State Representative Jim Butler

41st House District

House Bill 399 – Sponsor Testimony before the House Health Committee; Wednesday, June 6th, 2018

Chairman Huffman, Vice Chair Gavarone, Ranking Member Antonio, and Members of the House Health Committee, thank you for this opportunity to offer sponsor testimony for House Bill 399.

The need for transparency in healthcare costs is long overdue. Under the current system, it is only with great difficulty that a patient can extract a quote regarding a procedure, and even then, the quote is often not entirely complete. With precipitous increases in out-of-pocket expenses to patients over the past decade, I am sure you can appreciate that patients should be able to easily access the costs of their non-emergency healthcare, especially in this current era in which high deductible plans are quite common.

I am the author of the Ohio Price Transparency Law, which passed the Ohio General Assembly unanimously in June 2015. The Price Transparency Law states that, starting on January 1, 2017, all healthcare providers must provide each patient an upfront, good-faith estimate of the costs of anticipated non-emergency services before providing the service. The estimates must include:

(1) The amount a provider will charge;

(2) The amount the insurer intends to pay; and

(3) The patient's resulting out-of-pocket expenses.

The insurers must respond to inquiries from providers within a reasonable timeframe so an estimate can be prepared.

The Ohio Price Transparency Law is currently being blocked by a lawsuit filed by hospitals and other provider groups.

I have heard that some opposition to this law is due to the perceived increase in administrative burden that may be placed on providers if the onus of providing price estimates is placed on their shoulders. I would like to express that I am absolutely sympathetic to the degree with which physicians already feel oppressed by their administrative task load. After two years of discussions about the potential

administrative burden on providers and other potential difficulties in providing the estimates, I have drafted a new version of the Price Transparency Law (2.0). The new proposed law will require insurers, not providers, to give patients price estimates well before they are scheduled to get the healthcare services so patients have more time to make informed decisions. Additionally, I have proposed a series of reforms that will actually lower the overall administrative burden on providers.

The differences between the current law and Transparency 2.0 in HB399 are as follows:

(1) The one piece of information that only providers have is the specific service or product the patient is scheduled to receive. Accordingly, within 24 hours of a patient making an appointment for services, the provider will send the CPT codes or product identifier for the scheduled services to the insurer. Providers will use exactly the same mechanism as is currently used for prior authorizations and pre-certifications (pursuant to another Ohio law, by January 2018, every insurer must have a web-based system for providers to transmit this information);

(2) CPT codes for Evaluation and Management appointments are exempt from the requirements and need not be sent to the insurer;

(3) Insurers have the rest of the information, such as patient contact, insurance plan details, and deductible status. Upon receiving the CPT or product code from a provider, starting in 2019, the insurer will immediately send the patient a price estimate electronically via an app or email. The patient may request that a paper copy be mailed to them by the insurer if the appointment is more than two days out;

(4) A provider may voluntarily provide the estimate directly to the patient;

(5) If the patient requests, the provider will also give the patient the CPT code or product identifier for the scheduled service;

(6) Insurers must maintain websites for patients to use CPT codes or product identifiers to shop for services within the provider's network.

(7) The administrative burden on providers has increased substantially over the past several years, making it harder for providers to focus on caring for patients and leading to burnout. Accordingly, the following administrative burden reductions are part of the new bill:

a. The top 25% of physicians ranked based on approved prior authorization percentages over the preceding three years are exempt from all prior authorization requirements for all insurers;

b. No prior authorizations will be required for procedures or medications under $100 for 30-day supply;

c. Prohibits prior authorizations for ongoing treatment for chronic disease for drugs or products approved in the past. A prior authorization approval should be valid for the duration of the prescribed/ordered course of treatment;

d. No fail first protocol may be used if the patient has failed the treatment being required in the preceding five years;

e. No utilization review entity can require patients to repeat step therapy protocols or retry therapies failed under other benefit plans before qualifying for coverage of a current effective therapy;

f. Starting Jan. 1, 2019, after entry of necessary information on an insurance web portal, there must be links for one-click, online, automatic submission for prior authorizations;

g. The Ohio Office of Health Transformation, in consultation with the Ohio Department of Insurance and Department of Medicaid, will conduct a review of all administrative burdens, the utility of each (financial, time, and quality of care), and recommend changes to lower administrative burden by Dec 31, 2018. The findings and recommendations will be publicized and open to public comment;

h. Utilization review entities should provide, and vendors should display, accurate, patient-specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record (EHR) systems for providers' use for activities such as e-prescribing;

i. By Jan. 1, 2021, EHR vendors must provide an update to EHR software for providers to have the ability to transmit prior authorizations without a new narrative entry, but instead automatically copying the pertinent part of narrative in the patient's record that a provider can highlight and automatically send to payer for review;

j. A drug, product or medical service that is removed from a plan's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended should be covered without restrictions for the duration of the benefit year unless the drug, product or service is pulled from the market or prohibited; and

k. Utilization review entities should offer a minimum of a 60-day grace period for any step therapy or prior authorization protocols for patients who are already stabilized on a particular treatment upon enrollment in the plan. During this period, any medical treatment or drug regimen should not be interrupted while the utilization management requirements (e.g., prior authorization, step therapy overrides, formulary exceptions, etc.) are addressed.

Following unsuccessful attempts by the Governor and others to repeal the healthcare transparency law in the last budget, in May 2017, I proposed to the Ohio Hospital Association and Ohio State Medical Association replacing the current law with the compromise in this bill. They rejected the offer. The reason given was that even sending the additional CPT codes for a scheduled visit through a web portal that are not needed for prior authorization or pre-certification is too much of an administrative burden, notwithstanding all the additional reforms in the bill that lower the administrative burden on providers. Furthermore, the bill jointly proposed with the Ohio Hospital Association in an attempt to repeal the current law requires that the provider give proactive estimates for a list of certain services. Though giving estimates for only a portion of what patients might be receiving would be confusing to patients (for example, the cost for a C-section for triplets would be given, but not the cost for the care of the

babies in the NICU), it would also be a much greater administrative burden for providers that the Transparency 2.0 proposal in HB399 where insurance companies are required to give the estimate. Following the refusal to accept the compromise and the ongoing attempt to repeal the current law legislatively, intense litigation has commenced in the lawsuit filed by the Ohio Hospital Association and Ohio State Medical Association. If the Ohio Hospital Association and Ohio State Medical Association would agree to support the compromise in this bill, a pause in the lawsuit could be arranged to give time for the bill to pass.

Chairman Huffman, thank you for the opportunity to provide this testimony. I am happy to answer the committee's questions at this time. Thank you.