**REQUIRED PROVIDER NETWORK DISCLOSURES FOR CONSUMERS**

3901-8-16

(A) Purpose. The purpose of this rule is to implement and interpret applicable statutes including sections 3901.21 and 3923.16 of the Revised Code by further defining unfair trade practices and setting forth minimum standards for the adequate disclosure of any limitations or restrictions on access to providers/facilities to enrollees and to potential enrollees prior to enrollment in a particular health plan.

(B) Authority. This rule is issued pursuant to the authority vested in the superintendent of insurance under section 3901.041 of the Revised Code, general rule making authority; and section 3901.21 of the Revised Code, the unfair and deceptive acts statute.

(C) Definitions.

(1) “Enrollee” for the purpose of this rule shall mean any natural person who is entitled or potentially entitled to receive health care benefits provided by a health plan issuer.

(2) “Health benefit plan” for the purpose of this rule shall mean a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including benefit plans marketed in the individual or group market by all associations, whether bona fide or non-bona fide. "Health benefit plan" also means a limited benefit plan, except as follows. "Health benefit plan" does not mean any of the following types of coverage: a policy, contract, certificate, or agreement that covers only a specified accident, accident only, credit, disability income, long-term care, hospital indemnity, supplemental coverage, as described in [section 3923.37 of the Revised Code](http://www.lexis.com/research/buttonTFLink?_m=698d4e2a834ae15a0b34b5272a317d70&_xfercite=%3ccite%20cc%3d%22USA%22%3e%3c%21%5bCDATA%5bORC%20Ann.%203922.01%5d%5d%3e%3c%2fcite%3e&_butType=4&_butStat=0&_butNum=5&_butInline=1&_butinfo=OHCODE%203923.37&_fmtstr=FULL&docnum=1&_startdoc=1&wchp=dGLzVzB-zSkAz&_md5=248c2b088fe34c8511b5d0316a392ee7), specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; a medicare supplement policy of insurance, as defined by the superintendent of insurance by rule, coverage under a plan through medicare, medicaid, or the federal employees benefit program; any coverage issued under Chapter 55 of Title 10 of the United States Code and any coverage issued as a supplement to that coverage.

(3) “Health plan issuer” or “issuer” for the purpose of this rule shall mean an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract, to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company; a health insuring corporation; a fraternal benefit society; a self-funded multiple employer welfare arrangement; or a nonfederal, government health plan. "Health plan issuer" includes a third party administrator licensed under Chapter 3959 of the Revised Code to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent. “Health plan issuer” also includes a contracting entity as defined under Chapter 3963 of the Revised Code to the extent that the contracted for health care services are provided under a health benefit plan subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

(D) Requirements.

(1) Provider Directories. An issuer must ensure that the format and content of a provider directory of a health benefit plan is sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive by complying with at least the following requirements:

(a) Provider directories must be available to enrollees in hard paper copy and online.

(b) Provider directories must be reviewed and updated at least quarterly, and issuers must make a reasonable effort to provide assistance to individuals with limited English proficiency or disabilities.

(c) Provider directories must be updated within fifteen days of the issuer’s receipt of notification of the addition, expiration or termination of a provider from the issuer’s network or a change in a physician’s hospital affiliation. Notification is deemed received if the issuer knows or should have known of the addition, expiration or termination of a provider from the issuer’s network or a change in a physician’s hospital affiliation.

(d) Hard paper copies of the current directory or directories must be made available to enrollees as soon as reasonably practicable upon request.

(i)An issuer is deemed compliant with the requirement contained in paragraph (d) as long as the issuer:

(A) Provides at least the applicable section or portion of the provider directory that is relevant to an enrollee’s request; and

(B) Provides the hard paper copy to the enrollee within at least ten days of the date of the request.

(ii) Nothing in this section requires an issuer to publish or maintain separate hard copy and online provider directories as long as the requirements of this section can be satisfied by printing and providing the applicable portions of the directory.

(e) Hard paper copy provider directories must contain a clear and conspicuous statement noting that enrollees must contact the issuer to confirm the accuracy of hard paper copy provider directories, as changes may have occurred since the date of printing.

(f) The online provider directory shall not require enrollees to log-in or provide a member or group identification number for online access.

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

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

(ii) The specialty area or areas for which the provider is contracted to practice and included in the network;

(iii) Any in-network institutional affiliation of the provider, such as hospitals where the provider has privileges or provider groups in which the provider is a member;

 (iv) The tier to which a provider is assigned, if applicable;

(v) If known to the issuer, any languages, other than English, spoken by the provider; and

(vi) A notation of any provider whose practice is closed to new patients.

(h) An issuer’s provider directory or directories must make it clear to an enrollee which providers belong to each network and which network or networks are applicable to each specific plan offered for sale by the issuer. 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.

(i) Issuers must ensure that the name of a network is easily distinguishable and consistent wherever referenced in both print and online materials, including references made on the exchange as defined in division (W) of section 3905.01 of the Revised Code.

(j) An issuer’s online provider directory must include a method by which enrollees can search specific specialties of providers.

(k) An issuer’s online provider directory must include a method by which enrollees can search for specific providers by name and receive a listing of all networks, and the applicable health plans, to which the provider belongs.

(l) 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 contracted;

(iii) A listing of all providers affiliated with the facility who are in-network;

(iv) The tier to which a facility is assigned, if applicable; and

(v) A listing of any providers providing services at the facility who are not in-network. An issuer may comply with this requirement as follows:

(A) If the issuer knows, or should know, which providers providing services at the facility are not in-network, such providers must be listed in the provider directory or directories.

(B) If the issuer does not know which providers providing services at the facility are not in-network, the provider directory or directories must include a general statement notifying enrollees that there are providers providing services at the facility who are not in-network.

(2) Out-of-Network Coverage. With respect to out-of-network coverage, if applicable, an issuer must provide:

(a) A general explanation of the process and method used by the issuer to determine reimbursement for out-of-network health care services and describing any balance billing that may occur; and

 (b) Upon request by an enrollee or a provider, a disclosure of the approximate dollar amount the issuer will pay for a specific out-of-network health care service. The issuer shall also inform the enrollee through such disclosure 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.

(3) Identification Cards. Identification cards provided to enrollees, if any, 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. This requirement applies to coverage renewed on or after January 1, 2016 and to each subsequent renewal thereafter.

(E) Network Changes. An issuer shall not implement increased financial liability to enrollees resulting from any change in ownership, affiliation, or contractual arrangement, until the provider directory has been updated to reflect such changes.

(1) An issuer’s provider directory or directories must contain a clear and conspicuous statement describing the process for implementing increased financial liability as a result of any change in ownership, affiliation, or contractual arrangement, as described in division (E) of this rule. Additionally, an issuer must provide notification to an enrollee who may be affected by any change in ownership, affiliation, or contractual arrangement within fifteen days of receiving notification of the addition, expiration, or termination of a provider from the issuer’s network or a change in a physician’s hospital affiliation. Notification is deemed received if the issuer knows or should have known of the addition, expiration, or termination of a provider from the issuer’s network or a change in a physician’s hospital affiliation.

(2) Directories must conspicuously display the most recent date of update.

(F) Reporting to the Superintendent. The superintendent may require an issuer to submit reports upon request in order to demonstrate compliance with this rule.

(1) If reports are required, the superintendent shall prescribe the content, format, and frequency of the reports. The following information may be required for inclusion:

(a) Records documenting network and provider affiliation changes;

(b) Records documenting the timing and frequency of provider directory updates;

(c) Records related to claims handling prior to and after updates to provider directories as described in division (E) of this rule; and

(d) Any other information that the superintendent considers to be relevant in evaluating an issuer’s compliance with this rule.

(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.

(G) Severability. If any paragraph, term or provision of this rule is adjudged invalid for any reason, the judgment shall not affect, impair or invalidate any other paragraph, term or provision of this rule, but the remaining paragraphs, terms and provisions shall be and continue in full force and effect.