BEFORE THE SENATE INSURANCE & FINANCIAL INSTITUTIONS COMMITTEE
Opponent Testimony on Senate Bill 198
December 11, 2019

Chair Hackett, Vice Chair Hottinger, Ranking Member Craig, and members of the Senate Insurance & Financial Institutions Committee, my name is Keith Lake and I am the Vice President of Government Affairs for the Ohio Chamber of Commerce. I am here today to testify in opposition to Senate Bill 198.

The Ohio Chamber is the state's leading business advocate, and we represent nearly 8,000 companies that do business in Ohio. Our mission is to aggressively champion free enterprise, economic competitiveness and growth for the benefit of all Ohioans.

As you all know, unexpected or "surprise" medical bills are causing many Ohioans financial hardship. We applaud the sponsors for seeking to protect patients from the burden of receiving surprise bills in the future.

Health insurance plans and many of the employers who sponsor them go to great lengths to inform their enrolled employees about health care costs and quality. They provide transparency tools, provider directories, hotlines, and other resources that beneficiaries can use to find and access in-network care. Nonetheless, even the most proactive patients cannot always avoid encounters with out-of-network providers during the course of care.

That's why the Ohio Chamber is committed to working with the legislature to find a solution to this problem. However, that solution must not only protect patients by ending surprise billing, but it must also do so without driving up health insurance costs.

Health care costs are already rising at a rate far surpassing inflation. Average annual premiums for employer-sponsored health insurance rose an average of 4.9 percent in

2019, the biggest year-over-year percentage increase since 2011. Premiums have gone up 22 percent in the past five years and 54 percent in the past decade.

Unfortunately, we believe that both of the approaches utilized by SB 198 to determine how much providers should be paid by insurers in instances that generate surprise bills would lead to increased health insurance premiums.

Under SB 198, for individual claims of $700 or less, insurers are required to pay the lesser of the provider's billed charge or the "80th percentile of all provider charges in the same or similar specialty for the health care service provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent of insurance."

The provider's billed charge is the price that the provider sets unilaterally. While the billed charge might be the amount the providers would ideally like to be paid, no insurer acting as a responsible fiduciary is likely to ever voluntarily agree to pay billed charges.

Therefore, the lesser of the two choices could be the 80th percentile of all provider charges in a market. Whatever that 80th percentile number actually is for a particular medical service, by definition it's a number that's higher than what four-fifths of all providers in the market charge. Under either payment option – billed charges or the 80th percentile – the result is certain to lead to higher costs to insurers and, by extension, to the health insurance premiums paid by Ohio Chamber member companies.

In addition, mandating payment at the 80th percentile could dangerously undermine the ability of insurers to effectively develop provider networks that are essential to health care quality and affordability for employers by incentivizing providers to refuse all network contracts that do not pay them something near the 80th percentile of charges. For them, the choice would be simple: stay in-network at current contracted rates or go out-of-network and automatically collect the 80th percentile of charges.

The second approach SB 198 utilizes to determining how much providers should be paid governs claims that exceed $700. In these circumstances, the mechanism is binding arbitration.

On the surface, arbitration seems fair enough: sometimes the providers will win at arbitration, and sometimes the plans will win. However, states like New York that have already enacted laws punting payment disputes to an arbitrator to determine the reimbursement rate have experienced significant cost escalation.

Besides higher reimbursement amounts, arbitration also creates a new layer of bureaucracy and administrative waste, forcing both providers and insurers to funnel money that could be spent on more productive activities into paying for arbitration preparation expenses and, ultimately, an arbitrator's fees.

Neither plans nor providers will simply absorb the costs associated with the arbitration process, either. These extra costs are sure to get passed on by insurers to health insurance purchasers in the form of higher premiums. In short, arbitration encourages cost escalation. For these reasons, the Ohio Chamber opposes SB 198 in its current form.

The Ohio Chamber believes that a better approach to surprise billing would avoid the use of arbitration and instead specify a benchmark payment rate that the insurer must pay if no agreement is reached. A benchmark payment rate would provide certainty and finality and ensure swift resolution.

Preferably, the benchmark should be based on the private market's established rate for a service in a particular geographic area, such as the average in-network reimbursement for that service. Such a benchmark would also guarantee that providers are fairly compensated, because the reimbursement would be based on rates that the vast majority of providers already agree to accept.

SB 198 holds patients harmless by banning balance billing by providers for out-of-network services; this is important and necessary. However, the way SB 198 accomplishes this will merely turn surprise medical bills into surprise premium invoices. We respectfully urge this committee to revise SB 198 to not only protect patients and ensure providers are fairly compensated, but to do so without creating a process that would lead to increased health insurance premiums for employers. Thank you.