Joint Testimony of Ohio Hospital Association and Ohio State Medical Association

on House Bill 416 (Price Transparency)

House Insurance Committee

January 25, 2018

Good morning, Chairman Brinkman, Ranking Member Boccieri, and Members of the Committee.

My name is Sean McGlone. I am General Counsel at the Ohio Hospital Association. With me today is Tim Maglione, Senior Director of Government Relations at the Ohio State Medical Association. We appreciate the opportunity to provide joint testimony today regarding HB 416 and the concepts captured in this proposal. Our respective organizations have been working on this issue collaboratively for the past couple of years and share similar perspectives on this challenging topic.

As we frame this discussion, is it important to note that hospitals and physicians support efforts to make health care pricing more transparent. Providers across the health care spectrum have taken many meaningful steps in recent years to make prices more transparent – including efforts to publicly post prices for common services on websites, providing estimates for certain common and "shoppable" services, informing patients of cost-sharing obligations for scheduled services, responding to patient inquiries about the cost of services, purchasing expensive technologies to facilitate providing estimates to patients, and other similar efforts.

Hospitals, physicians, and other providers have taken these steps not because a law or regulation requires them to, but because the competitive health care market and patient demand has caused them to respond in this way. That is a good thing for patients and for the health care system generally, and market forces have pushed providers in that direction much more effectively than government regulation. In fact, no state legislative or regulatory approach to health care price transparency can really be held up as an effective model – many states are struggling with this issue, but none have legislated a silver bullet that moves the needle to providing meaningful transparency for consumers. But again, market forces have moved providers in that direction.

In our members' experience, the vast majority of them provide estimates to patients for any service if the patient requests an estimate. In an era of increasing consumerism, more and more patients are asking for estimates, and providers are responding.

Our members' goals as it relates to legislative proposals concerning price transparency are two-fold:

- To provide meaningful information to patients that allows them to assess the value of health care services; and
- To provide that information in a way that is administratively manageable and with which providers can comply. Nobody benefits from passing laws with which it is impossible to comply.

Some legislative proposals have required providers to give patients information on their "charges" or "list" prices, which are prices that are largely used only to negotiate discounts with health insurance companies. Virtually no patients pay the "list" price, and that information is meaningless to them. What patients want to know is how much something is going to cost them out of their pocket. They do not care what is negotiated vis a vis the provider and insurance company.

However, in order to provide meaningful price information to patients, providers and payers need to work collaboratively. Providers alone do not have all of the information necessary to provide a patient a meaningful estimate of the cost of a health care service. As you know, individuals' health plan coverage varies dramatically, and the only way to provide them a meaningful estimate is to get information about their coverage that only the payer has. For example, a provider cannot know where in a patient's deductible they are without obtaining that information from the payer. And in an era where $7,000 deductibles are increasingly common, that information is crucial to being able to tell a patient what their out-of-pocket obligation will be. Similarly, even if a deductible is met, there can be massive differences in a patient's out-of-pocket obligation if their plan pays 70% of the cost beyond the deductible or pays 90% beyond the deductible. This information can only be given by a provider if it is first provided by the patient's insurance company. And, the process of obtaining that information is time consuming and labor intensive and is in addition to what providers must already do to verify a patient's insurance eligibility and benefits, obtain prior authorization and submit a claim to the insurers for payment.

In recent years, the OHA and OSMA have supported a transparency proposal that we believe would be the most comprehensive consumer-level price transparency law in the country. That proposal includes:

- Require providers to provide estimates for <u>any service upon the patient's request</u>.
- Require providers to provide estimates for certain other "shoppable services" <u>even if a patient does not request the estimate</u>. <u>We are not aware of any state in the country that requires providers to provide estimates even if the patient does not request it</u>.
    - This requirement would be contingent on:
    - The payer giving the provider the information necessary to provide a meaningful estimate within a certain time of the request from the provider;
    - The service being scheduled at least 7 days in advance, in order to allow the provider and payer to work together to obtain the necessary information;

Our proposal has some other elements to be worked out, but we believe this framework would make Ohio a national leader in health care price transparency.

Another concept that our organizations believes merits discussion is the one presented by Rep. Huffman in HB 416. His proposal would:

- Require providers to provide estimates for any service scheduled seven days in advance upon the patient's request.
- For any service for which the payer requires prior authorization, the payer would be required to provide an estimate to the patient.

HB 416 merits consideration because it builds on an already-existing administrative process with which providers and payers are already familiar, and the systems are already built to accommodate the transfer of the information necessary to produce an estimate. When a provider submits information to a payer in order to get prior authorization, the payer has all of the information necessary to provide an estimate to the patient.

At the end of the day, providers and payers need to work together to provide meaningful price information to patients. We look forward to the opportunity to continue this dialogue with you and the payer community.

Thank you again for the opportunity to share our respective organizations' perspectives on this difficult issue. At this time, I would like to invite Tim Maglione to join me and we would be happy to answer any questions.