Ohio Administrative Code

Rule 3901-8-16 Required provider network disclosures for consumers.

Effective: November 16, 2023

(A) Purpose

The purpose of this rule is to implement and interpret applicable statutes including sections 3901.21 and 3923.16 of the Revised Code by further defining unfair trade practices and setting forth minimum standards for the adequate disclosure of any limitations or restrictions on access to providers/facilities to enrollees and to potential enrollees prior to enrollment in a particular health plan.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under section 3901.041 of the Revised Code, general rule making authority; and section 3901.21 of the Revised Code, the unfair and deceptive acts statute.

(C) Definitions

(1) "Enrollee" for the purpose of this rule means any natural person who is entitled or potentially entitled to receive health care benefits provided by a health plan issuer.

(2) "Health benefit plan" for the purpose of this rule has the same meaning as set forth in division (L) of section 3922.01 of the Revised Code.

(3) "Health plan issuer" or "issuer" for the purpose of this rule means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract, to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company; a health insuring corporation; a fraternal benefit society; a self-funded multiple employer welfare arrangement; or a nonfederal, government health plan. "Health plan issuer" includes a third

party administrator licensed under Chapter 3959. of the Revised Code to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent. "Health plan issuer" also includes a contracting entity as defined under Chapter 3963. of the Revised Code to the extent that the contracted 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.

(D) Requirements

(1) Provider directories. An issuer must ensure that the format and content of a provider directory of a health benefit plan is sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive by complying with at least the following requirements:

(a) Provider directories must be reviewed and updated at least quarterly;

(b) An issuer must update its provider directories within fifteen business days of the effective date of the addition, expiration or termination of a provider or facility from the issuer's network. If the issuer is not aware of the addition, expiration or termination of a provider or facility from the issuer's network prior to it taking effect, an issuer's provider directories must be updated within fifteen business days of the issuer becoming aware of such change. An issuer is deemed to be aware of the addition, expiration or termination of a provider or facility from the issuer's network if the issuer:

(i) Receives notification related to such change from a provider or facility; or

(ii) Takes any action with respect to the provider or facility, such as adjudicating or processing claims, which demonstrates that there is a change in the provider or facility's network status.

(c) Directories must conspicuously display the most recent date of update;

(d) Issuers must make a reasonable effort to provide assistance to individuals with limited English proficiency or disabilities with respect to accessing the provider directory or directories;

(e) Provider directories must be accessible to enrollees online and shall not require enrollees to log-in

or to provide a member or group identification number for online access;

(f) Provider directories must be accessible to enrollees in paper copy form. Upon request, issuers must provide the paper copy as soon as reasonably practicable. Paper copy provider directories must contain a clear and conspicuous statement noting that enrollees must contact the issuer to confirm the accuracy of paper copy provider directories, as changes may have occurred since the date of printing;

(i) An issuer is deemed compliant with the requirement contained in paragraph (D)(1)(f) of this rule as long as the issuer:

(a) Provides at least the applicable section or portion of the provider directory that is relevant to an enrollee's request in paper copy form; and

(b) Provides the paper copy to the enrollee within at least ten business days of the date of the request.

(ii) Nothing in this section requires an issuer to publish or maintain separate paper copy and online provider directories as long as the requirements of paragraph (D)(1)(f) of this rule can be satisfied by printing and providing the applicable portions of the directory.

(g) For each health benefit plan, the associated provider directory must include the following information for each in-network provider:

(i) Name;

(ii) Gender;

(iii) Specialty;

(iv) Board certifications;

(v) Accepting new patients;

(vi) Languages spoken by the physician or clinical staff; and

(vii) Office locations.

(h) An issuer's provider directory or directories must make it clear to an enrollee which providers and facilities 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;

(i) 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 a change in network status;

(j) 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 (X) of section 3905.01 of the Revised Code. The name of a network is easily distinguishable if a layperson without specialized insurance industry knowledge is able to easily differentiate among the issuer's networks based on the naming conventions used in the directory.

(k) An issuer's online provider directory must include a method by which enrollees can search specific specialties of providers;

(l) An issuer's online provider directory must include a method by which enrollees can search for specific providers and facilities by name and receive a listing of all networks, and the applicable health plans, to which the provider and facility belongs. Paragraph (D)(1)(l) of this rule, applies one year from the effective date of this rule; and

(m) For each health benefit plan, the associated provider directory must include the following information for each in-network facility:

(i) The location and contact information for each facility;

(ii) The specialty area or areas for which the facility is contracted and included in the network;

(iii) The tier to which a facility is assigned, if there is a financial impact to the enrollee; and

(iv) A general statement notifying enrollees that there may be providers of services at the facility, such as anesthesiologists, radiologists and laboratories, that are not in-network, and a method for contacting the issuer to obtain more detailed information.

(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

(b) 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. The issuer shall also inform the enrollee through such disclosure that such information is not binding on the issuer and that the amount for which the enrollee is responsible may change.

(3) Identification cards. Identification cards provided to enrollees, if any, must clearly and conspicuously denote:

(a) The name of any network(s) applicable to the coverage; and

(b) Whether such coverage is provided through the exchange as defined in division (X) of section 3905.01 of the Revised Code.

(E) Financial liability. An issuer shall not implement increased financial liability to enrollees resulting from:

(1) An enrollee's reasonable reliance on an incorrect or misleading provider directory or issuer's customer service representative's incorrect or misleading statements with respect to the directory; or

(2) The expiration or termination of a provider or facility from the issuer's network until the provider

directory has been updated to reflect such changes.

(F) Notice. An issuer must provide notice of the expiration or termination of a provider or facility from the issuer's network to an enrollee who has received health care services from that provider or facility within the previous twelve months:

(1) Notification must be provided as follows:

(a) Within fifteen business days of the effective date of the expiration or termination of a provider or facility from the issuer's network; or

(b) If the issuer is not aware of the expiration or termination of a provider or facility from the issuer's network prior to it taking effect, notice must be given within fifteen business days of the issuer becoming aware of such change.

(2) An issuer is deemed to be aware of the expiration or termination of a provider or facility from the issuer's network if the issuer:

(a) Receives notification related to such change from a provider or facility; or

(b) Takes any action with respect to the provider or facility, such as adjudicating or processing claims, which demonstrates that there is a change in the provider or facility's network status.

(G) Reporting to the superintendent. The superintendent may require an issuer to submit reports upon request in order to demonstrate compliance with this rule.

(1) If reports are required, the superintendent may prescribe the content, format, and frequency of the reports. The following information may be required for inclusion:

(a) Records documenting network changes;

(b) Records documenting the timing and frequency of provider directory updates;

(c) Records documenting the number of consumer complaints received related to the accuracy of the provider directory, difficulty in obtaining access to the directory, or difficulty in obtaining information related to out-of-network cost-sharing; and

(d) Any other information that the superintendent considers to be relevant in evaluating an issuer's compliance with this rule.

(2) All documents provided to the superintendent under paragraph (G) of this rule are considered work papers of the superintendent that are subject to section 3901.48 of the Revised Code and are confidential and privileged and are not considered a public record, as defined in section 149.43 of the Revised Code. The original documents and any copies of them are not 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.

(H) Severability

If any portion of this rule or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the rule or related rules which can be given effect without the invalid portion or application, and to this end the provisions of this rule are severable.