



MOUNT CARMEL

Testimony on House Bill 388 November 20, 2019

Chairman Oelslager, Vice Chair Scherer, Ranking Member Cera, and members of the House Finance Committee, thank you for the opportunity to provide testimony on House 388 and the important subject of surprise or balance billing.

I am Jason Koma, Regional Director of Government Affairs and Regional Development at Mount Carmel. Mount Carmel has provided high quality, comprehensive healthcare services in central Ohio for more than 130 years. Our team provides compassionate, people-centered care in central Ohio at four acute care hospitals as well as in surgery centers, emergency and ambulatory care centers, a rehabilitation hospital, a behavioral health hospital, hospice and home care. Mount Carmel is a member of Trinity Health, one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states.

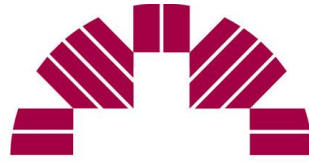
I want to thank this committee for moving the discussion forward on surprise or balance billing. Mount Carmel and our parent company Trinity Health are committed to addressing the affordability of health care for all patients and believe that patients should not be balance billed for emergency care or services obtained in any in-network facility when the patient could reasonably assume the provider was an in-network provider. Patients should also have certainty regarding their financial obligations, which are based on an in-network fee. Therefore, we are supportive of efforts to protect patients by banning surprise medical bills.

It is important to note that hospitals have few out-of-network claims today. In fact, within the 22 state footprint of Trinity Health, including here in Ohio at Mount Carmel, there have only been a handful of times in the last several years where patients have been sent a surprise bill for emergency services and those instances were quickly resolved.

That being said, I want to reiterate that we believe that patients should be protected from such bills. We support solutions to do so as long as those efforts stay true to that goal. Unfortunately, this legislation extends further by establishing a resolution process that will disrupt the private negotiations between insurers and hospitals. Therefore, we cannot support HB 388 as currently written.

As it stands now, when hospitals do have claims for emergency services provided to out-of-network members, hospitals and health plans either negotiate mutually agreeable out-of-network payment rates or resolve through legal means. This process should continue.

HB 388 and other potential proposals that regulate how hospitals and insurers resolve out-of-network claims, including rate setting or arbitration, will have the unintended consequence of eroding hospitals' market competition. Rate setting and/or arbitration will incentivize insurers to avoid contracting in good faith with hospitals and instead default to an arbitrary rate, such as the process outlined in HB 388. This will result in fewer in-network hospital options for patients.



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Currently, insurers and hospitals negotiate complex contracts that include many factors in determining payment rates, including an expectation to provide a full scope of services. For example, hospitals negotiate discounts with insurers based on the expected volume of patients and the ability to provide all services to the insurer's members. Benchmark rates do not account for these factors.

A benchmark rate would remove the ability of hospitals to negotiate with insurers, especially in smaller and rural markets where insurers may decide not to contract with hospitals, leading to fewer options for patients. Other potential processes such as arbitration are troubling as well. Arbitration will likely lead to rate setting because arbiters will ultimately rely on a benchmark rate. When it comes to hospitals and the complex contracts our facilities have with insurers, there is no successful model for hospital arbitration today.

Any proposal that mandates insurers to pay facilities set payment or benchmark rates when an out-of-network claim dispute arises is not necessary to prevent surprise billing. The goal here is simple and one that Mount Carmel supports. Let's protect patients from surprise billing.

Unfortunately, HB 388 goes beyond that by setting up a process that interferes with hospital and insurer negotiations and may limit patient in-network options. While I want to thank this committee again for bringing this important matter forward, we cannot support the bill as currently written.