



**Testimony of Kevin Conrad**  
**On Behalf of the Ohio Association of Health Underwriters**

**In Support of H.B. 388**

**Before the House Finance & Appropriations Committee**

**November 13, 2019**

Chairman Oelslager, Vice-Chairman Scherer, Ranking Member Cera and members of the House Finance Committee, I am appearing today as a Past-President and the current Vice-Legislative Chair of the Ohio Association of Health Underwriters (OAHU). OAHU members are licensed insurance agents and are experts in the sale and servicing of health insurance products in Ohio's individual, small group (1-50) and large group (51+) markets. I have been in the insurance business since 1985 and currently serve as the manager of the Columbus office of Rogers Benefit Group which has 33 offices in 18 states.

I think it's fair to say that for those Ohioans with health insurance, "surprise" health insurance bills are probably the most frequent, critical problem facing them when using the health care system today. OAHU hears from our members on a regular basis that one of their clients has been negatively affected by a "surprise bill" in a hospital setting. We hear examples of this occurring in both emergency and non-emergency situations. When surprise bills occur today, there is an undefined, protracted process that in many cases leaves the patient financially impaired.

In an August 12, 2019 analysis released by the Journal of the American Medical Association (JAMA) the authors concluded the following:

- In reviewing just under 5.54 million hospital inpatient admissions and just over 13.5 million emergency department admissions between 2010 and 2016, out-of-network billing increased from 32.3% to 42.8% of emergency room visits, and the mean potential liability to patients increased from \$220 to \$628.
- For inpatient visits, the incidence of out-of-network billing increased from 26.3% to 42% and the mean potential liability to patients increased from \$804 to \$2,040.

The conclusion of the research was as follows: “It appears that out-of-network billing is becoming more common and potentially more costly in both the emergency department and inpatient settings.”

With this as a background, OAHU supports H.B. 338 because it establishes an appeals process to negotiate reimbursement utilizing easily understood reimbursement criteria. Under the process, the reimbursement would be the **greatest** of the following three rates:

- The median in-network rate.
- The out of network rate if there is out of network coverage.
- The Medicare rate.

In addition, the consumer cannot be billed for the difference between the plan’s reimbursement and the provider’s charge.

Another option under H.B. 388 is for the out of network provider to negotiate a reimbursement directly with the emergency room facility. If the negotiation is not resolved within 30 days then the out of network provider may request arbitration. When the arbitration process is completed, the loser pays 70% of the arbitrator’s fees and the prevailing party pays 30%.

In conclusion, OAHU believes that H.B. 388 establishes a reasonable reimbursement methodology that should greatly increase the likelihood that providers and payors can come to a mutually agreeable payment. H.B. 388 rightly makes arbitration as a last resort.

I am happy to answer in questions.