Delivered Via Email

March 27, 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 Second Draft of 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 the second draft of proposed rule 3901-8-16, Required Provider Network Disclosures for Consumers.

We appreciate your staff’s work to address a number of the concerns raised in our first comment letter dated February 20, 2015. We are committed to working with the Ohio Department of Insurance (ODI) to achieve the Department’s underlying policy objective of the disclosure of meaningful, useful provider information to Ohio’s health care consumers through collective plan and provider responsibility while remaining true to the intended purpose of a provider directory.

To that end, the purpose of this letter is to provide the Department feedback on behalf of OAHP member plans relative to the second draft. Consistent with our approach to comments to the ODI’s first draft, below OAHP has outlined a series of general comments followed by a series of specific comments relative to the provisions proposed in the second draft.

Notification Trigger. First, OAHP member plans appreciate the Department’s recognition of the challenge that health plans face in ensuring that the information included in provider directories is up-to-date because plans rely upon providers informing them of any changes that impact the accuracy of the information included the directory. The Department’s inclusion of a “notification trigger” in Division (D)(1)(c) and Division (D)(1)(l)(v)(A) is positive and acknowledges the need to strengthen the obligation of providers to provide accurate and updated information. However, OAHP is concerned with the “notification is deemed received” language that accompanies the trigger language. Specifically, we are
concerned with the phrase “should have known.” The phrase is vague and creates potential legal liability for plans.

In a follow up conversation with ODI staff, we believe the intent of the “notification is deemed received” language is to address situations where a health plan might be aware of a change and acting on that information in one or more areas of a plan’s business (i.e. adjudicating claims for non-contracted providers) but not communicating that change across the business operations to update the plan’s provider directory. OAHP respectfully requests an opportunity to discuss ODI’s intent relative to the “should have known” standard and requests that the language be clarified to reflect the Department’s stated intent in order to provide health plans and providers a clear understanding of the standard to which they will be held.

**Out-of-Network Information.** As previously communicated, OAHP believes that the Department’s proposed rule provides an opportunity to improve on the type and accuracy of information included in a provider directory to further assist consumers as they shop for health insurance coverage and determine which providers are part of a particular plan’s network.

OAHP member plans, however, continue to be concerned that the proposed rule exceeds traditional function of a provider directory by requiring detailed benefit and/or cost information relative to specific benefit plans as information about non-network providers or the associated costs with obtaining health care services from out-of-network providers.

While it appears that the Department recognizes that out-of-network information may not be appropriately situated in a provider directory (as demonstrated by the deletion of the phrase “as part of its provider directory” under Division (D)(2)), the structure of the rule itself continues to contemplate that out-of-network information be required as part of the provider directory.

In a follow up conversation with ODI staff, we believe the intent of the Department’s revisions relative to Division (D)(2) is to provide health plans flexibility about exactly where they provide the required out-of-network information to consumers. In that conversation, the Department indicated that the out-of-network information could be “right along-side” of the provider directory information or within the directory itself. We understand that ODI’s underlying policy objective here is to be sure that the consumer has a general explanation about how the utilization of out-of-network services may impact that consumer’s potential health care costs. OAHP respectfully requests an opportunity to discuss this area of the proposed rule and requests further clarification to this language to provide clear guidance relative to the Department’s expectation and implementation of the language.

**Administratively Burdensome/Costly/Consumer Confusion.** OAHP continues to be concerned with how expensive and burdensome it will be to implement many of the rule’s provisions and is particularly concerned that the amount and type of information required under the proposed rule may only lead to consumer confusion.

In a follow up conversation with ODI staff relative to administrative burdens, ODI staff indicated that the Department does not intend for plans to maintain two separate provider directories – one in hard copy and another online version. It is our understanding that ODI intends for plans to maintain a single provider directory but not in two different formats – online/electronic and a hard paper copy. OAHP requests
an opportunity to discuss this area further and would also request that the rule be further refined to clearly reflect this intent.

Consistent with our first comment letter, OAHP continues to be concerned with the scope and breadth of the proposed rule. If this proposed rule is adopted, Ohio would be the only state in the country with this type of rule. Additionally, it is inconsistent with the National Association of Insurance Commissioner Model (NAIC) currently under consideration relative to this issue and goes well beyond the provider directory requirements included in the final federal regulations on the 2016 Notice of Benefit and Payment Parameters. OAHP also requests that the Department consider how the proposed rule impacts the National Committee for Quality Assurance (NCQA) requirements applicable to health plans.

In closing, OAHP member plans 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 directories while reflecting both plan and provider responsibility to improve the accuracy of this important consumer tool.

**SPECIFIC COMMENTS**

Attached 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**

**Division (C)(2).** OAHP respectfully requests that the Department reconsider applying the rule to excepted benefits.

**Requirements**

**Division (D)(1)(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.

- **OAHP Comment:** Please clarify that this section applies to both hard copy and online directories. OAHP requests that this language be refined to clarify that the Department does not intent for plans to maintain two separate provider directories but intends to require plans to maintain a single directory in two different formats.

**Division (D)(1)(e).** 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.
- OAHP Comments:
  
  - Please clarify that this section applies to both hard copy and online directories. OAHP requests that this language be refined to clarify that the Department does not intent for plans to maintain two separate provider directories but intends to require plans to maintain a single directory in two different formats.
  - Per NCQA requirements, new providers cannot be added to a directory prior to being credentialed. Adding new providers prior to such time is not only contrary to current requirement, but imposes a liability risk for health plans as they would be listing providers prior to verifying their credentials. Moreover, in terms of the fifteen day timeframe, to require credentialing be completed within 15 days is unrealistic and again is goes against other regulations that require 90 days. OAHP requests an adjustment to the timeframe to align with other regulatory timeframes.
  - Please clarify the Department’s definition of “should have known”. The phrase “should have known” is highly problematic. An issuer’s directory must reflect information that has been contractually submitted by the provider. A plan cannot assume responsibility for information it “should have known” and then represent that information about a contracted provider. The provider is legally obligated to submit that information to the health plan.

Division (D)(1)(d)(i)(B). Provides the hard paper copy to the enrollee within at least ten days of the date of the request.

- OAHP Comment: OAHP respectfully requests that “ten days...” be revised to “10 business days...”

Division (D)(1)(f). The online provider directory shall not require enrollees to log-in or provide a member or group identification number for online access.

- OAHP Comment: OAHP would note that to not require a member or group number makes the desired accuracy of such a search difficult to obtain. OAHP would request that the Department consider a disclaimer, such as: “In order for a member to obtain the most recent and accurate information, a member or a group ID number should be provided.” In instances where it is not provided, a health plan should not be held liable.

Division (D)(1)(g)(iv). The tier to which a provider is assigned, if applicable;
Division (D)(1)(g)(vi). A notation of any provider whose practice is closed to new patients

- **OAHP Comment**: OAHP requests that this language be revised to include a “notification trigger” – an insurer must provide this information when such information is received from the provider.

Division (D)(1)(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.

- **OAHP Comment**: Because referral processes vary by plan, OAHP respectfully requests that the Department consider an overarching statement be included directing members to the plan documents for greater specificity and details on the referral process.

Division (D)(1)(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.

- **OAHP Comment**: Can ODI provide additional clarification relative to the phrase “easily distinguishable”?

Division (D)(1)(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.

- **OAHP Comments**:
  - OAHP respectfully requests that the rule NOT require all “applicable health plans” or products be displayed for a provider, only the plan or product for which a member is searching. OAHP is concerned about the high likelihood of confusion for consumers
  - OAHP requests clarification relative to “applicable health plans”. Does this require a listing by metal level?
  - It is important to note that this provision will be very burdensome, expensive to accomplish, and particularly onerous for issuers to manage.

Division (D)(1)(l)(ii). The specialty area or areas for which the facility is contracted
- **OAHP Comment**: Can ODI provide additional clarification relative to the “specialty area or areas” language?

**Division (D)(1)(l)(iii).** A listing of all providers affiliated with the facility who are in-network;

- **OAHP Comments**:
  - Can the Department provide examples of this provisions’ requirement to be sure the industry understands what the expectations are. For example, does this include radiologist, pathologists etc.?
  - This provision is extremely problematic and the list would be very long.
  - Since members can view hospital privileges by provider, can ODI please provide feedback regarding why this information is needed by facility?

**Division (D)(1)(l)(v)(A).** 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 is not in-network, such providers must be listed in the provider directory or directories.

- **OAHP Comments**:
  - Please clarify the Department’s definition of “should have known” and provide examples. The phrase “should have known” is vague and does not provide industry a clear compliance standard.

**Division (D)(1)(l)(v)(B).** If the issuer does not know which providers providing services at the facility is 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.

- **OAHP Comments**:
  - OAHP continues to believe out-of-network information should not be contained in the network provider directory. A provider directory is by definition a listing of providers which the health plan endorses. Consumers of all types will find it difficult to navigate a confusing directory that includes both contracted and non-contracted providers. Plans have a difficult time getting updates from contracted providers, who have a legal obligation to communicate that information to plans. Plans are unable to enforce the submission of accurate and timely changes for non-contracted providers. If the plans try to implement a vague “should have known” standard, plans run the risk of subjecting themselves to legal liability if they get it incorrect.
Out-of-network information may not be available and changes frequently. OAHP also requests clarification from the Department relative to how this provision will be implemented for an on-line directory.

**Division (D)(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

- **OAHP Comments**:
  
  - Please confirm that this revised section means that the out-of-network coverage information required under this section is no longer required to be included in the provider directory?
  - OAHP continues to believe that members should be directed to their plan documents for information relative to out-of-network coverage.

**Division (D)(2)(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.

- **OAHP Comments**:

  - OAHP appreciates the “unbinding” nature of this language; however, this provision creates an expectation and an unreasonable burden on the plan to be able to provide an answer in a timely fashion.
  - Often for a plan to estimate the approximate amount of payment, a critical piece of information needed is the billed charged. For an out-of-network provider, it’s likely that the plan will have very limited information about billing rates, and hence unable to even predict payment levels.

**Division (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.

- **OAHP Comments**:

  - While OAHP understands the underlying goal relative to this provision, OAHP continues to believe that the language is vague, overly broad and
unclear thus making it difficult for insurers implement. OAHP requests further refinement of the language to provide industry a clear understanding of this compliance standard.

- OAHP also notes that this provision requiring issuers to withhold implementation of measures affecting financial liability until the directory is updated, would require very costly systems changes.

**Division (E)(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.

- OAHP Comments:

  - OAHP believes the Department’s underlying goal relative to this provision is for insurers to notify impacted members if a provider changes any type of participation status. However, OAHP continues to believe that the actual language is vague, overly broad and unclear thus making it difficult for insurers implement. OAHP requests further refinement of the language to provide industry a clear understanding of this compliance standard.

  - OAHP requests clarification from ODI relative to the phrase “enrollee who may be affected by change…”

  - Please provide comments relative to why the industry would send notification about a change in physician’s hospital affiliation? These changes are only validated during re-credentialing and would be very labor intensive to alert any member that has seen this provider of this change in hospital privileges.

**Division (F)(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.
- *OAHP Comments:*

  - OAHP appreciates the revisions made to the draft rule relative to confidentiality protection and would like to discuss further strengthening these provisions.
  - OAHP is concerned with the reporting requirements under the rule as some of the required reports would be very expensive and burdensome to produce.

Thank you for the opportunity to provide our feedback and concerns. We continue to appreciate your staff’s on-going commitment to work with the industry on this proposed rule. OAHP respectfully requests that the Department take into consideration these concerns and any that the Department might receive from individual health plans. OAHP looks forward to the opportunity for continued collaboration 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.

All the best,

[Signature]

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

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