Ohio Legislative Service Commission

Bill Analysis

Laura Gengo

Sub. H.B. 122

128th General Assembly
(As Reported by H. Health)

Reps. Boyd, Hagan, Letson, Winburn, Slesnick, Yuko

BILL SUMMARY

- Establishes requirements to be met by each health care insurer, that operates a system under which the insurer makes physician designations through the use of a grade, star, tier, or any other rating used to characterize a physician's cost efficiency, quality of care, or clinical performance.

- Applies the requirements regarding physician designations to the Medicaid program and third-party administrators that adjust or settle claims in connection with health insurance.

- Permits an insurer to disclose its physician designations to any individual, but requires the insurer to include with the disclosure a written statement that (1) designations are intended to be used only as a guide in selecting a physician, (2) designations should not be the sole factor used in selecting a physician, (3) designations have a risk of error, and (4) individuals should discuss physician designations with a physician before a selection is made.

- Requires an insurer to notify a physician before publicizing the physician's designation.

- Permits a physician who is the subject of a designation, the physician's representative, and the Superintendent of Insurance to request a description of the method and data used in making a physician designation and, after receiving the description, the complete method used in making the designation.

- Requires the insurer to afford a physician who is subject to a designation system an opportunity to appeal a decision regarding the physician's designation, including a decision to change a designation or a decision not to make a designation.

- Specifies that if the final decision resulting from an appeal is in favor of the physician, the health care insurer must modify its designation in accordance with the final decision.

- Provides that if a health care insurer is regulated by the Department of Insurance, a series of violations of the bill's requirements that, taken together, constitute a pattern or practice of violating those requirements are to be considered an "unfair and deceptive act or practice in the business of insurance."

- Provides that a physician who is adversely affected by a violation of any of the bill's requirements has a cause of action against a health care insurer and may seek a declaratory judgment, an injunction, or other appropriate relief.

- Specifies that any provision of a contract between a health care insurer and a physician that limits any of the physician's rights granted by the bill or that is otherwise contrary to the bill's provisions is unenforceable.

CONTENT AND OPERATION

Physician designation systems used by health care insurers

(R.C. 3964.01(A) to (C))

The bill creates standards and procedures to be followed by health care insurers that operate systems for making physician designations. The bill defines a "physician designation" as 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." The bill specifies that the term does not include information derived from satisfaction surveys, comments provided by beneficiaries of or individuals enrolled in a health care insurer's plan, or information for a health care insurer's program to assist individuals with estimating a physician's routine fees.

The bill defines a "health care insurer" as 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 Ohio law. The bill specifies that "health care insurer" includes all of the following:

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

(2) A health insuring corporation that holds a certificate of authority issued under Ohio law;

(3) An entity that offers a multiple employer welfare arrangement;

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

Application to Medicaid and other entities

(R.C. 3964.25 and 5111.0210)

The bill specifies that its requirements apply to Medicaid and third-party administrators[1] in the same manner that the requirements apply to health care insurers.

Requirements for how designations are made

(R.C. 3964.02)

The bill creates the following requirements for a health care insurer that operates a system for making physician designations:

Quality-of-care component--The bill requires the insurer to include a "quality-of-care component" in making each physician designation. The bill specifies that this requirement may be satisfied by incorporating one or more practice guidelines or performance measures. With regard to the guidelines or measures used, the bill requires the health care insurer to 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. The bill also requires the insurer, to the maximum extent possible, to 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

[1] Third-party "administrator" means any person who adjusts or settles claims on residents of Ohio in connection with life, dental, health, or disability insurance or self-insurance programs. It does not include any of the following: (1) a licensed insurance agent or solicitor whose activities are limited exclusively to the sale of insurance and who does not provide any administrative services, (2) any person who administers or operates the workers' compensation program of a self-insuring employer, (3) any person who administers pension plans for the benefit of the person's own members or employees or administers pension plans for the benefit of the members or employees of any other person, (4) any person that administers an insured plan or a self-insured plan that provides life, dental, health, or disability benefits exclusively for the person's own members or employees, or (5) any health insuring corporation holding a certificate of authority under Ohio law or an insurance company that is authorized to write life or sickness and accident insurance (R.C. 3959.01(B)).

Alliance or its successor. The bill requires each designation made in this manner to include a clear description of the weight given to the quality-of-care component in comparison to other factors.

Statistical analyses--The bill requires the insurer to use, in making a physician designation, statistical analyses that are accurate, valid, and reliable. The bill requires that, where reasonably possible, the analyses have been appropriately adjusted to reflect known statistical anomalies, including factors pertaining to patient population, case mix, severity of condition, comorbidities, and outlier events.

Assessment of data--The bill requires the insurer to make a physician designation only after completing a period of assessment of data pertinent to the designation. The bill requires the insurer to update the data at appropriate intervals.

Data from claims--The bill requires that if data from claims for payment are used in making a physician designation, the health care insurer must use accurate claims data and attribute the data appropriately to the physician. The bill also requires that aggregated claims data be used to supplement the insurer's claims data if aggregated claims data are reasonably available.

Recognition of physician responsibilities--The bill requires an insurer to make a physician designation in a manner that recognizes the physician's responsibility for making health care decisions and the financial consequences of those decisions. It also provides that the financial consequences of a physician's health care decisions must be attributed to the physician in a manner that is accurate and fair to the physician.

Disclosure of designations

(R.C. 3964.05 and 3964.07)

The bill permits a health care insurer to disclose its physician designations to a physician, a patient or potential patient, an individual who is or may become a beneficiary of or enrolled in a health care policy, contract, or plan offered by the insurer, or any other individual. The bill requires that when an insurer discloses a designation, the insurer include, in a conspicuous manner with the disclosure, a statement in writing and printed in boldface type 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.

Disclosure of nonpublic designations to physicians

(R.C. 3964.06)

The bill requires a health care insurer to notify a physician before disclosing the physician's designation to the public when the insurer makes or changes the designation. The notice is to be provided in writing and is to inform the physician of (1) the process by which the physician may request information regarding the method and data used in making the designation (see "**Descriptions of methods for making designations**," below) and (2) the opportunity to request an appeal of the designation (see "**Appealing designations**," below).

The bill prohibits the insurer from disclosing the designation after providing the notice until the latest occurring of the following:

(1) 90 days after providing the notice;

(2) 30 days after fulfilling any request for a description of the method and data used in making the designation;

(3) 30 days after fulfilling any request for the complete method used in making the designation;

(4) The date that the designation is in compliance with a final decision made pursuant to an appeal.

Descriptions of methods for making designations

(R.C. 3964.10, 3964.11, and 3964.12)

The bill permits a physician who is the subject of a designation, the physician's representative, and the Superintendent of Insurance to request that a health care insurer provide a description of the method used in making a physician designation and a description of all data used in making the designation. Under the bill the insurer is to provide the requested information to the requestor not later than 45 days after receiving the request. The bill requires that the description of the method used in making the physician designation be sufficiently detailed to allow the requestor to determine the effect of the method on the data used in making the designation. As applicable, the

description is to include an explanation of the use of algorithms or studies, the assessment of data, and the application of practice guidelines or performance measures.

The description of the data used is to be made in a manner that is reasonably understandable and allows the requestor to verify the data against his or her records. If the insurer has a contract that prevents the insurer from disclosing all or part of the data used in making the designation, the insurer may withhold the data but must provide sufficient information to allow the requestor to determine how the withheld data affected the designation.

After receiving a description of an insurer's method used in making a designation, the recipient may request that the insurer provide the complete method used in making the designation. The bill requires the insurer to provide the complete method to the requestor not later than 30 days after receiving a request for it.

The bill specifies that nothing in the Ohio Revised Code pertaining to trade secrets excuses a health care insurer from complying with the requirements described in the preceding two paragraphs.

Independent ratings examiner

(R.C. 3964.03)

The bill requires that a health care insurer operating a system for making physician designations 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 bill's requirements. Every six months, the independent ratings examiner is to submit a report to the Superintendent describing the methods used by the insurer in making physician designations and details the insurer's compliance with the bill.

Appealing designations

(R.C. 3964.15, 3964.16, and 3964.17)

The bill requires a health care insurer that operates a system for making physician designations to afford a physician who is subject to the designation system an opportunity to appeal the insurer's decision regarding the physician's designation. The bill specifies that the decisions that may be appealed include a decision by the insurer to change a previous designation or a decision not to make a designation. The bill permits a physician to be assisted by a representative during an appeal. Except with regard to any final decision modifications made by a health care insurer (discussed below), the bill prohibits any information regarding an appeal from being disclosed to the public.

The bill requires a health care insurer to establish procedures for appealing designation decisions. The bill requires the procedures to include, at a minimum, each of the following:

(1) A reasonable method for a providing notice that an appeal is being sought;

(2) Consideration of any information obtained from a request for the complete method or a description of the method and data used in making a designation;

(3) Consideration of an explanation of the designation decision, with the explanation supplied by the person or persons identified by the insurer as being responsible for making the decision (if requested by the physician or the physician's representative);

(4) 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;

(5) 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;

(6) An opportunity to meet with the person or persons responsible for conducting the appeal proceedings and making the final decision, either in person or by teleconference (if requested by the physician or the physician's representative).

The bill requires that appeals be completed not later than 45 days after the provision of notice of an appeal, unless another time is agreed to by the physician or the physician's representative. The bill also requires the insurer to issue a written final decision that states the reasons for upholding, modifying, or rejecting the designation decision subject to the appeal.

The bill requires that if the final decision regarding an appeal is in favor of the physician, the health care insurer must modify its designation in accordance with the final decision. If the designation was disclosed to the public before the appeal was made, the insurer is to make the necessary changes to the designation not later than 30 days after the final decision regarding the appeal is made. If the designation was not disclosed to the public before the appeal was made, the insurer is to make the necessary changes to the designation before the designation is disclosed to the public.

Enforcement actions by the Superintendent of Insurance

(R.C. 3901.20 and 3901.22 (not in the bill); R.C. 3964.21 and 3964.22)

The bill prohibits health care insurers from failing to comply with the bill's provisions or any rules adopted to carry out the bill's provisions. If a health care insurer is regulated by the Department of Insurance, a series of violations of the bill's requirements that, taken together, constitute a pattern or practice of violating those requirements are to be considered an "unfair and deceptive act or practice in the business of insurance." Existing law prohibits any person from engaging, in Ohio, in any trade practice that is an unfair or deceptive act or practice in the business of insurance. Under the existing law, the Superintendent of Insurance may conduct hearings to determine whether an unfair or deceptive act or practice in the business of insurance has occurred. If the Superintendent finds that a person has committed such an act or practice, current law permits the Superintendent to impose a civil penalty of up to $3,500 for each violation, revoke the person's license to engage in the practice of insurance, or impose other administrative remedies.

Causes of action for physicians

(R.C. 3964.23)

The bill provides that a physician who is adversely affected by a violation of any of the bill's requirements has a cause of action against a health care insurer and may seek a declaratory judgment, an injunction, or other appropriate relief.

Physicians' rights

(R.C. 3964.24)

The bill specifies that any provision of a contract between a health care insurer and a physician that limits any of the physician's rights granted by the bill or that is otherwise contrary to the bill's provisions is unenforceable.

Rule-making authority

(R.C. 3964.27)

The bill permits the Superintendent of Insurance to adopt rules in accordance with the Administrative Procedure Act (R.C. Chapter 119.) as the Superintendent considers necessary to carry out the bill's provisions.

HISTORY

ACTION	DATE
Introduced	04-02-09
Reported, H. Health	10-16-09

h0122-rh-128.docx/kl