

As Introduced

**134th General Assembly
Regular Session
2021-2022**

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, 1
3962.03, 3962.04, 3962.05, 3962.06, 3962.07, 2
3962.08, 3962.09, 3962.10, 3962.11, 3962.111, 3
3962.12, 3962.13, 3962.14, 3962.15, 5162.801, 4
and 5164.65 of the Revised Code regarding the 5
provision of health care cost estimates. 6

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

Section 1. That sections 3962.01, 3962.011, 3962.02, 7
3962.03, 3962.04, 3962.05, 3962.06, 3962.07, 3962.08, 3962.09, 8
3962.10, 3962.11, 3962.111, 3962.12, 3962.13, 3962.14, 3962.15, 9
5162.801, and 5164.65 of the Revised Code be enacted to read as 10
follows: 11

Sec. 3962.01. As used in this chapter: 12

(A) "Business day" means each day of the week except 13
Saturday, Sunday, or a legal holiday, as defined in section 1.14 14
of the Revised Code. 15

(B) "CPT code" means the current procedural terminology 16
code assigned to a health care product, service, or procedure 17

according to the CPT code set published by the American medical 18
association. 19

(C) "Health benefit plan" and "health plan issuer" have 20
the same meanings as in section 3922.01 of the Revised Code. 21

(D) "Health care provider" means an individual or facility 22
licensed, certified, or accredited under or pursuant to Chapter 23
3721., 3727., 4715., 4725., 4731., 4732., 4734., 4747., 4753., 24
4755., 4757., or 4779. of the Revised Code. 25

Sec. 3962.011. (A) For purposes of this chapter, a 26
reference to the time that an appointment for a health care 27
product, service, or procedure is made, except as provided in 28
division (B) of this section, means any of the following: 29

(1) The point in time that the appointment is made for the 30
health care product, service, or procedure; 31

(2) The point in time that a health care provider receives 32
a prescription or order from another health care provider to 33
provide the health care product, service, or procedure to a 34
patient; 35

(3) The point in time that a patient, pursuant to a 36
prescription or order from the patient's health care provider, 37
presents at the office or facilities of another health care 38
provider to receive, on a walk-in basis, the health care 39
product, service, or procedure. 40

(B) (1) If an event described in division (A) of this 41
section occurs before nine a.m. on a particular business day, 42
the time that the appointment is made for the health care 43
product, service, or procedure may, instead, be considered to be 44
nine a.m. that same business day. 45

(2) If an event described in division (A) of this section 46
occurs after five p.m. on a particular business day or occurs on 47
a day that is not a business day, the time that the appointment 48
is made for the health care product, service, or procedure 49
shall, instead, be considered to be nine a.m. on the next 50
business day. 51

Sec. 3962.02. With respect to the manner in which this 52
chapter is construed in relation to other provisions of the 53
Revised Code, both of the following apply: 54

(A) This chapter prevails over section 5162.80 of the 55
Revised Code, notwithstanding any conflicting provisions of that 56
section. 57

(B) This chapter extends to the medicaid program as 58
specified in section 5164.65 of the Revised Code. 59

Sec. 3962.03. (A) A health care provider is subject to the 60
requirement of this section to provide a cost estimate for a 61
health care product, service, or procedure according to the 62
following schedule: 63

(1) On and after the effective date of this section, the 64
requirement applies to each hospital that is a member of a 65
multi-hospital network. 66

(2) On and after September 1, 2022, the requirement 67
applies to each health care provider that is a member of a 68
multi-hospital network and is not already subject to division 69
(A)(1) of this section. 70

(3) On and after July 1, 2023, the requirement applies to 71
each health care provider that is not already subject to 72
division (A)(1) or (2) of this section. 73

(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: 74
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(1) When a patient seeks emergency services, as defined in section 1753.28 of the Revised Code; 80
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(2) When a health care provider believes that a delay in care associated with fulfilling the requirement could harm the patient; 82
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(3) When a circumstance described in section 3962.08 of the Revised Code occurs. 85
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(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. 87
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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. 97
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(D) A patient or the patient's representative may decline to receive the cost estimate required by this section. 100
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(E) Each health care provider or health plan issuer that 102

provides a cost estimate shall ensure that the estimate is 103
provided in a manner that complies with all applicable state and 104
federal laws pertaining to the privacy of patient-identifying 105
information. 106

(F) Nothing in this section prohibits a health care 107
provider or health plan issuer from collecting payment from a 108
patient or the patient's representative for an administered 109
health care product, service, or procedure, regardless of 110
whether the cost estimate required by this section is or is not 111
received by the patient or the patient's representative before 112
the product, service, or procedure is administered. 113

Sec. 3962.04. (A) Except as provided in division (B) of 114
this section, when a cost estimate required under section 115
3962.03 of the Revised Code is provided by a health care 116
provider, all of the following apply with respect to the 117
information to be included: 118

(1) The cost estimate shall identify the total amount the 119
health care provider will charge either of the following for 120
each health care product, service, or procedure: (a) the 121
patient, if the patient is paying out-of-pocket because the 122
patient is not insured under a health benefit plan or because 123
the patient chooses to pay out-of-pocket, or (b) the patient's 124
health plan issuer, if the patient is insured under a health 125
benefit plan and the issuer will be charged. The estimate shall 126
identify any facility fees, professional fees, or other fees 127
that are included in the amount that will be charged. The 128
estimate shall be accompanied by a short description of the 129
health care product, service, or procedure and the applicable 130
CPT code or, if no CPT code exists or another identifier is more 131
appropriate, another identifier typically used by health plan 132

issuers to process claims for that product, service, or 133
procedure. 134

(2) If the patient is insured under a health benefit plan, 135
the cost estimate shall include both of the following: 136

(a) A notation regarding whether the health care provider 137
is in-network or out-of-network for the patient's health benefit 138
plan; 139

(b) The amount the health care provider expects to receive 140
from the health plan issuer for the health care product, 141
service, or procedure based on the information the issuer gives 142
to the provider under division (E) (3) of this section. 143

(3) The cost estimate shall identify the difference, if 144
any, between the amount that will be charged and the amount that 145
the patient or other party responsible for the patient's care 146
will be required to pay to the health care provider for the 147
health care product, service, or procedure. 148

(B) (1) If a patient is to receive a health care product, 149
service, or procedure in a hospital, the hospital is responsible 150
for providing one comprehensive cost estimate to the patient or 151
the patient's representative within the applicable time frame 152
specified in division (D) of this section. The comprehensive 153
cost estimate shall include all information specified in 154
division (A) of this section associated with the health care 155
product, service, or procedure. 156

(2) A hospital's responsibility to provide a comprehensive 157
cost estimate applies in both of the following circumstances: 158

(a) When the health care product, service, or procedure is 159
to be provided by the hospital or its employees; 160

(b) When the health care product, service, or procedure is 161
to be provided by health care providers that are independent 162
contractors of the hospital. 163

(3) A health care provider that is an independent 164
contractor of a hospital shall submit to the hospital all CPT 165
codes or other identifiers the hospital needs to fulfill its 166
responsibility under division (B) (2) (b) of this section. 167

(C) A cost estimate provided under this section shall be 168
based on information provided at the time the appointment for a 169
health care product, service, or procedure is made, as specified 170
under any of the circumstances described in division (A) of 171
section 3962.011 of the Revised Code. The cost estimate need not 172
take into account any information that subsequently arises, such 173
as unknown, unanticipated, or subsequently needed health care 174
products, services, or procedures provided for any reason during 175
or after the initial appointment. Only one cost estimate is 176
required for each appointment that is made. 177

If particular information is not readily available at the 178
time the appointment is made, such as information regarding the 179
health care provider that will be providing the health care 180
product, service, or procedure, the health care provider may 181
base the cost estimate information specified in division (A) (1) 182
of this section on either an average estimated charge that is 183
submitted to the patient's health plan issuer for the product, 184
service, or procedure or the average out-of-pocket price that is 185
paid for the product, service, or procedure by patients who are 186
not insured under a health benefit plan. 187

(D) (1) Except as provided in division (D) (2) or (3) of 188
this section, a cost estimate provided under this section shall 189
be provided in accordance with whichever of the following time 190

frames is applicable: 191

(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. 192
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(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. 198
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(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. 205
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(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: 212
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(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 217
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the health care provider receives from the health plan issuer, 220
pursuant to division (E) (3) of this section, the information the 221
provider needs to generate the cost estimate. 222

(b) If the patient is not insured under a health benefit 223
plan and division (D) (2) (c) of this section does not apply, the 224
cost estimate shall be provided not later than thirty-six hours 225
after the time the appointment for the health care product, 226
service, or procedure is made, as specified under any of the 227
circumstances described in division (A) of section 3962.011 of 228
the Revised Code. 229

(c) If the health care product, service, or procedure is 230
to be provided less than three days after the time the 231
appointment for the product, service, or procedure is made, as 232
specified under any of the circumstances described in division 233
(A) of section 3962.011 of the Revised Code, the cost estimate 234
shall be provided at the time the patient presents to receive 235
the product, service, or procedure. 236

(3) A health care provider may elect to send the cost 237
estimate to the patient or the patient's representative by 238
regular mail if the health care product, service, or procedure 239
will be provided more than three days from the time the estimate 240
is generated. If this election is made, the health care provider 241
shall mail the cost estimate in accordance with the applicable 242
time frame specified in division (D) (1) or (2) of this section. 243

(E) In the case of a patient who is insured under a health 244
benefit plan, all of the following apply with respect to the 245
transmission of information between a health care provider and a 246
health plan issuer: 247

(1) Not later than twenty-four hours after the time an 248

appointment for a health care product, service, or procedure is 249
made, as specified under any of the circumstances described in 250
division (A) of section 3962.011 of the Revised Code, a health 251
care provider shall transmit to the patient's health plan issuer 252
all of the following: 253

(a) The patient's name; 254

(b) The patient's identification number, if one has been 255
assigned; 256

(c) The CPT code or other identifier the health plan 257
issuer requires for each health care product, service, or 258
procedure the patient is to receive; 259

(d) The health care provider's identification number; 260

(e) The charge for each product, service, or procedure the 261
patient has scheduled that will be delivered by a health care 262
provider that is out-of-network for the patient's health benefit 263
plan; 264

(f) Notification that the health care provider is 265
providing the cost estimate to the patient or the patient's 266
representative; 267

(g) Any other information the health plan issuer requires 268
from the health care provider. 269

(2) In the case of a health care product, service, or 270
procedure that will be provided pursuant to a prescription or 271
order from another health care provider, the health care 272
provider that received the prescription or order shall transmit 273
the information specified in division (E)(1) of this section to 274
the patient's health plan issuer not later than twenty-four 275
hours after receiving the prescription or order or, if received 276

when the provider's office or facility is closed, not later than 277
twenty-four hours after the office or facility reopens. 278

(3) After a health care provider transmits information 279
under division (E)(1) or (2) of this section to a health plan 280
issuer, the issuer shall give the provider all information the 281
provider needs to generate a cost estimate. The health plan 282
issuer shall give the needed information in accordance with 283
whichever of the following time frames is applicable: 284

(a) If the health care provider transmitted information to 285
the health plan issuer electronically through a provider portal 286
or similar electronic means, the issuer shall give the provider 287
the needed information not later than five minutes after 288
receiving the provider's transmission. 289

(b) During the period beginning on the effective date of 290
this section and ending September 1, 2022, if the health care 291
provider transmitted information to the health plan issuer 292
through a means other than those described in division (E)(3)(a) 293
of this section, the issuer shall give the provider the needed 294
information not later than twenty-four hours after receiving the 295
provider's transmission. During this period, however, if a 296
health care provider transmits the information to a health plan 297
issuer less than seventy-two hours before the health care 298
product, service, or procedure is to be delivered, a cost 299
estimate is not required to be provided. 300

(4) If a health plan issuer does not provide information 301
to a health care provider in accordance with division (E)(3) of 302
this section, the health care provider shall notify the patient. 303
The health care provider shall note in the portion of the cost 304
estimate pertaining to the information specified in divisions 305
(A)(2) and (3) of this section that the health plan issuer 306

information was not provided as required by law. In this case, 307
the health care provider shall include in the cost estimate the 308
the information specified in division (A) (1) of this section and 309
may include the information specified in division (A) (2) (a) of 310
this section as well as the amount to be paid to the provider 311
for the product, service, or procedure as specified in the 312
contract entered into by the provider and issuer or, if a 313
government pay scale applies instead of a contracted amount, the 314
amount specified in the applicable government pay scale. If the 315
information necessary to complete the estimate is subsequently 316
received and an updated estimate can be provided within the 317
applicable time frame established by division (D) of this 318
section, the health care provider shall provide the updated 319
estimate. 320

(F) (1) In addition to the other information that must be 321
included in a cost estimate provided under this section, the 322
cost estimate shall contain a disclaimer that both of the 323
following are the case: 324

(a) The information is only an estimate based on facts 325
available at the time the cost estimate was prepared and that 326
the amounts estimated could change as a result of unknown, 327
unanticipated, or subsequently needed health care products, 328
services, or procedures; changes to the patient's health benefit 329
plan; or other factors. 330

(b) The information does not take into account secondary 331
or other insurance the patient possesses, which may affect the 332
patient's out-of-pocket responsibility. 333

(2) A health care provider has discretion in how the 334
disclaimer described in division (F) (1) of this section is 335
expressed. 336

(G) (1) Except as provided in division (G) (2) of this 337
section, if the amount described in division (A) (3) of this 338
section changes by more than ten per cent before the patient 339
initially presents to receive the health care product, service, 340
or procedure, the health care provider shall provide to the 341
patient an updated cost estimate within the applicable time 342
frame established by division (D) of this section. 343

(2) Division (G) (1) of this section does not apply if a 344
patient is insured under a health benefit plan and the patient's 345
health plan issuer fails to transmit to the health care provider 346
the information that is needed for the provider to generate the 347
updated estimate. 348

(H) A cost estimate provided under this section may be 349
given verbally or in electronic or written form and shall be 350
presented in a manner that is easy to understand. If the cost 351
estimate is given in electronic or written form, all of the 352
following apply with respect to its format: 353

(1) The contents of the cost estimate shall be presented 354
in large font. 355

(2) Unless the cost estimate contains more than nine CPT 356
codes or other identifiers, the length of the cost estimate 357
shall not exceed one page. 358

(3) The subject line of the communication containing the 359
cost estimate shall state "Your Ohio Healthcare Price 360
Transparency Estimate." 361

Sec. 3962.05. (A) (1) If a health care provider elects to 362
have a patient's health plan issuer provide the cost estimate 363
required by section 3962.03 of the Revised Code in lieu of the 364
cost estimate being provided to the patient or the patient's 365

representative by the health care provider, the health care 366
provider shall transmit all of the following to the health plan 367
issuer: 368

(a) Notification that the health care provider is electing 369
to have the health plan issuer provide the cost estimate to the 370
patient or the patient's representative; 371

(b) The patient's name; 372

(c) The patient's identification number, if one has been 373
assigned; 374

(d) The CPT code or other identifier the health plan 375
issuer requires for each health care product, service, or 376
procedure the patient is to receive; 377

(e) The health care provider's identification number; 378

(f) The charge for each health care product, service, or 379
procedure the patient has scheduled that will be delivered by a 380
health care provider that is out-of-network for the patient's 381
health benefit plan; 382

(g) Any other information the health plan issuer requires 383
from the health care provider. 384

(2) During the period beginning on the effective date of 385
this section and ending immediately before September 1, 2022, 386
the health care provider may transmit the information described 387
in division (A) (1) of this section by any means, including by 388
facsimile or telephone. On and after September 1, 2022, the 389
health care provider shall notify the health plan issuer of the 390
election and, except as provided in division (C) of this 391
section, transmit the information through the issuer's portal 392
described in section 1751.72, 3923.041, or 5160.34 of the 393

Revised Code or a similar electronic means, including any 394
electronic communication that enables the health plan issuer to 395
electronically gather and process the required information. 396

(3)(a) Except as provided in division (A)(3)(b) of this 397
section, the transmission of the information shall occur not 398
later than twenty-four hours after the time the appointment for 399
the health care product, service, or procedure is made, as 400
specified under any of the circumstances described in division 401
(A) of section 3962.011 of the Revised Code. 402

(b) If the health care product, service, or procedure is 403
to be provided by one or more independent contractors of the 404
provider, the transmission of the information shall occur not 405
later than thirty-six hours after the time the appointment for 406
the product, service, or procedure is made, as specified under 407
any of the circumstances described in division (A) of section 408
3962.011 of the Revised Code. 409

(B) Not later than September 1, 2022, each health plan 410
issuer shall modify its portal as necessary to do both of the 411
following: 412

(1) Accommodate the transmission of information from 413
health care providers under this section; 414

(2) Allow a copy of the information to be transmitted 415
directly to the patient to whom the information pertains. 416

(C) If a health care provider is unable to transmit 417
information through a health plan issuer's portal due to the 418
lack of an internet connection, the provider may transmit the 419
information to the issuer by facsimile or telephone within the 420
applicable time frame specified in division (A)(3) of this 421
section. 422

Sec. 3962.06. (A) When a health care provider elects to 423
have a patient's health plan issuer provide the cost estimate 424
required by section 3962.03 of the Revised Code in lieu of the 425
cost estimate being provided to the patient or the patient's 426
representative by the health care provider, the health plan 427
issuer shall provide to the patient or the patient's 428
representative the information specified in divisions (A)(1) to 429
(3) of section 3962.04 of the Revised Code, as well as the 430
average rate the health plan issuer reimburses in-network 431
providers for the same health care product, service, or 432
procedure. The cost estimate shall be provided not later than 433
forty-eight hours after the health plan issuer receives the 434
information transmitted under section 3962.05 of the Revised 435
Code. 436

(B)(1) When an individual enrolls in a health benefit plan 437
offered by a health plan issuer, the issuer shall ask the 438
individual or the individual's representative whether the 439
individual would prefer to receive cost estimates by electronic 440
mail or other electronic means or by regular mail. Except in the 441
circumstances described in division (B)(2) of this section, the 442
health plan issuer shall send cost estimates to the individual 443
by the means elected. 444

(2) If a health care product, service, or procedure will 445
be provided less than three days from the time a cost estimate 446
is generated, the health plan issuer shall send the cost 447
estimate by electronic means unless the health plan issuer has 448
no method of sending the estimate electronically. If there is no 449
method of sending the estimate electronically, the health plan 450
issuer is not required to provide a cost estimate to the 451
patient. 452

(3) A health plan issuer shall be held harmless in any 453
claim that a cost estimate was not received if the electronic 454
mail address of the patient or the patient's representative on 455
file with the health plan issuer is incorrect, invalid, or no 456
longer used. 457

(C) A cost estimate provided under this section shall be 458
based on information provided at the time the appointment for a 459
health care product, service, or procedure is made, as specified 460
under any of the circumstances described in division (A) of 461
section 3962.011 of the Revised Code. The cost estimate need not 462
take into account any information that subsequently arises, such 463
as unknown, unanticipated, or subsequently needed health care 464
products, services, or procedures provided for any reason during 465
or after the initial appointment. Only one cost estimate is 466
required for each appointment made. 467

If particular information is not readily available at the 468
time the appointment is made, such as information regarding the 469
health care provider that will be providing the health care 470
product, service, or procedure, the health care provider's 471
transmission of information to the health plan issuer under 472
section 3962.05 of the Revised Code may include a notification 473
that a health care provider is unknown. In this case, the health 474
plan issuer may base the cost estimate provided under this 475
section on an average estimated charge submitted to the health 476
plan issuer for the health care product, service, or procedure 477
at that facility or location. 478

If a health care provider does not transmit to the health 479
plan issuer the information necessary to generate the cost 480
estimate, the health plan issuer shall, on and after September 481
1, 2022, send to the patient or the patient's representative, by 482

the same means used to send cost estimates, a notice that the 483
health care provider failed to transmit the necessary 484
information as required by law and, consequently, a cost 485
estimate could not be generated. This action shall be taken in 486
the event that a health care provider gives the health plan 487
issuer any indication that receipt of a health care product, 488
service, or procedure is scheduled on a specific date. 489

(D) In addition to the other information that must 490
included in a cost estimate provided under this section, both of 491
the following apply: 492

(1) The cost estimate shall contain a disclaimer that the 493
information is only an estimate based on facts available at the 494
time the cost estimate was prepared and that the amounts 495
estimated could change as a result of unknown, unanticipated, or 496
subsequently needed health care products, services, or 497
procedures; changes to the patient's health benefit plan; or 498
other factors. The health plan issuer has discretion in how the 499
disclaimer is expressed. 500

(2) If applicable, the cost estimate shall include a 501
notation that a particular health care provider is out-of- 502
network for the patient's health benefit plan. 503

(E) (1) Except as provided in division (E) (2) of this 504
section, if the amount in a cost estimate provided under this 505
section changes by more than ten per cent before the patient 506
initially presents to receive the health care product, service, 507
or procedure, the health plan issuer shall provide to the 508
patient an updated estimate by the means the patient or the 509
patient's representative has elected under division (B) (1) of 510
this section and within the time frame specified in division (A) 511
of this section. 512

(2) Division (E)(1) of this section does not apply if 513
there are less than three days from the time of the change in 514
the cost estimate and the time that the health care product, 515
service, or procedure is to be provided and the health plan 516
issuer has no method of sending the updated estimate through 517
electronic means. If the health plan issuer does have electronic 518
means by which to send the updated estimate, the issuer shall 519
use that means. 520

(F) With respect to the format of a cost estimate provided 521
under this section, all of the following apply: 522

(1) The contents of the cost estimate shall be presented 523
in large font and in a manner that is easy to understand. 524

(2) Unless the cost estimate contains more than nine CPT 525
codes or other identifiers, the length of the cost estimate 526
shall not exceed one page. 527

(3) The subject line of the communication containing the 528
cost estimate shall state "Your Ohio Healthcare Price 529
Transparency Estimate." 530

Sec. 3962.07. (A) Regardless of whether the cost estimate 531
required by section 3962.03 of the Revised Code is provided by a 532
health care provider under section 3962.04 of the Revised Code 533
or by a health plan issuer under section 3962.06 of the Revised 534
Code, the health care provider shall give to a patient or the 535
patient's representative the CPT code or other identifier the 536
patient's health plan issuer requires for each health care 537
product, service, or procedure the patient is to receive. Except 538
as provided in division (B)(4) of this section, the health care 539
provider also shall give to the patient or the patient's 540
representative the charge information specified in division (A) 541

(1) of section 3962.04 of the Revised Code associated with each 542
code or other identifier. 543

(B) A health care provider has the following options for 544
fulfilling the requirement of division (A) of this section: 545

(1) The health care provider may send the information to 546
the patient or the patient's representative through electronic 547
means. 548

(2) The health care provider may send the information to 549
the patient or patient's representative by regular mail if the 550
health care product, service, or procedure will be provided more 551
than three days from the time the appointment for the product, 552
service, or procedure is made, as specified under any of the 553
circumstances described in division (A) of section 3962.011 of 554
the Revised Code. 555

(3) The health care provider may give the information to 556
the patient or the patient's representative at the time the 557
health care product, service, or procedure is provided if there 558
are less than three days from the time the cost estimate is 559
generated and the time the product, service, or procedure is to 560
be provided, but only if the provider has no method of sending 561
the estimate through electronic means. 562

(4) In lieu of giving the patient or the patient's 563
representative the charge information specified in division (A) 564
(1) of section 3962.04 of the Revised Code, the health care 565
provider may provide to the patient or the patient's 566
representative an internet web site address where the patient or 567
the patient's representative may enter each CPT code or other 568
identifier and retrieve the charge information. If this option 569
is elected and the health care provider transmits the CPT codes 570

or identifiers to the patient's health plan issuer through a 571
portal as described in section 3962.05 of the Revised Code, the 572
provider may have the portal generate an automatic electronic 573
mail message to the individual with instructions on how to 574
retrieve charge information through the web site. Not later than 575
September 1, 2022, each health plan issuer shall ensure that its 576
portal is able to generate such an electronic mail message. 577

(C) Regardless of the option elected under division (B) of 578
this section, a health care provider shall provide the 579
information in a manner that complies with all applicable state 580
and federal laws pertaining to the privacy of patient- 581
identifying information. 582

(D) (1) Except as provided in division (D) (2) of this 583
section, a health care provider shall give the CPT codes or 584
other identifiers and charge information to the patient or the 585
patient's representative in accordance with whichever of the 586
following time frames is applicable: 587

(a) Not later than twenty-four hours after the time the 588
appointment for the health care product, service, or procedure 589
is made, as specified under any of the circumstances described 590
in division (A) of section 3962.011 of the Revised Code; 591

(b) If the health care product, service, or procedure is 592
to be provided less than twenty-four hours after the appointment 593
is made, as specified under any of the circumstances described 594
in division (A) of section 3962.011 of the Revised Code, at the 595
time the patient presents to receive the product, service, or 596
procedure. 597

(2) If the health care product, service, or procedure is 598
to be provided by one or more independent contractors of the 599

health care provider, the CPT codes or other identifiers and 600
charge information shall be given to the patient or the 601
patient's representative under any of the options described in 602
division (B) of this section and in accordance with whichever of 603
the following time frames is applicable: 604

(a) Not later than thirty-six hours after the time the 605
appointment for the health care product, service, or procedure 606
is made, as specified under any of the circumstances described 607
in division (A) of section 3962.011 of the Revised Code; 608

(b) If the health care product, service, or procedure is 609
to be provided less than thirty-six hours after the appointment 610
for the product, service, or procedure is made, as specified 611
under any of the circumstances described in division (A) of 612
section 3962.011 of the Revised Code, at the time the patient 613
presents to receive the product, service, or procedure. 614

Sec. 3962.08. (A) As used in this section, "office visit" 615
means the family of CPT codes for "Evaluation and Management, 616
Office Visits Established" (codes 99211, 99212, 99213, 99214, 617
and 99215) used for office or other outpatient visits for an 618
established patient and the family of CPT codes for services 619
similar to the foregoing, including vision services. 620

(B) Sections 3962.03 to 3962.07 of the Revised Code do not 621
apply in any of the following circumstances: 622

(1) When the only service a health care provider will 623
provide to a patient is an office visit; 624

(2) When a patient was scheduled for only an office visit 625
but, during the visit, it is determined that the patient needs a 626
health care product, service, or procedure and it is provided 627
during that single visit; 628

(3) When the patient seeks care without an appointment and 629
without a prescription or order from another health care 630
provider. 631

(C)(1) For purposes of fulfilling the cost estimate 632
requirement of section 3962.03 of the Revised Code with respect 633
to the charge for an office visit, a general designation for an 634
unknown level of office visit may be used if the charge for the 635
office visit will be in addition to a charge for a health care 636
product, service, or procedure and either of the following is 637
the case: 638

(a) A patient schedules an appointment for a health care 639
product, service, or procedure or presents to receive a product, 640
service, or procedure, but the health care provider is unable to 641
determine at that point the level of office visit that will be 642
provided. 643

(b) A patient seeks care from the health care provider 644
without an appointment and without a prescription or order from 645
another health care provider. 646

(2) If a general designation for an unknown level of 647
office visit is used pursuant to division (C)(1) of this 648
section, the cost estimate provided to the patient by the health 649
care provider under section 3962.04 of the Revised Code or by 650
the health plan issuer under section 3926.06 of the Revised Code 651
shall list the price range for all levels of office visits. 652

Sec. 3962.09. (A) If a health care provider believes that 653
a delay in care associated with fulfilling the cost estimate 654
requirement of section 3962.03 of the Revised Code could harm 655
the patient, the provider shall inform the patient or the 656
patient's representative of this fact and provide the health 657

care product, service, or procedure to the patient without 658
fulfilling the cost estimate requirement. 659

(B) After a health care product, service, or procedure is 660
provided as described in division (A) of this section, the 661
health care provider shall submit to the board or other agency 662
that licenses the provider or otherwise regulates the provider's 663
profession or business a report detailing why the provider 664
believed that a delay in care associated with fulfilling the 665
cost estimate requirement could harm the patient. The report 666
shall be submitted in the form and manner prescribed by the 667
board or agency. 668

(C) Annually, each board or other agency that receives 669
reports under division (B) of this section shall analyze the 670
reports and prepare a summary of its findings. Each summary 671
shall be submitted to the governor and, in accordance with 672
section 101.68 of the Revised Code, the general assembly. 673

Sec. 3962.10. A health care provider or health plan issuer 674
that provides a cost estimate under this chapter is not liable 675
in damages in a civil action for injury, death, or loss to 676
person or property that allegedly arises from an act or omission 677
associated with providing the estimate if the health care 678
provider or health plan issuer made a good faith effort to 679
collect the information necessary to generate the estimate and a 680
good faith effort to provide the estimate to the patient or the 681
patient's representative. 682

Sec. 3962.11. (A) (1) After completing an examination in 683
accordance with the time frames specified in section 3962.111 of 684
the Revised Code, if the superintendent of insurance, department 685
of health, department of medicaid, or appropriate regulatory 686
board, as the case may be, finds that a health plan issuer or 687

health care provider has committed a series of violations that, 688
taken together, constitute a consistent pattern or practice of 689
violating the requirements of this chapter to provide cost 690
estimates to patients or their representatives, the 691
superintendent, department, or board may impose on the health 692
plan issuer or health care provider over which the 693
superintendent, department, or board has jurisdiction any of the 694
administrative remedies specified in division (B) of this 695
section. 696

(2) Before imposing an administrative remedy as described 697
in division (A) (1) of this section, the superintendent, 698
department, or board shall give written notice to the health 699
plan issuer or health care provider informing the issuer or 700
provider of the reasons for the finding, the administrative 701
remedy that is proposed, and the opportunity to submit a written 702
request for an administrative hearing regarding the finding and 703
proposed remedy. If a hearing is requested, the superintendent, 704
department, or board shall conduct the hearing in accordance 705
with Chapter 119. of the Revised Code not later than fifteen 706
days after receipt of the request. 707

(B) In imposing administrative remedies under this 708
section, the superintendent, department, or appropriate 709
regulatory board may do either or both of the following: 710

(1) Levy a fine in an amount determined in accordance with 711
division (C) of this section; 712

(2) Order the health plan issuer or health care provider 713
to cease and desist from engaging in the violations. 714

(C) (1) For purposes of levying a fine under division (B) 715
(1) of this section, each finding described in division (A) (1) 716

of this section constitutes a single offense. 717

(2) The amount of the fine to be levied shall be 718
determined in accordance with whichever of the following is 719
applicable: 720

(a) For a first offense, the superintendent of insurance, 721
department of health, or department of medicaid may levy a fine 722
of not more than one hundred thousand dollars; the appropriate 723
regulatory board may levy a fine of not more than ten thousand 724
dollars. 725

(b) For a second offense, the superintendent or department 726
may levy a fine of not more than one hundred fifty thousand 727
dollars; the appropriate regulatory board may levy a fine of not 728
more than fifteen thousand dollars. 729

(c) For a third or subsequent offense, the superintendent 730
or department may levy a fine of not more than three hundred 731
thousand dollars; the appropriate regulatory board may levy a 732
fine of not more than thirty thousand dollars. 733

(3) In determining the amount of the fine to be levied 734
within the limits specified in division (C) (2) of this section, 735
the superintendent, department, or board shall consider all of 736
the following factors: 737

(a) The extent and frequency of the violations; 738

(b) Whether the violations were due to circumstances 739
beyond the control of the health plan issuer or health care 740
provider; 741

(c) Any remedial actions taken by the health plan issuer 742
or health care provider; 743

(d) The actual or potential harm to others resulting from 744

<u>the violations;</u>	745
<u>(e) Whether the health plan issuer or health care provider</u>	746
<u>knowingly and willingly committed the violations;</u>	747
<u>(f) The financial condition of the health plan issuer or</u>	748
<u>health care provider;</u>	749
<u>(g) Any other factors the superintendent, department, or</u>	750
<u>board considers appropriate.</u>	751
<u>(D) The amounts collected from levying fines under this</u>	752
<u>section shall be paid into the state treasury to the credit of</u>	753
<u>the general revenue fund.</u>	754
<u>Sec. 3962.111.</u> For purposes of division (A) of section	755
3962.11 of the Revised Code, all of the following time frames	756
apply:	757
<u>(A) An examination of a health plan issuer may occur on</u>	758
<u>and after May 1, 2023.</u>	759
<u>(B) An examination of a health care provider may occur in</u>	760
<u>accordance with whichever of the following is applicable:</u>	761
<u>(1) On and after May 1, 2023, in the case of a health care</u>	762
<u>provider described in division (A)(1) of section 3962.03 of the</u>	763
<u>Revised Code;</u>	764
<u>(2) On and after September 1, 2023, in the case of a</u>	765
<u>health care provider described in division (A)(2) of section</u>	766
<u>3962.03 of the Revised Code;</u>	767
<u>(3) On and after June 1, 2024, in the case of a health</u>	768
<u>care provider described in division (A)(3) of section 3962.03 of</u>	769
<u>the Revised Code.</u>	770
<u>Sec. 3962.12.</u> All of the following are invalid and	771

<u>unenforceable:</u>	772
<u>(A) Any contract clause that prohibits a health care</u>	773
<u>provider or health plan issuer from providing a patient with</u>	774
<u>information that facilitates the patient's ability to choose a</u>	775
<u>health care provider based on quality or cost, including any</u>	776
<u>clause that prohibits providing a patient with cost and quality</u>	777
<u>information regarding alternative providers when the patient</u>	778
<u>demonstrates an intention to seek care from a particular</u>	779
<u>provider;</u>	780
<u>(B) Any contract clause that prohibits a health plan</u>	781
<u>issuer from excluding any particular health care provider from a</u>	782
<u>list or other resource that ranks health care providers based on</u>	783
<u>quality or cost and is intended to help patients make decisions</u>	784
<u>regarding their care;</u>	785
<u>(C) Any contract clause that restricts patient access to</u>	786
<u>quality or cost information that is made available by a health</u>	787
<u>care provider or health plan issuer.</u>	788
<u>Sec. 3962.13. (A) All of the following may adopt any rules</u>	789
<u>necessary to carry out this chapter:</u>	790
<u>(1) The superintendent of insurance;</u>	791
<u>(2) The director of health;</u>	792
<u>(3) The medicaid director;</u>	793
<u>(4) Any other relevant department, agency, board, or other</u>	794
<u>entity that regulates, licenses, or certifies a health care</u>	795
<u>provider or health plan issuer.</u>	796
<u>(B) Any rules adopted under this section shall be adopted</u>	797
<u>in accordance with Chapter 119. of the Revised Code.</u>	798

Sec. 3962.14. Any individual who was a member of the 799
general assembly on the date of final legislative action 800
resulting in enactment of this section may intervene in 801
litigation that challenges all or part of this chapter or 802
section 5164.65 of the Revised Code. 803

Sec. 3962.15. In enacting sections 3962.01 to 3962.14 of 804
the Revised Code, it is the intent of the general assembly to 805
provide patients with the information they need to make informed 806
choices regarding their health care, to maximize health care 807
cost savings for all residents of this state, and to reduce the 808
burden of health care expenditures on government entities, 809
including costs incurred under the medicaid program. 810

Sec. 5162.801. Any member of the general assembly may 811
intervene in litigation that challenges all or part of section 812
5162.80 of the Revised Code. 813

Sec. 5164.65. On and after April 1, 2024, the medicaid 814
program shall comply with Chapter 3962. of the Revised Code as 815
if it were a health plan issuer subject to that chapter. This 816
requirement extends to all health care providers, as defined in 817
section 3962.01 of the Revised Code, that are medicaid providers 818
or that otherwise seek payment through the medicaid program or 819
medicaid managed care organizations for providing health care 820
products, services, or procedures to medicaid recipients. 821