May 5, 2020

Representatives Scott Oelslager and Jamie Callender, Co-Chairs
House Finance Committee
77 S. High St., 13th Floor
Columbus, Ohio 43215

Dear Co-Chairs Oelslager and Callender,

On behalf of the Ohio Association of Health Plans (OAHP), thank you for the opportunity to once again offer testimony on House Bill 388 (HB 388). OAHP offered verbal testimony in support of HB 388 to your committee on November 13, 2019. However, we have not had the opportunity to review the sub-bill accepted today. Therefore, OAHP is not taking a position on Sub. HB 388 until we have a chance to review the sub-bill.

The Ohio Association of Health Plans (OAHP) is the state's leading trade association representing the health insurance industry. OAHP's member plans provide health benefits to more than 9 million Ohioans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare, Medicaid and the Federal Insurance Marketplace. Our members offer a broad range of health insurance products to Ohioans in the commercial marketplace and are committed partners in public programs.

OAHP has and continues to advocate for a surprise billing solution based on three pillars. These three pillars are:

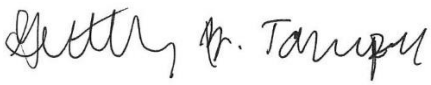
1. **Protect Ohioans from surprise medical bills by banning balance billing**. Ohioans deserve affordable high-quality health care and coverage; however, surprise medical bills give Ohioans little to no control over their health care costs and financial future. Patients should not be financially penalized when they receive out of network care through no fault of their own. Specifically, Ohio lawmakers should prohibit providers from sending a surprise bill to the Ohioan.

2. **A benchmark payment for out-of-network doctors should be based on local market rates or government fee schedules**. A payment benchmark should be established based on current local market rates (the in-network rate) or government fee schedules. Using a fair market driven rate or government fee schedule for a reimbursement benchmark would directly address the market failure of out-of-network outlier provider specialties.

3. **Appeals Process**. An appeals process should be established that works in tandem with the payment benchmark not one that becomes the default/primary vehicle instead of the established benchmark. Further, the appeals process should reduce consumers/employer's health insurance premiums by avoiding dispute processes which add unnecessary costs, delay, and bureaucracy to the health system. This can be done by allowing appeals on the accuracy of reimbursement.

OAHP looks forward to reviewing the sub-bill and evaluating it in relation to these pillars. Thank you for the opportunity to continue to comment on HB 388.

Sincerely,



Gretchen Blazer Thompson
Director of Government Affairs