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Senate Insurance and Financial Institutions Committee
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Chairman Hackett, Vice Chair Hottinger, Ranking Member Craig and members of the Senate Insurance and Financial Committee, thank you for the opportunity to offer testimony in opposition of Senate Bill 198 (SB 198), legislation that will only mask surprise out of network bills.

I am Miranda Motter, the President and CEO of the Ohio Association of Health Plans (OAHP), which is the state's leading trade association representing the health insurance industry. OAHP's member plans provide health benefits to more than 9 million Ohioans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare, Medicaid and the Federal Insurance Marketplace. OAHP's top priority is ensuring Ohioans have access to affordable, quality health care.

We believe SB 198 will:

- **Provide Ohioans artificial protection from surprise bills.** The bill merely shifts surprise out of network (front end) bills to surprise (back end) premium bills.
- **Increase health care costs.** The bill allows out-of-network doctors to charge whatever they want for their undisclosed out-of-network care.
- **Erode patient's provider networks.** The bill creates financial incentives for doctors to remain out of networks thereby jeopardizing the cost and quality benefits in network care provides.

What is a surprise bill and how often does it occur? A surprise bill is an unexpected bill a patient receives from an out-of-network doctor after receiving care in an emergency room or in a hospital that's *in* the patient's insurance network. Because *the doctor* is *out* of network, he or she is free to charge whatever he or she wants to charge. And, because that patient didn't have a chance to choose the out of network care provider, he is she is left with a very expensive, highly inflated surprise medical bill.

Data shows that unanticipated out of network treatment has occurred in roughly 1 in 5 emergency visits[1] and unanticipated out of network care has occurred in 1 in 10 elective inpatient visits in an in-network hospital.[2] As we've talked to policymakers, stakeholders, and interested parties about

[1] https://www.nejm.org/doi/full/10.1056/NEJMp1608571
[2] https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970

this issue, almost everyone has a story or a personal experience that involves a surprise medical bill.

Why is this happening? Insurers negotiate prices with in-network providers to keep health care costs low. Provider agree to accept a reimbursement rate in exchange for a guaranteed flow of that insurer's patients. But certain doctors – such as anesthesiologists, radiologists, pathologists, and emergency room doctors –are "guaranteed" a steady volume of patients without having to become part of a network. This means they can (and do) charge patients whatever they want – sometimes more than 5 times the Medicare[3] rate.

Recent studies show average out of network charges for these ancillary out-of-network providers as:[4]:

- Anesthesiologists - **5.8x** the Medicare rate
- Radiologist - **4.5x** the Medicare rate
- Pathologists - **4x** the Medicare rate
- Emergency medicine physician - **4x** the Medicare rate

The Involvement of Non-Traditional Stakeholders. This problem appears to be further exacerbated by the involvement of private equity and investment companies. Recent national reports reveal that a major force behind those who oppose banning surprise medical bills in Congress are investors in private equity and venture capital firms. As hospitals are looking to trim costs, they are outsourcing these ancillary services to management firms backed heavily by private equity and venture capital firms. These private investors need to protect the high profit margins and are pushing hard to defeat legislation in Congress to fix this problem. In October, U.S. House leaders (Energy and Commerce Chairman Frank Pallone, D-N.J., and ranking member Greg Walden, R-Ore.) launched an investigation into private equity firms that own physician-staffing companies to determine whether they use out-of-network billing as a strategy to drive up their pay rates.[5] [6]

More and more Ohioans are receiving surprise bills in this broken market and private equity investments appear to be influencing this behavior.

Ohioans Want to Pay Less for Health Care. Nearly 8 in 10 Americans across all political parties, support legislation to protect individuals from medical bills.[7]

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[3] https://jamanetwork.com/journals/jama/fullarticle/2598253
[4] https://www.ahip.org/wp-content/uploads/surprise_billing_issue_brief_2019.pdf
[5] https://khn.org/news/investors-deep-pocket-push-to-defend-surprise-medical-bills/; https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient-unity.html; https://www.politico.com/story/2019/09/13/health-groups-dark-money-hospital-bills-legislation-1495697?cid=apn; https://townhall.com/columnists/devonherrick/2019/09/30/dark-money-fights-to-preserve-surprise-billing-n2553909; https://www.pionline.com/washington/private-equity-firms-investigated-house-leaders-over-surprise-medical-bills
[6] https://thehill.com/policy/healthcare/466756-doctors-coalition-funded-by-private-equity-spends-4-million-lobbying-on
[7] https://khn.org/news/legislation-to-end-surprise-medical-bills-has-high-public-support-in-both-parties/?utm_campaign=KHN%3A%20First%20Edition&utm_source=hs_email&utm_medium=email&utm_conten

With medical debt as the number one source of personal bankruptcy filings in the United States[8], protecting consumers from surprise out-of-network costs has been a top priority of OAHP. An Ohio solution must provide end-to-end protection – protecting Ohioans from both surprise out-of-network bills and surprise premium bills.

What does this mean? First, Ohioans should be taken out of the middle and protected from balance billing. Second out-of-network doctors should be paid a commercially reasonable rate – a market tested rate. We don't believe Ohio should codify "surprise bills" by allowing out-of-network providers to charge (or balance bill) the purchaser of health care whatever he or she wants. That will not solve the problem; it will only mask it and make the problem worse for Ohioans down the road.

There's been much discussion over the past year on this issue. Most recent discussions occurred during the state's biennial budget process. Those discussed resulted in the Ohio General Assembly passing legislation that would have protected Ohioans from surprise bills. That provision didn't survive the budget process and as a result we continue to advance a solution that will provide Ohioans the protection they need, want and deserve.

OAHP's Position. Before I move to address a couple of issues discussed by opponents a few week ago, I want to take a few minutes to provider a finer point on OAHP's position as it relates to the three (3) pillars contained in the bill currently pending before this Committee.

- **Ban on Balance Billing.** *OAHP does not believe out of network doctors should be able to balance bill a health care consumer when the patient doesn't have the right to choose that out of network care. We believe all interested parties and policymakers support this position and many have even stated that before this Committee.*

- **Price for Out of Network Care.** *OAHP opposes allowing doctors to charge whatever they want for undisclosed and/or emergency out of network care. OAHP believes health care consumers should pay a reasonable, market-tested price for undisclosed and/or emergency out of network care.*

  Appeal Process. *OAHP opposes unilateral government setting pricing through a costly, risky arbitration process. This will increase health care costs and serve as the rule rather than the exception. OAHP believes out of network doctors should be afforded a dispute process if he/she doesn't believe the plan paid the correct amount.*

In conclusion, I would like to turn to a couple of issues opponents discussed before this committee last week.

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[8] https://www.usatoday.com/story/money/personalfinance/2017/05/05/this-is-the-no-1-reason-americans-file-for-bankruptcy/101148136/

Impact on Access and Networks. Some have argued that using a commercially reasonable rate will cause doctors to leave the state or cause more doctors to leave networks. We haven't seen any evidence of this type of behavior in other states that have implemented laws similar to HB 388. In fact, data appears to show the opposite. For example, California enacted a surprise billing law in 2017 that requires out-of-network doctors to be reimbursed using the greater of the in-network rate or 125% of Medicare. A recent study shows that in-network specialty doctors in California have actually increased since 2017.[9]

New York is NOT Better. Proponents of SB 198 have advocated that Ohio should adopt a New York approach – requiring payment of a percentage of billed charges and baseball-style arbitration. Advocates of a New York approach have argued that New York's law has saved consumers $400 million. Third-party health policy experts, however, dispute that premise and have stated that the "[s]tate's experience has shown limited relief for patients." Here are a couple of facts from the Brookings Institution's October 24 report that support this fact:[10]

- "Arbiters are told to focus on the 80th percentile of those rates, an amount higher than what 80% of doctors charge for that procedure." In New York, 80% of bill charges equates to:
    - Emergency medicine - **3.8x** the in-network rate
    - Radiology - **3.6x** the in-network rate
    - Pathology - **3.4x** in the in-network rate
- "On average, arbitration decisions have been 8% higher than that 80th percentile mark."
- "The number of bills undergoing arbitration went from 115 in 2015 to 1014 in 2018."
- "Insurers and doctors won about the same number of cases, and in 2018 more cases seemed to go in the provider's favor. Consumers appeared to lose either way. That's because even when the insurance plan won, it was on average only 11% less than the 80th percentile …" still about 3 times as much as a patient would pay if the doctor were in-network. Those extra costs get passed on in the form of higher premiums.:

Ohio is not New York and we should be cautious to adopt a model from a state with the second highest health care expenditures in the country and where health care spending per person is about 20% higher than the national average.[11] We don't believe Ohioans want to pay New York health care costs.

Ohioans Want Relief. OAHP opposes SB 198 because it does NOT provide end-to-end protection to Ohioans from surprise out of network bills and surprise premium bills. We believe Ohioans need relief from spiraling health costs and cannot afford to pay MORE for health care. We believe policymakers are well positioned to make an impact on the everyday lives of Ohioans. OAHP

[9] http://www.dmhc.ca.gov/Portals/0/Docs/DO/ab72.pdf?ver=2019-03-04-154101-503; https://www.ajmc.com/contributor/america's-health-insurance-plans/2019/08/can-we-stop-surprise-medical-bills-and-strengthen-provider-networks-california-did

[10] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/

[11] https://nyshealthfoundation.org/resource/health-care-spending-trends-in-new-york-state/

stands ready to share our experience, lend expertise and advance a solution that will work towards driving down health care costs in our state.

Thank you for the opportunity to provide comments here today. Health plans understand firsthand the pressures Ohio's employers, individuals and purchasers of health care are experiencing - health care costs are going up and as a result health insurance costs are rising. I applaud the Ohio General Assembly for tackling this issue not once, but twice on behalf of Ohioans. Thank you and I am happy to address any questions you might have.