As Introduced

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H. B. No. 160

Representative Holmes

Cosponsors: Representatives Click, Gross, Jones, Lanese, Loychik, Riedel, Stein, McClain, Zeltwanger

A BILL

To enact sections 3962.01, 3962.011, 3962.02, 3962.03, 3962.04, 3962.05, 3962.06, 3962.07, 3962.08, 3962.09, 3962.10, 3962.11, 3962.111, 3962.12, 3962.13, 3962.14, 3962.15, 5162.801, and 5164.65 of the Revised Code regarding the provision of health care cost estimates.

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

Section 1. That sections 3962.01, 3962.011, 3962.02, 3962.03, 3962.04, 3962.05, 3962.06, 3962.07, 3962.08, 3962.09, 3962.10, 3962.11, 3962.111, 3962.12, 3962.13, 3962.14, 3962.15, 5162.801, and 5164.65 of the Revised Code be enacted to read as follows:

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) "CPT code" means the current procedural terminology code assigned to a health care product, service, or procedure

according to the CPT code set published by the American medical association.

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

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, except as provided in division (B) of this section, means any of the following:

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

(2) The point in time that a health care provider receives a prescription or order from another health care provider to provide the health care product, service, or procedure to a 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 health care provider to receive, on a walk-in basis, the health care product, service, or procedure.

(B)(1) If an event described in division (A) of this section occurs before nine a.m. on a particular business day, the time that the appointment is made for the health care product, service, or procedure may, instead, be considered to be nine a.m. that same business day.

(2) If an event described in division (A) of this section occurs after five p.m. on a particular business day or occurs on a day that is not a business day, the time that the appointment is made for the health care product, service, or procedure shall, instead, be considered to be nine a.m. on the next business day.

Sec. 3962.02. With respect to the manner in which this chapter is construed in relation to other provisions of the Revised Code, both of the following apply:

(A) This chapter prevails over section 5162.80 of the Revised Code, notwithstanding any conflicting provisions of that section.

(B) This chapter extends to the medicaid program as specified in section 5164.65 of the Revised Code.

Sec. 3962.03. (A) A health care provider is subject to the requirement of this section to provide a cost estimate for a health care product, service, or procedure according to the following schedule:

(1) On and after the effective date of this section, the requirement applies to each hospital that is a member of a multi-hospital network.

(2) On and after September 1, 2022, the requirement applies to each health care provider that is a member of a multi-hospital network and is not already subject to division (A)(1) of this section.

(3) On and after July 1, 2023, the requirement applies to each health care provider that is not already subject to division (A)(1) or (2) of this section.

(B) Before a health care provider may provide 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, except that the cost estimate requirement does not apply in any of the following cases:

(1) When a patient seeks emergency services, as defined in section 1753.28 of the Revised Code;

(2) When a health care provider believes that a delay in care associated with fulfilling the requirement could harm the patient;

(3) When a circumstance described in section 3962.08 of the Revised Code occurs.

(C) A health care provider may elect to provide the cost estimate in the manner described in section 3962.04 of the Revised Code or, if the patient is insured under a health benefit plan, may elect to have the patient's health plan issuer provide the cost estimate after the provider has transmitted information to the issuer in accordance with section 3962.05 of the Revised Code. The health care provider shall notify the patient or the patient's representative of the provider's decision regarding the party that will provide the cost estimate.

The provision of a cost estimate by a health care provider does not preclude a health plan issuer from also providing a cost estimate to a patient or the patient's representative.

(D) A patient or the patient's representative may decline to receive the cost estimate required by this section.

(E) 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.

(F) Nothing in this section prohibits a health care provider or health plan issuer from collecting payment from a patient or the patient's representative for an administered health care product, service, or procedure, regardless of whether the cost estimate required by this section is or is not received by the patient or the patient's representative before the product, service, or procedure is administered.

Sec. 3962.04. (A) Except as provided in division (B) of this section, when a cost estimate required under section 3962.03 of the Revised Code is provided by a health care provider, all of the following apply with respect to the information to be included:

(1) The cost estimate shall identify the total amount the health care provider will charge either of the following for each health care product, service, or procedure: (a) the patient, if the patient is paying out-of-pocket because the patient is not insured under a health benefit plan or because the patient chooses to pay out-of-pocket, or (b) the patient's health plan issuer, if the patient is insured under a health benefit plan and the issuer will be charged. The estimate shall identify any facility fees, professional fees, or other fees that are included in the amount that will be charged. The estimate shall be accompanied by a short description of the health care product, service, or procedure and the applicable CPT code or, if no CPT code exists or another identifier is more appropriate, another identifier typically used by health plan

issuers to process claims for that product, service, or procedure.

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

(a) A notation regarding whether the health care provider is in-network or out-of-network for the patient's health benefit plan;

(b) The amount the health care provider expects to receive from the health plan issuer for the health care product, service, or procedure based on the information the issuer gives to the provider under division (E)(3) of this section.

(3) The cost estimate shall identify the difference, if any, between the amount that will be charged and the amount that the patient or other party responsible for the patient's care will be required to pay to the health care provider for the health care product, service, or procedure.

(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 include all information specified in division (A) of this section associated with the health care product, service, or procedure.

(2) A hospital's responsibility to provide a comprehensive cost estimate applies in both of the following circumstances:

(a) When the health care product, service, or procedure is to be provided by the hospital or its employees;

(b) When the health care product, service, or procedure is to be provided by health care providers that are independent contractors of the hospital.

(3) A health care provider that 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)(2)(b) of this section.

(C) A cost estimate provided under this section shall be based on information provided at the time the appointment for a health care product, service, or procedure is made, as specified under any of the circumstances described in division (A) of section 3962.011 of the Revised Code. The cost 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 during or after the initial appointment. Only one cost estimate is required for each appointment that is made.

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

(D)(1) Except as provided in division (D)(2) or (3) of this section, a cost estimate provided under this section shall be provided in accordance with whichever of the following time

frames is applicable:

(a) If the patient is insured under a health benefit plan and division (D)(1)(c) of this section does not apply, the cost estimate shall be provided not later than twenty-four hours after the health care provider receives from the health plan issuer, pursuant to division (E)(3) of this section, the information the provider needs to generate the cost estimate.

(b) If the patient is not insured under a health benefit plan and division (D)(1)(c) of this section does not apply, the cost estimate 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 under any of the circumstances described in division (A) of section 3962.011 of the Revised Code.

(c) If the health care product, service, or procedure is to be provided less than three days after the time the appointment for the health care product, service, or procedure is made, as specified under any of the circumstances described in division (A) of section 3962.011 of the Revised Code, the cost estimate shall be provided at the time the patient presents to receive the product, service, or procedure.

(2) In the case of a health care product, service, or procedure that is to be provided by one or more independent contractors of a health care provider, a cost estimate provided under this section shall be provided in accordance with whichever of the following time frames is applicable:

(a) If the patient is insured under a health benefit plan and division (D)(2)(c) of this section does not apply, the cost estimate shall be provided not later than thirty-six hours after

the health care provider receives from the health plan issuer, pursuant to division (E)(3) of this section, the information the provider needs to generate the cost estimate.

(b) If the patient is not insured under a health benefit plan and division (D)(2)(c) of this section does not apply, the cost estimate shall be provided not later than thirty-six hours after the time the appointment for the health care product, service, or procedure is made, as specified under any of the circumstances described in division (A) of section 3962.011 of the Revised Code.

(c) If the health care product, service, or procedure is to be provided less than three days after the time the appointment for the product, service, or procedure is made, as specified under any of the circumstances described in division (A) of section 3962.011 of the Revised Code, the cost estimate shall be provided at the time the patient presents to receive the product, service, or procedure.

(3) A health care 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 health care provider shall mail the cost estimate in accordance with the applicable time frame specified in division (D)(1) or (2) of this section.

(E) In the case of a patient who is insured under a health benefit plan, all of the following apply with respect to the transmission of information between a health care provider and a health plan issuer:

(1) Not later than twenty-four hours after the time an

appointment for a health care product, service, or procedure is made, as specified under any of the circumstances described in division (A) of section 3962.011 of the Revised Code, a health care provider shall transmit to the patient's health plan issuer 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 health care provider's identification number;

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

(f) Notification that the health care provider is providing the cost estimate to the patient or the patient's representative;

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

(2) In the case of a health care product, service, or procedure that will be provided pursuant to a prescription or order from another health care provider, the health care provider that 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, not later than twenty-four hours after the office or facility reopens.

(3) After a health care provider transmits information under division (E)(1) or (2) of this section to a health plan issuer, the issuer shall give the provider all information the provider needs to generate a cost estimate. The health plan issuer shall give the needed information in accordance with whichever of the following time frames is applicable:

(a) If the health care provider transmitted information to the health plan issuer electronically through a provider portal or similar electronic means, the issuer shall give the provider the needed information not later than five minutes after receiving the provider's transmission.

(b) During the period beginning on the effective date of this section and ending September 1, 2022, if the health care provider transmitted information to the health plan issuer through a means other than those described in division (E)(3)(a) of this section, the issuer shall give the provider the needed information not later than twenty-four hours after receiving the provider's transmission. During this period, however, if a health care provider transmits the information to a health plan issuer less than seventy-two hours before the health care product, service, or procedure is to be delivered, a cost estimate is not required to be provided.

(4) If a health plan issuer does not provide information to a health care provider in accordance with division (E)(3) of this section, the health care provider shall notify the patient. The health care provider shall note in the portion of the cost estimate pertaining to the information specified in divisions (A)(2) and (3) of this section that the health plan issuer

information was not provided as required by law. In this case, the health care provider shall include in the cost estimate the the information specified in division (A)(1) of this section and may include the information specified in division (A)(2)(a) of this section as well as the amount to be paid to the provider for the product, service, or procedure as specified in the contract entered into by the provider and issuer or, if a government pay scale applies instead of a contracted amount, the amount specified in the applicable government pay scale. If the information necessary to complete the estimate is subsequently received and an updated estimate can be provided within the applicable time frame established by division (D) of this section, the health care provider shall provide the updated estimate.

(F)(1) In addition to the other information that must be included in a cost estimate provided under this section, the cost estimate shall contain a disclaimer that both of the following are the case:

(a) The information is only an estimate based on facts available at the time the cost estimate 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 factors.

(b) The information does not take into account secondary or other insurance the patient possesses, which may affect the patient's out-of-pocket responsibility.

(2) A health care provider has discretion in how the disclaimer described in division (F)(1) of this section is expressed.

(G)(1) Except as provided in division (G)(2) of this section, if the amount described in division (A)(3) of this section changes by more than ten per cent before the patient initially presents to receive the health care product, service, or procedure, the health care provider shall provide to the patient an updated cost estimate within the applicable time frame established by division (D) of this section.

(2) Division (G)(1) of this section does not apply if a patient is insured under a health benefit plan and the patient's health plan issuer fails to transmit to the health care provider the information that is needed for the provider to generate the updated estimate.

(H) A cost estimate provided under this section may be given verbally or in electronic or written form and shall be presented in a manner that is easy to understand. If the cost estimate is given in electronic or written form, all of the following apply with respect to its format:

(1) The contents of the cost estimate shall be presented in large font.

(2) Unless the cost estimate contains more than nine CPT codes or other identifiers, the length of the cost estimate shall not exceed one page.

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

Sec. 3962.05. (A)(1) If a health care provider elects to have a patient's health plan issuer provide the cost estimate required by section 3962.03 of the Revised Code in lieu of the cost estimate being provided to the patient or the patient's

representative by the health care provider, the health care provider shall transmit all of the following to the health plan issuer:

(a) Notification that the health care provider is electing to have the health plan issuer provide the cost estimate to the patient or the patient's representative;

(b) The patient's name;

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

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

(e) The health care provider's identification number;

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

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

(2) During the period beginning on the effective date of this section and ending immediately before September 1, 2022, the health care provider may transmit the information described in division (A)(1) of this section by any means, including by facsimile or telephone. On and after September 1, 2022, the health care provider shall notify the health plan issuer of the election and, except as provided in division (C) of this section, transmit the information through the issuer's portal described in section 1751.72, 3923.041, or 5160.34 of the

Revised Code or a similar electronic means, including any electronic communication that enables the health plan issuer to electronically gather and process the required information.

(3)(a) Except as provided in division (A)(3)(b) of this section, the transmission of the information 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 under any of the circumstances described in division (A) of section 3962.011 of the Revised Code.

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

(B) Not later than September 1, 2022, each health plan issuer shall modify its portal as necessary to do both of the following:

(1) Accommodate the transmission of information from health care providers under this section;

(2) Allow a copy of the information to be transmitted directly to the patient to whom the information pertains.

(C) If a health care provider is unable to transmit information through a health plan issuer's portal due to the lack of an internet connection, the provider may transmit the information to the issuer by facsimile or telephone within the applicable time frame specified in division (A)(3) of this section.

Sec. 3962.06. (A) When a health care provider elects to have a patient's health plan issuer provide the cost estimate required by section 3962.03 of the Revised Code in lieu of the cost estimate being provided to the patient or the patient's representative by the health care provider, the health plan issuer shall provide to the patient or the patient's representative 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. The cost estimate shall be provided not later than forty-eight hours after the health plan issuer receives the information transmitted under section 3962.05 of the Revised Code.

(B)(1) When an individual enrolls in a health benefit plan offered by a health plan issuer, the issuer shall ask the individual or the individual's representative whether the individual would prefer to receive cost estimates by electronic mail or other electronic means or by regular mail. Except in the circumstances described in division (B)(2) of this section, the health plan issuer shall send cost estimates to the individual by the means elected.

(2) If a health care product, service, or procedure will be provided less than three days from the time a cost estimate is generated, the health plan issuer shall send the cost estimate by electronic means unless the health plan issuer has no method of sending the estimate electronically. If there is no method of sending the estimate electronically, the health plan issuer is not required to provide a cost estimate to the patient.

(3) A health plan issuer shall be held harmless in any claim that a cost estimate was not received if the electronic mail address of the patient or the patient's representative on file with the health plan issuer is incorrect, invalid, or no longer used.

(C) A cost estimate provided under this section shall be based on information provided at the time the appointment for a health care product, service, or procedure is made, as specified under any of the circumstances described in division (A) of section 3962.011 of the Revised Code. The cost 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 during or after the initial appointment. Only one cost estimate is required for each appointment made.

If particular information is not readily available at the time the appointment is made, such as information regarding the health care provider that will be providing the health care product, service, or procedure, the health care provider's transmission of information to the health plan issuer under section 3962.05 of the Revised Code may include a notification that a health care provider is unknown. In this case, the health plan issuer may base the cost estimate provided under this section on an average estimated charge submitted to the health plan issuer for the health care product, service, or procedure at that facility or location.

If a health care provider does not transmit to the health plan issuer the information necessary to generate the cost estimate, the health plan issuer shall, on and after September 1, 2022, send to the patient or the patient's representative, by

the same means used to send cost estimates, a notice that the health care 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 that a health care provider gives the health plan issuer any indication that receipt of a health care product, service, or procedure is scheduled on a specific date.

(D) In addition to the other information that must included in a cost estimate provided under this section, both of the following apply:

(1) The cost estimate shall contain a disclaimer that the information is only an estimate based on facts available at the time the cost estimate 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 factors. The health plan issuer has discretion in how the disclaimer is expressed.

(2) If applicable, the cost estimate shall include a notation that a particular health care provider is out-of-network for the patient's health benefit plan.

(E)(1) Except as provided in division (E)(2) of this section, if the amount in a cost estimate provided under this section changes by more than ten per cent before the patient initially presents to receive the health care product, service, or procedure, the health plan issuer shall provide to the patient an updated estimate by the means the patient or the patient's representative has elected under division (B)(1) of this section and within the time frame specified in division (A) of this section.

(2) Division (E)(1) of this section does not apply if there are less than three days from the time of the change in the cost estimate and the time that the health care product, service, or procedure is to be provided and the health plan issuer has no method of sending the updated estimate through electronic means. If the health plan issuer does have electronic means by which to send the updated estimate, the issuer shall use that means.

(F) With respect to the format of a cost estimate provided under this section, all of the following apply:

(1) The contents of the cost estimate shall be presented in large font and in a manner that is easy to understand.

(2) Unless the cost estimate contains more than nine CPT codes or other identifiers, the length of the cost estimate shall not exceed one page.

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

Sec. 3962.07. (A) Regardless of whether the cost estimate required by section 3962.03 of the Revised Code is provided 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, the health care provider shall give to a 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. Except as provided in division (B)(4) of this section, the health care provider also shall give to the patient or the patient's representative the charge information specified in division (A)

(1) of section 3962.04 of the Revised Code associated with each code or other identifier.

(B) A health care provider has the following options for fulfilling the requirement of division (A) of this section:

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

(2) The health care provider may send the 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 under any of the circumstances described in division (A) of section 3962.011 of the Revised Code.

(3) The health care provider may give the information to the patient or the patient's representative at the time the health care product, service, or procedure is provided if there are less than three days from the time the cost estimate is generated and the time the product, service, or procedure is to be provided, but only if the provider has no method of sending the estimate through electronic means.

(4) In lieu of giving the patient or the patient's representative the charge information specified in division (A)(1) of section 3962.04 of the Revised Code, the health care provider may provide to the patient or the patient's representative an internet web site address where the patient or the patient's representative may enter each CPT code or other identifier and retrieve the charge information. If this option is elected and the health care provider transmits the CPT 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. Not later than September 1, 2022, each health plan issuer shall ensure that its portal is able to generate such an electronic mail message.

(C) Regardless of the option elected under division (B) of this section, a health care provider shall provide the information in a manner that complies with all applicable state and federal laws pertaining to the privacy of patient-identifying information.

(D)(1) Except as provided in division (D)(2) of this section, a health care provider shall give the CPT codes or other identifiers and charge information to the patient or the patient's representative in accordance with whichever of the following time frames is applicable:

(a) Not later than twenty-four hours after the time the appointment for the health care product, service, or procedure is made, as specified under any of the circumstances described in division (A) of section 3962.011 of the Revised Code;

(b) If the health care product, service, or procedure is to be provided less than twenty-four hours after the appointment is made, as specified under any of the circumstances described in division (A) of 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

health care provider, the CPT codes or other identifiers and charge information shall be given to the patient or the patient's representative under any of the options described in division (B) of this section and in accordance with whichever of the following time frames is applicable:

(a) Not later than thirty-six hours after the time the appointment for the health care product, service, or procedure is made, as specified under any of the circumstances described in division (A) of section 3962.011 of the Revised Code;

(b) If the health care 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 under any of the circumstances described in division (A) of 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) Sections 3962.03 to 3962.07 of the Revised Code do not apply in any of the following circumstances:

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

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

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

(C)(1) For purposes of fulfilling the cost estimate requirement of section 3962.03 of the Revised Code with respect to the charge for an office visit, a general designation for an unknown level of office visit may be used if the charge for the office visit will be in addition to a charge for a health care product, service, or procedure and either of the following is the case:

(a) A patient schedules an appointment for a health care product, service, or procedure or presents to receive a product, service, or procedure, but the health care provider is unable to determine at that point the level of office visit that will be provided.

(b) A patient seeks care from the health care provider without an appointment and without a prescription or order from another health care provider.

(2) If a general designation for an unknown level of office visit is used pursuant to division (C)(1) of this section, the cost estimate provided to the patient by the health care provider under section 3962.04 of the Revised Code or by the health plan issuer under section 3926.06 of the Revised Code shall list the price range for all levels of office visits.

Sec. 3962.09. (A) If 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 without fulfilling the cost estimate requirement.

(B) After a health care product, service, or procedure is provided as described in division (A) of this section, the health care provider shall submit to the board or other agency that licenses the provider or otherwise regulates the provider's profession or business a report detailing why the provider believed that a delay in care associated with fulfilling the cost estimate requirement could harm the patient. The report shall be submitted in the form and manner prescribed by the board or agency.

(C) Annually, each board or other agency that receives reports under division (B) of this section 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. 3962.10. 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)(1) After completing an examination in accordance with the time frames specified in section 3962.111 of the Revised Code, if the superintendent of insurance, department of health, department of medicaid, or appropriate regulatory board, as the case may be, 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 health plan issuer or health care provider over which the superintendent, department, or board has jurisdiction any of the administrative remedies specified in division (B) of this section.

(2) Before imposing an administrative remedy as described in division (A)(1) of this section, the superintendent, department, or board shall give written notice to the health plan issuer or health care provider informing the issuer or provider 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 fine 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) For purposes of levying a fine under division (B)(1) of this section, each finding described in division (A)(1)

of this section constitutes a single offense.

(2) The amount of the fine to be levied shall be determined in accordance with whichever of the following is applicable:

(a) For a first offense, the superintendent of insurance, department of health, or department of medicaid 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.

(b) 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.

(c) 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 the fine to be levied within the limits specified in division (C)(2) of this section, the superintendent, department, or board shall consider all of 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) Whether 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 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. 3962.111. For purposes of division (A) of section 3962.11 of the Revised Code, all of the following time frames apply:

(A) An examination of a health plan issuer may occur on and after May 1, 2023.

(B) An examination of a health care provider may occur in accordance with whichever of the following is applicable:

(1) On and after May 1, 2023, in the case of a health care provider described in division (A)(1) of section 3962.03 of the Revised Code;

(2) On and after September 1, 2023, in the case of a health care provider described in division (A)(2) of section 3962.03 of the Revised Code;

(3) On and after June 1, 2024, in the case of a health care provider described in division (A)(3) of section 3962.03 of the Revised Code.

Sec. 3962.12. All of the following are invalid and

unenforceable:

(A) Any contract clause that 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 any clause that prohibits providing a patient with cost and quality information regarding alternative providers when the patient demonstrates an intention to seek care from a particular provider;

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

(C) Any contract clause that restricts patient access to quality or cost information that is made available 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 individual who was a member of the general assembly on the date of final legislative action resulting in enactment of this section may intervene in litigation that challenges all or part of this chapter or section 5164.65 of the Revised Code.

Sec. 3962.15. In enacting sections 3962.01 to 3962.14 of the Revised Code, it is the intent of the general assembly 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 costs incurred under the medicaid program.

Sec. 5162.801. Any member of the general assembly may intervene in litigation that challenges all or part of section 5162.80 of the Revised Code.

Sec. 5164.65. On and after April 1, 2024, the medicaid program shall comply with Chapter 3962. of the Revised Code as if it were a health plan issuer subject to that chapter. This requirement extends to all health care providers, as defined in section 3962.01 of the Revised Code, that are medicaid providers or that otherwise seek payment through the medicaid program or medicaid managed care organizations for providing health care products, services, or procedures to medicaid recipients.