



**Proponent Testimony – Sub. SB 162: Takebacks  
Ohio House Health Committee  
Presented by Monica Hueckel, VP, Advocacy, Ohio State Medical Association  
and Marc Antonchak, MD, Ohio Association of Rheumatology**

**June 3, 2026**

Chair Schmidt, Vice Chair Deeter, Ranking Member Somani, and members of the House Health Committee, my name is Monica Hueckel and I am testifying today 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. With me is Dr. Marc Antonchak, an OSMA member and current President of the the Ohio Association of Rheumatology. We would like to thank the committee for the opportunity to testify in support of Substitute Senate Bill 162, regarding insurance takebacks.

As you may know, takebacks 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 started out with different language at introduction, and the substitute version of this legislation before you now represents the result of months of negotiation and compromise with both the Ohio Department of Insurance and the health plans. Alongside the sponsor, we worked very hard with these interested parties in the Senate to come to an agreement, after which point, Substitute SB 162 was able to progress forward in the legislative process.

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

1. Establishing a 12-month timeframe for insurers to audit paid claims;
2. Extending the provider appeal period from 30 to 60 days; and,
3. Requiring electronic notification of takebacks when an electronic system exists.

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.

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 takeback of a payment to 12 months will create stability and ensure practices can continue providing the care their patients need.

As for appeals, the process of submitting an appeal is complex and time-consuming. Allowing for providers to respond to takeback determinations within 60 days rather than 30 days will give them a fair chance to submit the necessary documentation for their appeal.

Furthermore, requiring electronic notification, when available, will streamline communication between insurers and providers, and reduce more needless administrative burden on practices.

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 why should the process be unnecessarily complicated and burdensome for physicians and their staff to navigate?

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.

OSMA is thankful to members of the committee for your attention to our comments and concerns on Sub. SB 162, and appreciates the opportunity to be a meaningful contributor to the legislative process. After Dr. Antonchak is finished with the second portion of our testimony, he and I would be happy to answer any questions.

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Thank you, Monica, and thank you, Chair Schmidt and members of the Committee for the opportunity to provide testimony today. My name is Dr. Marc Antonchak and I am a physician rheumatologist working in an independent practice in central Ohio. Our practice employs around 150 people – including 10 physicians and 10 advanced practice providers – across two sites, and we see between 200 and 300 patients daily.

I would like to give a bit of clinical perspective on the issues Sub SB 162 will fix and provide some insight into the real-world impact of takebacks on physicians and medical practices, particularly as a physician providing care in an independent practice. Our team has dealt with plenty of entanglements regarding takebacks which have taken place several years over a payment date. Here are some examples:

1. A claim for infusion charges incurred on September 24, 2019 was paid by insurer on October 10, 2019. The insurer requested additional documentation to support medical necessity on November 16, 2020, over one year from the date of payment and for an infusion that was already deemed medically necessary by the health plan. Medical necessity documents were provided, again, including a letter from the rendering provider, but the takeback was processed on February 16, 2021. Our team lost the first appeal and then asked for help from our attorney consultants. Through lots of staff time and effort, we received a favorable decision on medical necessity of the infusion and were paid on Jan 26, 2022. The administrative burden of this was significant. This claim payment was over \$15,000 and took us almost two and a half years to get paid.

2. A claim for infusion charges incurred on November 21, 2023 was paid by the insurer on December 8, 2023. We received a takeback letter on November 4, 2025 and takeback occurred on December 2nd, 2025, which is past the twenty four month time period allowed under Ohio law. The letter from the insurer cited benefit maximum, but we have a valid authorization in place for the date of service that does not specify a benefit maximum. This authorization came directly from the health plan. This claim is still under appeal for payment of over \$9,000.
3. A claim for infusion charges incurred on February 21, 2024 was paid by the insurer on April 11, 2025 after several appeals on the original denial of payment. We then received a takeback letter dated November 16, 2025 stating the adjustment is the result of incorrect application of benefits. The takeback occurred on December 29, 2025. This claim is still in appeal and has taken a considerable amount of staff time. In fact, our staff have touched this encounter 20 different times to get and keep this claim paid, and this one is still pending.

I hope this has helped to illustrate how unsustainable and imbalanced the current takebacks process is for Ohio physicians and medical practices. The financial strain and uncertainty create a real, yet needless risk. This coupled with the time and effort required to try to appeal takeback determinations interferes with our ability to focus on providing the best possible care to the people in our community who need it.

SB 162 is important to me as a physician in our state as I believe it will truly help alleviate significant administrative burden for us, and allow for more time and resources to go toward patient care. I know that you also share the goal of improving health care for our communities, and so I urge the committee to support Substitute SB 162.

Thank you once again for the opportunity to testify today. At this time, Monica and I would be happy to answer any questions from the Committee.