As Reported by the House Insurance Committee

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Representatives Ferguson, Barhorst

Cosponsors: Representatives Gross, Young, T., Plummer, Click, Stein, Williams, Jordan, Merrin, Dean, Klopfenstein, Johnson, Kick, Wiggam, Creech, Stoltzfus, McClain, Powell, King, Claggett, Willis, Fowler Arthur, Miller, M., Dobos, Lear, Holmes, Hall, John, Stewart, Miranda

A BILL

To amend sections 3701.83 and 3727.44; to amend, for the purpose of adopting a new section number as indicated in parentheses, section 3727.44 (3727.41); to enact sections 3727.31, 3727.32, 3727.33, 3727.34, 3727.35, 3727.36, 3727.37, 3727.38, 3727.39, and 3727.40; and to repeal sections 3727.42, 3727.43, and 3727.45 of the Revised Code regarding the availability of hospital price information; and to amend the version of section 3701.83 of the Revised Code that is scheduled to take effect on September 30, 2024, to continue the change on and after that date.

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

Section 1. That sections 3701.83 and 3727.44 be amended; section 3727.44 (3727.41) be amended for the purpose of adopting a new section number as indicated in parentheses; and sections 3727.31, 3727.32, 3727.33, 3727.34, 3727.35, 3727.36, 3727.37,

3727.38, 3727.39, and 3727.40 of the Revised Code be enacted to read as follows:

Sec. 3701.83. There is hereby created in the state treasury the general operations fund. Moneys in the fund shall be used for the purposes specified in sections 3701.04, 3701.344, 3702.20, 3711.16, 3717.45, 3718.06, 3721.02, 3721.022, 3727.38, 3729.07, 3733.43, 3748.04, 3748.05, 3748.07, 3748.12, 3748.13, 3749.04, 3749.07, 4736.06, and 4769.09 of the Revised Code.

Sec. 3727.31. As used in sections 3727.31 to 3727.39 of the Revised Code:

(A) "Ancillary service" means a hospital item or service that a hospital customarily provides as part of a shoppable service.

(B) "Chargemaster" means the list maintained by a hospital of each hospital item or service for which the hospital has established a charge.

(C) "De-identified maximum negotiated charge" means the highest charge that a hospital has negotiated with all third-party payors for a hospital item or service.

(D) "De-identified minimum negotiated charge" means the lowest charge that a hospital has negotiated with all third-party payors for a hospital item or service.

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

(F) "Hospital" has the same meaning as in section 3722.01 of the Revised Code, notwithstanding the meaning of that term in

3727.01 of the Revised Code.

(G) "Hospital items or services" means all items or services, including individual items or services and service packages, that may be provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit, as applicable, for which the hospital has established a standard charge, including all of the following:

(1) Supplies and procedures;

(2) Room and board;

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

(4) Services of physicians and non-physician practitioners, employed by the hospital, the charges for which are generally referred to as professional fees;

(5) Any other item or service for which a hospital has established a standard charge.

(H) "Gross charge" means the charge for a hospital item or service that is reflected on a hospital's chargemaster, absent any discounts.

(I) "Machine-readable format" means a digital representation of information in a file that can be imported or read into a computer system for further processing. "Machine-readable format" includes.XML,.JSON, and.CSV formats.

(J) "Payor-specific negotiated charge" means the charge that a hospital has negotiated with a third-party payor for a hospital item or service.

(K) "Service package" means an aggregation of individual

hospital items or services into a single service with a single charge.

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

(M) "Standard charge" means the regular rate established by the hospital for a hospital item or service provided to a specific group of paying patients. "Standard charge" includes all of the following:

(1) The gross charge;

(2) The payor-specific negotiated charge;

(3) The de-identified minimum negotiated charge;

(4) The de-identified maximum negotiated charge;

(5) The discounted cash price.

(N) "Third-party payor" means an entity that is, by statute, contract, or agreement, legally responsible for payment of a claim for a hospital item or service.

Sec. 3727.32. A hospital shall make public both of the following:

(A) As described in section 3727.33 of the Revised Code, a digital file in a machine-readable format that contains a list of all standard charges for all hospital items or services;

(B) As described in section 3727.34 of the Revised Code, a consumer-friendly list of standard charges for the hospital's shoppable services.

Sec. 3727.33. (A) A hospital shall maintain a list of all standard charges for all hospital items or services in accordance with this section. The hospital shall ensure that the

list is available at all times to the public, including by posting the list electronically in the manner provided by this section.

(B) The standard charges contained in the list shall reflect the standard charges applicable to that location of the hospital, regardless of whether the hospital operates in more than one location or operates under the same license as another hospital.

(C) The list shall include the following information, as applicable:

(1) A description of each hospital item or service provided by the hospital;

(2) The following charges, expressed in dollar amounts, for each particular hospital item or service when provided in either an inpatient setting or an outpatient department setting, as applicable:

(a) The gross charge;

(b) The de-identified minimum negotiated charge;

(c) The de-identified maximum negotiated charge;

(d) The discounted cash price;

(e) The payor-specific negotiated charge, listed by the name of the third-party payor and health plan associated with the charge and displayed in a manner that clearly associates the charge with each third-party payor and health plan;

(f) Any code used by the hospital for purposes of accounting or billing for the hospital item or service, including the current procedural terminology (CPT) code,

healthcare common procedure coding system (HCPCS) code, diagnosis related group (DRG) code, national drug code (NDC), or other common identifier.

(D) The information contained in the list shall be published in a single digital file that is in a machine-readable format.

(E) The list shall be displayed in a prominent location on the home page of the hospital's publicly accessible internet web site or be accessible by selecting a dedicated link that is prominently displayed on that home page. If the hospital operates multiple locations and maintains a single internet web site, a separate list shall be posted for each location the hospital operates and shall be displayed in a manner that clearly associates the list with the applicable location.

(F) The list shall satisfy all of the following conditions:

(1) Be available free of charge; without having to register or establish a user account or password; without having to submit personal identifying information, including any information pertaining to an individual's health care coverage or other benefits; and without having to overcome any other impediment in order to access the list, including such impediments as entering a code or completing any type of security measure known as challenge-response authentication;

(2) Be accessible to a common commercial operator of an internet search engine to the extent necessary for the search engine to index the list and display the list as a result in response to a search query of a user of the search engine;

(3) Be formatted in a manner prescribed by the template

developed under division (G) of this section;

(4) Be digitally searchable;

(5) Use the following naming convention specified by the United States centers for medicare and medicaid services, specifically:

"<ein>_<hospital-name>_standardcharges.[jsonxmlcsv]."

(G) For purposes of division (F)(3) of this section, the director of health shall develop a template that each hospital shall use in formatting the list. In developing the template , the director shall do both of the following:

(1) Consider any applicable federal guidelines for formatting similar lists required by federal statutes or regulations and ensure that the design of the template enables health care consumers or other researchers to compare the charges contained in the lists maintained by each hospital;

(2) Design the template to be substantially similar to the template used by the United States centers for medicare and medicaid services for purposes similar to those of sections 3727.31 to 3727.39 of the Revised Code, if the director determines that designing the template in that manner serves the purposes of this section and that the department of health benefits from the director developing and requiring that substantially similar design.

(H) At least once each year, the hospital shall update the list it maintains under this section. The hospital shall clearly indicate the date on which the list was most recently updated, either on the list or in a manner that is clearly associated with the list.

Sec. 3727.34. (A) A hospital shall maintain and make publicly available a list of the standard charges described in divisions (C)(2)(b), (c), (d), and (e) of section 3727.33 of the Revised Code for the hospital's shoppable services. With respect to the shoppable services that are included on the list, both of the following apply:

(1) During the period beginning on the effective date of this section and ending December 31, 2024, the hospital may select the shoppable services to be included on the list, subject to all of the following:

(a) The list shall include at least three hundred shoppable services, unless the hospital provides fewer than three hundred shoppable services, in which case the list shall include the number of shoppable services that the hospital provides.

(b) Of the shoppabale services selected for purposes of division (A)(1)(a) of this section, the list shall include the seventy services specified as shoppable services by the United States centers for medicare and medicaid services, unless the hospital does not provide all of the seventy services, in which case the list shall include as many of those services as the hospital does provide.

(c) In selecting a shoppable service for purposes of inclusion on the list, a hospital shall do both of the following:

(i) Consider how frequently the hospital provides the service and the hospital's billing rate for that service;

(ii) Prioritize the selection of services that are among the services most frequently provided by the hospital.

(2) Beginning January 1, 2025, the hospital shall include on the list all shoppable services that the hospital provides.

(B) A hospital's list maintained under this section shall include all of the following information:

(1) A plain-language description of each shoppable service included on the list;

(2) The payor-specific negotiated charge that applies to each shoppable service included on the list and any ancillary service, listed by the name of the third-party payor and health plan associated with the charge and displayed in a manner that clearly associates the charge with the third-party payor and health plan;

(3) The discounted cash price that applies to each shoppable service included on the list and any ancillary service or, if the hospital does not offer a discounted cash price for one or more of the shoppable or ancillary services on the list, the gross charge for the shoppable service or ancillary service, as applicable;

(4) The de-identified minimum negotiated charge that applies to each shoppable service included on the list and any ancillary service;

(5) The de-identified maximum negotiated charge that applies to each shoppable service included on the list and any ancillary service;

(6) Any code used by the hospital for purposes of accounting or billing for each shoppable service included on the list and any ancillary service, including the current procedural terminology (CPT) code, healthcare common procedure coding system (HCPCS) code, diagnosis related group (DRG) code,

national drug code (NDC), or other common identifier.

(C) If applicable, the list shall do the following:

(1) State each location at which the hospital provides the shoppable service and whether the standard charges included in the list apply at that location to the provision of that shoppable service in an inpatient setting, an outpatient department setting, or in both of those settings, as applicable;

(2) Indicate if one or more of the shoppable services specified by the United States centers for medicare and medicaid services is not provided by the hospital.

(D) The list shall satisfy the following conditions, as applicable:

(1) Be displayed in the same manner prescribed by division (E) of section 3727.33 of the Revised Code for the list required under that section;

(2) Be available and accessible in the same manner prescribed by divisions (F)(1) and (2) of section 3727.33 of the Revised Code for the list required by that section;

(3) Be searchable by service description, billing code, and payor;

(4) Be formatted in a manner that is consistent with the template developed by the director of health under division (G) of section 3727.33 of the Revised Code for the list required under that section;

(5) Be updated in the same manner prescribed by division (H) of section 3727.33 of the Revised Code for the list required under that section.

Sec. 3727.35. Each time a hospital updates a list as required under sections 3727.33 and 3727.34 of the Revised Code, the hospital shall submit the updated list to the director of health. The director shall prescribe the form in which the updated list is to be submitted.

Sec. 3727.36. (A) A hospital shall not do any of the following:

(1) Fail to comply with the requirement to make public either or both of the lists described in section 3727.32 of the Revised Code;

(2) Fail to maintain either or both of the lists in accordance with each of the requirements of sections 3727.33 and 3727.34 of the Revised Code;

(3) Fail in any other manner to comply with the requirements that apply to the lists under sections 3727.31 to 3727.39 of the Revised Code.

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

(1) Evaluating complaints made by individuals to the director, including complaints made as described in section 3727.39 of the Revised Code;

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

(3) Auditing the internet web sites of hospitals for compliance;

(4) Confirming that each hospital has submitted updated lists in accordance with section 3727.35 of the Revised Code.

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

(D) The director shall create and make publicly available a list that identifies each hospital that is not in compliance with division (A) of this section. The list of noncompliant hospitals shall include any hospital that has been sent a notice of violation under section 3727.37 of the Revised Code, is subject to an order imposing an administrative penalty under section 3727.38 of the Revised Code, has been sent any other written communication from the director regarding a violation of division (A) of this section, or otherwise has been determined by the director to be not in compliance with division (A) of this section. In addition to the list of noncompliant hospitals being made publicly available, the materials that consist of these notices, orders, communications, and determinations are public records, as defined in section 149.43 of the Revised Code.

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

Sec. 3727.37. (A) If the director of health determines that a hospital has violated division (A) of section 3727.36 of the Revised Code, the director shall issue a notice of violation to the hospital. The director shall clearly explain in the notice the manner in which the hospital is not in compliance.

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

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

(C) A corrective action plan is subject to review and approval by the director. After the director reviews and approves the plan, the director shall monitor and evaluate the hospital's compliance with the plan.

(D) A hospital shall not do any of the following:

(1) Fail to respond to the director's requirement to submit a corrective action plan;

(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;

(3) Fail to complete the corrective action specified in a corrective action plan by the date specified in the plan.

Sec. 3727.38. (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 either of the following:

(a) Violates division (A) of section 3727.36 of the Revised Code;

(b) Violates division (D) of section 3727.37 of the Revised Code.

(2) Each day a violation continues is considered a separate violation.

(B) In imposing an administrative penalty under this section, the director 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 minimum amounts and considerations specified in division (C) of this section. For all penalties that are imposed, the director shall select amounts that are sufficient to ensure that hospitals comply with the requirements of sections 3727.31 to 3727.39 of the Revised Code.

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

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

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

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

(2) In setting the amount of the penalty to be imposed on

a hospital, the director shall consider all of the following:

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

(b) The seriousness of the violation;

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

(d) Any other matters as justice may require.

(D) An administrative penalty collected under this section shall be deposited into the state treasury to the credit of the general operations fund created by section 3701.83 of the Revised Code. The amounts deposited shall be used for purposes of administering and enforcing sections 3727.31 to 3727.39 of the Revised Code, except that the director may use a portion for purposes of informing the public about the availability of hospital price information and other consumer rights under those sections.

Sec. 3727.39. (A) As used in this section:

(1) "Collection action" means any of the following actions taken with respect to a debt for hospital items or services that were purchased by or provided to a patient:

(a) Attempting to collect a debt from a patient or patient guarantor by referring the debt, directly or indirectly, to a debt collector, a collection agency, or other third party retained by or on behalf of the hospital;

(b) Suing the patient or patient guarantor, or enforcing an arbitration or mediation clause in any hospital documents including contracts, agreements, statements, or bills;

(c) Directly or indirectly causing a report to be made to

a consumer reporting agency.

(2) "Collection agency" means either of the following:

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

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

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

(4) "Debt" means any obligation or alleged obligation of a consumer to pay money arising out of a transaction, whether or not the obligation has been reduced to judgment.

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

(6) "Medical creditor" means a facility or provider to whom a patient owes money for health care services or the facility or provider that provided health care services and to

whom the patient previously owed money if the debt has been purchased by a medical debt buyer.

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

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

(B) If a patient or patient guarantor believes that a violation of division (A) of section 3727.36 of the Revised Code has occurred, the patient or patient guarantor may submit a complaint to the director of health. The director shall evaluate the complaint as described in section 3727.36 of the Revised Code.

(C) If the director of health determines that a hospital violated division (A) of section 3727.36 of the Revised Code, and the hospital was in violation on the date that hospital items or services were purchased by or provided to a patient, the hospital shall not take, or continue to take, a collection action against the patient or patient guarantor for a debt owed for the hospital items or services.

(D) In addition to the duties described in section 3727.37 of the Revised Code, all of the following apply to a hospital

that has been determined by the director to have violated division (A) of section 3727.36 of the Revised Code:

(1) The hospital shall refund the payer any amount of the debt the payer has paid and shall pay a penalty to the patient or patient guarantor in an amount that is twice the total amount of the debt.

(2) The hospital shall dismiss any suit it may have brought to collect the debt and shall pay any attorney's fees and costs incurred by the patient or patient guarantor relating to the suit.

(3) The hospital shall remove or cause to be removed from the patient's or patient guarantor's credit report any report made to a consumer reporting agency relating to the debt.

(E)(1) Nothing in this section prohibits a hospital from billing a patient, patient guarantor, or third-party payor, including a health insurer, for hospital items or services provided to the patient.

(2) Nothing in this section requires a hospital to refund any payment made to the hospital for hospital items or services provided to the patient, as long as a collection action is not taken in violation of this section.

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

(G) After the one-year period described in division (F) of this section, a medical creditor or medical debt collector shall send a patient at least one additional bill at least thirty days

before reporting a medical debt to any consumer reporting agency. The amount reported to the consumer reporting agency shall be the same as the amount stated in the bill, and the bill shall state that the debt is being reported to a consumer reporting agency. A medical debt collector shall also provide the notice required by 15 U.S.C. 1692g at least thirty days before reporting a debt to a consumer reporting agency.

Sec. 3727.40. The director of health shall prepare reports and submit them in accordance with both of the following:

(A) On an annual basis, the director shall prepare a report on hospitals that are in violation of division (A) of section 3727.36 or division (D) of section 3727.37 of the Revised Code. The director shall submit the report to the general assembly in accordance with section 101.68 of the Revised Code, the chairperson of the standing committee of the house of representatives with primary responsibility for health legislation, the chairperson of the standing committee of the senate with primary responsibility for health legislation, and the governor.

(B) On a periodic basis, the director shall prepare a report containing recommendations for modifying sections 3727.31 to 3727.39 of the Revised Code, including recommendations in response to changes in 45 C.F.R. Part 180 made by the United States centers for medicare and medicaid services. The director shall submit the report to the general assembly in accordance with section 101.68 of the Revised Code.

Sec. ~~3727.44~~ 3727.41. ~~The~~ Each hospital shall provide a full disclosure of the provisions of section 3924.21 of the Revised Code to every beneficiary, as defined in section 3901.38 of the Revised Code, who receives services at the hospital.

The director of health may adopt rules to carry out the purposes of ~~sections 3727.42 and 3727.43~~ this section~~of the Revised Code~~. All rules adopted pursuant to this section shall be adopted in accordance with Chapter 119. of the Revised Code.

Section 2. That existing sections 3701.83 and 3727.44 of the Revised Code are hereby repealed.

Section 3. That sections 3727.42, 3727.43, and 3727.45 of the Revised Code are hereby repealed.

Section 4. That the version of section 3701.83 of the Revised Code that is scheduled to take effect September 30, 2024, be amended to read as follows:

Sec. 3701.83. There is hereby created in the state treasury the general operations fund. Moneys in the fund shall be used for the purposes specified in sections 3701.04, 3701.344, 3711.16, 3717.45, 3718.06, 3721.02, 3721.022, 3727.38, 3729.07, 3733.43, 3748.04, 3748.05, 3748.07, 3748.12, 3748.13, 3749.04, 3749.07, 4736.06, and 4769.09 of the Revised Code.

Section 5. That the existing version of section 3701.83 of the Revised Code that is scheduled to take effect September 30, 2024, is hereby repealed.

Section 6. Sections 4 and 5 of this act take effect September 30, 2024.