Ohio Association of Health Plans

Representing Ohio's Health Insurers

May 27, 2009

The Honorable Barbara Boyd, Chair
Ohio House Health Committee
Statehouse
Columbus, Ohio 43215

Dear Representative Boyd:

I am writing to express concerns with HB 81. The bill would place a mandate on individuals and groups purchasing health insurance to pay for benefits for the expense of equipment, supplies and medication for the diagnosis, treatment and management of diabetes and for diabetes education -- regardless of whether that individual or group of individuals wants to purchase that coverage. Additionally, the language in HB 81 is very broad and could lead to unnecessarily higher costs for coverage than necessary.

I apologize for not being able to appear before your committee today as prior engagements do not allow me to testify in person. However, knowing how important this bill is to you and your interest in moving forward, I wanted to make sure we provided you with feedback as you consider the details of HB 81.

In the past, we have testified on similar bills and have met with various sponsors and advocates to express our continued concern with mandating disease specific coverage and some of the unintended consequences of similar language. As the statewide trade association representing health insurance companies, we continually hear from our members about the impact that mandates have on the cost of providing health insurance benefits. Each new mandate comes at a cost that is born by individuals and employers purchasing health insurance for their employees.

Our members strive to provide cost effective coverage for primary care and preventative services to keep patients well and therefore avoid unnecessary health care costs. Our member plans understand the value of patient education in order to achieve optimum health status and avoid complications of chronic diseases such as diabetes. It's good medicine and contributes to cost-effective care.

Through a survey of our members in the past, we have concluded the following:

- More than 90% of fully insured health plans include diabetes equipment and supplies in their standard commercial products. Syringes, glucometers, lancets and chemstrips are routinely covered.
- Plans that do not offer this coverage in their standard commercial product generally have riders available to add this coverage.
- Insulin, oral agents and medications are covered under the supplemental prescription coverage offered by health plans.
- Every plan responding covers diabetes self-management education and nutrition therapy ordered by and coordinated through the patient's network physician at some level.
- Most plans routinely produce brochures and newsletters and coordinate community education forums on diabetes.
- Most plans provide intensive disease management programs for their enrollees with chronic diseases, such as diabetes.

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The bottom line is that coverage for the types of services the bill is trying to mandate with the passage of HB 81 are already available in the marketplace. However, not all individuals or groups choose to purchase this coverage, participate in the available programs and the coverage may not be as broad as the language in HB 81. For example, current coverage may limit the number of strips or supplies covered in one month to avoid a situation where the strips or supplies are changed and therefore new ones prescribed to fit new equipment being used. Additionally, the education provided may be more abundant currently in group settings and only available to the extent the bill calls for if the individual's circumstances require a series of one-on-one educational sessions. These are all trade offs to ensure that the limited healthcare dollars are focused on providing the maximum benefits at the highest outcomes and lowest costs. HB 81 would take away these safeguards.

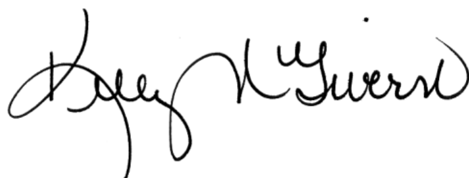
Aside from the philosophical concerns surrounding government mandated benefits, we are concerned with the technical problems HB 81 creates and the precedent it sets in the marketplace. Specifically, the bill requires basic coverage for medications and certain supplies that are now considered supplemental benefits. Carving out certain drugs and supplies only for diabetes from the supplemental benefit and providing through a basic benefit structure creates an administrative problem of efficiently administering the prescription drug coverage. While HB 81 tries to address this issue by allowing the supplemental services to remain – not all employers or individuals choose this coverage and in fact may choose other vendors to provide these services. The language in HB 81 would still require the creation of a new administrative process to handle those situations thus increasing the costs of these benefits. This issue was raised with SB 116, from the 126th General Assembly and addressed in this law by requiring the coverage only if the pharmacy or other supplemental coverage had been purchased.

Additionally, we believe the definition of what must be covered under the bill is open-ended and will ultimately lead to disagreements over how far the coverage extends. For example, will insurers be required to cover special shoes or the future I-Pod that allows the user to also test their blood sugar? We suggest tightening up the language to assure that new treatments are only covered if proven more beneficial than other treatments. We suggest adding language to limit coverage to those services proven effective through evidence based medicine in addition to the medical necessity requirement already in the bill. We also believe that any educational programs must "adhere to" ADA standards of care and not simply be based upon. Finally, it should also be clarified that the number of hours in the bill are maximum hours and only if the required settings are medical necessary.

Finally, our experience in the past and those of other states have shown that once a treatment, service, or drug is mandated to be covered by state law, the price of those treatments, services or drugs becomes more expensive. Again, this unintended consequence has been addressed most recently in SB 186 from the 127th General Assembly which requires coverage of routine patient care for individuals enrolled in a clinical trial. This bill included language that specified that the reimbursement is not required if the facility or the provider does not have a contract with the health insurer.

Ohio's health plans are committed to providing quality health care at affordable costs to all enrollees. Preventive care and education are integral parts of quality benefits. However, the health plans cannot support the government deciding what must be added to or changed in an already comprehensive benefits package when so many Ohioans remain uninsured.

Sincerely,



Kelly McGivern
President and CEO

Cc: Members of House Health Committee