

Thank you for the opportunity to provide sponsor testimony on House Bill 388, the Family Pocketbook Protection Act... legislation that will protect Ohioans from surprise medical bills and will do so in a way that will NOT increase health care costs.

This Family Pocketbook Protection Act helps families...it helps consumers...it helps patients.

If ever there were an issue we could all agree on, it is addressing the issue of surprise medical bills and giving Ohioans the peace of mind they deserve.

According to a recent study, 1 in 3 privately insured Ohioans have received a surprise medical bill in the last 12 months and 4 out of 5 Ohioans worry about surprise medical bills.¹ A surprise bill is an unexpected medical bill a patient receives from an out of network doctor after receiving care in an emergency room or in a hospital that's *in* the patient's insurance network.

¹ <https://www.healthcarevaluehub.org/advocate-resources/ohio-consumer-healthcare-experience-state-survey>

These bills are a “surprise” because they are unexpected AND generally very high. According to a recent study from Stanford University, surprise bills in patients bills rose from 26% to 42%, over a six-year period, while average costs in those bills have nearly tripled during that time.²

Recently, this issue has received a lot of attention in Congress and here in Ohio. Why? Nearly 8 in 10 Americans, across all political parties, support legislation to protect people from surprise medical bills.³ At a time when congressional action appears uncertain at best, Ohio is well positioned to lead the country by advancing a free market solution that will fix this problem for Ohioans. The Ohio House already has a clear record on this very issue. Just a few short months ago, this Committee and the Ohio House approved surprise billing legislation as part of the biennial budget.

²[https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2740802?guestAccessKey=9fba6e0c-f029-401a-9675-737db3e67b5d&utm_source=For The Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tf1&utm_term=081219](https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2740802?guestAccessKey=9fba6e0c-f029-401a-9675-737db3e67b5d&utm_source=For%20The%20Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tf1&utm_term=081219)).

³ https://khn.org/news/legislation-to-end-surprise-medical-bills-has-high-public-support-in-both-parties/?utm_campaign=KHN%3A%20First%20Edition&utm_source=hs_email&utm_medium=email&utm_content=76753922&hsenc=p2ANqtz-5-ApVJKhrXV2qHfkE8pH152iTa6odGlsEM24cmZPbKsyc3m_JrygviihroqEcEVKsFKcTTnMEAGRW8g0NaiKaNWAva&hsmi=76753922

In short, HB 388 prohibits balance billing, utilizes a free market payment approach and provides a baseball style arbitration process.

Bans Balance Billing. HB 388 protects Ohioans from surprise bills when they did NOT have a chance to choose in network care – specifically, out of network emergency care and out of network care in in-network hospitals.

Let me give you two examples.

Emergency Care. John Smith is home alone and has a heart attack. Sometime later, his wife comes home and finds him. He is unconscious. His wife calls 911 and the ambulance comes and takes him to an emergency room to receive emergency care. The ambulance takes John to a hospital that is not in his network and he is treated by a surgeon that is out of his plan's network. John is treated and goes home.

John recovers and his health is restored. Weeks later, John opens his mail and he receives an out of network bill for both the out of network hospital and the out of network doctor. He doesn't know what to do. He didn't know they were out of his network and now he's stuck with a very high bill.

Out of Network Care in an In-Network Hospital. John Smith knows he needs to have his hip replaced. It's not an emergency, so he does his research and schedules his surgery at a hospital that's in his network and he selects a surgeon that is also in his network. After ensuring all of the "known" services were provided by in network facilities/providers, he schedules and his proceeds with his surgery. Two weeks later, he receives his explanation of benefits from his insurer that reflects the in-network services from his surgery.

A couple of days later, however, John receives a separate bill from an out of network anesthesiologist from his in-network hospital. He is shocked by the high out of network bill.

He thought he did everything right – he did his research, he made sure he used an in-network hospital and in-network surgeon. No one told him that the hospital’s anesthesiologist was out of network. Now he’s stuck with a high out of network bill and he doesn’t know what to do.

HB 388 protects John Smith in both of these examples by prohibiting the out of network doctor from sending John Smith a surprise medical bill.

Free Market Payment Approach. In both these situations, HB 388 would require the health plan to pay the out of network doctor and/or emergency room hospital a reasonable, market rate for the out of network service.

Under the bill, the health plan must pay the HIGHEST of the 3 rates:

- (1) the in-network, market rate (what the plan pays in network providers for that service)
- (2) the price paid for the out of network service (if there is out of network coverage, what a plan pays for the out of network service)
- (3) the Medicare rate (or what Medicare pays for the service)

Baseball Style Arbitration. If an out of network doctor or emergency room hospital thinks the health plan didn't pay the correct amount, the doctor or hospital can dispute the accuracy of the payment through a streamlined "baseball style" arbitration process.

Other Out of Network Care. In all other out of network care situations, HB 388 allows out of network providers to charge “whatever they want” when the patient agrees, up front, to pay for the out of network service.

We owe it to Ohioans to try and solve problem for them. I am happy to any questions you may have at this time.