HEALTH CARE TRANSPARENCY

WHY IT'S IMPORTANT?

Per the Centers for Medicare and Medicaid Services (CMS), annual health spending growth is anticipated to grow at an average of 5.7 percent through 2019 and at an average growth rate of 6 percent from 2020 to 2025.[1] In turn, the United States spends more money on health care than any other nation in the developed world and - despite the trillions of dollars we invest in health care each year - we are missing opportunities to improve the overall value of those investments and to improve health outcomes among consumers. This problem is further complicated due to the significant price variation that exists for hospital and physician services both within and across markets.

As consumers become more engaged in making decisions about their health care, the availability of price information becomes even more important. This is vital as consumers typically pay for at least some portion of their care and may be unaware of the range in potential costs. Thus, price transparency is an important tool to improve consumer engagement.

Better price transparency would also help consumers to better understand their financial responsibilities and assist purchasers of health insurance to better manage their overall health care costs. Greater transparency also promises to mitigate volatile and unexplainable price variation across different access points of care.

In an era of rising health care costs and insurance premiums, purchasers of health care are interested in knowing more than just their out-of-pocket insurance expenses. Consumers deserve to know the various prices and factors that compose out-of-pocket costs, and this includes knowing how much health care providers charge for the services they deliver. Only then will Ohio be able to say that true transparency is a reality, rather than a goal.

Ohio must continue the push for provider transparency

Ohio's health plans already comply with a series of state and federal transparency requirements that assist their health care consumers in understanding their insurance costs. However, prices charged by hospitals and providers at the point of service remain the mystery variable preventing patients from understanding the totality of their health care costs. This forces patients to receive and ultimately pay for hidden and unexplained charges after a health care service is received.

According to a July 2015 report by the Catalyst for Payment Reform, Ohio is among the states receiving an "F" in regards to enacted price transparency laws.[2]

The 131st General Assembly attempted to improve Ohio's position by passing legislation that requires health care providers to provide patients with the prices charged for non-emergency services or procedures prior to delivering care. This was an important step forward to empowering Ohioans to make informed decisions about the care they receive; however, the FY 2018-2019 budget bill eliminates this provision - thus eliminating the requirement on providers to disclose price to consumers.

- ✓ OAHP supports public policy efforts to holdfast in efforts to equip Ohio's health care consumers by require providers to disclose price information.

[1] Centers for Medicare and Medicaid Services. National Health Expenditure Fact Sheet. 2015.
[2] *Report Card on State Price Transparency Laws*. Catalyst for Payment Reform. July 2015.

Protect Ohioans against "surprise billing"

Patients in Ohio and across the nation continue to be mired by the issue of surprise billing. "Surprise billing" is the term commonly used when a consumer of a health care service is billed after the fact for unknowingly receiving out-of-network care when visiting an in-network facility. In 2016, at least six states, including California, Florida, and Texas, passed legislation to address the practice of surprise billing.

- ✓ OAHP supports legislation that protects Ohio's health care consumers from such practices.

Address the new, growing trend of 'freestanding ERs.'

Ohioans who choose to obtain care at freestanding emergency rooms will likely receive unexpected bills after visiting the facility. The United States is home to an estimated 360 freestanding ERs - 60 percent of which are in Colorado, Ohio, and Texas. Patients in need of quick or convenient care often visit these ERs thinking they are neighborhood urgent care facilities - but they are not. These facilities are often affiliated with larger hospitals, but located away from the primary campus or, in some cases, they are independent freestanding emergency departments. Following an episode of care in one of these facilities, a patient often receives a bill that is considerably higher than those anticipated in urgent care settings. In fact, the Colorado-based Center for Improving Value in Health Care reported that costs associated with non-emergent care delivered in freestanding ERs exceeded urgent care rates by at least $400.[3]

- ✓ OAHP supports state policy solutions that require disclosures by freestanding ERs and strengthen Ohio's certificate of need program, by strictly monitoring unnecessary health care facility costs and encouraging better coordination and planning of new services and facility construction.

Take on the unexplained and rising prices of prescription drugs.

Drug costs remain one of the primary drivers behind overall health care costs in the United States. Although there are federal actions that can be taken to address this problem, Ohio policymakers can also address this problem by requiring drug manufactures to disclosure drug price information. America's Health Insurance Plans (AHIP) has noted that spending on drugs is expected to rise from $337 billion in 2015 to $560-590 billion in 2020.[4] Additionally, CMS projects prescription drug spending to grow at an annual average of 6.7 percent from 2016 through 2025.[5] As we face continued growth in the pharmaceutical space, the time is right for Ohio to require drug manufacturers to disclose the rationale and detail behind their products' costs. OAHP supports state legislation that emphasizes the importance of transparency of drug costs.

[3] Center for Promoting Value in Health Care. *Utilization Spot Analysis: Free Standing Emergency Departments*. July 2016
[4] America's Health Insurance Plans, *High-Priced Drugs: Estimates of Annual Per-Patient Expenditures for 150 Specialty Medications*. April 2016
[5] Centers for Medicare and Medicaid Services. National Health Expenditure Fact Sheet. 2015

APPENDIX: Current Transparency Requirements on Ohio's Health Plans

Health insurance companies operating in Ohio have long been held accountable by a series of transparency requirements found in both state and federal code. These provisions include:

- **45 CFR 156.230 – Out of Network Cost Sharing** (Eff. 1/1/2018)
  Applies to QHP issuers. Requires each qualified health plan (QHP) that uses a provider network to either:
  - 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
  - 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.

- **ORC 5162.80 – Assistance with Reasonable Good-Faith Estimates** (Eff. 1/1/2017)
  Applies to health plan issuers. If a health plan issuer is contacted by a health care provider seeking information needed to respond to patient's request for a good faith estimate of charges, reimbursements, and out-of-pocket expenses for health care services, the issuer shall provide information in response to the provider's request within a reasonable time.

- **OAC 3901-8-16 – Provider Directories Disclosures** (Eff. 1/1/2016)
  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:
  - which providers and facilities belong to each network;
  - which networks are applicable to each specific health benefit plan;
  - 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
  - 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.

- **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. Should an individual be seeking information on a specific health plan, issuers are required to make available:
  - 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
  - expected enrollee contribution for specific services both for situations in which the enrollee has and has not met associated deductibles.

- **42 USC 18031 and 45 CFR 156.220 – Transparency in Coverage** (Eff. 2/27/2012)
  Applies to 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. QHP issuers must 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:
    - Claims payment policies and practices;
    - Periodic financial disclosures;
    - Data on enrollment;
    - Data on disenrollment;
    - Data on the number of claims that are denied;
    - Data on rating practices;
    - Information on cost-sharing and payments as to out-of-network coverage; and
    - Information on enrollee rights under title I of the Affordable Care Act.

- **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.

- **ORC 3923.81(B) – System to Obtain In-Network Cost Sharing** (Eff. 3/23/2007)
  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.

- **ORC 3923.62 – Disclosure of UCR for Dental Benefits** (Eff. 10/12/1994)
  Applies to sickness and accident insurers and TPAs providing dental benefits and which base benefits on usual and customary fees charged by dentists. If requested by a policyholder or covered person, the issuer must disclose:
  (1) the frequency of determination of UCR fees;
  (2) a general description of the methodology used to determine UCR;
  (3) the geographic area used to determine UCR; and
  (4) if UCR fees are determined through sampling of dental claims and then selecting a percentile of the fees, the percentile that is used.