



**Delivered Via Email**

February 20, 2015

The Honorable Mary Taylor  
Director, Ohio Department of Insurance  
Ohio Department of Insurance  
50 W. Town Street  
Third Floor - Suite 300  
Columbus, Ohio 43215  
(614) 644-2658

Re: Comments on Proposed Rule 3901-8-16

Dear Lt. Governor Taylor,

On behalf of the Ohio Association of Health Plans (OAHP), I would like to thank you for the opportunity to review and comment on proposed rule 3901-8-16, Required Provider Network Disclosures for Consumers. Also, I appreciate your staff meeting with me and members of OAHP's leadership team regarding the draft rule. I am glad we had the opportunity to discuss our initial concerns and to hear from your staff about the underlying policy objective relative to the various draft provisions. We appreciate your staff's on-going commitment to work with the industry on this proposed rule and we intend to provide the Department additional feedback in the areas your staff requested.

The purpose of this letter is to provide the Department industry feedback on behalf of OAHP member health plans – plans that provide health insurance coverage to Ohioans in both the traditional commercial insurance market and Ohio's health insurance exchange Marketplace. Below you will find a series of general OAHP comments followed by a series of specific comments relative to the various proposed rule provisions.

First, OAHP member plans want Ohio's health care consumers to have the best information to make informed decisions regarding their health care coverage. A provider directory is one of the important tools available to consumers to find out which providers are part of a health plan's network. Health plans consistently work to ensure provider directories are up-to-date; however, plan efforts to ensure provider directories are up-to-date and accurate can be challenging because up-to-date provider directories depend on providers informing the health plan of any changes that impact the accuracy of the information included in the directory. To that end, we believe the Department's proposed rule provides an opportunity to strengthen the relationship and obligation of providers to provide accurate and updated information to health plans so they may disclose such information to consumers vis-à-vis the provider directory.

Second, the traditional function of a provider directory is to provide consumers information about which providers are part of a health plan's network. The provider directory is not intended to provide consumers detailed benefit and/or cost information relative to specific benefit plans. Nor is it intended to provide information about non-network providers or the associated costs with obtaining health care services from out-of-network providers. The proposed rule goes well beyond the scope and purpose of a provider "directory." OAHP does, however, believe that the proposed rule provides an opportunity to improve on the type and accuracy of information included in the directory to further assist consumers as they shop for health insurance coverage and determine which providers are part of a particular plan's network.

Lastly, OAHP is very concerned with how broad the Department's proposed rule is. If Ohio adopts this proposed rule, Ohio law will be:

- Significantly different from any other state;
- Inconsistent with the National Association of Insurance Commissioner Model (NAIC) currently under consideration relative to this issue; and
- Far reaching and well beyond the Notice of Benefit and Payment Parameters Proposed rule relative to provider directories.

We look forward to working collaboratively with the Ohio Department of Insurance and other key stakeholders, particularly the provider community, to create a uniform set of standards that maintain the traditional function of provider directors while reflecting both plan and provider responsibility to improve the accuracy of this important consumer tool.

### **SPECIFIC COMMENTS**

Below you will find a series of specific comments and/or questions on the provisions included in the proposed draft rule. Where there are questions, OAHP is requesting responses and, where necessary, revisions to the various proposed provisions.

#### **Definitions**

**Enrollees (Division (C)(1)).** The current definition of "enrollee" includes both a shopping consumer and an enrollee. Please clarify the Department's intent relative to this definition. Does the Department intend to apply all of the rule's requirements to both a shopper and an enrollee? For example, estimates of out of network expenses depend on a person being enrolled in a specific plan.

**Health Benefit Plan (Division (C)(2)).** The rule should not apply to excepted benefits.

**Health Plan Issuer (Division (C)(3)).** Please clarify whether the Department intends to apply the proposed rule instances where the networks have been leased.

## Requirements

### Provider Directories.

1. Under the Division (D)(1) the format and content of a provider directory must be “sufficiently complete and clear to avoid deception or the capacity to mislead or deceive.”
  - Please provide clarification on this standard. How will the Department review and enforce this standard?
  
2. Under Division (D)(1)(a)(i) the “[h]ard paper copy provider directories must be reviewed and updated at least quarterly, and must be offered to accommodate individuals with limited English proficiency or disabilities. Hard paper copies of the current directory or directories must be made available to enrollees as soon as reasonably practicable upon request.”
  - We would note that hard paper copies become out of date the moment they are printed.
  - The proposed rule requires quarterly updates. This timeframe is inconsistent with NAIC requirements.
  - Please provide clarification on the phrase “as soon as reasonably practicable upon request.”
  
3. Under Division (D)(1)(a)(ii) “[a]n issuer must also post online the current provider directory for each health benefit plan, which shall be reviewed and updated at least quarterly. The online provider directory shall not require enrollees to log-in for online access. In addition, the issuer shall update the online provider directory within fifteen days of the addition or termination of a provider from the issuer's network or a change in a physician's hospital affiliation.”
  - The quarterly timeframe is inconsistent with the NAIC Model Act which requires online provider directories be updated on a monthly basis.
  - Insurers should be required to update provider directories only to the extent they know of the updated information and only after the provider has reported the updated information.
  - Insurers generally do not have information relative to a change in a physician’s hospital affiliation and thus should not be required to include that information.
  
4. Under Division (D)(1)(b), for each health benefit plan, “the associated provider directory must include the following information for each in-network provider:”
  - (i) \*\*\*
  
  - (ii) The specialty area or areas for which the provider is licensed to practice and included in the network;
    - Does the Department intend to require carriers to include hospital based providers such as emergency room physicians, radiologists and pathologists? Many of these providers are hospital employed with frequent turnover. We are beholden to the hospitals to communicate their provider changes to the plan, which oftentimes does not occur in a timely manner.
    - Insurers currently do not have information relative to the specialty area or areas for which the provider is licensed to practice. Rather, insurers do have information related to the specialty areas that the provider is contracted and credentialed to provide to plan members.

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

- Please provide clarification on “affiliation.”
- Insurers currently do not have information relative to institutional affiliations where the provider has admitting privileges or to provider groups in which the provider is member.
- Additionally, including affiliations in provider directories would be burdensome and possibly confusing because affiliations do not always correlate to in-network and out-of-network status.

(iv) Whether the provider may be accessed without referral;

We note that referrals are a benefit issue and member’s individual certificate governs the benefit, not the provider directory.

(v) \*\*\*

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

- Insurers should be required to include this information in provider directories only as reported by providers.

5. OAHP understands that Division (D)(1)(c) and (d) are critical components of the proposed rule and look forward to working with you to clarify the language to meet the Department’s underlying goals while minimizing the impact and any unintended consequences.

6. Would the Department consider limiting Division (D)(1)(f) to the individual market?

7. Division (D)(1)(g) requires that provider directories include, among other things, the following information for each in-network facility: the facility specialty areas, a list of providers affiliated with the facility, and staff providing services at a facility who are not-in-network.

- Insurers should be required to report only information that is reported by providers. In-network facilities generally do not provide information to insurers relative to out-of-network providers.
- While this information may be known to the provider and the facility, the insurer does not necessarily have that information.
- A complete listing of all affiliations may be burdensome and confusing to a shopping consumer.
- OAHP respectfully requests that the Department consider amending this provision to allow insurers to include a disclosure in their provider directories that remind shopping consumers to contact the hospital/facility to verify all of the providers at that hospital/facility are part of the plan’s network.

### **Out of Network Coverage.**

OAHP member plans are very concerned with the entirety of Division (D)(2) for a number of reasons.

First, and as previously noted, the traditional function of a provider directory is to provide consumers information about a health plan's in-network providers. Directories are not intended to provide consumers information relative to out-of-network providers or the costs associated with utilizing an out-of-network provider. Second, Division (D)(2)(a) of the proposed rule would require health plans to disclose proprietary information. Lastly, including this information in the provider directory could potentially be confusing to consumers.

OAHP respectfully recommends that the provider directory refer enrollees who have questions about out-of-network providers and/or the costs associated with those out-of-network providers to their own plan documents, Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC) and consumer service representatives for information about reimbursement methodologies. OAHP looks forward to further discussions with the Department relative to this section of the proposed rule.

### **Identification Cards.**

Division (D)(3) requires identification cards to 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 Ohio's health insurance exchange.

- As currently drafted this provision requires an off cycle production and distribution of identification cards which could lead to enrollee confusion.
- This provision will impose a significant administrative and operational burden on Ohio's health plans as it will result in a substantial expenditure of health plan resources and time to make this programmatic change.
- This provision could also result in Ohio's exchange consumers being treated differently than Ohio's non-exchange consumers. If providers able to identify subsidized patients they might be incentivized to limit their health care services to only non-subsidized patients.

### **Network Changes.**

Division (E) prohibits issuers from implementing increased financial liability to enrollees resulting from any change in ownership, affiliation, or contractual arrangement, until the online provider directory has been updated to reflect such change in a manner that the average consumer would reasonably understand the financial impact of such changes.

- Please clarify this provision. As currently drafted it is unclear exactly what it applies to and what the insurer's obligations are. For example, what is "increased liability to enrollees?" What type of "ownership, affiliation or contractual arrangements" does this rule refer to? What type of information needs to be posted to the online directory?

### **Reporting to the Superintendent.**

Does the Department intend to provide confidentiality protection to the records required under Division (F)?

Thank you for the opportunity to provide our feedback and concerns. OAHP respectfully requests that the Department take into consideration these concerns and any that the Department might

receive from individual health plans. OAHF looks forward to the opportunity to work collaboratively with the Department and other stakeholders to create a uniform set of standards that maintain the traditional function of provider directories while reflecting both plan and provider responsibility to improve the accuracy of this important consumer tool.

If you have any questions relative to any of the questions, comments or concerns raised in this letter, please feel free to contact me at (614) 228-4662 or [mmotter@oahp.org](mailto:mmotter@oahp.org).

All my best,

A handwritten signature in black ink that reads "Miranda C. Motter". The signature is written in a cursive style with a large, prominent "M" at the beginning.

Miranda C. Motter  
President & CEO  
Ohio Association of Health Plans

cc: Carrie Haughwout, ODI Assistant Director of Policy and Product Coordination  
Allison Conklin, ODI Legislative Liaison