveland Clinic is a not-for-profit, integrated healthcare system dedicated to patient-centered care, teaching, and research. Cleveland Clinic Health System operates 23 hospitals with more than 6,600 staffed beds, including a main campus near downtown Cleveland and 15 Northeast Ohio regional hospitals, as well as 276 outpatient locations. Cleveland Clinic employs over 5,700 physicians and scientists and over 16,500 nurses. Last year, our system cared for 3.3 million patients, including 13.7 million outpatient visits and 323,000 hospital admissions and observations. Cleveland Clinic is proud to be Ohio's largest private employer and is dedicated to being a leader in patient experience, clinical outcomes, research, and education for patients.

As part of our commitment to price transparency, since 2015 Cleveland Clinic has regularly made estimates for care available to patients when scheduling surgical and diagnostic services and upon request for all other services. Our comprehensive pricing information has been available on our website since January 2021, when federal price transparency rules became effective. In 2022, we prepared nearly 850,000 individual estimates for our patients.

We also have a patient self-service module (see graphic below) where, either through their MyChart account or through Cleveland Clinic's website, patients have the ability to produce their own estimates for 300 common services that are considered "shoppable," allowing patients to compare the same services between hospitals. Cleveland Clinic's cost estimator tool provides a financial estimate for a medical service based on insurance coverage and what patients have been charged in the past for the same service. Our comprehensive hospital charges list is also posted on our website.



Cleveland Clinic is fully transparent in its rates and is a leader and supporter of price transparency for its patients. We support language in Sub. HB 49 that aligns state requirements with federal law. We appreciate that the new language does not create a bifurcated reporting system that would require hospitals to adhere to two sets of reporting requirements at the state and federal level. We are also grateful that Sub. HB 49 incorporates hospitals' use of patient cost estimator tools to provide meaningful price transparency for consumers.

Despite these improvements to hospital price transparency language in the substitute bill, Cleveland Clinic has serious concerns with new language added to Sub. HB 49 that would insert state government into third party contracts by prohibiting a hospital or health system from requiring a third-party payor or self-pay individual to pay facility fees in connection with any health care items or services at a hospital acquired outpatient facility. The implications of the proposed language are ambiguous, especially the concept of "facility fee," and we still are working to fully understand the potential operational and financial impacts, though we believe they would be significant.

Specifically, the bill states that its prohibition on payment of facility fees would apply to "independent outpatient physician facilities" that are acquired by hospitals/health systems *or have been acquired in the past*. We interpret this to apply to any building that a hospital may have acquired from an independent physician at any point in time. For Cleveland Clinic – which celebrated its centennial in 2021 – and likely for other hospitals with a historical footprint in their communities, identifying the provenance of long-owned facilities may prove difficult, particularly given that necessary documentation may no longer exist beyond what is required for record retention purposes.

Additionally, the language does not indicate whether a hospital/health system could ever "cure" a facility of acquired status – for example, by tearing down the acquired facility and building a new one in its place, or by repurposing part or all of the facility to provide different health care services than those offered by the physicians it was acquired from. In both cases, potential patients would



seem to have sufficient notice that they are receiving care from the hospital/health system, but it is not clear whether a hospital could bill for hospital services provided at the facility under the proposed legislation.

We assert that the question of whether facilities fees are payable by private third-party payers is best addressed through private contracting between those payers and hospitals/health systems, as is the current practice. Further, our transparency on pricing allows patients to self-determine if they are willing to pay a facility fee or select another provider.

I appreciate your consideration of our feedback, and I thank you again for allowing me to provide written interested party testimony on behalf of Cleveland Clinic.