As Introduced

136th General Assembly
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H. B. No. 219

Representative Deeter

To enact section 3901.93 of the Revised Code to establish network adequacy standards for health insurers.

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

Section 1. That section 3901.93 of the Revised Code be enacted to read as follows:

Sec. 3901.93. (A) As used in this section:

(1) "Business day" has the same meaning as in section 3901.81 of the Revised Code.

(2) "Cost sharing" has the same meaning as in section 3902.50 of the Revised Code.

(3) "Covered benefit," "covered person," "health benefit plan," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(4) "Emergency services" has the same meaning as in section 1753.28 of the Revised Code.

(5) "Material change" means any change to a network plan or the population of covered persons that impacts the ability of a health plan issuer to comply with this section.

(6) "Network plan" means a health benefit plan under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the health plan issuer.

(7) "Provider" has the same meaning as in section 1751.01 of the Revised Code.

(8) "Specialty health care services" means the delivery of covered benefits in a manner that is physically accessible and provides communication and accommodations needed by covered persons with disabilities.

(B)(1) A health plan issuer that delivers, issues for delivery, or uses a network plan in this state shall maintain a network that ensures that all covered persons, including both children and adults, have access to both of the following:

(a) A sufficient network of providers in terms of the number and specialty, including providers that serve predominantly low-income and medically underserved individuals, to allow access to covered benefits without unreasonable travel or delay;

(b) Emergency services that are available at all times.

(2) For tiered network plans, the adequacy of the network is determined, for the purposes of this section, based on the lowest cost sharing tier.

(C) The superintendent of insurance shall establish reasonable criteria for the purpose of evaluating the adequacy of a network plan under this section, taking into account all of the following:

(1) The ratio, for each specialty associated with a covered benefit, of full-time equivalent providers, including facility based providers, to covered persons;

(2) The ratio of full-time equivalent primary care providers to covered persons;

(3) The geographic accessibility of providers, including primary care providers, specialty providers, hospitals, and facility-based providers;

(4) The geographic variation and population dispersion of covered persons;

(5) Waiting times for an appointment with in-network providers;

(6) Hours of operation of in-network providers;

(7) The ability of the network to meet the needs of covered persons, including the following:

(a) Persons who are low-income;

(b) Children;

(c) Adults;

(d) Persons with serious, chronic, or complex health conditions;

(e) Persons with physical or mental disabilities;

(f) Persons with limited English proficiency.

(8) The volume of technological and specialty care services available to serve the needs of covered persons requiring those services;

(9) The number of in-network providers accepting new

patients.

(D) The superintendent shall establish requirements for network plans to have a minimum number of providers within a specified area, limits on travel distance to providers, and limits on travel time to providers.

(E) The superintendent shall conduct periodic surveys of covered persons and providers to assist the superintendent in monitoring the adequacy of a network plan and shall publish the results of those surveys on the department of insurance's web site.

(F)(1) A health plan issuer shall establish and maintain a process to assure that covered persons obtain covered benefits at an in-network level, including in-network cost sharing, from an out-of-network provider, or shall make other arrangements acceptable to the superintendent, when either of the following applies:

(a) The health plan issuer has a sufficient network but does not have an appropriate in-network provider available to provide the covered benefit to the covered person without unreasonable travel or delay.

(b) The health plan issuer has an insufficient number or type of appropriate in-network providers available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2) The health plan issuer shall inform a covered person who is diagnosed with a condition or disease that requires specialty health care services of the process required by division (E)(1) of this section when either of the following apply:

(a) The health plan issuer does not have an in-network provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease.

(b) The health plan issuer cannot provide reasonable access to an in-network provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(3) The health plan issuer shall treat the health care services the covered person receives from an out-of-network provider under division (F) of this section as if the services were provided by an in-network provider, including by counting the covered person's cost sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from in-network providers under the network plan.

(4) The health plan issuer shall address requests to obtain a covered benefit from an out-of-network provider in a timely fashion appropriate to the covered person's condition.

(5) The health plan issuer shall document all requests to obtain a covered benefit from an out-of-network provider in accordance with this section and shall provide such documentation to the superintendent upon request.

(6) Nothing in division (F) of this section shall be construed to absolve a health plan issuer from establishing and maintaining an adequate network of providers in accordance with this section or to allow covered persons to circumvent the use of covered benefits available through a health plan issuer's in-network providers.

(G) A health plan issuer shall establish and maintain adequate arrangements to ensure all covered persons have reasonable access to in-network providers located near the covered person's home or place of employment. In determining whether the health plan issuer has complied with this division, the superintendent shall give due consideration to the relative availability of providers with the requisite expertise and training in the service area under consideration.

(H) A health plan issuer shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of in-network providers to furnish covered benefits under the network plan.

(I) No health plan issuer shall deliver, issue for delivery, or use a network plan in this state before a copy of the plan, the premium rates, and an access arrangement are filed with the department of insurance in a form and manner determined by the superintendent. If the superintendent finds that the network plan or the access arrangement does not meet the requirements of this section, the superintendent shall provide written notice of such finding to the health plan issuer, and the health plan issuer shall not deliver, issue for delivery, or use the network plan in this state. A health plan issuer shall notify the superintendent of any material change to a network plan or access arrangement approved under this division not later than fifteen business days after the change occurs or is implemented. An access arrangement submitted under this division shall include all the following:

(1) The factors used by the health plan issuer to build the provider network, including a description of the network and the criteria used to select and tier providers;

(2) The health plan issuer's procedures for making and authorizing referrals within and outside the network;

(3) The health plan issuer's process for monitoring and assuring, on an ongoing basis, the adequacy of the network to meet the health care needs of covered persons;

(4) The health plan issuer's efforts to address the needs of covered persons, including children, adults, persons with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic, or complex medical conditions;

(5) The health plan issuer's methods for assessing the health care needs of covered persons and the satisfaction of covered persons with services;

(6) The health plan issuer's method of informing covered persons of the covered benefits included in the network plan and procedures for navigating the plan, such as:

(a) Grievance and appeals procedures;

(b) Processes for choosing and changing providers;

(c) Processes for updating provider directories;

(d) A statement of health care services offered, including those services offered through preventive care benefit;

(e) Procedures for covering and approving emergency, urgent, and specialty care.

(7) The health plan issuer's system for ensuring the coordination and continuity of care for both of the following:

(a) Covered persons referred to specialty physicians;

(b) Covered persons using ancillary services, including

social services and other community resources, and for ensuring appropriate discharge planning.

(8) The health plan issuer's process for enabling covered persons to change primary care professionals;

(9) The health plan issuer's proposed plan for providing continuity of care in the event of contract termination between the health plan issuer and any in-network providers or in the event of the health plan issuer's insolvency or other inability to continue operations, including an explanation of how covered persons will be notified of the contract termination or the health plan issuer's insolvency or other cessation of operations and transitioned to other providers in a timely manner;

(10) The health plan issuer's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care, and pathology or laboratory services at in-network hospitals;

(11) Any other information required by the superintendent to determine compliance with this section.

(J) The health plan issuer shall make available to covered persons a provider directory that clearly identifies which providers and facilities belong to each network and which networks are applicable to each specific plan offered in this state. If a covered person receives care from an out-of-network provider that is listed, incorrectly, as an in-network provider in a directory provided under this division, the health plan issuer shall compensate the provider at the provider's billed rate at no expense to the covered person beyond the regular cost sharing obligation for in-network services.

(K) The superintendent may adopt rules in accordance with

Chapter 119. of the Revised Code to administer and enforce this section.