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OHIO LEGISLATIVE SERVICE COMMISSION

Office of Research
and Drafting

Legislative Budget
Office

H.B. 219
(with AMO784-1)
136th General Assembly

Fiscal Note & Local Impact Statement

[Click here for H.B. 219's Bill Analysis](#)

Version: In House Insurance

Primary Sponsor: Rep. Deeter

Local Impact Statement Procedure Required: No

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Highlights

- The bill may increase the Department of Insurance's administrative costs to comply with the bill requirements and to ensure health plan issuers conform with the bill provisions. Any increase in such costs would be paid from the Department of Insurance Operating Fund (Fund 5540).
- The bill's requirements may increase costs to the state and local governments to provide health benefits to employees and their beneficiaries under their health benefit plans. Any such plans that already comply with the bill requirements would experience no cost increase.
- The bill will create administrative costs for the Ohio Department of Medicaid in preparing required quarterly reports. The scale of the costs is unknown.

Detailed Analysis

Health plan issuer

The bill requires a health plan issuer that delivers, issues for delivery, or uses a network plan in this state to maintain a network that ensures that all covered persons have access to (1) a sufficient network of providers in terms of the number and specialty, to allow access to covered benefits without unreasonable travel or delay, and (2) emergency services that are available at all times. The bill provides that for tiered network plans, the adequacy of the network is determined based on the lowest cost-sharing tier. The bill 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. The bill also requires a health plan issuer to monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of in-network providers to furnish covered benefits under the network plan.

The bill prohibits a health plan issuer from delivering, issuing for delivery, or using a network plan in this state before sending a copy of the plan, the premium rates, and an access arrangement are filed with the Department of Insurance. The bill requires a health plan issuer to notify the Superintendent of Insurance of any material change to a network plan or access arrangement approved under the bill by not later than 15 business days after the change occurs or is implemented. The bill specifies that 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 the bill, the health plan issuer must 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. The bill also specifies other requirements to health plan issuers regarding network adequacy standards, which are described in the LSC bill analysis.

The bill requires the Superintendent of Insurance to (1) establish reasonable criteria to evaluate the adequacy of a network plan, including considering all criteria specified under the bill, (2) establish requirements related to the minimum number of providers within a specified area and limits on travel distance and travel time to providers, (3) conduct periodic surveys of covered persons and providers to assist in monitoring the adequacy of a network plan, and (4) to publish the results of such surveys on the Department of Insurance's website. The bill requires the Superintendent to consider the relative availability of providers in the area when determining compliance with the proximity of providers to covered persons. The Superintendent is permitted to adopt rules to administer and enforce the bill's provisions.

The bill also requires health plan issuers to complete provider enrollment and credentialing within 90 days of receiving a complete application. The bill also provides temporary enrollment and billing privileges for providers that miss the deadline.

Fiscal effect

The bill may increase the Department of Insurance's administrative costs to comply with the bill requirements and to ensure health plan issuers conform with the bill provisions. Any increase in such costs would be paid from the Department of Insurance Operating Fund (Fund 5540).

The bill's provisions apply to health plan issuers, including nonfederal government health plans. As a result, the bill's requirements may increase costs to the state and local governments to establish and maintain adequate provider networks based on criteria under the bill and to comply with the bill's other provisions. Any such plans that already comply with the bill provisions would experience no cost increase.

Medicaid

The bill requires the Ohio Department of Medicaid (ODM) to complete provider enrollment and credentialing within 90 days of receiving a complete application. The bill also permits temporary enrollment and billing privileges for providers whose applications are still pending after 90 days. If a temporary provider is later denied, ODM may seek recovery of Medicaid payments made during the provisional period.

The bill also requires ODM to file quarterly reports with the Governor, standing committees of both houses of the General Assembly that have primary oversight of the state's Medicaid Program, and the Legislative Service Commission. These reports are to detail the

number of new providers and temporary providers, the time taken to review each agreement, and the number of temporary providers later determined ineligible to enroll.

Fiscal effect

The bill will increase administrative costs for ODM in preparing the required quarterly reports. The scale of these costs is unknown.