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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, Abdullahi, Bird, Brennan, Brent, Brewer, Brown, Callender, Carruthers, Dell'Aquila, Demetriou, Denson, Forhan, Isaacsohn, Jarrells, Jones, Lampton, Lorenz, Mathews, Miller, A., Miller, J., Peterson, Rogers, Sweeney, Upchurch

Senators Cirino, Dolan, Huffman, S., Johnson, Lang, Reineke, Schuring

A BILL

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

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

Section 1. That section 3727.44 be amended; section 3727.44 (3727.38) be amended for the purpose of adopting a new section number as indicated in parentheses; and new section 3727.42 and sections 3727.31, 3727.32, 3727.33, 3727.34,

3727.35, 3727.351, 3727.36, 3727.37, and 3727.41 of the Revised Code be enacted to read as follows:

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

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

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

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

(1) Publicly available information;

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

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

(D) "Publicly available information" means information that is lawfully made available from federal, state, or local

government records or widely available media.

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

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

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

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

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

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

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

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

(B)(1) Subject to divisions (C) and (D) of this section, a hospital located in this state shall maintain and make publicly

available a list of the standard charges for the hospital's shoppable services, as required by the federal price transparency law.

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

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

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

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

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

(1) Improve the accuracy and performance of the internet-based price estimator tool;

(2) Regularly update the underlying data used by the internet-based price estimator tool and audit price estimates generated by the tool for quality assurance purposes.

(D)(1) A hospital shall not sell personal data acquired from the use of the hospital's internet-based price estimator tool by a person in this state.

(2) A hospital shall not use, sell, or process personal data acquired from the use of the hospital's internet-based price estimator tool by a person in this state for the purposes of targeted advertising.

Sec. 3727.33. (A) A hospital shall not do any of the following:

(1)(a) Fail to comply with the requirement to make public the list described in section 3727.32 of the Revised Code;

(b) Fail to comply with the requirements to make public either or both of the lists described in the federal price transparency law.

(2)(a) Fail to maintain the list required by section 3727.32 of the Revised Code in accordance with the requirements of that section;

(b) Fail to maintain either or both of the lists required by the federal price transparency law in accordance with the requirements of 45 C.F.R. 180.

(3) Fail in any other manner to comply with the requirements that apply to the lists under sections 3727.31 to 3727.38 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;

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

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

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

(D)(1) The director of health 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 3727.34 of the Revised Code, is subject to an order imposing an administrative penalty under section 3727.35 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.

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

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

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

(E) Not later than ninety days after the effective date of this section, the director of health 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. 3727.34. (A) If the director of health determines that a hospital has violated division (A) of section 3727.33 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 of health 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 of health. 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. 3727.35. (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:

(a) Violates division (A) of section 3727.33 of the Revised Code;

(b) Violates division (D) of section 3727.34 of the Revised Code.

(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.

(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

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 3727.38 of the Revised Code.

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

(a) In the case of a hospital with a bed count of thirty or fewer, three 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, ten dollars per bed;

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

(2) In setting the amount of the penalty to be imposed on a hospital, the director of health 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 hospital price transparency fund created by section 3727.351 of the Revised Code.

Sec. 3727.351. There is hereby created in the state

treasury the hospital price transparency fund, consisting of administrative penalties collected under section 3727.35 of the Revised Code. The director of health shall administer the fund. The amounts deposited shall be used for purposes of administering and enforcing sections 3727.31 to 3727.38 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. 3727.36. (A) As used in this section:

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

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

(b) A person who 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.

(2) "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.

(3) "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.

(4) "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.

(5) "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.

(6) "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.

(7) "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 to another. "Medical debt collector" includes a medical debt buyer.

(B) 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.

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

additional bill at least thirty days prior to reporting a medical debt to any consumer reporting agency.

(2) The bill shall state that the medical creditor or medical debt collector intends to report the debt to a consumer reporting agency.

(D) The amount reported to the consumer reporting agency shall be the same as the amount stated in the bill.

(E) A medical debt collector shall also provide the notice required by 15 U.S.C. 1692g at least thirty days prior to reporting a debt to a consumer reporting agency.

Sec. 3727.37. The director of health shall prepare reports and submit them in accordance with all 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 3727.33 or division (D) of section 3727.34 of the Revised Code.

(B) Within sixty days after any change to the federal price transparency law, the director shall prepare a report of the director's recommendations for conforming sections 3727.31 to 3727.38 of the Revised Code with the change or, alternatively, stating that no conforming changes are necessary.

(C) The director shall submit the reports required by divisions (A) and (B) of this section 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.

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

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

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

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

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

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

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

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

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

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

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

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

(1) Supplies and procedures;

(2) Room and board;

(3) Use of the facility 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 health care facility, the charges for which are generally referred to as professional fees;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(S) "Standard charge" means the regular rate established by a health care facility for a health care service or item 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.

(T) "Third-party payor" means an entity, excluding governmental health plans, that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care service or item.

Sec. 3727.42. (A) Beginning July 1, 2027, and subject to division (B) of this section, a hospital or multi-hospital system that acquires, or acquired in the past, an existing, independent outpatient physician facility and operates that facility as an outpatient facility subject to the control and direction of the hospital or multi-hospital system shall not require a third-party payor or self-pay individual to pay facility fees in connection with any health care services or items provided to a patient at that outpatient facility.

(B) The requirements of this section apply only to existing outpatient physician facilities purchased or otherwise acquired by a hospital or multi-hospital system. Nothing in this section shall be construed to apply to an outpatient facility that is constructed by a hospital or multi-hospital system, or that did not previously operate as an outpatient physician facility prior to its acquisition by a hospital or multi-hospital system.

Section 2. That existing section 3727.44 of the Revised Code is hereby repealed.

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