Comments on Ohio Department of Insurance Rule 3901-8-16:

Required Provider Network Disclosures for Consumers

Ohio Consumers for Health Coverage
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Good Afternoon. My name is Kathleen Gmeiner and I am here today to offer the comments of the Ohio Consumers for Health Coverage on proposed rule 3901-8-16 Required Provider Network Disclosures for Consumers.

Introduction

Ohio Consumers for Health Coverage supports the adoption of a rule to require health insurance companies to fully and timely disclose the providers who are in their networks. As networks have become more selective and as costs are increasingly shifted to consumers in group and individual market plans, it is more important than ever that consumers can timely and correctly determine which providers are actually in their network.

We will direct our comments to particular parts of the rule that we believe are very important to preserve and parts that we believe could still be improved.

We are pleased that this rule places responsibility on insurers (issuers) to keep their published provider networks up to date, whether the provider directly informs them of leaving the network or whether the information comes to the issuer in another manner, such as the claims handling process. For people who are in a position to choose a provider this rule will help them find an in-network provider and have greater confidence that the provider whose services they are using actually is in the network.

Overarching concern

However, many people are being billed by out of network providers that they did not choose. This happens when out-of-network anesthesiologists, radiologists, pathologists, emergency room physicians and others are selected by an in-network hospital or surgeon without the knowledge or consent of the patient. It happens in emergencies, as the comments of Wendy McVicker of Athens, Ohio demonstrate. It happens because networks may have a very low participation level of certain specialists. It also happens because facilities do not always assign providers based on the patient's plan limitations. This rule does not protect consumers from balance billing in these situations, and we would urge that the following is necessary:

- Hold consumers harmless from balance billing by providers over whose selection they did not have control;
- Require issuers to offer an adequate selection of providers;
- Require an in-network hospital or other facility to assign to a patient providers who are in their network.

Whether it is through new legislation, a subsequent rule or both, we urge the Ohio Department of Insurance to take steps to institute these solutions to the very troublesome problems affecting Ohio's private market consumers.

Section Comments

(C) Definitions

(1) *Enrollee*:
OCHC supports the definition of "enrollee" to include any natural person, including one "potentially entitled" to receive health care benefits. This assures that the provider network will be available to those who are in the plan selection process.

(D) Requirements

(1)(a) Updating schedule:
OCHC believes that the provider director should be reviewed and updated more frequently than quarterly. With only a quarterly update, many consumers will still be at risk of selecting a provider who is not in the network. We strongly urge a monthly update requirement.

(1) (a) –(b) Updating requirement:
Issuers should be require to do more than simply respond to a notice from a provider of their network change or "adjudicating or processing claims." By the time the claim is processed and the issuer learns that the provider dropped out of the network, the consumer is stuck with an out of network bill. Issuers should be required to routinely communicate with network members, asking for confirmation that they remain in the network, and updating the network accordingly. Perhaps this is the intent of the word "reviewed" in (D) (1) (a), but that is not clear.

(1)(d) OCHC supports the requirement that issuers must make reasonable efforts to provide assistance to individuals with limited English proficiency or disabilities. We strongly urge ODI to look at issuer web sites to determine whether they meet the requirements for serving individuals with visual and hearing impairments and providing notices in alternative languages as to how consumers can access the information in the language they speak/read.

(1)(l) OCHC supports the requirement that the online directory include a method by which enrollees can search for a listing of all networks and the applicable health plans to which the provider and facility belong. This supports the consumer's ability to shop for a plan that includes both their doctor and hospital.

(1) (m) OCHC supported an earlier version of the rule which required "a listing of all providers affiliated with the facility" and "a listing of any staff [1]providing services at the facility who are not in-network."

In the final proposed rule, however, that requirement is eliminated and instead the issuer is only required to make a "general statement notifying enrollees that there may be providers of services at the facility, such as anesthesiologists, radiologists and laboratories, who are not in-network, and a method for contacting the issuer to obtain more detailed information."

Having a list of the providers at the facility and those who are not in the network is empowering to consumers. It tells the consumer—if you choose this plan there is a good chance you will find providers at this facility that are in-network. Similarly, if the consumer sees that the in-network facility does not have an in-network ER, the consumer may well decide not to go with that plan.

Simply saying that "there may be providers who are not in-network" provides the consumer no information to make an informed decision. It is also pointless to simply tell the consumer how to contact the issuer for more information, because in the plan selection process it is not realistic and often not possible to obtain the information of what providers are not in the network. OCHC strenuously urges that the rule be revised to require the issuer to provide a listing of all providers affiliated with the facility; and a listing of any providers providing services at the facility who are not in-network.

(2) (b) OCHC supports the requirement that the issuer shall provide, upon request by an enrollee, a disclosure of the amount of any deductibles, copayments, coinsurance or other amounts for which the enrollee may be responsible. However, OCHC opposes absolving the issuer of taking responsibility for the information it provides. If the amount turns out to be incorrect, the issuer should take responsibility and hold the consumer harmless from unexpected charges.

(E) Financial Liability

OCHC supports the requirement in (E) that an issuer shall not implement increased financial liability to enrollees resulting from the expiration or termination of a provider or facility from the network until the provider directory has been updated to reflect such changes. However, clarification is needed on what "increased financial liability" means. Does it mean that if a consumer is charged 20% coinsurance for an in-network provider and 40% coinsurance for an out-of-network provider, the consumer will pay 20%? But what about the balance billing issue? What happens to the consumer if the provider refuses to accept the allowed amount from the

[1] OCHC did ask that "staff" be changed to "staff and contractors."

issuer because the provider is no longer in network? Let's say the issuer pays 80% instead of 60% of the allowed amount, but the provider bills the consumer the difference between the allowed amount and the charged amount? Will the insurance company that failed to update the directory make up for that charge? OCHC urges the last question to be answered "yes," and that the rule be clarified to make that clear.

(F) Notice

OCHC supports this provision of the rule that requires the issuer to inform consumers that have used a provider that that provider is no longer part of the network. We urge the Department to clarify the notice that is required. Such notice should be in writing and sent by U.S. mail, unless the issuer and the insured have agreed to a different mode of notice. We also urge the Department to strengthen the rule to clarify the consequences of failure to notify the insured that the provider is not in the network. Our suggestion is that the issuer be required to hold the consumer harmless from all out-of-network charges, including balance billing.

OCHC appreciates the opportunity to make these comments on this important first step toward protecting consumers who are at great financial risk when they secure out of network medical services.