BULLETIN NO. 2009-06

REVISION OF BULLETIN 94-8: DISCLOSURE AND USE OF PROVIDER DISCOUNTS

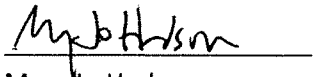
(Effective February 10, 2009)

This bulletin addresses the claim payment practices of insurance companies and regulated third party payers that have negotiated discount prices for health services with health care providers, primarily hospitals. This bulletin does not apply to health insuring corporations licensed pursuant to Chapter 1751 of the Ohio Revised Code.

The Department administers Ohio Revised Code Section 3901.19 et seq., the Unfair and Deceptive Practices Act. Ohio Revised Code Section 3901.21 defines as an unfair and deceptive act the making of a statement that is untrue, deceptive or misleading. Accordingly, misrepresenting the terms of an insurance policy is subject to an enforcement action as an unfair and deceptive trade practice.

The Department considers it to be an unfair and deceptive act to not calculate the co-payment to be paid by an individual entitled to coverage under an insurance policy on the basis set forth in that insurance policy. It is also an unfair and deceptive act for the insurance company or other third party payer, whose contract provides for a calculation of a covered individual's co-payment, not to disclose such method of calculation in the certificate or evidence of coverage provided to individuals entitled to coverage. Such disclosure may also be made with the use of explanations of benefits or other similar non-contractual communications with individuals entitled to coverage. Licensees of the Department are subject to a market conduct examination should they fail to provide disclosure. Please note that Revised Code Section 3923.81, effective March 23, 2007, requires that out of pocket costs for a person covered by a health benefit plan issued by an insurer or multiple employer welfare arrangement not exceed the amount the insurer or multiple employer welfare arrangement would pay under applicable reimbursement rates negotiated with the applicable provider or pharmacy.

Next, health insurers and other third party payers typically have provisions in their health contracts that set limits on payments. Where such provisions set limits for an annual or lifetime maximum payment to an individual entitled to coverage, the Department considers it to be an unfair and deceptive practice to calculate such limit on a basis other than actual payments unless such calculation is in accordance with a specific provision within the contract. When the policy has a limit based on other than actual cash payments, that provision must be disclosed in any certificate or evidence of coverage. Such disclosure may also be made with the use of explanations of benefits or other similar non-contractual communications with individuals entitled to coverage.



Mary Jo Hudson
Superintendent of Insurance