As Reported by the House Health Committee

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Representative Boyd

Cosponsors: Representatives Hagan, Letson, Winburn, Slesnick, Yuko

A B I L L

To enact sections 3964.01 to 3964.03, 3964.05 to 3964.07, 3964.10 to 3964.12, 3964.15 to 3964.17, 3964.21 to 3964.25, 3964.27, and 5111.0210 of the Revised Code to establish standards for physician designations by health care insurers.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 3964.01, 3964.02, 3964.03, 3964.05, 3964.06, 3964.07, 3964.10, 3964.11, 3964.12, 3964.15, 3964.16, 3964.17, 3964.21, 3964.22, 3964.23, 3964.24, 3964.25, 3964.27, and 5111.0210 of the Revised Code be enacted to read as follows:

Sec. 3964.01. As used in this chapter:

(A) "Health care insurer" means an entity that offers a policy, contract, or plan for covering the cost of health care services for individuals who are beneficiaries of or enrolled in the policy, contract, or plan, to the extent that the entity and the policy, contract, or plan are subject to the laws of this state. "Health care insurer" includes all of the following:

(1) A sickness and accident insurance company authorized to do the business of insurance in this state;

(2) A health insuring corporation that holds a certificate of authority issued under Chapter 1751. of the Revised Code;

(3) An entity that offers a multiple employer welfare arrangement, as defined in section 1739.01 of the Revised Code;

(4) The state, a political subdivision, or any other government entity that offers a public employee health benefit plan.

(B) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(C) "Physician designation" means a grade, star, tier, or any other rating used by a health care insurer to characterize or represent the insurer's assessment or measurement of a physician's cost efficiency, quality of care, or clinical performance. "Physician designation" does not include either of the following:

(1) Information derived solely from satisfaction surveys or other comments provided by individuals who are beneficiaries of or enrolled in a policy, contract, or plan offered by a health care insurer;

(2) Information for a program established by a health care insurer to assist individuals with estimating a physician's routine fees for providing services.

(D) "Third-party administrator" has the same meaning as "administrator" in section 3959.01 of the Revised Code.

Sec. 3964.02. If a health care insurer operates a system for making physician designations, all of the following apply with respect to each physician designation that is made:

(A) The health care insurer shall include a quality-of-care component in making the physician designation. Inclusion of the quality-of-care component may be satisfied by incorporating one or

more practice guidelines or performance measures pursuant to division (F) of this section. The resulting designation shall include a clear description of the weight given to the quality-of-care component in comparison to other factors used in making the designation.

(B) The health care insurer shall use statistical analyses in making the physician designation. The insurer shall use statistical analyses that are accurate, valid, and reliable. Where reasonably possible, the insurer shall use statistical analyses that have been appropriately adjusted to reflect known statistical anomalies, including factors pertaining to patient population, case mix, severity of condition, comorbidities, and outlier events.

(C) The health care insurer shall make a physician designation only after completing a period of assessment of data pertinent to the designation. The insurer shall update the data at appropriate intervals.

(D) If data from claims for payment are used in making the physician designation, the health care insurer shall use accurate claims data and attribute the data appropriately to the physician. If reasonably available, aggregated claims data shall be used to supplement the insurer's claims data.

(E) The health care insurer shall make the physician designation in a manner that recognizes the physician's responsibility for making health care decisions and the financial consequences of those decisions. The financial consequences of the physician's health care decisions shall be attributed to the physician in a manner that is accurate and fair to the physician.

(F) If practice guidelines or performance measures are used in making the physician designation, the health care insurer shall use guidelines or measures that are evidence-based, whenever

possible; consensus-based, whenever possible; and pertinent to the physician's area of practice, location, and patient-population characteristics. To the maximum extent possible, the insurer shall use practice guidelines or performance measures that have been established by nationally recognized health care organizations, including the national quality forum or its successor, or the AQA alliance or its successor.

Sec. 3964.03. (A) A health care insurer that operates a system for making physician designations shall appoint and pay for an independent ratings examiner, who is approved by the superintendent of insurance, to ensure that the health care insurer is in compliance with the requirements of this chapter. Every six months, the independent ratings examiner shall submit a report to the superintendent of insurance that describes the methods used by the insurer in making physician designations and details the insurer's compliance with this chapter.

(B) For purposes of division (A) of this section, the superintendent shall establish a process for approving independent ratings examiners.

Sec. 3964.05. Except as provided in section 3964.06 of the Revised Code, a health care insurer may disclose any or all of its physician designations to any of the following:

(A) A physician;

(B) A patient or potential patient;

(C) An individual who is or may become a beneficiary of or enrolled in a health care policy, contract, or plan offered by the insurer;

(D) Any other individual.

Sec. 3964.06. (A) When a health care insurer makes a

physician designation, including a change in a designation, the insurer shall notify the physician before disclosing the designation to the public. The notice shall be provided in writing and shall inform the physician of both of the following:

(1) The process by which the physician may request information under sections 3964.10 and 3964.11 of the Revised Code regarding the method and data used in making the designation;

(2) The opportunity to request an appeal of the designation pursuant to section 3964.15 of the Revised Code.

(B) After providing the written notice required under division (A) of this section, the health care insurer shall not disclose the physician designation until the latest occurring of the following:

(1) Ninety days after providing the notice;

(2) Thirty days after fulfilling any request for information under section 3964.10 of the Revised Code;

(3) Thirty days after fulfilling any request for information under section 3964.11 of the Revised Code;

(4) The date that the designation is in compliance with a final decision made pursuant to an appeal requested under section 3964.15 of the Revised Code.

Sec. 3964.07. (A) When a health care insurer discloses a physician designation under section 3964.05 of the Revised Code, the insurer shall include with the disclosure a statement specifying all of the following:

(1) That physician designations are intended to be used only as a guide in selecting a physician;

(2) That physician designations should not be the sole factor

used in selecting a physician;

(3) That physician designations have a risk of error;

(4) That individuals should discuss physician designations with a physician before a selection is made.

(B) The statement required by this section shall accompany the disclosure of the physician designation in a conspicuous manner, shall be provided in writing, and shall be printed in boldface type.

Sec. 3964.10. (A) Any of the following may submit a request to a health care insurer asking that the insurer provide a description of the method used by the insurer in making a physician designation and, for a particular designation, a description of all data used in making the designation:

(1) The physician who is the subject of the designation;

(2) A representative of the physician who is the subject of the designation;

(3) The superintendent of insurance.

(B) Not later than forty-five days after receiving a request under this section, the health care insurer shall provide the requested information to the person who submitted the request. In providing the information, the insurer is subject to all of the following:

(1) The description of the method used in making the physician designation shall be sufficiently detailed to allow the person who submitted the request to determine the effect of the method on the data used in making the designation. As applicable, the description shall include an explanation of the use of algorithms or studies, the assessment of data, and the application of practice guidelines or performance measures.

(2) The description of the data used in making the physician designation shall be made in a manner that is reasonably understandable and allows the person who submitted the request to verify the data against the person's records.

(3) If the health care insurer has a contract with another person that prevents the insurer from disclosing all or part of the data used in making the physician designation, the insurer may withhold the data but shall provide sufficient information to allow the person who submitted the request to determine how the withheld data affected the designation.

Sec. 3964.11. After receiving a description of a health care insurer's method used in making a physician designation pursuant to a request submitted under section 3964.10 of the Revised Code, the recipient may submit a request to the insurer asking that the insurer provide the complete method used by the insurer in making the physician designation.

Not later than thirty days after receiving a request under this section, the health care insurer shall provide the requested information to the person who submitted the request.

Sec. 3964.12. Neither sections 1333.61 to 1333.69 of the Revised Code nor any other provision of the Revised Code pertaining to trade secrets excuses a health care insurer from complying with sections 3964.10 and 3964.11 of the Revised Code.

Sec. 3964.15. A health care insurer that operates a system for making physician designations shall afford a physician who is subject to the physician designation system an opportunity to appeal the insurer's decision regarding the physician's designation, including a decision by the insurer to change a previous designation or to make no designation. In appealing the decision, the physician may be assisted by a representative.

Except for modifications made in accordance with section 3964.17 of the Revised Code, information regarding an appeal requested under this section shall not be disclosed to the public.

Sec. 3964.16. A health care insurer shall establish procedures for the conduct of appeals under section 3964.15 of the Revised Code. At a minimum, the procedures established by the insurer shall include all of the following:

(A) A reasonable method for a physician or a physician's representative to provide notice to the insurer that an appeal is being sought;

(B) Consideration of any information obtained by the physician or the physician's representative pursuant to section 3964.10 or 3964.11 of the Revised Code;

(C) If requested by the physician or the physician's representative, consideration of an explanation of the decision regarding the physician designation, with the explanation supplied by the person or persons identified by the health care insurer as being responsible for making the designation decision;

(D) With respect to the data and method used by the insurer to make the physician designation decision, an opportunity for the physician or the physician's representative to submit to the insurer corrected data for the insurer's consideration and to have the appropriateness of the method evaluated by the insurer;

(E) Disclosure of the name, title, qualifications, and relationship to the health care insurer of the person or persons designated by the insurer as responsible for conducting the appeal proceedings and making the final decision;

(F) If requested by the physician or the physician's representative, an opportunity to meet with the person or persons responsible for conducting the appeal proceedings and making the

final decision, either by meeting in person at a location reasonably convenient to the physician or the physician's representative or by teleconference.

(G) Completion of the appeals process not later than forty-five days after the physician or physician's representative provides notice that an appeal is being sought, unless another time is agreed to by the physician or the physician's representative;

(H) Issuance of a written final decision that states the reasons for upholding, modifying, or rejecting the physician designation decision subject to the appeal.

Sec. 3964.17. If the final decision regarding an appeal under section 3964.15 of the Revised Code is in favor of the physician, the health care insurer shall modify its designation of the physician in accordance with the final decision. In modifying the designation, the insurer is subject to both of the following:

(A) If the designation was disclosed to the public before the appeal was made, the insurer shall make the necessary changes to the designation not later than thirty days after the final decision regarding the appeal is made.

(B) If the designation was not disclosed to the public before the appeal was made, the insurer shall make the necessary changes to the designation before the designation is disclosed to the public.

Sec. 3964.21. A health care insurer shall not fail to comply with sections 3964.02 to 3964.17 of the Revised Code or any rules adopted under section 3964.27 of the Revised Code.

Sec. 3964.22. In the case of a health care insurer that is

regulated by the department of insurance, a series of violations of section 3964.21 of the Revised Code that, taken together, constitutes a pattern or practice of violating that section shall be considered an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

Sec. 3964.23. A physician who is adversely affected by a violation of section 3964.21 of the Revised Code has a cause of action against the health care insurer and may seek a declaratory judgment, an injunction, or other appropriate relief.

Sec. 3964.24. Any provision of a contractual arrangement between a health care insurer and physician that limits any of the physician's rights granted by this chapter or that is otherwise contrary to the provisions of this chapter is unenforceable.

Sec. 3964.25. This chapter applies to a third-party administrator in the same manner that the chapter applies to a health care insurer.

Sec. 3964.27. The superintendent of insurance may adopt rules as the superintendent considers necessary to carry out the purposes of this chapter. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 5111.0210. Chapter 3964. of the Revised Code applies to the medicaid program in the same manner that the chapter applies to a health care insurer, as defined in section 3964.01 of the Revised Code.