Ohio State Medical Association

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Statement of the Ohio State Medical Association
to the Senate Insurance and Financial Institutions Committee

Proponent Testimony: SB 198 – Surprise Billing

Presented by Monica Hueckel, Senior Director, Government Relations
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Chair Hackett, Vice Chair Hottinger, Ranking Member Craig, and members of the Senate Insurance and Financial Institutions 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 comment on SB 198 today. Physicians are supportive of efforts to eliminate the burden of surprise medical bills on patients, and the OSMA has been working on this issue for about 4 years now. In the deliberations surrounding the topic during the last several years, we have scaled back our original suggested legislative model slightly and through negotiation, have moved toward a workable bill amenable to all parties involved. Although there is still no full consensus with every different physician specialty, OSMA is committed to working with the legislature and other interested parties to create a meaningful, evenhanded solution.

SB 198 creates 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. The OSMA appreciates Senators Huffman and Antonio for their dedication to addressing this issue 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. 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. Which is what SB 198 will accomplish.

Under SB 198, providers would be prohibited from billing a covered person for the difference between the charge and the reimbursement of unanticipated out-of-network care provided at an in-network facility. The insurer would also be barred from requiring cost-sharing for unanticipated out-of-network care at a rate higher than if the care were to be provided by an in-network provider. The plan would have 30 days to pay the submitted claim or attempt to negotiate reimbursement. If those negotiations do not result in an agreement, either party can request arbitration.

The arbitration process set up in SB 198, also called "Independent Dispute Resolution" (IDR), is initiated if either the provider or insurer is not satisfied with the attempt to negotiate a payment rate for a service. Both parties would give a final offer they feel is most appropriate, and an independent arbitrator would pick from one of the two options. The conditions for arbitration are: if the claim exceeds $700, or if there are multiple claims that a provider bundles together to total more than $700. If the claim does not meet this criteria, the plan must pay at a minimum the lesser of the provider charge or the 80th percentile of all provider charges in the same or similar geographic area.

In this decision, the arbitrator would consider a variety of relevant factors, including but not limited to:

- The provider's training, education, experience, and specialization or sub-specialization;
- The acuity level of patients treated by the provider and the provider's quality/outcome metrics;
- Contracted rates for other providers under other plans in the same geographic area;
- The history of prior contracted rates between the provider and plan;
- The circumstances and complexity of the case under dispute; and,
- The individual provider's usual charges for the service.

Then, the arbitrator would award the prevailing party its final offer. The non-prevailing party would be responsible for the cost of arbitration and in the event of a settlement, the arbitrator's fees would be split equally between the provider and insurer.

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.

SB 198 is modeled after statute already in place in a handful of other states in the country. The IDR process has a proven record for maintaining existing in-network insurance relationships, preserving a fair rate for both providers and insurers, and avoiding a decrease in patient care access (which is particularly important for our state's rural and underserved areas). According to a study conducted by the Georgetown University Center on Health Insurance Reforms, New York's IDR process has resulted in a significant decrease in out-of-network claims and consumer complaints about unexpected medical bills. Additionally, there is no evidence of any resulting increase in insurance premiums.

Information from other states that have passed an IDR process suggests that with the IDR process, Ohio can create better patient protections and health plans with enhanced transparency, network participation, and fewer out-of-network claims/surprise bills. By establishing a fair and predictable arbitration process and benchmarks, the IDR model, based on how typical contract negotiations between providers and insurers are conducted, has been shown to encourage providers and insurers to contract. Data shows that, after the implementation of the law in NY, the number of providers and plans in contract rose by 35%. Other states - including Colorado, Texas, and Washington - have recently passed similar legislation based on New York's model in light of these positive outcomes.

The OSMA believes that SB 198 represents an opportunity for Ohio to create some of the strongest patient protections in the country without threatening access to quality care. We appreciate the work of the Ohio Legislature to make meaningful improvements to health care delivery to Ohio's patients in a way that is responsible and effective for all parties involved.

Again, I would like to thank the committee for the opportunity to testify in support of SB 198. Chair Hackett, this concludes my testimony for today and I would be happy to entertain any questions the committee may have at this time.