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**Comments on Rule 3901-8-16: Required provider network disclosures for consumers.**

**Ohio Consumers for Health Coverage**

**February 20, 2015**

The Ohio Consumers for Health Coverage (OCHC) commends the Ohio Department of Insurance for issuing this rule requiring Ohio’s Health Plans to provide information about plan networks to consumers with the goal of providing accurate and timely information to the consumer about providers who are “in-network” and “out-of-network.”

We also think there are a number of ways that the rule could be strengthened to better address some of the specific issues that confront consumers as they attempt to select a plan and to select a provider.

In addition, there is some language in the proposed NAIC disclosure model act that could be added to this rule and enhance its benefit to consumers.

1. **3901-8-16 (C) Definitions**

OCHC suggests that the word “network” be defined, and that when used throughout the rule it be preceded by “health plan” so as to read “health plan network.” This will help to distinguish the network from a hospital-based or other provider-based network.

1. **3901-8-16 (D) Requirements**

OCHC strongly supports the requirement that both on-line and paper directories be available. For consumers who do not have access to on-line information or have not become comfortable with their ability to find and correctly interpret on-line information, the paper copy is essential.

We urge that the word “accurate” precede “complete and clear.”

Provider directories. The format and content of a provider directory of a health benefit plan shall be sufficiently *accurate*, complete and clear to avoid deception or the capacity to mislead or deceive.

**3901-8-16 (D) (1) (a) (i)** Because of the time sensitivity of making provider choices, OCHC believes that hard copies should be mailed as soon as “reasonably practicable,” but that there should also be a defined time limit beyond which is considered outside the range of what is reasonably practicable. Therefore we would urge that the following italicized language be added:

Hard paper copies of the current directory or directories must be made available to enrollees as soon as reasonably practicable upon request, *but in no case shall the paper copy be mailed more than one week after the request is received.*

**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. In addition, with the ease of doing on-line updating, we see no reason that the provider directory cannot be updated within five business days of the addition or termination of a provider. In addition, the issuer should review the directory monthly, not quarterly. The proposed NAIC model act calls for monthly review, and we believe that is more appropriate given the level of provider movement that often occurs within plans. We also believe that there should be some responsibility on the issuer to reach out to providers who are no longer billing the plan to determine whether they are accepting patients with the plan. Finally, it is important that there be a way that consumers can report inaccuracies. We suggest the following italicized changes to 3901-8-16 (D) (ii)

An issuer must also post online the current provider directory for each health benefit plan, which shall be reviewed and updated at least *monthly*. *Issuers must contact any provider in the directory who has not billed the issuer for six or more months or has billed claims* *that do not exceed $500 in the past quarter to determine whether that provider is still accepting patients*. The online provider directory shall *be available to anyone who wants to see it, without being* required to log-in for online access. In addition, the issuer shall update the online provider directory within *five* business days of the addition or termination of a provider from the issuer's network or a change in a physician's hospital affiliation. *A dedicated phone number should be posted in both the paper directory and the on-line directory to which an enrollee can report inaccuracies in the directory.*

**3901-8-16 (D) (1) (b)** OCHC supports the range of provider-based information required to be disclosed. All of these items are important for consumers, and particularly support the requirement that it be disclosed if the provider is not taking new patients. We would ask that one additional item be included, which is the tier to which the provider is assigned, when applicable.

**3901-8-16 (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.*

**3901-8-16 (D) (1) (d)** OCHC strongly supports this section because names of networks have confused both shoppers and enrollees when selecting a plan or provider. In fact, we are finding that even providers are confused about the plan that they are in. Clarity and consistency in stating the plan’s name is essential.

**3901-8-16 (D) (1) (g)** As networks have narrowed, Ohioans have experienced being “balanced billed.” This has occurred even after using care to select an in-network provider. This occurs because out of network providers are sometimes selected by the in-network provider, without the patient’s control. It also happens because provider directories are inaccurate. We support the language in subsection 3901-8-16 (D) (1) (g), but would suggest three additional changes.

1. In (g) (iv) we would add the italicized language “or contractors” to those at a facility who are not in-network. For example, often a hospital may contract with an emergency room group. In addition a lab to which blood or other specimens are sent is more likely to be a contractor.
2. However, even when disclosed, it is sometimes impossible for an enrollee to resolve the situation in a way that insures that all professionals who provide a service are in-network. Therefore, OCHC strongly urges that an enrollee be held harmless when an in-network provider assigns an out of network provider to provide a service to the patient. For example, if a patient chooses an in-network hospital and an in-network surgeon, the patient should not pay a higher bill because the hospital assigned an out-of-network anesthesiologist. The burden of resolving this issue should fall to the insurance company and the assigning provider (likely a hospital), and not on the patient.
3. Finally, we would also ask that the 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.

For each health benefit plan, the associated provider directory must include the following information for each in-network facility:

(i) The location and contact information for each facility;

(ii) The specialty area or areas for which the facility is licensed or accredited;

(iii) A listing of all providers affiliated with the facility; and

(iv) A listing of any staff *or contractors* providing services at the facility who are not in-network.

Items (2) and (3) should be addressed in a separate section, possibly re-named 3901-8-16 (D) (1) (h)

(1) An enrollee shall be held harmless if the enrollee was assigned an out-of-network provider by an in-network provider

(2) An enrollee shall be held harmless if the enrollee chose an out-of-network provider on the belief that the provider was in-network because the directory is inaccurate.

**3901-8-16 (D)(2)** We support the requirement that the provider directory list the methodology for calculating the amount the enrollee will owe to an out of network provider with examples of the approximate charge. We would suggest that the information should not be limited to enrollees and that the disclosure also be made when the issuer is pre-certifying a planned procedure.

An issuer must disclose *to any person who requests the information*, the approximate dollar amount the issuer will pay for a specific out-of-network health care service*.* The issuer shall also *disclose* that such approximation is not binding on the issuer and that the approximate dollar amount that the issuer will pay for a specific out-of-network health care service may change. *An issuer shall also make this disclosure to the enrollee at the time of scheduling/pre-certifying a planned procedure.*

**3901-8-16 (D)(3)** OCHC supports the requirement that a card furnished to the enrollee “must clearly and conspicuously denote the name of any network(s) applicable to the coverage and must clearly and conspicuously denote whether such coverage is provided through the exchange as defined in division (W) of section 3905.01 of the Revised Code.”

**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 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 (E) (1)** OCHC supports this section, but would add the following language that appears in italics

An issuer's hard paper copy and online provider directory or directories must contain a clear and conspicuous statement, in fourteen point, bold font, describing the process for implementing increased financial liability as a result of any change in ownership, affiliation, or contractual arrangement, as described in paragraph (E) of this rule. *In that same statement the enrollee shall be given a toll free telephone number the enrollee can call to answer any questions the enrollee might have.*

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

OCHC supports the reporting requirement, however, would add four things to the rule.

* 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 issuer complaints received related to problems with the provider directory or difficulty finding in-network providers.

**Related Issues**

There are related issues that need to be addressed, but OCHC recognizes that they may need to be addressed in separate rules.

* There should be a mechanism for an enrollee to get coverage for medically necessary out-of-network care at in –network cost to the enrollee.
* There should be a process for assuring continuity of coverage and care if/when a provider leaves the network during a patient’s course of treatment.

Sincerely,



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