Am. Sub. H.B. 166
As Passed by the Senate
INSCD9 and MCDCD55

_____ moved to amend as follows:

In line 162 of the title, delete "3727.46,"

In line 163 of the title, delete "3727.461, 3747.462,"

In line 167 of the title, delete "3902.60,"; after "3959.20," insert "3962.01, 3962.011, 3962.02, 3962.03, 3962.04, 3962.05, 3962.06, 3962.07, 3962.08, 3962.081, 3962.09, 3962.10, 3962.11, 3962.12, 3962.13, 3962.14, 3962.15,"

In line 179 of the title, after "5162.72," insert "5164.65,"

In line 195 of the title, delete "5162.80,"

In line 341, delete "3727.46, 3727.461, 3727.462,"

In line 344, delete "3902.60,"; after "3959.20," insert "3962.01, 3962.011, 3962.02, 3962.03, 3962.04, 3962.05, 3962.06, 3962.07, 3962.08, 3962.081, 3962.09, 3962.10, 3962.11, 3962.12, 3962.13, 3962.14, 3962.15,"

In line 353, after "5162.72," insert "5164.65,"

Delete lines 40998 through 41053

Delete lines 44543 through 44548

After line 44866, insert:

"**Sec. 3962.01.** As used in this chapter:

(A) "Business day" means each day of the week except Saturday, Sunday, or a legal holiday as defined in section 1.14 of the Revised Code.

(B) "Current procedural terminology code" or "CPT code" means the code assigned to a medical, surgical, or diagnostic product, service, or procedure that is published in the CPT code set published by the American medical association.

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

(D) "Health plan issuer" has the same meaning as in section 3922.01 of the Revised Code.

(E) "Health care provider" means an individual or facility licensed, certified, or accredited under or pursuant to Chapter 3721., 3727., 4715., 4725., 4731., 4732., 4734., 4747., 4753., 4755., 4757., or 4779. of the Revised Code.

Sec. 3962.011. (A) For purposes of this chapter, a reference to the time that an appointment for a health care product, service, or procedure is made, means, except as provided in division (B) of this section, any of the following:

(1) The point in time that an appointment for a health care product, service, or procedure is made;

(2) The point in time that a health care provider receives a prescription or order from another provider to provide a health care product, service, or procedure to the patient;

(3) The point in time that a patient, pursuant to a prescription or order from the patient's health care provider, presents at the office or facilities of another provider to

receive, on a walk-in basis, the product, service, or procedure.

(B)(1) If the point in time in which an event described in division (A) of this section occurs is before nine a.m. on a particular business day, the point in time may, instead, be considered to be nine a.m. that same business day.

(2) If the point in time in which an event described in division (A) of this section occurs is after five p.m. on a particular business day, or occurs on a day that is not a business day, the point in time shall, instead, be considered to be nine a.m. on the next business day.

Sec. 3962.02. This chapter applies notwithstanding section 5162.80 of the Revised Code.

Sec. 3962.03. (A) Beginning on the effective date of this section, this section applies to a health care provider that is a hospital or hospital system or is owned by a hospital or hospital system. On and after March 1, 2020, this section applies to all other health care providers.

(B) Before a health care provider provides a health care product, service, or procedure to a patient, the patient or the patient's representative shall receive a reasonable, good faith cost estimate for the product, service, or procedure. This requirement does not apply when a patient seeks emergency services, a health care provider believes that a delay in care associated with fulfilling this requirement could harm the patient, or a circumstance described in section 3962.08 of the Revised Code occurs.

A health care provider may elect to provide the cost estimate as described in section 3962.04 of the Revised Code or, if the

patient is insured, elect for the patient's health plan issuer to provide the cost estimate after the provider has transmitted information to the issuer in accordance with section 3962.05 of the Revised Code. The provider shall notify the patient or the patient's representative who will provide the cost estimate. The provision of a cost estimate by the provider does not preclude the issuer from also providing a cost estimate to the patient or the patient's representative.

Each health care provider or health plan issuer that provides a cost estimate shall ensure that the estimate is provided in a manner that complies with all applicable state and federal laws pertaining to the privacy of patient-identifying information.

Sec. 3962.04. (A) Except as provided in division (B) of this section, a cost estimate provided by a health care provider shall contain all of the following:

(1) The total amount the provider will charge the patient if the patient is paying out-of-pocket or the patient's health plan issuer for each health care product, service, or procedure the patient is to receive, inclusive of facility, professional, and other fees, along with a short description and the applicable CPT code for the product, service, or procedure or, if no CPT code exists, another identifier the health plan issuer requires;

(2) If the patient is insured under a health benefit plan, both of the following:

(a) A notation of whether the provider is in-network or out-of-network for the patient;

(b) The amount the health care provider expects to receive from the health plan issuer for the product, service, or procedure. The amount specified in the estimate shall be the

amount the health plan issuer has agreed to reimburse the provider for the product, service, or procedure under a contract with the provider or the applicable government pay scale, if any.

(3) The difference, if any, that the patient or other party responsible for the patient's care would be required to pay to the provider for the product, service, or procedure;

(4) If the patient is not insured under a health benefit plan, the total amount the provider will charge the patient if the patient is paying out-of-pocket for each product, service, or procedure the patient is to receive, inclusive of facility, professional, and other fees, along with a short description and the applicable CPT code for the product, service, or procedure or, if no CPT code exists, another identifier that a health plan issuer would normally require.

(B)(1) If a patient is to receive a health care product, service, or procedure in a hospital, the hospital is responsible for providing one comprehensive cost estimate to the patient or the patient's representative within the applicable time frame specified in division (D) of this section. The comprehensive cost estimate shall contain both of the following:

(a) All information specified in division (A) of this section associated with products, services, or procedures to be provided by the hospital or its employees;

(b) All information specified in division (A) of this section associated with products, services, or procedures to be provided by health care providers who are independent contractors of the hospital.

(2) A health care provider who is an independent contractor of a hospital shall submit to the hospital all CPT codes or other

identifiers the hospital needs to fulfill its responsibility under division (B)(1)(b) of this section.

(C) A cost estimate required by this section shall be based on information provided at the time the appointment is made, as specified in section 3962.011 of the Revised Code, for the health care product, service, or procedure. In addition, the estimate need not take into account any information that subsequently arises, such as unknown, unanticipated, or subsequently needed health care products, services, or procedures provided for any reason after the initial appointment. Only one estimate is required per visit.

If specific information, such as the health care provider who will be providing the health care product, service, or procedure, is not readily available at the time the appointment is made, the provider may base the cost estimate information specified in division (A)(1) of section 3962.04 of the Revised Code on either an average estimated charge for the product, service, or procedure that is submitted to the patient's health plan issuer or the average out-of-pocket price for the product, service, or procedure paid by patients who are uninsured.

(D)(1) Except as provided in division (D)(2) or (3) of this section, the cost estimate required by this section shall be provided not later than twenty-four hours after the time the appointment for the health care product, service, or procedure is made, as specified in section 3962.011 of the Revised Code, or, if the product, service, or procedure is to be provided less than twenty-four hours after the appointment for the product, service, or procedure is made, as specified in section 3962.011 of the Revised Code, at the time the patient presents to receive the product, service, or procedure.

(2) If the health care product, service, or procedure is to be provided by one or more independent contractors of the provider, the cost estimate shall be provided not later than thirty-six hours after the time the appointment for the product, service, or procedure is made, as specified in section 3962.011 of the Revised Code, or, if the product, service, or procedure is to be provided less than thirty-six hours after the appointment for the product, service, or procedure is made, as specified in section 3962.011 of the Revised Code, at the time the patient presents to receive the product, service, or procedure.

(3) A provider may elect to send the cost estimate to the patient or the patient's representative by regular mail if the health care product, service, or procedure will be provided more than three days from the time the estimate is generated. If this election is made, the provider shall mail the cost estimate not later than the following, as applicable:

(a) If the provider would otherwise be required to comply with division (D)(1) of this section, twenty-four hours after the time the appointment for the health care product, service, or procedure is made, as specified in section 3962.011 of the Revised Code;

(b) If the provider would otherwise be required to comply with division (D)(2) of this section, thirty-six hours after the time the appointment for the health care product, service, or procedure is made, as specified in section 3962.011 of the Revised Code.

(E)(1) If the patient is insured, a health care provider shall, not later than twenty-four hours after an appointment is made, as specified in section 3962.011 of the Revised Code, transmit to the patient's health plan issuer the patient's name;

the patient's identification number, if one has been assigned; the CPT code or other identifier the issuer requires for each health care product, service, or procedure the patient is to receive; the provider's identification number; the provider's charge for each product, service, or procedure the patient has scheduled that will be delivered by a provider who is not in-network for the patient's health benefit plan; notification that the provider is providing the cost estimate to the patient or the patient's representative; and any other information the issuer requires from the provider.

(2) If the provider is to provide a product, service, or procedure pursuant to a prescription or order from another provider, the provider who received the prescription or order shall transmit the information specified in division (E)(1) of this section to the patient's health plan issuer not later than twenty-four hours after receiving the prescription or order or, if received when the provider's office or facility is closed, twenty-four hours after the office or facility reopens.

(3) Not later than five minutes after receiving information pursuant to division (E)(1) or (2) of this section, the health plan issuer shall give to the health care provider all information the provider needs to generate a cost estimate.

If a health plan issuer does not provide the information necessary to generate the estimate, the health care provider shall notify the patient. The provider may note in the portion of the estimate pertaining to the information required by divisions (A)(2) and (3) of this section that health plan issuer information was not provided as required by law. In this case, the provider may specify only the information required by division (A)(1) of this section and, at the provider's discretion, the information required by division (A)(2) of this section. If the information

necessary to complete the estimate is subsequently received and an updated estimate can be provided within the time limit established by division (D) of this section, the health care provider shall provide the updated estimate.

(F) The cost estimate required by this section shall contain a disclaimer that the information is only an estimate based on facts available at the time it was prepared and that the amounts estimated could change as a result of unknown, unanticipated, or subsequently needed health care products, services, or procedures; changes to the patient's health benefit plan; or other changes. The provider has discretion in how the disclaimer is expressed.

(G) If the amount estimated under division (A)(3) or (4) of this section changes by more than ten per cent before the patient initially presents for the health care product, service, or procedure, the health care provider shall supply to the patient an updated estimate within the time limit established by division (B) or (D) of this section, as applicable.

(H) The cost estimate required by this section may be provided verbally or in electronic or written form and shall be easy to understand. If the estimate is provided in electronic or written form, all of the following apply:

(1) It shall be provided in large font.

(2) Unless the estimate contains more than nine CPT codes or other identifiers, it shall be limited to one page.

(3) The subject line of the communication containing the estimate shall state "Your Ohio Healthcare Price Transparency Estimate."

(I) A patient may decline to receive a cost estimate under this section.

(J) Nothing in this section prohibits a health care provider or health plan issuer from collecting payment from a patient for an administered health care product, service, or procedure regardless of whether the patient does or does not receive a cost estimate under this section before the product, service, or procedure is received.

Sec. 3962.05. (A)(1) If a health care provider elects for a patient's health plan issuer to provide a cost estimate in lieu of the provider, the provider shall notify the issuer of this election through the issuer's portal described in section 1751.72, 3923.041, or 5160.34 of the Revised Code or, beginning January 1, 2020, the connector portal established under section 3962.09 of the Revised Code. In addition, the provider shall, except as provided in division (B) of this section, also transmit to the health plan issuer through the appropriate portal all of the following:

(a) The patient's name;

(b) The patient's identification number, if one has been assigned;

(c) The CPT code or other identifier the health plan issuer requires for each health care product, service, or procedure the patient is to receive;

(d) The provider's identification number;

(e) The charge for each product, service, or procedure the patient has scheduled that will be delivered by a provider who is out-of-network for the patient's health benefit plan;

(f) Any other information the health plan issuer requires from the provider.

The portal also shall be able to transmit a copy of this information directly to the patient to whom the information pertains.

Except as provided in division (A)(2) of this section, the transmission shall occur not later than twenty-four hours after the time the appointment for the health care product, service, or procedure is made, as specified in section 3962.011 of the Revised Code.

(2) If the health care product, service, or procedure is to be provided by one or more independent contractors of the provider, the transmission shall occur not later than thirty-six hours after the time the appointment for the product, service, or procedure is made, as specified in section 3962.011 of the Revised Code.

A health plan issuer shall modify its portal as necessary to accommodate the information transmission.

(B) If a health care provider attests to the department of insurance that it is unable to transmit information through a health plan issuer's portal or through the connector portal, the provider may transmit the information by facsimile or telephone call to the department of insurance. The department shall enter the information on the provider's behalf in the relevant portal. Under these circumstances, the provider may compile patient information and transmit it to the department in a batch once every business day.

Sec. 3962.06. (A) Under the circumstances described in division (A)(1) of section 3962.05 of the Revised Code, a health plan issuer shall provide a cost estimate to the patient or the patient's representative containing the information specified in

divisions (A)(1) to (3) of section 3962.04 of the Revised Code, as well as the average rate the health plan issuer reimburses in-network providers for the same health care product, service, or procedure.

(B) A health plan issuer shall ask the patient or the patient's representative whether the patient would prefer to receive cost estimates by electronic mail or other electronic means or by regular mail. The issuer shall send cost estimates by the means elected.

If the means elected is by electronic mail or or other electronic means, the estimate shall be sent automatically, but not later than five minutes after the health plan issuer has received the necessary information from the health care provider. If the means elected is by regular mail, the estimate shall be mailed not later than forty-eight hours after the issuer has received the necessary information from the health care provider if the health care product, service, or procedure will be provided more than three days from the time the estimate is generated. For purposes of calculating the forty-eight hours, hours on a Saturday, Sunday, or legal holiday shall be excluded.

If no election is made, the estimate shall be sent as follows:

(1) If the health care product, service, or procedure will be provided more than three days from the time the estimate is generated, by regular mail;

(2) If the health care product, service, or procedure will be provided less than three days from the time the estimate is generated and the electronic mail address of the patient or patient's representative is on file with the issuer, by electronic mail.

A health plan issuer shall be held harmless if the electronic mail address of the patient or the patient's representative on file with the issuer is incorrect, invalid, or no longer used.

(C)(1) The cost estimate required by this section shall be based on information provided at the time an appointment is made, as specified in section 3962.011 of the Revised Code. In addition, the estimate need not take into account any information that subsequently arises, such as unknown, unanticipated, or subsequently needed health care products, services, or procedures provided for any reason after the initial appointment. Only one estimate is required per visit.

(2) If specific information, such as the provider who will be providing the health care product, service, or procedure, is not readily available at the time the appointment is made, the health care provider may transmit that a provider is unknown and the health plan issuer may base the estimate on an average estimated charge submitted to the health plan issuer for the product, service, or procedure at that facility or location.

(3) If a health care provider does not transmit to the health plan issuer the information necessary to generate the cost estimate, the issuer shall send to the patient or the patient's representative, by the same means used to send estimates, a notice that the provider failed to transmit the necessary information as required by law and, consequently, a cost estimate could not be generated. This action shall be taken in the event a provider gives the issuer any indication that receipt of a health care product, service, or procedure is scheduled, such as through precertification.

(D) The estimate required by this section shall contain both of the following:

(1) A disclaimer that the information is only an estimate based on facts available at the time it was prepared and that the amounts estimated could change as a result of other factors; unknown, unanticipated, or subsequently needed health care products, services, or procedures; or changes to the patient's health benefit plan. The health plan issuer has discretion in how the disclaimer is expressed.

(2) If applicable, a notation that a specific health care provider is out-of-network for the enrollee.

(E) The cost estimate required by this section shall be provided in large font, be easy to understand, and, unless the estimate contains more than nine CPT codes or other identifiers, be limited to one page. The subject line of the communication containing the estimate shall state "Your Ohio Healthcare Price Transparency Estimate."

(F) If the amount in a cost estimate required by this section changes by more than ten per cent before the patient presents for the health care product, service, or procedure, the health plan issuer shall supply to the patient an updated estimate by the means the patient or the patient's representative has elected under division (B) of this section and within the time frames specified in that division.

(G) A patient may decline to receive a cost estimate under this section.

(H) A patient is responsible for payment for an administered health care product, service, or procedure even if the patient does not receive a cost estimate under this section before the product, service, or procedure is received.

Sec. 3962.07. (A) Regardless of whether a cost estimate is

provided to a patient by a health care provider under section 3962.04 of the Revised Code or by a health plan issuer under section 3962.06 of the Revised Code, a provider shall give the patient or the patient's representative the CPT code or other identifier the patient's health plan issuer requires for each health care product, service, or procedure the patient is to receive along with the charge information specified in division (A)(1) of section 3962.04 of the Revised Code associated with each code or other identifier. The provider has the following options for fulfilling this requirement:

(1) The provider may send this information to the patient or the patient's representative through electronic means.

(2) The provider may send this information to the patient or patient's representative by regular mail if the health care product, service, or procedure will be provided more than three days from the time the appointment for the product, service, or procedure is made, as specified in section 3962.011 of the Revised Code.

(3) The provider may provide to the patient or the patient's representative a web site address where that individual may enter each code or identifier and retrieve the charge information. If this option is elected and the provider transmits the codes or identifiers to the patient's health plan issuer through a portal as described in section 3962.05 of the Revised Code, the provider may have the portal generate an automatic electronic mail message to the individual with instructions on how to retrieve charge information through the web site.

(4) If the product, service, or procedure is to be provided less than three days from the time the appointment for the

product, service, or procedure was made, the provider may give the information to the patient or the patient's representative at the time the patient presents for the product, service, or procedure to be received.

Regardless of the manner in which the provider has elected to fulfill this requirement, the provider shall fulfill the requirement in accordance with all applicable state and federal laws pertaining to the privacy of patient-identifying information.

The CPT codes or other identifiers and charge information shall, except as provided in division (B) of this section, be given to the patient or the patient's representative not later than twenty-four hours after the time the appointment for the health care product, service, or procedure is made, as specified in section 3962.011 of the Revised Code, or, if the product, service, or procedure is to be provided less than twenty-four hours after the appointment for the product, service, or procedure is made, as specified in section 3962.011 of the Revised Code, at the time the patient presents to receive the product, service, or procedure.

(B) If the health care product, service, or procedure is to be provided by one or more independent contractors of the provider, the CPT codes or other identifiers and charge information shall be given to the patient or the patient's representative not later than thirty-six hours after the time the appointment for the product, service, or procedure is made, as specified in section 3962.011 of the Revised Code, or, if the product, service, or procedure is to be provided less than thirty-six hours after the appointment for the product, service, or procedure is made, as specified in section 3962.011 of the Revised Code, at the time the patient presents to receive the

product, service, or procedure.

Sec. 3962.08. (A) As used in this section, "office visit" means the family of CPT codes for "Evaluation and Management, Office Visits Established" (codes 99211, 99212, 99213, 99214, and 99215) used for office or other outpatient visits for an established patient and the family of CPT codes for services similar to the foregoing, including vision services.

(B) The requirement of section 3962.03 of the Revised Code does not apply in any of the following circumstances:

(1) When the only service a health care provider will provide is an office visit;

(2) When the patient was scheduled for only an office visit but during the visit it is determined that the patient needs a product, service, or procedure to be provided during that single visit;

(3) When the patient seeks care without an appointment and without a prescription or order from another provider.

(C) In the event a patient schedules or presents for health care products, services, or procedures in addition to an office visit but the health care provider is unable to estimate the level of office visit to be provided, or in the circumstances described in division (B)(3) of this section, the provider may enter a general designation for an unknown level of office visit. The estimate provided through the health care provider or health plan issuer under section 3962.03 of the Revised Code shall list the general designation and price range for all levels of office visits.

Sec. 3962.081. In the event that a health care provider

believes that a delay in care associated with fulfilling the cost estimate requirement of section 3962.03 of the Revised Code could harm the patient, the provider shall inform the patient or the patient's representative of this fact and provide the health care product, service, or procedure to the patient. After the product, service, or procedure is provided, the provider shall submit to the department of insurance a report, in the form and manner prescribed by the department, detailing why the provider believed that a delay in care could harm the patient. Annually, the department shall analyze the reports and prepare a summary of its findings. Each summary shall be submitted to the governor and, in accordance with section 101.68 of the Revised Code, the general assembly.

Sec. 3962.09. Not later than January 1, 2020, the department of insurance shall create or procure a connector portal that health care providers may use to transmit the information specified in section 3962.05 of the Revised Code to health plan issuers. The department shall ensure that the computer systems and software used in operating the connector portal are compatible with the computer systems and software manufactured by various vendors and used by health care providers and health plan issuers. In doing so, the department shall engage in active efforts to share with those vendors any information necessary to operate the connector portal in a manner that accomplishes both of the following, while also ensuring that the portal maintains the privacy of patient-identifying information in accordance with all applicable state and federal laws:

(A) Grants health care providers a means by which they may instantly transmit information and populate data fields that health plan issuers need to generate cost estimates under section

3962.06 of the Revised Code;

(B) Grants health plan issuers a means by which they may retrieve information directly from the connector portal in a seamless manner.

Sec. 3962.10. A health care provider or health plan issuer that provides a cost estimate under this chapter is not liable in damages in a civil action for injury, death, or loss to person or property that allegedly arises from an act or omission associated with providing the estimate if the health care provider or health plan issuer made a good faith effort to collect the information necessary to generate the estimate and a good faith effort to provide the estimate to the patient or the patient's representative.

Sec. 3962.11. (A) If, after completing an examination, the superintendent of insurance, department of health, department of medicaid, or appropriate regulatory board, as applicable, finds that a health plan issuer or health care provider has committed a series of violations that, taken together, constitute a consistent pattern or practice of violating the requirements of this chapter to provide cost estimates to patients or their representatives, the superintendent, department, or board may impose on the issuer or provider any of the administrative remedies specified in division (B) of this section.

Before imposing an administrative remedy, the superintendent, department, or board shall give written notice to the health plan issuer or health care provider informing that party of the reasons for the finding, the administrative remedy that is proposed, and the opportunity to submit a written request for an administrative hearing regarding the finding and proposed remedy. If a hearing is

requested, the superintendent, department, or board shall conduct the hearing in accordance with Chapter 119. of the Revised Code not later than fifteen days after receipt of the request.

(B) In imposing administrative remedies under this section, the superintendent, department, or appropriate regulatory board may do either or both of the following:

(1) Levy a monetary penalty in an amount determined in accordance with division (C) of this section;

(2) Order the health plan issuer or health care provider to cease and desist from engaging in the violations.

(C)(1) A finding by the superintendent, department, or appropriate regulatory board that a health plan issuer or health care provider has committed a series of violations that, taken together, constitutes a consistent pattern or practice of violating the requirements of this chapter to provide cost estimates to patients or their representatives, shall constitute a single offense for purposes of levying a fine as described in division (B)(1) of this section.

(2) For a first offense, the superintendent or department may levy a fine of not more than one hundred thousand dollars; the appropriate regulatory board may levy a fine of not more than ten thousand dollars.

For a second offense, the superintendent or department may levy a fine of not more than one hundred fifty thousand dollars; the appropriate regulatory board may levy a fine of not more than fifteen thousand dollars.

For a third or subsequent offense, the superintendent or department may levy a fine of not more than three hundred thousand dollars; the appropriate regulatory board may levy a fine of not

more than thirty thousand dollars.

(3) In determining the amount of a fine to be levied within the limits specified in division (C)(2) of this section, the superintendent, department, or appropriate regulatory board shall consider the following factors:

(a) The extent and frequency of the violations;

(b) Whether the violations were due to circumstances beyond the control of the health plan issuer or health care provider;

(c) Any remedial actions taken by the health plan issuer or health care provider;

(d) The actual or potential harm to others resulting from the violations;

(e) If the health plan issuer or health care provider knowingly and willingly committed the violations;

(f) The financial condition of the health plan issuer or health care provider;

(g) Any other factors the superintendent, department, or appropriate board considers appropriate.

(D) The amounts collected from levying fines under this section shall be paid into the state treasury to the credit of the general revenue fund.

Sec. 3962.12. A contract clause that does any of the following is invalid and unenforceable:

(A) Prohibits a health care provider or health plan issuer from providing a patient with information that facilitates the patient's ability to choose a health care provider based on quality or cost, including providing a patient with cost and

quality information for alternative providers when the patient demonstrates an intention to see a particular provider;

(B) Prohibits a health plan issuer from excluding any particular health care provider from a list or other resource that ranks providers based on quality or cost and is intended to help patients make decisions regarding their care;

(C) Restricts patient access to quality or cost information provided by a health care provider or health plan issuer.

Sec. 3962.13. (A) All of the following may adopt any rules necessary to carry out this chapter:

(1) The superintendent of insurance;

(2) The director of health;

(3) The medicaid director;

(4) Any other relevant department, agency, board, or other entity that regulates, licenses, or certifies a health care provider or health plan issuer.

(B) Any rules adopted under this section shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 3962.14. Any member of the general assembly may intervene in litigation that challenges sections 3962.01 to 3962.13 or section 5164.65 of the Revised Code.

Sec. 3962.15. It is the general assembly's intent in enacting sections 3962.01 to 3962.14 of the Revised Code to provide patients with the information they need to make informed choices regarding their health care, to maximize health care cost savings for all residents of this state, and to reduce the burden of

health care expenditures on government entities, including medicaid."

After line 66433, insert:

"**Sec. 5164.65.** The medicaid program shall comply with Chapter 3962. of the Revised Code as if it were a health plan issuer. This requirement extends to medicaid managed care organizations."

In line 82924, delete "5162.80,"

After line 96582, insert:

"**Section 751.___.** CHALLENGES TO HEALTH CARE COST ESTIMATE STATUTE

Any member of the General Assembly may intervene in litigation that challenges section 5162.80 of the Revised Code."

The motion was _____ agreed to.

SYNOPSIS

Health care price transparency

R.C. 3727.46, 3727.461, 3727.462, and 3902.60 (removed); 3962.01 to 3962.15 and 5164.65 (reinstated); R.C. 5162.80 (reinstated); Section 751.___ (reinstated)

Removes the Senate-passed health care price transparency provisions, which would have (1) generally required only hospitals, beginning January 1, 2020, to provide to patients or their representatives, on request, verbal or written cost estimates for scheduled services, (2) required a health plan issuer to provide to its covered persons health care cost

estimates to at least the same extent it is required to do so under federal law, and (3) repealed existing health care price transparency requirements.

Restores, the House-passed health care price transparency provisions, which generally require health care providers and health plan issuers, as well as the Medicaid program, to provide patients or their representatives with cost estimates for nonemergency health care products, services, or procedures before each is provided and to do so within specified time limits.