

**As Reported by the Senate Small Business and Economic Opportunity
Committee**

135th General Assembly

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Sub. H. B. No. 49

Representatives Ferguson, Barhorst

**Cosponsors: Representatives Gross, Young, T., Plummer, Click, Stein, Williams,
Jordan, Merrin, Dean, Klopfenstein, Johnson, Kick, Wiggam, Creech, Stoltzfus,
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Jarrells, Jones, Lampton, Lorenz, Mathews, Miller, A., Miller, J., Peterson, Rogers,
Sweeney, Upchurch**

A BILL

To amend section 3727.44; to amend, for the purpose 1
of adopting a new section number as indicated in 2
parentheses, section 3727.44 (3727.38); to enact 3
new section 3727.42 and sections 3727.31, 4
3727.32, 3727.33, 3727.34, 3727.35, 3727.351, 5
3727.36, 3727.37, and 3727.41; and to repeal 6
sections 3727.42, 3727.43, and 3727.45 of the 7
Revised Code regarding facility fees and the 8
availability of hospital price information. 9

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

Section 1. That section 3727.44 be amended; section 10
3727.44 (3727.38) be amended for the purpose of adopting a new 11
section number as indicated in parentheses; and new section 12
3727.42 and sections 3727.31, 3727.32, 3727.33, 3727.34, 13
3727.35, 3727.351, 3727.36, 3727.37, and 3727.41 of the Revised 14

Code be enacted to read as follows: 15

Sec. 3727.31. Except as otherwise expressly provided or 16
clearly appearing from the context, any term used in sections 17
3727.31 to 3727.38 of the Revised Code that is not otherwise 18
defined in this section has the same meaning as when used in a 19
comparable context in the federal price transparency law. 20

As used in sections 3727.31 to 3727.38 of the Revised 21
Code: 22

(A) "Hospital" has the same meaning as in section 3722.01 23
of the Revised Code, notwithstanding the meaning of that term in 24
section 3727.01 of the Revised Code. 25

(B) "Personal data" means any information that is linked 26
or reasonably linkable to an identified or identifiable person 27
in this state. "Personal data" does not include either of the 28
following: 29

(1) Publicly available information; 30

(2) Personal data that has been deidentified or aggregated 31
using commercially reasonable methods such that neither the 32
associated person, nor a device linked to that person, can be 33
reasonably identified. 34

(C) "Process" or "processing" means any operation or set 35
of operations that are performed on personal data, whether or 36
not by automated means, including the collection, use, storage, 37
disclosure, analysis, deletion, transfer, or modification of 38
personal data. 39

(D) "Publicly available information" means information 40
that is lawfully made available from federal, state, or local 41
government records or widely available media. 42

(E) "Shoppable service" means a service that may be 43
scheduled by a health care consumer in advance. 44

(F) "Targeted advertising" means displaying an 45
advertisement that is selected based on personal data obtained 46
from the use of a hospital's internet-based price estimator tool 47
by a person in this state. "Targeted advertising" does not 48
include any of the following: 49

(1) Advertising in response to the user's request for 50
information or feedback; 51

(2) Advertisements based on activities within a hospital's 52
own web sites or online applications; 53

(3) Advertisements based on the context of a user's 54
current search query, visit to a web site, or online 55
application; 56

(4) Processing personal data solely for measuring or 57
reporting advertising performance, reach, or frequency. 58

(G) "Federal price transparency law" means section 2718(e) 59
of the "Public Health Service Act," 42 U.S.C. 300gg-18, and 60
hospital price transparency rules adopted by the United States 61
department of health and human services and the United States 62
centers for medicare and medicaid services implementing that 63
section, including the rules and requirements under 45 C.F.R. 64
180. 65

Sec. 3727.32. (A) Each hospital located in the state shall 66
comply with the federal price transparency law. 67

(B)(1) Subject to divisions (C) and (D) of this section, a 68
hospital located in this state shall maintain and make publicly 69
available a list of the standard charges for the hospital's 70

shoppable services, as required by the federal price 71
transparency law. 72

(2) With respect to the shoppable services that are 73
included on the list, both of the following apply: 74

(a) Beginning two years after the effective date of this 75
section and ending four years after the effective date of this 76
section, the hospital shall include at least four hundred 77
shoppable services on the list, unless the hospital provides 78
fewer than four hundred shoppable services, in which case the 79
list shall include the number of shoppable services that the 80
hospital provides. 81

(b) Beginning four years after the effective date of this 82
section, the hospital shall include at least five hundred 83
shoppable services on the list, unless the hospital provides 84
fewer than five hundred shoppable services, in which case the 85
list shall include the number of shoppable services that the 86
hospital provides. 87

(3) The hospital shall publish the list in a machine- 88
readable format that conforms with any template required by the 89
federal price transparency law, and which is also readable in 90
plain language without the use of software. 91

(C) A hospital that maintains an internet-based price 92
estimator tool deemed by the United States centers for medicare 93
and medicaid services to meet the requirements of the federal 94
price transparency law regarding the list of standard charges 95
for shoppable services also meets the requirements of this 96
section if the hospital takes reasonable steps to do both of the 97
following: 98

(1) Improve the accuracy and performance of the internet- 99

<u>based price estimator tool;</u>	100
<u>(2) Regularly update the underlying data used by the</u>	101
<u>internet-based price estimator tool and audit price estimates</u>	102
<u>generated by the tool for quality assurance purposes.</u>	103
<u>(D) (1) A hospital shall not sell personal data acquired</u>	104
<u>from the use of the hospital's internet-based price estimator</u>	105
<u>tool by a person in this state.</u>	106
<u>(2) A hospital shall not use, sell, or process personal</u>	107
<u>data acquired from the use of the hospital's internet-based</u>	108
<u>price estimator tool by a person in this state for the purposes</u>	109
<u>of targeted advertising.</u>	110
<u>Sec. 3727.33. (A) A hospital shall not do any of the</u>	111
<u>following:</u>	112
<u>(1) (a) Fail to comply with the requirement to make public</u>	113
<u>the list described in section 3727.32 of the Revised Code;</u>	114
<u>(b) Fail to comply with the requirements to make public</u>	115
<u>either or both of the lists described in the federal price</u>	116
<u>transparency law.</u>	117
<u>(2) (a) Fail to maintain the list required by section</u>	118
<u>3727.32 of the Revised Code in accordance with the requirements</u>	119
<u>of that section;</u>	120
<u>(b) Fail to maintain either or both of the lists required</u>	121
<u>by the federal price transparency law in accordance with the</u>	122
<u>requirements of 45 C.F.R. 180.</u>	123
<u>(3) Fail in any other manner to comply with the</u>	124
<u>requirements that apply to the lists under sections 3727.31 to</u>	125
<u>3727.38 of the Revised Code.</u>	126

(B) The director of health shall monitor each hospital's 127
compliance with division (A) of this section. The monitoring may 128
occur by any of the following methods: 129

(1) Evaluating complaints made by individuals to the 130
director; 131

(2) Reviewing any credible analysis prepared regarding 132
compliance or noncompliance by hospitals; 133

(3) Auditing the internet web sites of hospitals for 134
compliance. 135

(C) In reviewing an application for renewal of a 136
hospital's license under Chapter 3722. of the Revised Code, the 137
director of health shall consider whether the hospital is 138
violating or has violated division (A) of this section. 139

(D) (1) The director of health shall create and make 140
publicly available a list that identifies each hospital that is 141
not in compliance with division (A) of this section. The list of 142
noncompliant hospitals shall include any hospital that has been 143
sent a notice of violation under section 3727.34 of the Revised 144
Code, is subject to an order imposing an administrative penalty 145
under section 3727.35 of the Revised Code, has been sent any 146
other written communication from the director regarding a 147
violation of division (A) of this section, or otherwise has been 148
determined by the director to be not in compliance with division 149
(A) of this section. 150

(2) The list of noncompliant hospitals is a public record, 151
as defined in section 149.43 of the Revised Code. 152

(3) After the director of health has determined that a 153
hospital is not in compliance with division (A) of this section, 154
the materials that consist of notices, orders, communications, 155

and determinations under sections 3727.31 to 3727.38 of the 156
Revised Code are public records, as defined in section 149.43 of 157
the Revised Code. 158

(E) Not later than ninety days after the effective date of 159
this section, the director of health shall create the initial 160
list of noncompliant hospitals and include the list on the 161
internet web site maintained by the department of health. The 162
director shall update the list and web site at least every 163
thirty days thereafter. 164

Sec. 3727.34. (A) If the director of health determines 165
that a hospital has violated division (A) of section 3727.33 of 166
the Revised Code, the director shall issue a notice of violation 167
to the hospital. The director shall clearly explain in the 168
notice the manner in which the hospital is not in compliance. 169

When a notice of violation is issued, the director shall 170
require the hospital to submit a corrective action plan to the 171
director. In the notice, the director shall indicate the form 172
and manner in which the corrective action plan is to be 173
submitted and clearly specify the date by which the hospital is 174
required to submit the plan. The date that is specified shall 175
not be less than fifteen days after the notice is sent. 176

(B) A hospital that receives a notice of violation shall 177
submit to the director of health a corrective action plan in the 178
form and manner indicated, and by the date specified, in the 179
notice. In the plan, the hospital shall provide a detailed 180
description of the corrective action the hospital will take to 181
address each violation identified by the director. The hospital 182
shall specify the date by which it will complete the corrective 183
action. The date that is specified shall not be more than ninety 184
days after the plan is submitted. 185

(C) A corrective action plan is subject to review and approval by the director of health. After the director reviews and approves the plan, the director shall monitor and evaluate the hospital's compliance with the plan. 186
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(D) A hospital shall not do any of the following: 190

(1) Fail to respond to the director's requirement to submit a corrective action plan; 191
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(2) Fail to submit a corrective action plan in the form and manner indicated in the notice of violation or by the date specified in that notice; 193
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(3) Fail to complete the corrective action specified in a corrective action plan by the date specified in the plan. 196
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Sec. 3727.35. (A) (1) Notwithstanding any conflicting provision of the Revised Code, the director of health shall impose an administrative penalty on a hospital if the hospital does both of the following: 198
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(a) Violates division (A) of section 3727.33 of the Revised Code; 202
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(b) Violates division (D) of section 3727.34 of the Revised Code. 204
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(2) Each day a hospital violates both division (A) of section 3727.33 of the Revised Code and division (D) of section 3727.34 of the Revised Code is considered a separate violation. 206
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(B) In imposing an administrative penalty under this section, the director of health shall act in accordance with Chapter 119. of the Revised Code. The amount of the penalty to be imposed on a hospital shall be selected by the director, subject to the maximum amounts and considerations specified in 209
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division (C) of this section. For all penalties that are 214
imposed, the director shall select amounts that are sufficient 215
to ensure that hospitals comply with the requirements of 216
sections 3727.31 to 3727.38 of the Revised Code. 217

(C) (1) An administrative penalty imposed under this 218
section shall not be higher than the following: 219

(a) In the case of a hospital with a bed count of thirty 220
or fewer, three hundred dollars; 221

(b) In the case of a hospital with a bed count that is 222
greater than thirty and equal to or fewer than five hundred 223
fifty, ten dollars per bed; 224

(c) In the case of a hospital with a bed count that is 225
greater than five hundred fifty, five thousand five hundred 226
dollars. 227

(2) In setting the amount of the penalty to be imposed on 228
a hospital, the director of health shall consider all of the 229
following: 230

(a) Previous violations by the hospital's operator; 231

(b) The seriousness of the violation; 232

(c) The demonstrated good faith of the hospital's 233
operator; 234

(d) Any other matters as justice may require. 235

(D) An administrative penalty collected under this section 236
shall be deposited into the state treasury to the credit of the 237
hospital price transparency fund created by section 3727.351 of 238
the Revised Code. 239

Sec. 3727.351. There is hereby created in the state 240

treasury the hospital price transparency fund, consisting of 241
administrative penalties collected under section 3727.35 of the 242
Revised Code. The director of health shall administer the fund. 243
The amounts deposited shall be used for purposes of 244
administering and enforcing sections 3727.31 to 3727.38 of the 245
Revised Code, except that the director may use a portion for 246
purposes of informing the public about the availability of 247
hospital price information and other consumer rights under those 248
sections. 249

Sec. 3727.36. (A) As used in this section: 250

(1) "Collection agency" means either of the following: 251

(a) A person who engages in a business that has as its 252
purpose the collection of debts; 253

(b) A person who collects or attempts to collect, directly 254
or indirectly, debts owed or due or asserted to be owed or due 255
to another, takes assignment of debts for collection purposes, 256
or directly or indirectly solicits for collection debts owed or 257
due or asserted to be owed or due to another. 258

(2) "Consumer reporting agency" means any person that, for 259
monetary fees, dues, or on a cooperative nonprofit basis, 260
regularly engages, in whole or in part, in the practice of 261
assembling or evaluating consumer credit information or other 262
information on consumers for the purpose of furnishing consumer 263
reports to third parties. "Consumer reporting agency" includes a 264
person described in section 603 of the "Fair Credit Reporting 265
Act," 15 U.S.C. 1681a(f). "Consumer reporting agency" does not 266
include a business entity that provides check verification or 267
check guarantee services only. 268

(3) "Debt" means any obligation or alleged obligation of a 269

consumer to pay money arising out of a transaction, whether or 270
not the obligation has been reduced to judgment. 271

(4) "Debt collector" means any person employed or engaged 272
by a collection agency to perform the collection of debts owed 273
or due or asserted to be owed or due to another. 274

(5) "Medical creditor" means a facility or provider to 275
whom a patient owes money for health care services or the 276
facility or provider that provided health care services and to 277
whom the patient previously owed money if the debt has been 278
purchased by a medical debt buyer. 279

(6) "Medical debt buyer" means a person that is engaged in 280
the business of purchasing medical debts for collection 281
purposes, whether it collects the medical debts itself or hires 282
a third party for collection or an attorney for litigation to 283
collect the medical debts. The term includes a person that 284
purchased the medical debt from a facility or provider, from 285
another medical debt buyer, or from any other party. 286

(7) "Medical debt collector" means a person that is 287
engaged in the business of collecting or attempting to collect, 288
directly or indirectly, medical debts originally owed or due or 289
asserted to be owed or due to another. "Medical debt collector" 290
includes a medical debt buyer. 291

(B) No medical creditor or medical debt collector shall 292
communicate with or report any information to any consumer 293
reporting agency regarding a patient's medical debt for a period 294
of one year, beginning on the date when the patient is first 295
sent a bill for the medical debt. 296

(C) (1) After the one-year period, a medical creditor or 297
medical debt collector shall send a patient at least one 298

<u>additional bill at least thirty days prior to reporting a</u>	299
<u>medical debt to any consumer reporting agency.</u>	300
<u>(2) The bill shall state that the medical creditor or</u>	301
<u>medical debt collector intends to report the debt to a consumer</u>	302
<u>reporting agency.</u>	303
<u>(D) The amount reported to the consumer reporting agency</u>	304
<u>shall be the same as the amount stated in the bill.</u>	305
<u>(E) A medical debt collector shall also provide the notice</u>	306
<u>required by 15 U.S.C. 1692g at least thirty days prior to</u>	307
<u>reporting a debt to a consumer reporting agency.</u>	308
<u>Sec. 3727.37. The director of health shall prepare reports</u>	309
<u>and submit them in accordance with all of the following:</u>	310
<u>(A) On an annual basis, the director shall prepare a</u>	311
<u>report on hospitals that are in violation of division (A) of</u>	312
<u>section 3727.33 or division (D) of section 3727.34 of the</u>	313
<u>Revised Code.</u>	314
<u>(B) Within sixty days after any change to the federal</u>	315
<u>price transparency law, the director shall prepare a report of</u>	316
<u>the director's recommendations for conforming sections 3727.31</u>	317
<u>to 3727.38 of the Revised Code with the change or,</u>	318
<u>alternatively, stating that no conforming changes are necessary.</u>	319
<u>(C) The director shall submit the reports required by</u>	320
<u>divisions (A) and (B) of this section to the general assembly in</u>	321
<u>accordance with section 101.68 of the Revised Code, the</u>	322
<u>chairperson of the standing committee of the house of</u>	323
<u>representatives with primary responsibility for health</u>	324
<u>legislation, the chairperson of the standing committee of the</u>	325
<u>senate with primary responsibility for health legislation, and</u>	326
<u>the governor.</u>	327

Sec. ~~3727.44~~ 3727.38. The director of health may adopt 328
rules to carry out the purposes of sections ~~3727.42 and 3727.43~~ 329
3727.31 to 3727.38 of the Revised Code. All rules adopted 330
pursuant to this section shall be adopted in accordance with 331
Chapter 119. of the Revised Code. 332

Sec. 3727.41. As used in sections 3727.41 and 3727.42 of 333
the Revised Code: 334

(A) "Campus" means the physical area immediately adjacent 335
to a hospital's main buildings, other areas and structures that 336
are not strictly contiguous to the main buildings but are 337
located within seven hundred fifty feet of the main buildings, 338
and any other areas determined on an individual case basis, by 339
the department of health, to be part of the hospital's campus. 340

(B) "Chargemaster" means the list maintained by a health 341
care facility of each health care service or item for which the 342
health care facility has established a charge. 343

(C) "De-identified maximum negotiated charge" means the 344
highest charge that a health care facility has negotiated with 345
all third-party payors for a health care service or item. 346

(D) "De-identified minimum negotiated charge" means the 347
lowest charge that a health care facility has negotiated with 348
all third-party payors for a health care service or item. 349

(E) "Discounted cash price" means the charge that applies 350
to an individual who pays cash, or a cash equivalent, for a 351
health care service or item. 352

(F) "Governmental health plan" means a plan established or 353
maintained for its beneficiaries by the government of the United 354
States, the government of any state or political subdivision 355
thereof, or by any agency or instrumentality of the government 356

of the United States or the government of any state or political 357
subdivision thereof, including medicare and medicaid managed 358
care health plans. 359

(G) "Gross charge" means the charge for a health care 360
service or item that is reflected on a health care facility's 361
chargemaster, absent any discounts. 362

(H) "Health care facility" means any hospital, outpatient 363
department, satellite unit, or any other inpatient or outpatient 364
facility owned by a hospital or multi-hospital system. 365

(I) "Health care service or item" means any service or 366
item, including service packages, that may be provided by a 367
health care facility to a patient in connection with an 368
outpatient department, satellite unit, or other outpatient 369
facility visit for which the health care facility has 370
established a standard charge, including all of the following: 371

(1) Supplies and procedures; 372

(2) Room and board; 373

(3) Use of the facility and other areas, the charges for 374
which are generally referred to as facility fees; 375

(4) Services of physicians and non-physician 376
practitioners, employed by the health care facility, the charges 377
for which are generally referred to as professional fees; 378

(5) Any other service or item for which a health care 379
facility has established a standard charge. 380

(J) "Hospital" has the same meaning as in section 3727.01 381
of the Revised Code. 382

(K) "Multi-hospital system" means two or more hospitals 383

that are subject to the control and direction of one common 384
owner responsible for the operational decisions of the entire 385
system or that have integrated administrative functions and 386
medical staff that report to one governing body as the result of 387
a formal legal or contractual obligation. 388

(L) "Outpatient" means a patient who is not admitted as an 389
inpatient and whose length of stay is less than twenty-four 390
hours. 391

(M) (1) "Outpatient facility" means a health care facility 392
that meets all of the following requirements: 393

(a) Is an off-campus facility located apart from a 394
hospital; 395

(b) Provides diagnosis or diagnosis and treatment for 396
ambulatory patients; 397

(c) Conducts patient care under the professional 398
supervision of persons licensed to practice medicine or surgery 399
in the state, or in the case of dental diagnosis or treatment, 400
under the professional supervision of persons licensed to 401
practice dentistry in the state; 402

(d) Offers to patients not requiring hospitalization the 403
services of licensed physicians in various medical specialties, 404
and which provides to its patients a reasonably full range of 405
diagnostic and treatment services. 406

(2) "Outpatient facility" includes any outpatient 407
physician facility, satellite unit, or other off-campus health 408
care facility that fulfills the requirements of division (M) (1) 409
of this section. 410

(N) (1) "Outpatient physician facility" means an outpatient 411

facility independently owned and operated by one or more private 412
licensed physicians, whether organized for individual or group 413
practice. 414

(2) "Outpatient physician facility" does not include any 415
health care facility owned, operated by, or subject to the 416
control and direction of any hospital or multi-hospital system. 417

(O) "Payor-specific negotiated charge" means the charge 418
that a health care facility has negotiated with a third-party 419
payor for a health care service or item. 420

(P) "Satellite unit" means a unit owned and operated by a 421
hospital that is providing diagnostic, therapeutic, or 422
rehabilitative services on an outpatient basis at a 423
geographically separate off-campus location from the hospital 424
that owns and operates the unit. 425

(Q) "Self-pay individual" means an individual who does not 426
have benefits for a health care service or item under a health 427
plan offered by a third-party payor or who does not seek to have 428
a claim for that item or service submitted to the third-party 429
payor. 430

(R) "Service package" means an aggregation of individual 431
health care services or items into a single service with a 432
single charge. 433

(S) "Standard charge" means the regular rate established 434
by a health care facility for a health care service or item 435
provided to a specific group of paying patients. "Standard 436
charge" includes all of the following: 437

(1) The gross charge; 438

(2) The payor-specific negotiated charge; 439

<u>(3) The de-identified minimum negotiated charge;</u>	440
<u>(4) The de-identified maximum negotiated charge;</u>	441
<u>(5) The discounted cash price.</u>	442
<u>(T) "Third-party payor" means an entity, excluding</u>	443
<u>governmental health plans, that is, by statute, contract, or</u>	444
<u>agreement, legally responsible for payment of a claim for a</u>	445
<u>health care service or item.</u>	446
<u>Sec. 3727.42. (A) Beginning July 1, 2027, and subject to</u>	447
<u>division (B) of this section, a hospital or multi-hospital</u>	448
<u>system that acquires, or acquired in the past, an existing,</u>	449
<u>independent outpatient physician facility and operates that</u>	450
<u>facility as an outpatient facility subject to the control and</u>	451
<u>direction of the hospital or multi-hospital system shall not</u>	452
<u>require a third-party payor or self-pay individual to pay</u>	453
<u>facility fees in connection with any health care services or</u>	454
<u>items provided to a patient at that outpatient facility.</u>	455
<u>(B) The requirements of this section apply only to</u>	456
<u>existing outpatient physician facilities purchased or otherwise</u>	457
<u>acquired by a hospital or multi-hospital system. Nothing in this</u>	458
<u>section shall be construed to apply to an outpatient facility</u>	459
<u>that is constructed by a hospital or multi-hospital system, or</u>	460
<u>that did not previously operate as an outpatient physician</u>	461
<u>facility prior to its acquisition by a hospital or multi-</u>	462
<u>hospital system.</u>	463
Section 2. That existing section 3727.44 of the Revised	464
Code is hereby repealed.	465
Section 3. That sections 3727.42, 3727.43, and 3727.45 of	466
the Revised Code are hereby repealed.	467