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Health insurers in Ohio must keep provider directories up-to-date

Written by: Ben Sutherly, December 15, 2015

Watchful Ohioans will gain some protection from surprise medical bills as well as greater knowledge about insurance plans' provider networks under a rule that takes effect in January.

The rule, put in place by the state Department of Insurance, will require health-insurance companies to update their directories of health-care providers at least every three months.

And within 15 business days of a doctor or other health-care provider leaving the network, the insurance company must not only update its directory but also notify consumers who have received health-care services from that provider in the previous year.

Insurance carriers also must, upon request, give consumers nonbinding estimates of how much the consumer would pay for care from an out-of-network provider.

And those carriers also must note in their directories whether doctors and other providers are accepting new patients, plus the specific geographic locations where a doctor or another provider's care would be considered "in-network."

Consumer advocates say that aspect of the rule will help consumers and regulators determine whether health-insurance companies are including adequate numbers of doctors, hospitals and other providers in their networks.

The rule will not apply to dental plans, a change from the initial proposal.

As a result of the rule, people who are shopping for health coverage can get unfettered access to various health insurers' online provider networks — information that, in many cases, has been available only to an insurance company's customers who logged in.

"Our goal with this rule is very much to make sure consumers have good, reliable information as they're shopping for health plans," said Carrie Haughawout, assistant director of policy and product coordination at the Department of Insurance.

The rule also is intended to give insurance companies clarity about what's expected of them, Haughawout said. Although the rule does not impose fines or penalties for paperwork violations, the department might investigate if an insurer regularly fails to comply.

And under the rule, insurance companies can't pass on the additional costs of an out-of-network provider's care to consumers if the carrier's directory lists that provider as "in-network."

"That's a powerful incentive for the insurance company" to keep its directories current, Haughawout said.

But the rule will not require insurance companies to detail for consumers the out-of-network doctors who work at an in-network hospital.

That requirement had been considered during the rule-making process but was dropped in response to concerns expressed by the Ohio Association of Health Plans, which represents the industry.

"As it relates to which providers are out-of-network, (the association) was concerned about health plans being required to report information that insurers don't have," Miranda Motter, the association's president and CEO, said in a statement.

"While out-of-network information may be known to providers and facilities, in-network facilities generally don't provide information relative to out-of-network providers to the health plan."

Instead, insurance companies must include a general statement letting consumers know that the hospital might have out-of-network providers such as anesthesiologists, radiologists and laboratories.

"This just isn't very helpful if you're looking at an in-network hospital with an out-of-network surgeon," said Kathleen Gmeiner, director of the consumer-advocacy project Ohio Consumers for Health Coverage.

"That's just not something that a consumer's going to know. What's really needed here is legislation that deals with surprise medical bills."

Wendy McVicker learned the hard way that she had received care from an out-of-network health-care provider.

McVicker, 64, of Athens, Ohio, was seriously injured in a bicycle crash in July 2014 and had to be flown by medical helicopter to Columbus.

The initial bill from MedFlight was $25,800. Her insurance company's payment left McVicker and her husband with a balance of more than $15,000. After several appeals, the couple settled and paid nearly $7,500, she said.

"You think you're covered, and then there are all these surprises," McVicker said. "I think that's so unfair and so hard on people. It seems like there's almost no way to find out. It's very hard to get informed.

"It astonishes me that we still deal with this impenetrable kudzu of insurance regulations and 'irregulations.'