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May 21, 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: Proposed Rule 3901-8-16

Dear Lt. Governor Taylor:

Thank you for the opportunity to comment on Rule 3901-8-16, required provider network disclosures for consumers, which is currently open for comment. The Ohio Association of Health Plans (OAHP) respectfully requests that the below comments receive full consideration during this important business impact analysis (BIA) process. As you know, OAHP member plans have been working with the Ohio Department of Insurance during the drafting phase of this rule and we appreciate the work the Department has done to address concerns voiced throughout that process. OAHP member plans have reviewed this rule and continued to have concerns relative to: (1) the notification triggers, (2) the administrative burden and costs associated with implanting this rule and (3) the potential confusion to and impact on Ohio’s health care consumers with some of the rule’s requirements. We’ve also included a couple of areas we’re requesting clarification of the language.

Again, we appreciate the work done by the Department on this rule and look forward to continued work together to further address these remaining concerns. Below please find a summary of these concerns.

Notification Triggers

1. Issuers should only be required to update provider information if they are aware of a change.
   a. Division (E) Network Changes

      - Concern: One continued problematic area is the requirement that the provider directory be updated before an insurer may “implement increased financial liability to enrollees resulting from an addition, expiration or termination of a provider or facility from the issuer’s network or a change in a provider’s hospital affiliation. . . . “. Issuers may not be aware of affiliation changes when they occur and this may require
issuers to pay full out of network charges in situations where the issuer only learns of affiliation change later.

- Recommendation: To address this issue, OAHP recommends deleting the phrase “increased financial liability” from the rule.

b. Division (D)(1) (g)(vi): If known by the issuer, [a] notation of any provider whose practice is closed to new patients.

- Additionally, OAHP requests the following clarification: Is this a notation for the specific provider not taking new patients or an entire practice? There are multiple practices that are open but an individual may not be taking new patients.

c. Division (D)(1) (l)(iii) A listing of all providers known by the issuer to be affiliated with the facility that are in-network;

- OAHP also requests a clear definition of “affiliation”; plans and providers may define this differently and thus it will be important for all parties to have a clear understanding of that term.

2. Division (D)(1)(c). Directories must conspicuously display the most recent date of update.

- Concern: The language requires that directories conspicuously display the most recent date of update. It is important to note that the directory will be updated only to the extent the providers have communicated the changes to the issuers.

- Recommendation: OAHP would respectfully request that this requirement reflect the shared responsibility with the provider and allow the following disclaimer: “The information reflected in this directory was updated on xx/xx/xxxx with the changes known to the issuer at that point.”

**Administrative Burden and Costs**

Division (D)(1)(j). An issuer's online provider directory must include a method by which enrollees can search specific specialties of providers.

- Concern. The rule requires an issuer's online provider directory to include a method by which enrollees can search for specific providers and facilities by name and receive a listing of all networks and applicable health plans, to which the provider and facility belongs. Generally, current search functionality allows the user to pick a network first, and then the search returns results from within that network. Plans can add this additional feature with IT resource investment but the industry does have concerns that there is more risk in members being confused if the results return the desired provider listing, but the member does not note the potential provider network limitations and mistakenly relies on the fact that the provider was displayed upon search.

- Recommendation: That the rule be revised to state that plans should not be required to build this additional search feature, as long as their current search functionality allows providers to be distinguished by network.
Potential Confusion to and Impact on Ohio’s Health Care Consumers

1. Division (D)(1)(g). The language requires, for each health benefit plan, the associated provider directory to include the following information for each in-network facility:

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

   - Concern: Industry continues to have concerns with this requirement, as this information changes regularly. “All providers” could be a significant volume of providers depending on the facility, and OAHHP is unsure how useful this information would be.

2. Division (D)(3) Identification Cards. The language requires that identification cards clearly and conspicuously denote the name of any network’s applicable to the coverage and must clearly conspicuously denote whether such coverage is provided through the exchange as defined in division (W) of section 3905.01 of the Revised Code.

   - Concern: First, OAHHP member plans have experienced first-hand some of the effects of communicating to the provider community whether an individual is an on or off exchange member. Some providers do not want to provide services to on exchange members because they either: (1) do not want anything to do with federal health care reform or the health insurance Exchanges or (2) see those members as being higher-risk in terms of ability to pay (considering they are within certain FPL levels and receiving subsidies as-is). The industry is concerned about this particularly in light of this language that might only serve to exacerbate this issue. This treatment, which is based on the consumer’s on-exchange status, is discriminatory and will leave many consumers without the ability to see their preferred providers.

   Second, the various provisions set forth in this draft rule place all kinds of additional requirements on health plans to ensure their provider directories conform to the language set forth in the rule. If providers discriminate against on-Exchange consumers, issuers will be forced to create additional directories for on and off exchange products. And unfortunately, several of the products offered on-exchange are guaranteed available off-exchange which we assume would include the same provider directory. Again, which will lead to problems with administering the provider network requirements and ensuring compliance with the same.

   - Recommendation: OAHHP would request that the phrase “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” in Division (D)(3) be deleted.

3. Division (D)(1)(g)(iv) and (D)(1)(l)(iv).
   Under these two sections, the associated provider directory for each the health benefit plan must include the following information for each in-network provider and each in-network facility:

   ***
(iv) The tier to which a [provider or facility] is assigned.

- Concern: OAHP is concerned that this information might be confusing to a consumer and that this information isn’t really meaningful unless the tier impacts the enrollees financial liability.

- Recommendation: OAHP respectfully requests that this provision be revised to state “the tier to which a [provider or facility] is assigned if it impacts the enrollee’s financial liability.”

Issues for Clarification

1. Division (E) Network Changes.

- Concern: This provision also requires the issuer to “provide notification to and who may be affected by such change within fifteen business days of the effective date of the change.” This appears to require more than just updating the provider directory. Does this mean a letter must be sent to all enrollees (per the rule’s definition of an “enrollee”)? If not to all enrollees, then to whom? Enrollees that have seen the provider in the past 12 months? Enrollees that are actively in treatment? What type of notice is required? A letter, and email, a posting on a website? This seems particularly troublesome.
  
  o Recommendation: Further clarification is provided in the rule relative to the Department’s expectation and implementation of this requirement.

  o It is important to that that current ODI Bulletin 2009-1 requires prior notice to enrollees only in situations involving a change in network affiliation involving a hospital or “major physician group”. This rule would extend this notification requirement to network changes involving any provider.

- Concern: The provision doesn’t clearly define “effective date”. It will be important to clarify this phrase and to ensure that it means the date the provider is approved through credentialing. For a variety of reasons, plans are concerned that the vagueness of this may require plans to add un-credentialed providers to the directories.
  
  o Recommendation: That this provision be revised to define effective date as the date the provider is approved through credentialing.

2. Division (D)(1)(g). The language requires, for each health benefit plan, the associated provider directory to include the following information for each in-network facility:

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

- Concern: This language assumes that the provider only has one address. For some providers, that is not the case.

- Recommendation: OAHP requests language that clarifies that plans may list the provider’s “primary address.”
3. Division (C)(3), Health Plan Issuer definition.
   - Concern: The rule defines “health benefit plan” as not including “coverage under a plan through . . . Medicaid”. The rule then defines “issuer” as an entity that pays the cost of health care services under a “health benefit plan.” The requirements in the rules apply to “issuers”. Clearly the intent of the two definitions, read together, is that the rule’s requirements do not apply to Medicaid. However, we believe the last sentence in the definition of “health plan issuer” makes the rule with respect to its application to Medicaid unclear. See the definition of “contracting entity” which does not specifically exclude Medicaid managed care plans.

   - Recommendation: OAHP would request the following clarifying language to the definition of “health plan issuer”: Except as to plans not included in the definition of health benefit plan, “health plan issuer” also includes a contracting entity as defined under Chapter 3963 to the extent that the contract[ed] 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.”

Again, we appreciate the work done by the Department on this rule and look forward to continued work together to further address these remaining concerns. If you have any questions, please don’t hesitate to contact me at mmotter@oahp.org or (614) 228-4662.

Thank you in advance for your consideration.

Sincerely,

Miranda C. Motter

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

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