BEFORE THE HOUSE FINANCE COMMITTEE
Proponent Testimony on House Bill 388
November 13, 2019

Chair Oelslager, Vice Chair Scherer, Ranking Member Cera, and members of the House Finance Committee, my name is Keith Lake and I am the Vice President of Government Affairs for the Ohio Chamber of Commerce. I am here today to testify in support of House Bill 388, legislation to protect patients from the burden of costly, surprise medical bills.

The Ohio Chamber is the state's leading business advocate, and we represent nearly 8,000 companies that do business in Ohio. Our mission is to aggressively champion free enterprise, economic competitiveness and growth for the benefit of all Ohioans.

As you all know, unexpected or "surprise" medical bills are a big problem for many employees and their covered families. Not only have I heard numerous anecdotal stories from Ohio Chamber member companies about their employees who have received unexpected medical bills after receiving health care services but, according to a recent Kaiser Family Foundation analysis, approximately 18 percent of emergency visits and eight percent of in-network hospital stays in Ohio had at least one out-of-network charge in 2017.

The vast majority of Ohio Chamber member companies offer comprehensive health benefits to their employees and their families. In fact, more than 97 percent of all firms with 50 employees or more offer health insurance to their employees, as do a sizable number of firms with fewer than 50 employees. This means that a majority of Ohioans get their health coverage from an employer-sponsored private health insurance plan.

So, while the issue of surprise billing may primarily be a dispute between providers and health insurers, the solution to the problem of surprise billing impacts both employees and employers.

Health insurance plans and many of the employers who sponsor them go to great lengths to inform their enrolled employees about health care costs and quality. They provide transparency tools, provider directories, hotlines, and other resources that beneficiaries can use to find and access in-network care. Nonetheless, even the most proactive patients cannot always avoid encounters with out-of-network providers during the course of care.

That's why the Ohio Chamber is committed to working with the legislature to find a solution to this problem. A solution that protects patients by ending surprise billing, ensures fair provider compensation, and does so without driving up health insurance costs.

Health care costs are already rising at a rate far surpassing inflation. Average annual premiums for employer-sponsored health insurance rose an average of 4.9 percent in 2019, the biggest year-over-year percentage increase since 2011. Premiums have gone up 22 percent in the past five years and 54 percent in the past decade.

Guarding against unnecessarily raising health insurance premiums is why the Ohio Chamber believes that any solution to surprise billing should establish a reasonable benchmark and avoid the use of arbitration.

The reality is that most providers do not generate surprise medical bills. They participate in networks, form agreements with insurance companies, agree to reasonable compensation, and are paid in full. Further, in some instances when a patient does receive a surprise bill, the insurer and provider come to mutual agreement on payment.

However, when they cannot come to an agreement, a benchmark is needed to determine an appropriate payment amount. A benchmark is an amount which the insurer must reimburse providers for out-of-network services, and that a provider must accept as payment-in-full for the services.

Preferably, the benchmark should be based on the private market's established rate for a service in a particular geographic area, such as the average in-network reimbursement

for that service. Not only would such a benchmark reflect the rates established by the private market for these services, but it would also encourage network participation.

Binding arbitration, on the other hand, doesn't solve the problem. It only punts the dispute to an arbitrator to set the reimbursement rate. Arbitration creates administrative waste, funneling money that would otherwise be spent on the provision of medical care into paying for arbitration preparation expenses and, ultimately, an arbitrator's fees.

In the end, arbitration encourages cost escalation. Extra costs will get passed on by insurers to health insurance purchasers in the form of higher premiums. In effect, arbitration will merely turn surprise medical bills into surprise premium invoices.

HB 388, while not perfect, is a workable approach to solving the problem of surprise billing, which is why the Ohio Chamber supports it.

First and foremost, HB 388 holds patients harmless by banning balance billing by providers for out-of-network services and by limiting whatever cost-sharing an insurer requires of a patient to an amount no more than what they would require if the service were performed by an in-network provider.

Second, HB 388 establishes a reasonable benchmark in law that favors the rates established by the free market. It does so by requiring health plans to reimburse providers in out-of-network billing situations the highest of three possible rates: either 1) the median contracted rate that is paid to an in-network provider – in other words, the rate mutually agreed to between insurers and most providers; 2) the amount the health plan currently uses to determine payments for out-of-network health care services; or 3) the amount paid by Medicare.

Under most circumstances, the median in-network rate is going to be the highest of these three options. Thus, the HB 388 approach would ensure fair payment to providers without discouraging network participation.

Third, while the Ohio Chamber would prefer an approach to addressing surprise billing that doesn't rely on arbitration, the arbitration process that's contemplated in HB 388 is more of an arbitration as last resort, not as the primary dispute resolution mechanism.

Under the bill, in lieu of accepting the greater of the three possible rates the insurer is required to pay the provider for an out-of-network service, the provider may opt instead to negotiate with the insurer – and the insurer is required to attempt a good faith negotiation.

Only if negotiations fail to result in an agreed-to reimbursement is arbitration a possibility, and only the provider may request arbitration. In addition, in deciding which party's offer to award, the arbitrator must consider only the accuracy or inaccuracy of the reimbursement initially offered by the insurer, not any other factors. These features would limit the inflationary concerns we have about arbitration generally.

In conclusion, HB 388 will eliminate the vast majority of surprise medical bills, thus protecting patients, and ensure providers are fairly compensated, without creating a process that would lead to increased health insurance premiums for employers. For these reasons, the Ohio Chamber supports HB 388. Thank you.