Ohio State Medical Association

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Statement of the Ohio State Medical Association
to the House Finance Committee

Opponent Testimony: HB 388 – Surprise Billing

Presented by Monica Hueckel, Senior Director, Government Relations
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Chair Oelslager, Vice Chair Scherer, Ranking Member Cera, and members of the House Finance Committee, my name is Monica Hueckel and I am the Senior Director of Government Relations for the Ohio State Medical Association (OSMA), the state's largest professional organization representing Ohio physicians, medical residents, and medical students.

The OSMA appreciates the opportunity to testify today and share our concerns about House Bill 388. Physicians are supportive of efforts to relieve the excessive burden of surprise medical bills on patients, and the OSMA has been working on this issue for about 4 years now. Patients should not be stuck in the middle of payment disputes between providers and insurance companies. We remain committed to working with the legislature and other interested parties to create a meaningful, evenhanded solution.

What we have sought to establish here in Ohio is a comprehensive and fair system which would eliminate the surprise billing burden in a way that would not cause severe disruptions to the delivery of quality care. Surprise billing should be addressed with a balanced, evidence-based, and proven approach to reconciling differences between physician charges and plan payments, while at the same time protecting patients by removing them completely from the dispute.

We believe the intent of HB 388 is good; however, we have significant concerns about the system it would set up. Under the bill, the plan must reimburse the greatest of the following three amounts:

- The median amount the health plan issuer negotiated with in-network providers or facilities for the service in question;
- The rate the health plan issuer pays for out-of-network services under the health benefit plan; or,
- The rate paid by Medicare for the service in question.

The provider is also given the option to inform the plan that they wish to negotiate, in which case the plan must attempt a good faith negotiation with the provider or facility. If, in 30 days, they are unable to reach a settlement, the provider or facility may request arbitration. The insurer must submit as its final offer the greatest of the three amounts listed above. Each party's final offer (and the arbitrator's decision) must be based solely on the accuracy or inaccuracy of the greatest of those three reimbursement amounts previously described. The nonprevailing party must pay 70% of the arbitrator's fees and the costs of arbitration, and the prevailing party must pay the remaining 30%.

Additionally, the bill sets up a process for an out-of-network provider and a patient to negotiate a rate and for the patient to still receive the care if the provider gives the patient certain cost information up front and the patient gives informed consent.

While this arbitration model, also called “Independent Dispute Resolution” (IDR), is a generally favorable system for removing patients from the situation entirely, its specific execution in House Bill 388 is concerning. Although it would impact a small section of medical billing, we strongly believe it would have a far-reaching negative ripple effect on physician-insurer contracting.

Any successful policy to address out-of-network or “surprise” billing must encourage contracting between the two parties. A true market-based solution is not a system in which plans set the rates, but one which protects patients while providing a fair means to settle any payment dispute and encouraging providers and plans to reach a settlement. There is little incentive for plans to contract with more providers if they can continue to pay significantly lower reimbursement rates for care delivery by capping the in-network reimbursement rate.

A comprehensive, fair surprise billing solution should incentivize greater insurer accountability and transparency, as well as network adequacy. Network adequacy is already an issue in Ohio and HB 388 proposes to fundamentally change how contracting functions in a way that we fear might only exacerbate the problem.

Overall, the OSMA believes that Ohio has the opportunity to create some of the strongest patient protections in the country without threatening access to quality care, but unfortunately, we believe House Bill 388 falls short.

Thank you for your attention to and consideration of the OSMA’s concerns about this legislation today. Chair Oelslager, that concludes my testimony and I would be happy to answer any questions the committee may have at this time.