



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

BULLETIN 94 - 9

TO: Health Maintenance Organizations Licensed Pursuant To Chapter 1742 of the Ohio Revised Code
FROM: Harold T. Duryee, Director of Insurance
SUBJECT: Disclosure and Use of Provider Discounts
DATE: November 23, 1994

A handwritten signature in black ink, appearing to read "Harold T. Duryee", written over the printed name in the header.

This bulletin addresses the claim payment practices of Health Maintenance Organizations (HMO) licensed pursuant to Ohio Revised Code Chapter 1742, which have negotiated prices with health care providers, primarily hospitals for basic health care services.

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 HMO contract 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 HMO contract on the basis set forth in that contract. It is also an unfair and deceptive act for the HMO whose contract provides for a different method of 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 solicitation materials or other similar non-contractual communications with enrollees entitled to coverage.

Also, HMOs are governed by Section 1742.09(B)(2) of the Ohio Revised Code. That section states in part: "(An HMO)...may not impose co-payment charges on basic health care services that exceed thirty per cent of the total cost of providing to its enrollees any single covered service...".

The Department position is that "total cost" as used in that statute means the payments actually made to providers of basic health services rendered to an individual entitled to services, and does not include administrative costs or additional expenses incurred by the HMO. Next, "any single covered service" includes all health services rendered for a specific health condition covered by the HMO contract.

If an HMO and its providers negotiate a discount so the HMO does not have to pay the provider the billed charges, the benefit of the negotiated payment must be considered in the calculation of an enrollee's co-payment. The total cost of a service, is the amount the HMO has agreed to pay the provider, not the billed charges.

HMOs are instructed to report to the Department that they are in compliance with the position stated in this bulletin. Noncompliance with these laws could result in a market conduct examination and other administrative actions against the licensee. Send the report to the Office of Life and Health Services at the Department.