Chairman Hackett, Vice Chair Hottinger, Ranking Member Craig and members of the Senate Insurance and Financial Institutions Committee. I am appearing today in my capacity as Vice-President of Government Affairs for the National Association of Health Underwriters (NAHU). My testimony in opposition to S.B. 198 is on behalf of NAHU and our state chapter, the Ohio Association of Health Underwriters**.**

NAHU is a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists who work daily to help millions of individuals and employers purchase, administer and utilize health insurance coverage. The members of NAHU help consumers navigate a labyrinth of healthcare coverage options that work best for them, but they also expend an extraordinary amount of time assisting consumers who use their benefits, particularly around claims adjudication. It is not uncommon for an agent to spend many months working to resolve billing issues. Our agents have found that offers to negotiate to 125% of Medicare are routinely refused. The time expended on these negotiations between the carrier and provider can be lengthy, even for amounts as small as $300.

After consultation with our members, what we found is a system stacked against the consumers, who have no leverage with the provider or hospital. Patients are asked to sign paperwork that allows balance-billing from non-network providers with vague and ambiguous language. Often they are asked to do this when under duress, during an emergency, or while actively preparing for a procedure. Some who were in the unfortunate situation of not being conscious at the beginning of care find that they have received almost all of their care from out-of-network providers, from the ambulance to ER doctor and hospital. The amounts billed are so high in many cases that the result is collection action and a damaged credit report.

The need to address surprise billing has been identified at the state and federal level with much of the attention on the topic focusing on whether to use a benchmarking or arbitration approach for resolution. Over the past several months the US Senate has focused on ways to address this in the Senate HELP Committee's Lower Health Care Costs Act of 2019. In studying that proposal, the bipartisan Congressional Budget Office found that setting a benchmark payment rate would save the most money at an estimated $25 billion over 10 years. In comparison, the arbitration method proposed would save an estimated $17-20 billion over 10 years, but could potentially cost healthcare providers and employers an estimated $1 billion over the same decade. This is because arbitration does not address the problem of exorbitant costs, but instead places the burden on the consumer to challenge and negotiate the bill through a costly and administratively burdensome arbitration process.

A recent study by Brookings on New York's independent dispute resolution, or "baseball" style arbitration, put in place in 2015, has resulted in higher costs paid by consumers that have participated in the arbitration process. Similar to Ohio's proposal, New York allows arbiters to consider the 80th percentile of billed charges when determining the final payment amount. A provider's billed charges are not the same as a provider's in-network negotiated rates and the billed charges are typically several times more than an in-network negotiated rate. Therefore, allowing arbiters to use the 80th percentile of billed charges as a reference for independent dispute resolution drives the final payment amount even higher than standard charges. In fact in New York, the

Department of Financial Services reports that arbitration decisions have averaged 8% higher than the 80th percentile of charges.

The data from the New York arbitration process indicates a trend of increasing costs, not cost savings for consumers, for both in and out of network providers. The elevated out-of-network reimbursement now attainable through arbitration will effect provider negotiations with commercial insurers, resulting in providers leaving networks to obtain a higher out of network reimbursement or demanding an increase for in-network payment rates which will only increase costs for consumers in the form of exorbitant out of network costs or higher premiums to cover elevated in network provider costs. The end result of this type of arbitration is an incentive for providers to leave their networks and for costs to continue to increase for consumers.

California is also often used as an example for state action on surprise billing. California AB 72 (2016) uses a benchmark set at locally negotiated market reimbursement rates for out of network care. This means doctors are paid the greater of either the insurer’s average contracted rate or 125% of the Medicare reimbursement rate and consumers can not be billed beyond that amount for their in-network cost-sharing. Many critics of benchmarking surmise that the system does not incentivize providers to join networks, however, the opposite has been found. Since this law has been put in place, data has shown that out of 11 health plans, representing 96% of covered lives in the fully insured commercial market in California, the number of physicians in provider networks is 16% higher than prior to the law going into affect.

Surprise medical billing reflects a concerted business decision by a small number of providers and specialists to exploit a market loophole. While most doctors work hand-in-hand with hospitals and insurance providers to ensure American families receive quality, affordable care, there is a small, but significant, number of out-of-network providers who intentionally forego participation in provider networks to charge above-market rates for services that consumers expect to be in-network or covered in an emergency. This is largely attributable to a handful of out of state private equity firms acquiring physician practices and staffing firms and then exploiting market loopholes at the expense of Ohio patients.

We are advocating four primary solutions to curb the practice of surprise billing:

- Ban balance-billing when patients inadvertently see out-of-network providers.
- Reimburse providers based on the negotiated rate for that service.
- Establish an independent dispute resolution process, but not arbitration.
- Require hospitals disclose out-of-network physicians in non-emergencies.