Ohio Association of Health Plans

May 14, 2025

Chairman Steve Huffman
Senate Health Committee
1 Capitol Square
Columbus, Ohio 43215

Chairman Huffman, Vice Chair Johnson, Ranking Member Liston, and members of the Senate Health Committee: on behalf of OAHP, thank you for the opportunity to offer testimony to Sub House Bill 96.

First, we would like to highlight a couple of amendments OAHP would like to see **included** in the Senate Budget sub bill:

- **Default Notifications (SC0625):** Allows an insurer to conduct business electronically via an automated transaction without first obtaining affirmative consent from the insured. Requires the insurer to communicate a procedure by which the insured may opt out of electronic communications and, instead, conduct business on paper. Specifies that automated transaction of business related to individual health insurance policies constitutes delivery to the insured unless the insured communicates to the insurer in writing or electronically that the insured does not agree to delivery by automated transaction. **This would allow insureds the convenience of electronic notifications, saving both time and money.**
- **Facility Fees (amendment number forthcoming):** This amendment would limit facility fees in hospitals to outpatient facilities that are constructed or that did not previously operate as an outpatient physician facility prior to its acquisition by a hospital. **OAHP pulled previous facility fee language due to implementation issues in Indiana. We took feedback and revised the language to ensure Ohio does not have the same problem.**
- **Provider Payment Method (SC0454):** Replaces the bill's prohibition against insurers mandating providers to accept payment by credit card with a requirement that insurers allow providers to opt out of payment by credit card. Requires an insurer to disclose only those fees that are charged by the insurer, as opposed to

fees "associated with a particular payment method," which may include fees charged by a financial institution, credit card issuer, or payment processor. Extends the time within which an insurer must change a health care provider's payment method following a request by the provider. Allow an insurer to unilaterally change a provider's payment method if the insurer has not generated a payment to the provider in more than one year. **OAHP has worked with ODI and has sign off from the Department and the Governor's Office on this language.**

OAHP supports **removal** of the language below that was included in the House version:

- **PBM Amendment, Dispensing Fee (SC0291; INSCD6):** The provision institutes a mandated dispensing fee on every prescription filled in Ohio. The mandated per prescription fee is, estimated to be between $10.50-$15.47, and conservative estimates project the cost to be $6.4 billion dollars over the next decade. **This language would increase drug costs at a time where prescription drug costs are already too high for Ohio businesses and consumers.**

Additionally, OAHP has concerns with Medicaid language that was included in the House sub bill. We would encourage the Senate to **remove or amend** these harmful provisions:

- **Federal medical assistance percentage for expansion eligibility group (OBMCD32 & MCDCD58):** Ohio Association of Health Plans is part of Ohio Medicaid Matters, a coalition of more than 80 organizations, including the state's leading human services agencies, health advocacy associations and hospital systems. We believe Medicaid is foundational to Ohio's economic success, and we want as many Ohioans as possible to have the health care they need to work and thrive. As currently proposed, "shall" trigger language in HB 96 would immediately discontinue medical assistance for the 770,000 Ohioans in the Medicaid expansion group if federal funding dips below 90%. Ohio Medicaid Matters is asking lawmakers to enable flexibility and change the trigger language from "shall" to "may."" **Using "may" allows the legislature and administration to retain control over the best strategy to minimize the impact of any cut in the federal matching rate.**

- **Automatic Enrollment in Medicaid MCO plan (SC0106):** The language (MCDCD53) that was added specifies that the Ohio Department of Medicaid (ODM) must allow individuals participating in the Medicaid program to enroll in the MCO plan of their choosing and requires ODM to randomly assign an individual to an MCO plan without giving preference to a specific MCO plan or group of plans if the individual fails to select a plan. Historically, ODM has utilized a quality-based assignment methodology when an individual does not self-select an MCO to reward higher

performing MCOs with increased enrollment. Quality-based assignment methodologies incentivize MCOs to ensure members are receiving quality care through how an MCO performs on national quality measures such as HEDIS measures. Quality-based assignment methodologies can also be used to ensure MCOs are meeting specific program integrity requirements such as provider network standards and timely claims payment. Since the quality-based assignment methodology is the same for all MCO participating in the Next Generation program, all MCOs have an equal opportunity at hitting the measurement targets. At the start of the Next Generation managed care program in 2023, ODM paused the quality-based assignment methodology to ensure the MCO entrants received adequate membership. **Those MCOs have met the membership threshold put in place by ODM and in May ODM reinstated the quality-based assignment methodology.**

- **Electronic Visit Verification System (EVV) (SC0107; MCDCD48):** Establishes duties on, and grants authority to, ODM, DODD, Medicaid managed care organizations (MCOs), and other entities in the event the ODM Director establishes an electronic visit verification (EVV) system in rule. The EVV requirement is part of the Federal Cures Act. The Cures Act states that the states must ensure that EVV claims are matched with EVV visit transaction, claims without matching transactions are denied.
  The omnibus bill prohibits MCOs from denying a claim that is not supported by info in the EVV system. Furthermore, the budget bill states that an MCO to conduct a post-payment audit or review to consider info in the EVV system as part of our audit or review protocol, but prohibits an audit based solely on the EVV system. **If the Federal Law says the claims need to match or will be denied, the budget language should be null and void because Federal Law trumps state law.**

- **Medicaid audit of Medicaid MCOs (MCDCD61):** Requires ODM to conduct an annual financial audit of each Medicaid MCO and submit a report to the General Assembly and JMOC concerning these audits. The MCOs are currently required to submit the following annual financial reports to ODM:
  - The Annual Audit Report as required by ORC Section 1751.321;
  - Annual NAIC Financial Report and Annual Cost Report Reconciliation

  This adds additional, unneeded administrative and financial burden to the MCOs and ODM.

We encourage members of the committee to discuss these provisions in regard to access and help control costs for businesses and enrollees. Thank you for your time and consideration!