As Introduced

132nd General Assembly

Regular Session **H. B. No. 399**

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Representatives Henne, Butler

Cosponsors: Representatives DeVitis, Keller, Hood, Becker, Romanchuk, Sprague, Dean, Goodman, Wiggam

A BILL

To amend section 5162.80; to amend for the purpose of adopting a new section number as indicated in parentheses, section 5162.80 (3962.02); and to enact sections 191.11, 191.12, 3962.01, 3962.03, 3962.04, 3962.05, 3962.06, 3962.10, 3962.11, 3962.12, 3962.16, 3962.17, 3962.21, 3962.22, 3962.23, 3962.24, 3962.25, 3962.26, 3962.27, 3962.28, 3962.29, 3962.30, 3962.31, 3962.32, 3962.35, 3966.01, 3966.02, 3966.03, 3966.04, 3966.05, 3966.06, 3966.07, 3966.08, 3966.09, and 5164.65 of the Revised Code to enact the Ohio Right to Shop Act to require health insurers to establish shared savings incentive programs for enrollees.

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

Section 1. That section 5162.80 be amended; section 5162.80 (3962.02) be amended for the purpose of adopting a new section number as indicated in parentheses; and sections 191.11, 191.12, 3962.01, 3962.03, 3962.04, 3962.05, 3962.06, 3962.10,

3962.11, 3962.12, 3962.16, 3962.17, 3962.21, 3962.22, 3962.23, 3962.24, 3962.25, 3962.26, 3962.27, 3962.28, 3962.29, 3962.30, 3962.31, 3962.32, 3962.35, 3966.01, 3966.02, 3966.03, 3966.04, 3966.05, 3966.06, 3966.07, 3966.08, 3966.09, and 5164.65 of the Revised Code be enacted to read as follows:

Sec. 191.11. As used in this section, "health plan issuer" has the same meaning as in section 3962.01 of the Revised Code.

Not later than January 1, 2019, the office of health transformation shall create a standardized prior authorization form for use by health plan issuers for purposes of division (D) of section 3962.22 of the Revised Code.

Sec. 191.12. As used in this section, "health care provider" has the same meaning as in section 3962.01 of the Revised Code.

Not later than June 30, 2018, the office of health transformation, in consultation with the department of insurance and department of medicaid, shall analyze the administrative burdens placed on health care providers. The analysis shall assess the extent to which the burdens negatively affect the quality of care that health care providers are able to provide, the amount of time that health care providers are able to spend with patients, and the financial stability of health care providers.

Sec. 3962.01. As used in this chapter:

(A) "Emergency service" means a service furnished to an individual in an emergency, including when the individual presents for care at an emergency department, is directly admitted to a hospital by an individual specified in division (B)(1) of section 3727.06 of the Revised Code, or another

instance where a health care provider determines that taking the time to provide a cost estimate for a product, service, or procedure or to transmit the necessary information to the patient's health plan issuer to provide the cost estimate would endanger the patient.

(B) "Enrollee" means an individual who is enrolled in a health plan issuer's health benefit plan.

(C) "Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract, to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care products, services, or procedures under a health benefit plan. "Health plan issuer" includes all of the following:

(1) A sickness and accident insurance company;

(2) A health insuring corporation;

(3) A medicaid managed care organization, as defined in section 5167.01 of the Revised Code;

(4) The medicaid program, if a health care product, service, or procedure is provided to a medicaid recipient on a fee-for-service basis;

(5) A third-party payer, as defined in section 3901.38 of the Revised Code.

(D) "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.

(E) "Necessary information" means all of the following:

(1) The name and license number, or other identifier the relevant health plan issuer typically requires, of the health care provider who will provide a health care product, service, or procedure;

(2) The applicable CPT code published by the American medical association for a health care product, service, or procedure or, if no CPT code exists, another identifier the relevant health plan issuer requires;

(3) The date that a health care product, service, or procedure is to be provided.

(F) "Prescriber" has the same meaning as in section 4729.01 of the Revised Code, except that it excludes a veterinarian licensed under Chapter 4741. of the Revised Code.

(G) "Step therapy protocol" means a protocol or program that establishes a specific sequence in which prescription drugs, items of medical equipment, diagnostic tests, or medical procedures that are for a medical condition and are medically necessary for a particular patient are covered by a health plan issuer.

Sec. ~~5162.80~~ 3962.02. (A) ~~A~~ This section applies on and after January 1, 2019.

(B) Except as provided in section 3962.04 of the Revised Code and in emergency situations, a health care provider ~~of medical services licensed, accredited, or certified under Chapter 3721., 3727., 4715., 4725., 4731., 4732., 4734., 4747., 4753., 4755., 4757., or 4779. of the Revised Code~~ shall provide ~~in writing~~ to a patient or the patient's representative, before ~~products, services, or procedures are~~ a health care product, service, or procedure that is not an emergency service is

provided to the patient, a reasonable, good-faith estimate of all of the following for ~~the provider's non-emergency products, services, or procedures~~ the product, service, or procedure, unless a cost estimate is provided directly to the patient or patient's representative by a health plan issuer pursuant to section 3962.10 of the Revised Code:

(1) The total amount the provider will charge the patient or the ~~consumer's~~ patient's health plan issuer for the 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 published by the American medical association for the product, service, or procedure or, if no CPT code exists, another identifier the health plan issuer requires;

(2) ~~The~~ If the patient is insured under a health benefit plan, the amount the health care provider expects to receive from the health plan issuer ~~intends to pay~~ for the product, service, or procedure~~;~~ . The amount specified in the estimate shall be the amount the health plan issuer will 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 ~~consumer~~ patient or other party responsible for the ~~consumer's~~ 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 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 published by the American medical association for the product, service, or procedure or, if no CPT code exists, another identifier the health plan issuer requires.

Notwithstanding any requirement or exemption under this chapter, a health care provider shall comply with division (B)(4) of this section if a patient is not insured under a health benefit plan.

(C) The cost estimate required by this section shall be based on information provided at the time an appointment is made or, in the absence of an appointment, at the time the patient initially presents 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 check-in or 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 on an average estimated charge for the product, service, or procedure.

(D) The cost estimate required by this section shall be provided within twenty-four hours of the date the appointment for the health care product, service, or procedure is made or the time the patient initially presents for the product, service, or procedure, whichever is sooner.

If a health plan issuer does not provide the information

necessary to complete 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 (B)(2) and (3) of this section that insurance information was not provided as required by law. In this case, the provider may specify only the information required by division (B)(1) of this section and, at the provider's discretion, the information required by division (B)(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 this division, the health care provider shall provide the updated estimate.

(E) The cost 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 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.

(2) A notation that a specific health care provider is out-of-network for the patient, but only if the patient is insured and that information is provided by the health plan issuer.

(F) If the amount estimated under division (B)(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 (D) of this section.

(G) The cost estimate required by this section may be provided verbally or in electronic or written form.

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

(I) 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.

(J)(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. The comprehensive cost estimate shall contain both of the following:

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

(b) All information in division (B) 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 (J)(1)(b) of this section.

(3) In the event a hospital must provide the necessary information for one independent contractor, the hospital shall submit the information not later than forty-eight hours after

the appointment is made. In the event a hospital must provide the necessary information for two or more independent contractors, the hospital shall submit the information not later than seventy-two hours after the appointment is made.

~~(B) Any health plan issuer contacted by a provider described in division (A) of this section in order for the provider to obtain information so that the provider can comply with division (A) of this section shall provide such information to the provider within a reasonable time of the provider's request.~~

~~(C) As used in this section, "health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract, to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company and a health insuring corporation. "Health plan issuer" also includes a managed care organization under contract with the department of medicaid and, if the services are to be provided on a fee-for-service basis, the Medicaid program.~~

~~(D) The medicaid director shall adopt rules, in accordance with Chapter 119. of the Revised Code, to carry out this section.~~

Sec. 3962.03. (A) This section applies during the period beginning on the effective date of this section and ending December 31, 2018.

(B) In the case of health care products, services, and procedures for which a health care provider submits to a health

plan issuer CPT codes and product identifiers for purposes of obtaining precertification of health benefit plan coverage, the health plan issuer shall provide cost estimates directly to patients or their representatives. Each estimate shall contain the same information that is required when an estimate is provided under section 3962.02 of the Revised Code, but shall expressly state at the top of the estimate, in boldface type, both of the following:

(1) That the estimate is being provided only for those health care products, services, and procedures for which the health care provider is requesting verification of health benefit plan coverage and that the estimate may not include all products, services, and procedures the patient is scheduled to receive;

(2) That beginning January 1, 2019, an estimate will be provided for all health care products, services, and procedures the patient is to receive rather than only those for which the provider is requesting verification of health benefit plan coverage, except for office visits as provided in section 3962.04 of the Revised Code.

Sec. 3962.04. (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.

(B) The requirements in sections 3962.02 and 3962.10 of the Revised Code do not apply when the only service a health care provider will provide is an office visit.

(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, the provider may enter, and the web site the health plan issuer creates under division (D)(1)(a) of section 3962.11 of the Revised Code shall provide for, a general designation for an unknown level of office visit. The estimate provided through the health care provider or health plan issuer under section 3962.02 or 3962.10 of the Revised Code, respectively, shall list the general designation and price range for all levels of office visits.

Sec. 3962.05. On request of a patient or the patient's representative, a health care provider shall provide the necessary information pertaining to a health care product, service, or procedure directly to the patient not more than twenty-four hours after the patient or the patient's representative makes an appointment or, in the absence of an appointment, the patient presents for the health care product, service, or procedure.

Sec. 3962.06. The department of health, the department of medicaid, and the licensing boards created under Title XLVII of the Revised Code that regulate health care providers shall collaborate to publish a document that specifies the responsibilities of health care providers under section 3962.02 of the Revised Code. The agency or board with jurisdiction over a health care provider shall send a copy of the document to the provider annually. The copy may be sent by electronic means.

Sec. 3962.10. (A) This section applies on and after January 1, 2019.

(B) Except as provided in section 3962.04 of the Revised Code and in emergency situations, a health plan issuer shall

directly provide to an enrollee or the enrollee's representative a reasonable, good faith estimate of the amounts specified in divisions (B)(1) to (3) of section 3962.02 of the Revised Code. The cost estimate shall be provided before any health care product, service, or procedure that is not an emergency service is provided to the enrollee.

(C) When an individual is enrolled in a health benefit plan, and during a health plan issuer's open enrollment period, the issuer shall ask the enrollee or the enrollee's representative whether that individual would prefer to receive cost estimates by electronic mail, a smartphone application, or regular mail. The health plan issuer shall send cost estimates by the means elected. If the means elected is by electronic mail or smartphone application, 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 twenty-four hours after the health plan issuer has received the necessary information from the health care provider if the procedure will be provided more than two days from the date the estimate is generated. If no election is made, the estimate shall be sent as follows:

(1) By electronic mail, if the email address of the enrollee or the enrollee's representative is on file with the health plan issuer;

(2) By regular mail, unless the health care product, service, or procedure will be provided less than two days from the date the estimate is generated.

(D)(1) The cost estimate required by this section shall be

based on information provided at the time an appointment is made or, in the absence of an appointment, at the time the patient initially presents 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 check-in or 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 or when the enrollee presents for the health care product, service, or procedure, the health care provider may transmit that a provider is unknown as part of the necessary information and the health plan issuer may base the estimate on an average estimated charge for the product, service, or procedure at that facility or location.

(3) If a health care provider does not supply to the health plan issuer the necessary information to generate the cost estimate, the issuer shall send to the enrollee or the enrollee's representative, by the same means used to send estimates, a notice that the provider failed to supply 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.

(E) 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 enrollee'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.

(F) The 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 product identifiers, be limited to one page.

(G)(1) A health plan issuer shall provide the estimate required by this section within five minutes of receiving the necessary information from the health care provider pursuant to section 3962.11 of the Revised Code.

(2) If the amount in the estimate required by this section changes by more than ten per cent from the time an appointment is made to the time the enrollee presents for the health care product, service, or procedure, the health plan issuer shall supply to the enrollee an updated estimate within five minutes of receiving the updated information.

(H) An enrollee may decline to receive a cost estimate under this section.

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

(J) The affirmative obligation of a health plan issuer to provide an estimate directly to a patient as required by this section obviates the requirements on a health care provider to provide an estimate pursuant to section 3962.02 of the Revised Code unless the provider elects to fulfill the obligation pursuant to section 3962.12 of the Revised Code.

Sec. 3962.11. (A) This section applies on and after January 1, 2019.

(B) Not more than twenty-four hours after an enrollee or the enrollee's representative makes an appointment or, in the absence of an appointment, the enrollee presents for a health care product, service, or procedure, a health care provider shall provide to a health plan issuer the necessary information through the web site described in division (D)(1)(a) of this section.

(C)(1) If an enrollee is to receive a health care product, service, or procedure in a hospital, the hospital is responsible for providing to a health plan issuer the necessary information, including both of the following:

(a) All necessary information associated with products, services, or procedures to be provided by the hospital or its employees;

(b) All necessary information 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 (C)(1)(b) of this section.

(3) In the event a hospital must provide the necessary information for one independent contractor, the hospital shall submit the necessary information not later than forty-eight hours after the appointment is made. In the event a hospital must provide the necessary information for two or more independent contractors, the hospital shall submit the necessary information not later than seventy-two hours after the appointment is made.

(D)(1) To facilitate a health care provider's transmission of the necessary information and to promote health care price transparency for enrollees, each health plan issuer shall create and maintain all of the following:

(a) A web site for health care providers to transmit the necessary information. A health plan issuer shall maintain only one web site for all of its and its affiliates' and related entities' health benefit plans through which providers may enter necessary information without regard to the specific plan offered by the issuer. The web site shall permit all providers to quickly and easily enter the necessary information for each patient appointment or visit. The issuer shall not require the provider to enter more than the necessary information, such as the patient's particular plan.

(b) A web site that can be instantly accessed by a health care provider that elects to provide cost estimates pursuant to section 3962.12 of the Revised Code through which the provider, upon entering the necessary information, may generate within five minutes a cost estimate that the provider may then give the patient electronically, in writing, or verbally;

(c) A web site through which an enrollee or the enrollee's representative, upon entering the necessary information, may

search for other health care providers and generate a corresponding cost estimate for a health care product, service, or procedure for the purpose of cost comparison.

(2) Access to a web site created and maintained in accordance with this section shall be provided free of charge.

(3) Not later than October 15, 2018, each health plan issuer shall report to the superintendent of insurance the internet addresses of its web sites that comply with this section. The superintendent shall post those addresses on the web site of the department of insurance. The superintendent shall monitor the health plan issuers' web sites to ensure compliance with this section. The superintendent may impose a fine or withhold licensure if an issuer fails to create and maintain web sites that comply with this section.

Sec. 3962.12. (A) A health care provider may elect to provide an enrollee or enrollee's representative with a cost estimate by complying with section 3962.10 of the Revised Code as if the provider were a health plan issuer. If a health care provider elects to provide a cost estimate under this section, a health plan issuer shall give the provider access to the web site created under division (D)(1)(b) of section 3962.11 of the Revised Code.

On request, and not more than five minutes after all necessary information has been received from a health care provider, a health plan issuer shall submit to the health care provider all information that is needed by the provider to generate the cost estimate. The health plan issuer may provide the information either verbally or in electronic form. The health plan issuer shall not charge a health care provider for the information.

A health plan issuer shall make itself readily available to provide information to a health care provider to generate the cost estimate.

(B) A health plan issuer is not required to provide a cost estimate pursuant to section 3962.10 of the Revised Code if a health care provider elects to provide the estimate under this section, but the health plan issuer may provide a cost estimate at its discretion using the necessary information received from the health care provider.

Sec. 3962.16. 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 required to complete the estimate and a good faith effort to provide the estimate to the patient or enrollee.

Sec. 3962.17. (A) If, after completing an examination involving information collected from a six-month period, the superintendent of insurance, department of health, 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 enrollees, 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 enrollees, 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 that occurs on or earlier than four years after the first 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 additional offense that occurs on or earlier than seven years after a first 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. 3962.21. Once a health care provider seeking to generate a cost estimate submits CPT codes to a web site a health plan issuer has created under division (D)(1)(a) of section 3962.11 of the Revised Code, the web site shall direct the provider to a link that the provider can use to obtain online precertification from the issuer. Once CPT codes are submitted for the purpose of generating a cost estimate, a health plan insurer shall not require the provider to submit the codes again for the purpose of precertification.

Sec. 3962.22. (A) Beginning July 1, 2018, a health plan issuer shall not require a prescriber to obtain prior authorization before prescribing a drug or item of medical equipment to a patient or performing a medical procedure or diagnostic test on a patient if that prescriber, within the immediately preceding three-year period before the effective date of this section, was in the top twenty-five per cent of prescribers who had prior authorization requests approved. A health plan issuer shall notify each prescriber who is exempt from the requirement. Every six months thereafter, beginning January 1, 2019, a health plan issuer shall make a redetermination of which prescribers qualify for the exemption and notify them. Health plan issuers may combine information they have about prescribers and apply the exemption uniformly.

(B) A health plan issuer shall not require a prescriber to obtain prior authorization for a drug that costs one hundred dollars or less for a thirty-day supply or for an item of medical equipment, procedure, or diagnostic test that costs one hundred dollars or less.

(C) A health plan issuer shall not require a prescriber to

obtain prior authorization for a drug or item of medical equipment that had been the subject of a prior authorization request for the same course of treatment if the drug or item is to treat a chronic disease or medical condition.

(D) A health plan issuer shall not require a prescriber to use a prior authorization form that differs from the standardized prior authorization form created by the office of health transformation under section 191.11 of the Revised Code.

Sec. 3962.23. A health plan issuer shall not impose a step therapy protocol on a prescriber who is seeking to prescribe a drug or perform a diagnostic test or medical procedure for treatment of a patient's particular condition that is in a later step of the applicable sequence if both of the following are the case:

(A) The patient has already tried, in the five-year period preceding the date the prescription is to be issued or the test or procedure is to be performed, either of the following:

(1) A drug that is in a lower step of the sequence or a drug in the same pharmacologic class or with the same mechanism of action that is in a lower step of the sequence;

(2) A diagnostic test or medical procedure that is in a lower step of the sequence.

(B) With respect to a drug, the drug is determined to lack efficacy or effectiveness, have a diminished effect on the patient's condition, or cause the patient to experience an adverse event. With respect to a diagnostic test or medical procedure, the test or procedure is contraindicated for the patient because it poses a danger to the patient's health.

Sec. 3962.24. A health plan issuer shall offer a grace

period of at least sixty days for any step therapy protocol or prior authorization protocol for a patient who is already stabilized on a particular medical treatment or drug regimen upon enrollment in the issuer's plan. During this period, a medical treatment or drug regimen shall not be interrupted while any utilization management requirements, such as prior authorization, step therapy overrides, or formulary exceptions, are addressed.

Sec. 3962.25. A health plan issuer shall cover for the entire duration of a health benefit plan period, without restrictions, a drug, item of medical equipment, medical procedure, or diagnostic test that is removed from the issuer's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended unless the drug, item, procedure, or test is no longer made available to any patient or is prohibited.

Sec. 3962.26. A utilization review entity that is part of a health plan issuer, or under contract with an issuer, shall not require a patient to repeat step therapy protocols or retry therapies that failed under coverage provided by another health plan issuer before authorizing coverage of a different drug or therapy.

Sec. 3962.27. A utilization review entity that is part of a health plan issuer, or under contract with a health plan issuer, shall provide accurate, patient-specific, and updated formularies that include prior authorization and step therapy protocol requirements in electronic health record systems for use in e-prescribing and other purposes.

Sec. 3962.28. A utilization review entity that is part of a health plan issuer, or under contract with a health plan

issuer, that requires health care providers to adhere to prior authorization protocols shall accept and respond to prior authorization and step therapy protocol override requests exclusively through secure electronic transmissions using standard electronic transactions for pharmacy and medical services benefits. Facsimile, proprietary payer web-based portals, telephone discussions, and nonstandard electronic forms shall not be considered electronic transmissions.

Sec. 3962.29. Not later than January 1, 2021, a vendor of electronic health record systems shall provide updated software that enables health care providers to transmit prior authorization requests or step therapy protocol overrides without having to resubmit the same information.

Sec. 3962.30. Not later than January 1, 2021, the department of insurance shall ensure that a single health information exchange exists that a health care provider can use to generate cost estimates and precertifications for patients regardless of each patient's coverage.

Sec. 3962.31. Not later than January 1, 2021, health plan issuers shall perform medical chart audits electronically through health information exchanges.

Sec. 3962.32. To the extent possible, in complying with sections 3962.22 to 3962.30 of the Revised Code, a health plan issuer shall also comply with sections 1751.72, 3923.041, and 5160.34 of the Revised Code, as applicable, regarding prior authorizations.

Sec. 3962.35. (A) All of the following may adopt any rules necessary to carry out this chapter:

(1) The superintendent of insurance;

(2) The medicaid director;

(3) The director of health;

(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. 3966.01. As used in this chapter:

(A) "Allowed amount" means the contractually agreed upon amount paid by a health plan issuer to a health care provider for covered health care services provided to a patient under a health benefit plan.

(B) "Health care provider" has the same meaning as in section 3701.74 of the Revised Code.

(C) "Health benefit plan" and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(D) "Shared savings incentive program" means a program established by a health plan issuer in accordance with section 3966.05 of the Revised Code under which the health plan issuer provides to an individual covered under a health benefit plan offered by the issuer a shared savings incentive payment for utilizing a shoppable health care service.

(E) "Shoppable health care service" means a health care service for which a health plan issuer offers a shared savings incentive payment under a shared savings incentive program.

Sec. 3966.02. (A) Except as provided in section 3966.06 of the Revised Code, a health plan issuer shall develop and

implement a shared savings incentive program for individuals covered under a health benefit plan offered by the issuer. The program shall provide incentive payments to insured individuals who elect to receive a shoppable health care service from a health care provider that charges less than the average price paid by the issuer for that health care service. Shoppable health care services shall include health care services in the following categories:

(1) Physical and occupational therapy services;

(2) Obstetrical and gynecological services;

(3) Radiology and imaging services;

(4) Laboratory services;

(5) Infusion therapy;

(6) Inpatient and outpatient surgical procedures;

(7) Outpatient nonsurgical diagnostic tests or procedures;

(8) Any other category determined by the superintendent of insurance.

(B)(1) A health plan issuer may calculate incentives offered under the program in any of the following manners:

(a) As the difference in price between the shoppable health care service and the average price paid by the issuer for that service;

(b) As a flat dollar amount;

(c) By any other reasonable methodology approved by the superintendent of insurance.

(2) The shared savings incentive program shall provide

insured individuals with at least fifty per cent of the issuer's saved costs for each shoppable health care service. An issuer is not required to provide a payment or credit to an insured individual if the issuer's saved costs is fifty dollars or less.

An insured individual may elect to have the health plan issuer apply the balance of any shared savings incentive payment due to the individual to offset the cost of any out-of-pocket expenses incurred by the individual under the health benefit plan. An incentive payment may be used as an offset in this manner during the three plan years immediately following the plan year during which the incentive payment is credited to the individual.

(C) A health plan issuer shall calculate the average price paid for a health care service based on the average amount paid by the issuer to a health care provider in this state for the service under the health benefit plan over a twelve-month period occurring not earlier than two calendar years before the calculation, adjusted for inflation using the price index for personal consumption expenditures by function: health, published by the United States bureau of labor statistics or its successor index. A health plan issuer annually shall recalculate the average price paid data. An issuer may use an alternative methodology for calculating the average price for a health care service if the methodology is approved by the superintendent.

(D) A health plan issuer shall issue any shared savings incentive payments due to an insured individual under this section without any action or request on the part of the insured individual. Each health plan issuer shall develop and maintain an internet-based system by which an insured individual can track the individual's current shared savings incentive payments

and incentive payment history.

Sec. 3966.03. A health plan issuer shall establish an interactive mechanism on its public web site that enables an insured individual to request and obtain from the issuer information on the average price paid by the issuer to a participating health care provider for a particular health care service, as calculated under division (C) of section 3966.02 of the Revised Code. The interactive mechanism shall allow an insured individual to compare costs among network providers.

Sec. 3966.04. A health plan issuer shall make its shared savings incentive program available under all health benefit plans offered in this state by the issuer. The issuer shall annually, at enrollment or renewal, provide to an insured individual notice about the availability of the program.

Sec. 3966.05. (A) Prior to offering a shared savings incentive program to an insured individual, a health plan issuer shall file a description of the program with the superintendent of insurance in the manner determined by the superintendent.

(B) The superintendent shall review a filing made by a health plan issuer pursuant to this section to ensure the program complies with the requirements of this chapter.

(C) Filings and any supporting documentation made under this section are confidential until the filing has been reviewed by the superintendent.

Sec. 3966.06. If an insured individual elects to receive a shoppable health care service from a health care provider that is out-of-network under the individual's health benefit plan, the health plan issuer shall provide to the individual, in a health savings account established by the issuer for the

individual, a shared savings incentive payment equal to fifty per cent of the savings to the issuer. The savings shall be calculated as the difference in price between the shoppable health care service and the average price paid by the issuer for that service, as described in section 3966.02 of the Revised Code. The insured individual may access the funds in the health savings account for use toward any cost sharing requirement specified for the service under the plan, as if the service was provided by an in-network provider or other medical services.

Sec. 3966.07. A shared savings incentive payment made by a health plan issuer to an insured individual under a shared savings incentive program is not an administrative expense of the issuer for rate development or rate filing purposes.

Sec. 3966.08. (A) Beginning in 2019 and annually thereafter, a health plan issuer shall file with the superintendent of insurance the following information from the most recent calendar year about its shared savings incentive program:

(1) The total number of shared savings incentive payments made by the issuer;

(2) The monetary total of all shared savings incentive payments made by the issuer;

(3) The total number of shared savings incentive payments made by the issuer for each category of shoppable health care services described in division (A) of section 3966.02 of the Revised Code;

(4) The average monetary total of shared savings incentive payments made by the issuer for each category of shoppable health care service described in division (A) of section 3966.02

of the Revised Code;

(5) The total savings achieved for all shoppable health care services as compared to the average prices for those services;

(6) The total number of insured individuals who participated in the program;

(7) The percentage of individuals insured by the issuer who participated in the program.

(B) Beginning in 2019 and annually thereafter, the superintendent shall submit an aggregate report for all health plan issuers filing information under division (A) of this section. The report shall be submitted to all of the following individuals and entities:

(1) The speaker of the house of representatives;

(2) The president of the senate;

(3) The ranking minority members of the house of representatives and the senate;

(4) The standing committees in the house of representatives and the senate having jurisdiction over health insurance matters.

Sec. 3966.09. The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement the provisions of this chapter.

Sec. 5164.65. In accordance with the definition of "health plan issuer" established under section 3962.01 of the Revised Code, the medicaid program shall comply with Chapter 3962. of the Revised Code as a health plan issuer.

Section 2. That existing section 5162.80 of the Revised Code is hereby repealed.

Section 3. Sections 3966.01 to 3966.09 of the Revised Code, as enacted by this act, shall take effect six months after the effective date of this act.