

Proponent Testimony – SB 162: Takebacks
Ohio Senate Financial Institutions, Insurance, and Technology Committee
Presented by Monica Hueckel, VP, Advocacy, Ohio State Medical Association
and John Bastulli, MD, President, Ohio State Medical Association

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Chair Wilson, Vice Chair Lang, Ranking Member Craig, and members of the Senate Financial Institutions, Insurance, and Technology Committee, my name is Monica Hueckel and I am testifying today with Dr. John Bastulli on behalf of the Ohio State Medical Association (OSMA), the state's oldest and largest professional organization representing Ohio physicians, medical residents, and medical students. We would like to thank the committee for the opportunity to testify in support of Senate Bill 162, regarding insurance takebacks.

Takebacks, also referred to as clawbacks, occur when an insurance company retroactively denies or reclaims payments made to healthcare providers, often months or years after the payment claim was originally processed. These unpredictable takebacks of already paid claims create unnecessary financial risk, administrative stress, and barriers to patient care, making them a tremendous burden for healthcare providers. The time providers and their staff are forced to take to attempt to determine validity of alleged overpayments and/or appeal those overpayments diverts significant time from patient care and results in loss of critical practice revenue.

SB 162 sets out to level the playing field and create a more fair and balanced system by:

- 1. Changing Ohio's current 24-month insurer takeback timeframe, decreasing it to the same timeframe given to a provider to submit a claim, and also prohibit insurers from changing these timeframes during a contract period.**

This 24-month timeframe is creating a completely unworkable and unsustainable financial path for all healthcare practices and providers, and putting extreme financial uncertainty on patients seeking care.

- 2. Prohibiting insurers from charging a provider for appealing a determination of overpayment.**
It has been reported that some insurers may assess fees for providers appealing determinations of overpayment.

Providers already jump through numerous hoops to get reimbursed for services provided to patients. From prior authorizations, denied claims, requests for massive amounts of documentation and health plans having their own definitions of medical necessity, healthcare providers are struggling to keep their doors open.

Takebacks also erode patient trust in the healthcare system. Patients may receive unexpected bills, experience treatment delays, and incur increased costs as a result of those denials/delays causing worsening health conditions. All of the hassle and financial burden might discourage patients from seeking recommended or necessary medical care altogether, which can have disastrous outcomes.

Insurers may argue that a takeback time period is necessary for insurers to review for coding and billing errors, confirm patient coverage, and review medical necessity. But why should that time period for insurers to review claims be so long and unequal to the time given to physicians to submit all the documentation that is to be reviewed?

All of the information given with a claim is already required from practices on the front end by insurers, not just the back end. Health plans already require prior approval of healthcare services. They then review the claims for those services prior to paying providers. They do not need an additional 24 months to review a payment they have already made, using information they have seen both before and after the service. Limiting the time frame to do a clawback of a payment to the same time frame a health plan gives a provider to submit a claim will allow the same rules to apply to health plans that they give to practices and providers. This will simply create stability and ensure practices can continue providing the care their patients need.

OSMA is thankful to members of the committee for your attention to our comments and concerns on this legislation, and appreciates the opportunity to be a meaningful contributor to the legislative process. After Dr. Bastulli is finished with the second portion of our testimony, he and I would be happy to answer any questions.

Thank you, Monica and thank you, Chair Wilson and members of the Committee for the opportunity to provide testimony today. My name is Dr. John Bastulli and I am the current President of the Ohio State Medical Association and a practicing anesthesiologist in Cleveland.

Now that we have explained the problem that this legislation aims to address, I would like to give a bit of clinical perspective on this issue and provide some insight into the real-world impact of takebacks on physicians and medical practices. I will do this by sharing a few examples of situations with takebacks that OSMA has been able to gather from our physician members and their office staff, from all over the state. Here are some of those:

- *Example 1:* A claim for charges incurred on November 3, 2021 was paid by insurer December 24, 2021. The insurer audited the claim in March 2022, and took the payment back in June 2022, stating the records for the procedure did not support the level of service, despite the fact that the procedure had been approved in advance by the insurer and the provider had submitted documentation which supported the exact pre-approved procedure. Unfortunately, the provider appeal of the takeback was unsuccessful after extra work by the practice to submit additional documentation.
- *Example 2:* For a claim with the date of service of August 8, 2023, the insurer was billed on August 30, 2023 and insurance paid the claim on September 5, 2023. Insurer did a takeback on July 10, 2024 because it turns out, the patient's insurance was terminated on June 30, 2023 (before the date of service). The provider would not have known the patient's insurance coverage had been terminated, and the insurer had pre-approved the service to be done in August despite the termination of coverage in June. As far as the provider is concerned, they rendered the service with insurer approval and then, the insurer did a takeback of payment nearly a year after the service.

- *Example 3:* A provider received a takeback request from the insurer from claims that the insurer stated were processed “in error.” These claims created a lot of extra work and confusion for impacted patients who as a result of the takeback, were now receiving bills from their provider in 2024 that were for services completed years ago in 2020, 2021, and 2022. Patients had been under the impression that these procedures were fully covered.

These are just a few examples which illustrate how unsustainable and imbalanced the current takebacks process is for Ohio physicians and medical practices. SB 162 will help alleviate significant administrative burden for our providers, and allow for more time and resources to go toward patient care.

Thank you again for the opportunity to testify this afternoon. At this time, we would be happy to answer any questions from the Committee.