

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.

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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:

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

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

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

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(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.

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

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(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.

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(6) "Network plan" means a health benefit plan under which 19
the financing and delivery of medical care, including items and 20
services paid for as medical care, are provided, in whole or in 21
part, through a defined set of providers under contract with the 22
health plan issuer. 23

(7) "Provider" has the same meaning as in section 1751.01 24
of the Revised Code. 25

(8) "Specialty health care services" means the delivery of 26
covered benefits in a manner that is physically accessible and 27
provides communication and accommodations needed by covered 28
persons with disabilities. 29

(B) (1) A health plan issuer that delivers, issues for 30
delivery, or uses a network plan in this state shall maintain a 31
network that ensures that all covered persons, including both 32
children and adults, have access to both of the following: 33

(a) A sufficient network of providers in terms of the 34
number and specialty, including providers that serve 35
predominantly low-income and medically underserved individuals, 36
to allow access to covered benefits without unreasonable travel 37
or delay; 38

(b) Emergency services that are available at all times. 39

(2) For tiered network plans, the adequacy of the network 40
is determined, for the purposes of this section, based on the 41
lowest cost sharing tier. 42

(C) The superintendent of insurance shall establish 43
reasonable criteria for the purpose of evaluating the adequacy 44
of a network plan under this section, taking into account all of 45
the following: 46

<u>(1) The ratio, for each specialty associated with a</u>	47
<u>covered benefit, of full-time equivalent providers, including</u>	48
<u>facility based providers, to covered persons;</u>	49
<u>(2) The ratio of full-time equivalent primary care</u>	50
<u>providers to covered persons;</u>	51
<u>(3) The geographic accessibility of providers, including</u>	52
<u>primary care providers, specialty providers, hospitals, and</u>	53
<u>facility-based providers;</u>	54
<u>(4) The geographic variation and population dispersion of</u>	55
<u>covered persons;</u>	56
<u>(5) Waiting times for an appointment with in-network</u>	57
<u>providers;</u>	58
<u>(6) Hours of operation of in-network providers;</u>	59
<u>(7) The ability of the network to meet the needs of</u>	60
<u>covered persons, including the following:</u>	61
<u>(a) Persons who are low-income;</u>	62
<u>(b) Children;</u>	63
<u>(c) Adults;</u>	64
<u>(d) Persons with serious, chronic, or complex health</u>	65
<u>conditions;</u>	66
<u>(e) Persons with physical or mental disabilities;</u>	67
<u>(f) Persons with limited English proficiency.</u>	68
<u>(8) The volume of technological and specialty care</u>	69
<u>services available to serve the needs of covered persons</u>	70
<u>requiring those services;</u>	71
<u>(9) The number of in-network providers accepting new</u>	72

patients. 73

(D) The superintendent shall establish requirements for 74
network plans to have a minimum number of providers within a 75
specified area, limits on travel distance to providers, and 76
limits on travel time to providers. 77

(E) The superintendent shall conduct periodic surveys of 78
covered persons and providers to assist the superintendent in 79
monitoring the adequacy of a network plan and shall publish the 80
results of those surveys on the department of insurance's web 81
site. 82

(F) (1) A health plan issuer shall establish and maintain a 83
process to assure that covered persons obtain covered benefits 84
at an in-network level, including in-network cost sharing, from 85
an out-of-network provider, or shall make other arrangements 86
acceptable to the superintendent, when either of the following 87
applies: 88

(a) The health plan issuer has a sufficient network but 89
does not have an appropriate in-network provider available to 90
provide the covered benefit to the covered person without 91
unreasonable travel or delay. 92

(b) The health plan issuer has an insufficient number or 93
type of appropriate in-network providers available to provide 94
the covered benefit to the covered person without unreasonable 95
travel or delay. 96

(2) The health plan issuer shall inform a covered person 97
who is diagnosed with a condition or disease that requires 98
specialty health care services of the process required by 99
division (E) (1) of this section when either of the following 100
apply: 101

(a) The health plan issuer does not have an in-network 102
provider of the required specialty with the professional 103
training and expertise to treat or provide health care services 104
for the condition or disease. 105

(b) The health plan issuer cannot provide reasonable 106
access to an in-network provider with the required specialty 107
with the professional training and expertise to treat or provide 108
health care services for the condition or disease without 109
unreasonable travel or delay. 110

(3) The health plan issuer shall treat the health care 111
services the covered person receives from an out-of-network 112
provider under division (F) of this section as if the services 113
were provided by an in-network provider, including by counting 114
the covered person's cost sharing for such services toward the 115
maximum out-of-pocket limit applicable to services obtained from 116
in-network providers under the network plan. 117

(4) The health plan issuer shall address requests to 118
obtain a covered benefit from an out-of-network provider in a 119
timely fashion appropriate to the covered person's condition. 120

(5) The health plan issuer shall document all requests to 121
obtain a covered benefit from an out-of-network provider in 122
accordance with this section and shall provide such 123
documentation to the superintendent upon request. 124

(6) Nothing in division (F) of this section shall be 125
construed to absolve a health plan issuer from establishing and 126
maintaining an adequate network of providers in accordance with 127
this section or to allow covered persons to circumvent the use 128
of covered benefits available through a health plan issuer's in- 129
network providers. 130

(G) A health plan issuer shall establish and maintain 131
adequate arrangements to ensure all covered persons have 132
reasonable access to in-network providers located near the 133
covered person's home or place of employment. In determining 134
whether the health plan issuer has complied with this division, 135
the superintendent shall give due consideration to the relative 136
availability of providers with the requisite expertise and 137
training in the service area under consideration. 138

(H) A health plan issuer shall monitor, on an ongoing 139
basis, the ability, clinical capacity, and legal authority of 140
in-network providers to furnish covered benefits under the 141
network plan. 142

(I) No health plan issuer shall deliver, issue for 143
delivery, or use a network plan in this state before a copy of 144
the plan, the premium rates, and an access arrangement are filed 145
with the department of insurance in a form and manner determined 146
by the superintendent. If the superintendent finds that the 147
network plan or the access arrangement does not meet the 148
requirements of this section, the superintendent shall provide 149
written notice of such finding to the health plan issuer, and 150
the health plan issuer shall not deliver, issue for delivery, or 151
use the network plan in this state. A health plan issuer shall 152
notify the superintendent of any material change to a network 153
plan or access arrangement approved under this division not 154
later than fifteen business days after the change occurs or is 155
implemented. An access arrangement submitted under this division 156
shall include all the following: 157

(1) The factors used by the health plan issuer to build 158
the provider network, including a description of the network and 159
the criteria used to select and tier providers; 160

<u>(2) The health plan issuer's procedures for making and</u>	161
<u>authorizing referrals within and outside the network;</u>	162
<u>(3) The health plan issuer's process for monitoring and</u>	163
<u>assuring, on an ongoing basis, the adequacy of the network to</u>	164
<u>meet the health care needs of covered persons;</u>	165
<u>(4) The health plan issuer's efforts to address the needs</u>	166
<u>of covered persons, including children, adults, persons with</u>	167
<u>limited English proficiency or illiteracy, diverse cultural or</u>	168
<u>ethnic backgrounds, physical or mental disabilities, and</u>	169
<u>serious, chronic, or complex medical conditions;</u>	170
<u>(5) The health plan issuer's methods for assessing the</u>	171
<u>health care needs of covered persons and the satisfaction of</u>	172
<u>covered persons with services;</u>	173
<u>(6) The health plan issuer's method of informing covered</u>	174
<u>persons of the covered benefits included in the network plan and</u>	175
<u>procedures for navigating the plan, such as:</u>	176
<u>(a) Grievance and appeals procedures;</u>	177
<u>(b) Processes for choosing and changing providers;</u>	178
<u>(c) Processes for updating provider directories;</u>	179
<u>(d) A statement of health care services offered, including</u>	180
<u>those services offered through preventive care benefit;</u>	181
<u>(e) Procedures for covering and approving emergency,</u>	182
<u>urgent, and specialty care.</u>	183
<u>(7) The health plan issuer's system for ensuring the</u>	184
<u>coordination and continuity of care for both of the following:</u>	185
<u>(a) Covered persons referred to specialty physicians;</u>	186
<u>(b) Covered persons using ancillary services, including</u>	187

social services and other community resources, and for ensuring 188
appropriate discharge planning. 189

(8) The health plan issuer's process for enabling covered 190
persons to change primary care professionals; 191

(9) The health plan issuer's proposed plan for providing 192
continuity of care in the event of contract termination between 193
the health plan issuer and any in-network providers or in the 194
event of the health plan issuer's insolvency or other inability 195
to continue operations, including an explanation of how covered 196
persons will be notified of the contract termination or the 197
health plan issuer's insolvency or other cessation of operations 198
and transitioned to other providers in a timely manner; 199

(10) The health plan issuer's process for monitoring 200
access to physician specialist services in emergency room care, 201
anesthesiology, radiology, hospitalist care, and pathology or 202
laboratory services at in-network hospitals; 203

(11) Any other information required by the superintendent 204
to determine compliance with this section. 205

(J) The health plan issuer shall make available to covered 206
persons a provider directory that clearly identifies which 207
providers and facilities belong to each network and which 208
networks are applicable to each specific plan offered in this 209
state. If a covered person receives care from an out-of-network 210
provider that is listed, incorrectly, as an in-network provider 211
in a directory provided under this division, the health plan 212
issuer shall compensate the provider at the provider's billed 213
rate at no expense to the covered person beyond the regular cost 214
sharing obligation for in-network services. 215

(K) The superintendent may adopt rules in accordance with 216

<u>Chapter 119. of the Revised Code to administer and enforce this</u>	217
<u>section.</u>	218