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Bill Analysis

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SUMMARY

- Requires health plan issuers to establish and maintain adequate provider networks to assure all covered benefits are accessible to covered persons.
- Requires network plans to allow covered persons access to emergency services at all times.
- Requires the Superintendent of Insurance to establish reasonable criteria to evaluate a network plan's adequacy.
- Requires the Superintendent to establish requirements regarding the minimum number of providers within a specified area and limits on travel distance and time to providers.
- Requires the Superintendent to periodically conduct and publish surveys of covered persons and providers to assist in monitoring network adequacy.
- Requires a health plan issuer to establish and maintain a process to assure covered persons are able to obtain covered benefits at an in-network level from an out-of-network provider whenever there are not a sufficient number of in-network providers.
- Requires a health plan issuer to establish and maintain adequate arrangements to ensure all covered persons have reasonable access to in-network providers near the covered person's home or place of employment.
- Requires a health plan issuer to monitor the ability, clinical capacity, and legal authority of in-network providers to furnish covered benefits under the network plan.
- Prohibits a health plan issuer from delivering, issuing for delivery, or using a network plan before a copy of the plan, premium rates, and an access arrangement are filed with the Department of Insurance.

- Requires a health plan issuer to notify the Superintendent of any material change to a network plan or access arrangement within 15 business days of the change or implementation of the change.
- Requires a health plan issuer to provide covered persons a directory that identifies which providers and facilities belong to each network and which networks are applicable to each specific plan offered in Ohio.
- Authorizes the Superintendent to adopt rules to administer and enforce the bill's provisions.

DETAILED ANALYSIS

Network adequacy requirements

Network plan adequacy

The bill requires each health plan issuer that delivers, issues for delivery, or uses a network plan to maintain a network that ensures all covered persons have access to emergency services at all times and have access to a sufficient network of other providers, in terms of number and specialty, to allow them to obtain covered benefits without unreasonable travel or dely. A "network plan" is defined as a health benefit plan under which the financing and delivery of medical care, including items and services paid for as medical care, are provided through a defined set of providers under contract with the health plan issuer The bill requires the plan to include a sufficient number of providers that serve predominantly low-income and medically underserved individuals. Furthermore, for tiered network plans, the bill specifies that network adequacy is determined based on the lowest cost sharing tier.[1]

Approval of network plans and access arrangement

The bill prohibits a health plan issuer from delivering, issuing for delivery, or using a network plan before sending a copy of the plan, premium rates, and an access arrangement to the Department of Insurance for evaluation. The information must be submitted in a form and manner designated by the Superintendent of Insurance. The bill requires the access arrangement to include all the following:

- Factors used to build the network, including criteria used to select and tier health care providers and facilities;
- The issuer's procedures for making and authorizing referrals within and outside its network;
- The issuer's procedures for monitoring and assuring on an ongoing basis the sufficiency of its network;

[1] R.C. 3901.93(A)(6) and (B).

- The 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;
- The issuer's methods for assessing the health care needs of covered persons and the satisfaction of covered persons with services;
- The issuer's methods to inform covered individuals of covered benefits, including grievance and appeal processes, how to choose or change participating providers, the process for updating its participating provider directories, a statement of health care services offered, and procedures for covering and approving emergency, urgent, and specialty care;
- The issuer's system for ensuring coordination and continuity of care for covered individuals referred to specialty physicians or using covered ancillary services;
- The issuer's process for enabling covered persons to change primary care professionals;
- The issuer's proposed plan for providing continuity of care for covered individuals in the event of a contract termination between the issuer and a participating provider or the issuer's insolvency or other inability to continue operations;
- The issuer's process for monitoring access to specialist services (i.e., emergency room care, anesthesiology, radiology, hospitalist care, and pathology and laboratory services) at in-network hospitals;
- Any other information required by the Superintendent.[2]

If the network plan or access arrangement does not meet the adequacy requirements prescribed by the bill, the Superintendent must notify the health plan issuer and the health plan issuer is prohibited from using the plan in Ohio. A health plan issuer must notify the Superintendent of any material change to a network plan or access arrangement within 15 business days after the change occurs or is implemented.[3] The bill defines a "material change" as any change to a network plan or the population of covered persons that impacts the ability of a health plan issuer to comply with the bill's provisions.[4]

Network sufficiency

Under the bill, the Superintendent of Insurance is required to establish evaluation criteria for network adequacy. The criteria must consider all the following:

- For each specialty, the ratio of full-time equivalent providers to covered persons;

[2] R.C. 3901.93(I).

[3] R.C. 3901.93(I).

[4] R.C. 3901.93(A)(5).

- The ratio of full-time equivalent primary care providers to covered persons;
- The geographic accessibility of providers;
- The geographic variation and population dispersion of providers;
- Waiting times for an appointment with in-network providers;
- Hours of operation of in-network providers;
- The ability of the network to meet the needs of covered persons, including the following:
  - Persons who are low-income;
  - Children;
  - Adults;
  - Persons with serious, chronic, or complex health conditions;
  - Persons with physical or mental disabilities;
  - Persons with limited English proficiency.
- The volume of technological and specialty care services available to serve the needs of covered persons requiring those services;
- The number of in-network providers accepting new patients.[5]

Additionally, the Superintendent must establish requirements for network plans to have a minimum number of providers within a specified area and limits on travel distance and time to providers.[6] To monitor the adequacy of the network plan, the Superintendent is required to conduct periodic surveys of covered persons and providers and publish the results on the Department of Insurance's website.[7]

Coverage at in-network level of benefits

The bill requires health plan issuers to establish and maintain a process to assure that covered persons obtain covered benefits at an in-network level (in terms of cost sharing and other factors) when there is no in-network provider of a certain specialty or the health plan issuer cannot provide reasonable access to an in-network provider with a certain specialty.

If a covered person has a condition or disease that requires specialty health care services, the health plan issuer is required to inform the covered person of that process. In such a case, the health plan issuer must treat the specialty health care services provided by an out-of-network provider as if the specialty health care 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

[5] R.C. 3901.93(C).

[6] R.C. 3901.93(D).

[7] R.C. 3901.93(E).

plan. "Specialty health care services" are defined as the delivery of covered benefits in a manner that is physically accessible and provides communication and accommodations needed by covered persons with disabilities.[8]

The health plan issuer is required to address requests to obtain a covered benefit from an out-of-network provider in a timely fashion relative to the covered person's condition. The health plan issuer is also required to document all requests for treatment from an out-of-network provider and provide such documentation to the Superintendent when requested. The bill clarifies that none of the requirements for coverage at an in-network level of benefits absolves a health plan issuer from establishing and maintaining an adequate network of providers.[9]

Proximity of providers to covered persons

The bill requires a health plan issuer to establish and maintain adequate arrangements with providers to assure that covered persons have reasonable access to participating providers near the covered persons' homes or jobs. In determining compliance with this provision, the Superintendent is required to consider the relative availability of providers in the area.[10]

Additionally, a health plan issuer is required to monitor the ability, clinical capacity and legal authority of participating providers to provide all covered benefits to covered persons.[11]

Provider directory

The bill requires a health plan issuer to make available a provider directory that clearly identifies which providers and facilities belong to each network and which network is applicable to each specific plan offered. If a covered person receives care from an out-of-network provider that is incorrectly listed in the directory, the issuer must compensate the provider at the provider's billed rate at no additional cost to the covered person.[12]

Rulemaking authority

The Superintendent of Insurance is authorized to adopt rules to administer and enforce the bill's provisions.[13]

[8] R.C. 3901.93(A)(8).

[9] R.C. 3901.93(F).

[10] R.C. 3901.93(G).

[11] R.C. 3901.93(H).

[12] R.C. 3901.93(J).

[13] R.C. 3901.93(K).

HISTORY

Action	Date
Introduced	04-01-25