House Insurance Committee
Wednesday, March 7, 2018

Comments of Miranda Creviston Motter
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Chairman Brinkman, Vice Chair Henne, Ranking Member Boccieri,and members of the House Insurance Committee, on behalf of the Ohio Association of Health Plans (OAHP), thank you for the opportunity to offer our concerns on House Bill 416.

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.

Today's health care landscape presents us with many challenges. One major challenges is the need to ensure that health care consumers have access to health care cost information.

OAHP's concerns are focused in two key areas – (1) the need to ensure shared responsibility by both the provider and the plan for transparency and (2) the need to provide the consumer the complete picture of health care costs.

- ***H.B. 416 largely eliminates a providers' responsibility to share price or cost information directly with consumers.*** Under HB 416 providers would be required to given consumers an estimate of the cost of a heath care service only if that service does not require a prior authorization. If a prior authorization is required, that responsibility shifts from the provider to the health insurer.

- ***HB 416 will only give Ohio health care consumers a partial picture of health care costs.*** Under HB 416, providers are only required to disclose insurance cost information. Providers are not required to disclose the actual price of the health care service. Health care consumers have access to their insurance cost information. What they don't have access to is provider price information. Giving health care consumers a partial picture of health care costs is not transparency and does not fully equip consumers to make health care decisions.

Health Insurers Support Transparency. OAHP and its member plans have consistently supported provider transparency measures that equip Ohioans with the information necessary to make informed decisions about the health care services they receive. As health care costs continue to rise, it is vital that providers directly offer their patients the necessary information about the price or cost of services delivered. This information is in addition to the insurance and out-of-pocket information a consumer receives directly from their insurer and will provide them with a complete picture of the charges pertaining to their health care episode.

This is one of the major reasons OAHP opposed the Administration's budget proposal that would have eliminated ORC 5162.80, the section of law that providers are protesting and is currently in litigation. While we believe minor changes or adjustments may be needed to ultimately make that language more workable, the provider accountability that is embedded in current law is critically important for health care consumers. Throughout all of our conversations with policymakers on this issue, OAHP consistently stated its opposition to shifting that responsibility to insurers.

This is important. Why? Insurers strongly believe they are accountable – and are held accountable – today under both state and federal law and regulations (attached). In fact, many health plans are taking this a step further and are offering cost information to their enrollees in new and innovative ways. Many health plans currently offer tools that can help consumers save on health care. Plans are dedicated to educating their members and empowering them to make decisions that positively impact their health and wellness. Because of this, plans highlight transparency tools and cost variation to their enrollees.

To that end, OAHP is not supportive of legislation that would shift the provider accountability to insurers by requiring the provider to share cost information with the insurer, thereby placing ultimate responsibility on the insurer to communicate provider cost information, insurance coverage information and out of pocket information.

Certain providers are already required to disclose price information and many others disclose price information when they are pursing pre-service payments. As this Committee considers transparency requirements, it is important to remember hospitals are already required to disclose price list information to health care consumers. Ohio Revised Code Section 3727.42 has been in effect since 1986 and requires every hospital to compile and make available for inspection by the public a price information list containing certain information. In fact, the Ohio Hospital Association referenced this law during the last hearing on this bill. As a result, disclosure of price information directly to the consumer should not be administratively burdensome to many providers because they are already required to do so under current Ohio law.

Additionally, many hospitals and providers already disclose price information when they are pursing pre-service payments from health care consumers. I am sure we all have our own personal story of being asked by a health care provider to pay for a health care service upfront. This type of practice demonstrates the fact that providers know the information, are providing it today and are willing to spend the time to disclose price information when it means that they might get paid up front for services that have not yet been performed.

Consumers don't care about price information. One of the major arguments we've heard from heath care providers about transparency is that consumers don't care about price information, but

rather they only care about their out of pocket costs and thus providers should not be required to disclose information that consumers don't want. As health care spending continues to increase, Ohio's health care consumers should be able to decide for themselves whether they care about price information or not.

- On February 14th, CMS released new data on projected national health expenditures for 2017-2026. This data tells us that national health spending will continue to increase[1], the price for medical goods and services is on the rise[2] and among the major sectors of healthcare, spending growth is projected to be fastest for prescription drugs.[3]

- As health care spend has increased, consumers are being asked to pay more for health care services, and thus understanding and anticipating those costs is increasingly important to them.

- The ultimate goal is that greater transparency ultimately saves the health care consumer money and begins to drive down health care costs.

To argue that transparency is administratively burdensome and that consumers don't care about price information is just not accurate and is the exact problem policymakers not only in Ohio but across the country are intending to fix.

Ohio health care consumers need a complete picture of health care costs. As health care costs continue to rise, it is vital that providers directly offer their patients the necessary information about the costs of the services they receive. This information in addition to the insurance and out-of-pocket information a consumer ***already*** receives directly from their insurer will prove a health care consumer a complete picture of charges.

As this Committee considers this legislation, OAHP would like to offer the following modifications for consideration:

- Focus on what the provider is charging the consumer for health care, not what the health insurance company will pay for.
- Empower consumers by asking the provider to give reasonable estimates to patients directly for the amount the provider will charge, rather than shift the responsibility to the insurer where there is a prior authorization.

To that end, OAHP urges you to thoughtfully consider the impact that this bill will have on Ohio's health care consumers. If enacted, ***HB 416 would only give Ohio health care consumers a partial***

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[1] *National health spending will increase at an average annual rate of 5.5 percent during the full projection period (2017-2026).*

[2] *The price for medical goods and services is on the rise and projected to increase from historically low rates in 2014-2016 (1.1 % per year) and average 2.5% per year in 2017-2026.*

[3] *Among the major sectors of healthcare, spending growth is projected to be fastest for prescription drugs, averaging 6.3 percent for 2017-2026.*

picture of health care costs. Therefore, OAHP urges you to vote against HB 416 as currently drafted.

Thank you for the opportunity to comment on this bill. As always, OAHP and its member plans stand ready to work with state policymakers to achieve the shared goal of affordable and quality healthcare for all Ohioans.

State and Federal Transparency Laws

1. ORC 3901.241 – List of Top 20% of Services and Cost-Sharing (Eff. 9/29/2015)
   - Applies to issuers offering health benefit plans on the federal insurance exchange.
   - Requires issuers to make available to individuals seeking information on a plan:
     a. a list of the top twenty percent of services (according to utilization by individuals insured by the insurer) and the enrollee's expected contribution (including copayments and cost sharing) for each such service; and
     b. expected enrollee contribution for specific services both for situations in which the enrollee has and has not met associated deductibles.

2. ORC 3923.81(B) – System to Obtain In-Network Cost Sharing (Eff. 3/23/07)
   - Applies to sickness and accident insurers, health insuring corporations, and MEWAs.
   - Requires issuers to establish and maintain a system whereby a person covered by a health benefit plan may obtain information regarding potential out-of-pocket costs for services provided by in-network providers.

3. OAC 3901-8-02 – Disclosure of Provider Discounts (Eff. 11/14/2008)
   - Applies to third party payers including insurance companies, preferred provider organizations, labor organizations, employers, third party administrators, MEWAs, and any other persons obligated under a benefits contract to reimburse for covered services, except that third party payer does not include health insuring corporations.
   - Requires payers to disclose the existence (not the amount) of any negotiated discount on billed charges that will be paid by a third party payer. The existence of the discount may be disclosed by the payer in the policy or certificate of coverage.

4. OAC 3901-8-16 – Provider Directories Disclosures (Eff. 1/1/16)
   - Applies to health plan issuers, defined as any entity subject to the insurance laws and rules of the state or the jurisdiction of the superintendent of insurance that contracts to pay for or reimburse the costs of health care services under a health benefit plan, including insurance companies, health insuring corporations, MEWAs, fraternal benefit societies and nonfederal, government health plans.
   - Requires provider directories to clearly disclose:
     a. which providers and facilities belong to each network;
     b. which networks are applicable to each specific health benefit plan;
     c. a general statement notifying enrollees that there may be providers at a facility (such as anesthesiologist, radiologists and laboratories) that are not in-network, and a method for contacting the issuer for more information; and
     d. an explanation of the process used to determine reimbursement for out-of-network services and describing any balance billing that may occur.
   - Requires issuers, upon an enrollee's request, to disclose the amount of any deductibles, copayments, coinsurance or other amounts for which the enrollee may be responsible. The issuer shall inform the enrollee that such disclosure is not binding on the issuer and that the amount for which enrollee is responsible may change.

5. 42 USC 18031 and 45 CFR 156.220 – Transparency in Coverage (Eff. 2/27/2012)
   - Applies to qualified health plan (QHP) issuers under federal law, which includes issuers that offer coverage in the individual and small group health insurance markets both on and off the exchange.
   - Requires QHP issuers to make available the amount of enrollee cost sharing under a plan of coverage with respect to the furnishing of a specific item of service by a participation provider in a timely manner upon request of an individual. At a minimum, such information must be made available to such individual through an Internet Web site and such other means for individuals without access to the Internet.
   - Requires QHP issuers to submit the following information to HHS and to make such information available to the public:
     a. Claims payment policies and practices;
     b. Periodic financial disclosures;
     c. Data on enrollment;
     d. Data on disenrollment;
     e. Data on the number of claims that are denied;
     f. Data on rating practices;
     g. Information on cost-sharing and payments as to out-of-network coverage; and
     h. Information on enrollee rights under title I of the Affordable Care Act.

6. 45 CFR 156.230 – Out of Network Cost Sharing (Eff. 1/1/2018)
   - Applies to QHP issuers.
   - Beginning in 2018, requires each QHP issuer that uses a provider network to either:
     a. count the cost sharing paid by an enrollee for an essential health benefit (EHB) provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing or
     b. provide a written notice to the enrollee by the longer of when the issuer would respond to a prior authorization, or 48 hours before providing the benefit, that additional costs may be incurred for an EHB provided by an out-of-network ancillary provider in an in-network setting, including balance billing charges, unless the costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

   Under this rule, an ancillary provider is a provider of a service that is ancillary to the service provided by the primary provider, such as anesthesiology or radiology.