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Insurance Committee
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Proponent Testimony
House Bill 440

Chair Brinkman, Vice Chair Henne, Ranking Member Boccieri and members of the House Insurance Committee

My name is Deborah Silverstein and I live at 1072 Erin Drive in Kent, Ohio.

Medical debt is the single greatest reason for personal bankruptcy. What most don't realize is that the majority of those declaring bankruptcy due to medical debt had insurance at the onset of their illness. I almost experienced that phenomenon first hand.

Medical debt is the biggest reason for debt collections. I did experience that, being sent to collections twice while disputing a bill for services I never received.

On December 30, 2016 I fell and broke my hip while visiting my family in Michigan for the holidays. My initial reaction was fear – not of the broken hip, but of the financial implications needing medical care meant. While I had insurance, the deductible was high, and the co-insurance was also high. I knew this injury would be financially devastating to me. While I had met my high deductible for 2016, I also knew that my care would continue into the new year and a new deductible would be imposed.

I tried to will my leg to move but couldn't. I resisted calling for an ambulance while hoping that somehow my hip would miraculously be ok. Of course, that didn't happen. My brother finally called 911. And so, began the next hurdle of being a "good consumer of health care" and navigating the health care market place.

I had no choice of ambulance service. I had no choice of hospital. Once arriving at the hospital, I had no choice of Emergency Room physician, no choice of radiologist, no choice of surgeon, no choice of anesthesiologist and no choice of hospitalist, who oversaw my care after surgery.

Where was my market? Where were my choices? Where was my freedom?

I did try, despite the effects of being on a morphine drip, to be that good consumer of health care. I knew the hospital was in my network, but I did ask every person who came near me if they were in my network. All assured me they were. When I was told who the surgeon would be, I asked that they check to make sure she was in my network. I was assured she was.

When I was taken to pre-op, I met the anesthesiologist. Being that good consumer of health care, I asked her if she was in my network. She was the only one who admitted that she

probably wasn't in my network and told me it was my responsibility to determine that before needing her services. I asked how I was supposed to do that, and she did acknowledge that it would have been impossible. However, she admonished me that in the future, I should plan to break my bones in an area with in network providers. She went so far as to inquire of my insurance company and informed my sister that I should have gone to Benton Harbor, Michigan, a four-hour drive, for care.

It turned out, despite their assurances, that not one doctor in that in-network hospital was in-network. Most of them worked for a physician group owned by the in-network hospital, but that hospital chose to keep them out of network.

The Affordable Care Act requires that in an emergency, such as my broken hip, insurance companies must pay out of network providers at in-network rates. My insurance company did do that. However, the law does not prevent those out of network providers from balance billing. So, if the out of network anesthesiologist billed $4000 for services and in-network rates were $1500, she could bill me for the difference of $2500.

Of course, in this instance it wouldn't be the anesthesiologist billing me and pocketing the difference, it would have been the hospital. The anesthesiologist would never have known it was done, would never see the money, but it would have been done in her name.

When I was released from the hospital, I declined going to rehab, as we were in the new deductible period. I estimated my out of pocket expenses to be around $7000 already and couldn't incur any more debt. I did a short term of home-based physical therapy, but once released from that, I declined further therapy due to cost. I was on my own.

The market works very well for the providers, as they can manipulate it to their advantage. However, the market in health care rarely exists for patients. Most of the high bills in health care occur in situations like mine or in life threatening illnesses. Choices, if they exist at all, are very limited, leaving the patient to the mercy of the bean counters. Rarely does the patient win.

Abuses like what occurred to me would be ended by House Bill 440. The elimination of networks would eliminate the jeopardy patients are in any time they need immediate care. Patients would again have the free choice of doctor, hospital and pharmacy, the choices that are most important to them.

Most importantly, we would have the peace of mind and security of knowing we could receive care without jeopardizing everything we have ever worked for.