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**Comments on Revised Draft Rule 3901-8-16:**

**Required provider network disclosures for consumers**

**Ohio Consumers for Health Coverage**

**March 27, 2015**

The Ohio Consumers for Health Coverage (OCHC) appreciates the opportunity to comment on the second draft of Proposed Rule 3901-8-16, distributed on March 16, 2015, pertaining to insurance company disclosure of provider networks.

We appreciate that the Department has added in a requirement that in health plans where providers are in tiers, the tiers of the providers must be included in the directory. In addition, some of the reorganization in Section (D) “Requirements” adds to the rule’s clarity.

However, there is one new section that we believe is unacceptable from any consumer’s viewpoint. That section is Section (F) (2) re “Reporting.” The section states:

(2) All documents provided to the superintendent under division (F) of this section shall be considered work papers of the superintendent that are subject to section 3901.48 of the Revised Code and are confidential and privileged and shall not be considered a public record, as defined in section 149.43 of the Revised Code. The original documents and any copies of them shall not be subject to subpoena and shall not be made public by the superintendent or any other person, except as otherwise provided in section 3901.48 of the Revised Code.

There is no justification for those reports being considered “work papers of the superintendent.” The reports include data from the insurance company which is not particular to any one consumer and should raise no confidentiality concerns. It is important that if this disclosure rule is to have any teeth at all that the public can be aware of insurance company compliance.

OCHC also renews its request for certain changes in the rule. The rule uses the word “enrollee” in many places where the consumer who is still in the position of choosing a plan should be able to review the directory. We strongly urge that the word *public* be substituted for *enrollee* in each of the places mentioned in our previous comments, repeated here:

**3901-8-16 (D) (1) (a) (ii)** OCHC is concerned that those who get access is limited to enrollees. OCHC supports expanding those who can get access to the provider network to the public, and not just enrollees. This is important so that those in the plan selection process can know the providers in the plan’s network.

**3901-8-16 (D) (1) (h), formerly (D)(1)(c)** For the same reasons stated above in 3901-8-16 (D) (a) (ii), we believe it is important that all consumers can view the directory since consumers are making decisions to select a plan based on the providers in the plan. We suggest the italicized changes below.

An issuer's provider directory or directories must make it clear to *any person accessing the directory, not limited to enrollees,* which providers belong to each network and which network or networks are applicable to each specific plan offered for sale by the issuer. *Plans sold in the exchange shall be specifically identified as “Marketplace” or other appropriate term to inform the viewer that the plan is in the exchange.* Additionally, provider directories must contain a general statement describing with clarity whether and how tiers may apply to specific plans and any referral process or requirements that may apply.

We do appreciate that there is language in the rule that says an enrollee does not have to enter an ID number, but we believe the rule would be clearer if the word enrollee was changed to “consumer” or “member of the public.”

In 3901(D)(1)(l)(iii) the word “staff “ has been removed from those that the facility must disclose and replaced with the more generic “providers.” This is an improvement that we hope will give consumers more notice that certain providers are NOT in the network, such as a contracted ER group. However, we still believe that it is important for the Department to tackle the problem of surprise bills, particularly since people that go to an ER in an in-network facility will be unlikely to be aware of the out of network group that runs the ER, because once a consumer knows that the hospital is in-network he/she has no reason to think they must check out the E.R. against the provider directory. We urge the Department to take up the issue of holding consumers harmless when they are balance billed in these circumstances by out of network providers. OCHC also renews its request that an enrollee be held harmless when the enrollee chooses an out-of-network provider *whom he/she believes is in-network*, because the directory is inaccurate.

**3901-8-16 (E) Network Changes**

OCHC strongly supports the requirement that an issuer shall not implement increased financial liability until an on-line provider directory is updated. However, we would urge that this also apply to the paper directory. In addition, there should be a remedy for patients whose providers leave mid-year. A patient should not be expected to check the provider directory every time he/she goes to the provider, even when the patient sees the provider regularly.

**3901-8-16 (F) Reporting**

OCHC renews its request that reporting requirements be strengthened as stated below, and refers to its statement at the beginning of these comments that strenuously objects to reports being treated as a work product shielded from the public’s view.

* The reporting should be mandatory and not discretionary with the Superintendent. This is important so that the public is able to determine whether issuers are following the rules.
* There should be penalties for non-compliance.
* There should be a requirement that the issuer report the number of out-of-network claims by plan, specialty and date. This will enable both the Superintendent and the public to be better informed about particular plan networks that may not be adequate.
* There should be a summary of consumer complaints received related to problems with the provider directory or difficulty finding in-network providers.

We would point to a law in Texas, for example, that requires insurance companies to report the percentage of out of network providers within in-network facilities in their plan. Such a report can give the public a much better understanding of the adequacy of networks.

Thanks for your this opportunity to comment.

Sincerely,



Kathleen Gmeiner, Project Director

Ohio Consumers for Health Coverage

kgmeiner@uhcanohio.org

(614) 456-0060 x 223