



State Of Ohio
Department of Insurance
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George V. Voinovich
Governor
Harold T. Duryee
Director

BULLETIN 94 - 8

TO: Health Insurance Companies And Other Third Party Payers
FROM: Harold T. Duryee, Director of Insurance
SUBJECT: Disclosure and Use of Provider Discounts
DATE: November 23, 1994

A handwritten signature in cursive script, appearing to read "Harold T. Duryee", written in dark ink.

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 Maintenance Organizations licensed pursuant to Chapter 1742 of the Ohio Revised Code.

The Department administers Ohio Revised Code 3901.21, the Unfair and Deceptive Trade Practice Act. That statute 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.

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.

The Department instructs all health insurers and other third party payers to conduct an audit of claims denied for the reason that the annual or lifetime maximum has been provided. Based on the preceding paragraph each health insurer or other third party payer shall make additional payments as appropriate for each claim. All health insurers and other third party payers shall submit a report of all affected accounts including any payments to the Department within 120 days of the date of this bulletin. Further if a health insurer or other third party payer has no accounts or payments to report, that information should be sent to the Department within the time period set forth above. Failure to report may be cause for a market conduct examination. Send the report to the Office of Life and Health Services at the Department.