#### As Introduced

## **132nd General Assembly**

# Regular Session 2017-2018

H. B. No. 399

### Representatives Henne, Butler

Cosponsors: Representatives DeVitis, Keller, Hood, Becker, Romanchuk, Sprague, Dean, Goodman, Wiggam

#### A BILL

То	amend se	ction 5162	2.80; to	amend for	the purp	ose	1
	of adopt:	ing a new	section n	number as	indicated	d in	2
	parenthes	ses, secti	ion 5162.8	80 (3962.0	02); and t	to	3
	enact sed	ctions 191	1.11, 191	.12, 3962	.01, 3962	.03,	4
	3962.04,	3962.05,	3962.06,	3962.10,	3962.11,		5
	3962.12,	3962.16,	3962.17,	3962.21,	3962.22,		6
	3962.23,	3962.24,	3962.25,	3962.26,	3962.27,		7
	3962.28,	3962.29,	3962.30,	3962.31,	3962.32,		8
	3962.35,	3966.01,	3966.02,	3966.03,	3966.04,		9
	3966.05,	3966.06,	3966.07,	3966.08,	3966.09,	and	10
	5164.65	of the Rev	rised Code	e to enact	t the Ohio	)	11
	Right to	Shop Act	to requi:	re health	insurers	to	12
	establish	n shared s	savings i	ncentive p	programs :	for	13
	enrollees	S.					14

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

Section 1. That section 5162.80 be amended; section	15
5162.80 (3962.02) be amended for the purpose of adopting a new	16
section number as indicated in parentheses; and sections 191.11,	17
191.12, 3962.01, 3962.03, 3962.04, 3962.05, 3962.06, 3962.10,	18

3962.11, 3962.12, 3962.16, 3962.17, 3962.21, 3962.22, 3962.23,	19
3962.24, 3962.25, 3962.26, 3962.27, 3962.28, 3962.29, 3962.30,	20
3962.31, 3962.32, 3962.35, 3966.01, 3966.02, 3966.03, 3966.04,	21
3966.05, 3966.06, 3966.07, 3966.08, 3966.09, and 5164.65 of the	22
Revised Code be enacted to read as follows:	23
Sec. 191.11. As used in this section, "health plan issuer"	24
has the same meaning as in section 3962.01 of the Revised Code.	25
Not later than January 1, 2019, the office of health	26
transformation shall create a standardized prior authorization	27
form for use by health plan issuers for purposes of division (D)	28
of section 3962.22 of the Revised Code.	29
Sec. 191.12. As used in this section, "health care	30
provider" has the same meaning as in section 3962.01 of the	31
Revised Code.	32
Not later than June 30, 2018, the office of health	33
transformation, in consultation with the department of insurance	34
and department of medicaid, shall analyze the administrative	35
burdens placed on health care providers. The analysis shall	36
assess the extent to which the burdens negatively affect the	37
quality of care that health care providers are able to provide,	38
the amount of time that health care providers are able to spend	39
with patients, and the financial stability of health care	40
providers.	41
Sec. 3962.01. As used in this chapter:	42
(A) "Emergency service" means a service furnished to an	43
individual in an emergency, including when the individual	44
presents for care at an emergency department, is directly	45
admitted to a hospital by an individual specified in division	46
(B) (1) of section 3727.06 of the Revised Code, or another	47

instance where a health care provider determines that taking the	48
time to provide a cost estimate for a product, service, or	49
procedure or to transmit the necessary information to the	50
patient's health plan issuer to provide the cost estimate would	51
<pre>endanger the patient.</pre>	52
(B) "Enrollee" means an individual who is enrolled in a	53
health plan issuer's health benefit plan.	54
(C) "Health plan issuer" means an entity subject to the	55
insurance laws and rules of this state, or subject to the	56
jurisdiction of the superintendent of insurance, that contracts,	57
or offers to contract, to provide, deliver, arrange for, pay	58
for, or reimburse any of the costs of health care products,	59
services, or procedures under a health benefit plan. "Health	60
<pre>plan issuer" includes all of the following:</pre>	61
(1) A sickness and accident insurance company;	62
(2) A health insuring corporation;	63
(3) A medicaid managed care organization, as defined in	64
section 5167.01 of the Revised Code;	65
(4) The medicaid program, if a health care product,	66
service, or procedure is provided to a medicaid recipient on a	67
<pre>fee-for-service basis;</pre>	68
(5) A third-party payer, as defined in section 3901.38 of	69
the Revised Code.	70
(D) "Health care provider" means an individual or facility	71
licensed, certified, or accredited under or pursuant to Chapter	72
3721., 3727., 4715., 4725., 4731., 4732., 4734., 4747., 4753.,	73
4755., 4757., or 4779. of the Revised Code.	74
(E) "Necessary information" means all of the following:	75

(1) The name and license number, or other identifier the	76
relevant health plan issuer typically requires, of the health	77
care provider who will provide a health care product, service,	78
or procedure;	79
(2) The applicable CPT code published by the American	80
medical association for a health care product, service, or	81
procedure or, if no CPT code exists, another identifier the	82
relevant health plan issuer requires;	83
(3) The date that a health care product, service, or	84
procedure is to be provided.	85
(F) "Prescriber" has the same meaning as in section	86
4729.01 of the Revised Code, except that it excludes a	87
veterinarian licensed under Chapter 4741. of the Revised Code.	88
(G) "Step therapy protocol" means a protocol or program	89
that establishes a specific sequence in which prescription	90
drugs, items of medical equipment, diagnostic tests, or medical	91
procedures that are for a medical condition and are medically	92
necessary for a particular patient are covered by a health plan	93
<u>issuer.</u>	94
Sec. 5162.80 3962.02. (A) A This section applies on and	95
after January 1, 2019.	96
(B) Except as provided in section 3962.04 of the Revised	97
Code and in emergency situations, a health care provider of	98
medical services licensed, accredited, or certified under-	99
Chapter 3721., 3727., 4715., 4725., 4731., 4732., 4734., 4747.,	100
4753., 4755., 4757., or 4779. of the Revised Code shall provide	101
in writing to a patient or the patient's representative, before	102
products, services, or procedures are a health care product,	103
service, or procedure that is not an emergency service is	104

provided to the patient, a reasonable, good-faith estimate of	105
all of the following for the provider's non-emergency products,	106
services, or procedures the product, service, or procedure,	107
unless a cost estimate is provided directly to the patient or	108
patient's representative by a health plan issuer pursuant to	109
section 3962.10 of the Revised Code:	110
(1) The total amount the provider will charge the patient	111
or the <del>consumer's <u>patient's</u> health plan issuer for the product,</del>	112
service, or procedure the patient is to receive, inclusive of	113
facility, professional, and other fees, along with a short	114
description and the applicable CPT code published by the	115
American medical association for the product, service, or	116
procedure or, if no CPT code exists, another identifier the	117
health plan issuer requires;	118
(2) The If the patient is insured under a health benefit	119
plan, the amount the health care provider expects to receive	120
from the health plan issuer intends to pay for the product,	121
service, or procedure: . The amount specified in the estimate	122
shall be the amount the health plan issuer will reimburse the	123
provider for the product, service, or procedure under a contract	124
with the provider or the applicable government pay scale, if	125
any.	126
(3) The difference, if any, that the consumer patient or	127
other party responsible for the <del>consumer's <u>patient's</u> care would</del>	128
be required to pay to the provider for the product, service, or	129
procedure;	130
(4) If the patient is not insured under a health benefit	131
plan, the total amount the provider will charge the patient for	132
each product, service, or procedure the patient is to receive,	133
inclusive of facility, professional, and other fees, along with	134

a short description and the applicable CPT code published by the	135
American medical association for the product, service, or	136
procedure or, if no CPT code exists, another identifier the	137
health plan issuer requires.	138
Notwithstanding any requirement or exemption under this	139
chapter, a health care provider shall comply with division (B)	140
(4) of this section if a patient is not insured under a health	141
benefit plan.	142
(C) The cost estimate required by this section shall be	143
based on information provided at the time an appointment is made	144
or, in the absence of an appointment, at the time the patient	145
initially presents for the health care product, service, or	146
procedure. In addition, the estimate need not take into account	147
any information that subsequently arises, such as unknown,	148
unanticipated, or subsequently needed health care products,	149
services, or procedures provided for any reason after the	150
initial check-in or appointment. Only one estimate is required	151
per visit.	152
If specific information, such as the health care provider	153
who will be providing the health care product, service, or	154
procedure, is not readily available at the time the appointment	155
is made, the provider may base the cost estimate on an average	156
estimated charge for the product, service, or procedure.	157
(D) The cost estimate required by this section shall be	158
provided within twenty-four hours of the date the appointment	159
for the health care product, service, or procedure is made or	160
the time the patient initially presents for the product,	161
service, or procedure, whichever is sooner.	162
If a health plan issuer does not provide the information	163

necessary to complete the estimate, the health care provider	164
shall notify the patient. The provider may note in the portion	165
of the estimate pertaining to the information required by	166
divisions (B)(2) and (3) of this section that insurance	167
information was not provided as required by law. In this case,	168
the provider may specify only the information required by	169
division (B)(1) of this section and, at the provider's	170
discretion, the information required by division (B)(2) of this	171
section. If the information necessary to complete the estimate	172
is subsequently received and an updated estimate can be provided	173
within the time limit established by this division, the health	174
care provider shall provide the updated estimate.	175
(E) The cost estimate required by this section shall	176
<pre>contain both of the following:</pre>	177
(1) A disclaimer that the information is only an estimate	178
based on facts available at the time it was prepared and that	179
the amounts estimated could change as a result of unknown,	180
unanticipated, or subsequently needed health care products,	181
services, or procedures; changes to the patient's health benefit	182
plan; or other changes. The provider has discretion in how the	183
disclaimer is expressed.	184
(2) A notation that a specific health care provider is	185
out-of-network for the patient, but only if the patient is	186
insured and that information is provided by the health plan	187
<u>issuer.</u>	188
(F) If the amount estimated under division (B)(3) or (4)	189
of this section changes by more than ten per cent before the	190
patient initially presents for the health care product, service,	191
or procedure, the health care provider shall supply to the	192
patient an updated estimate within the time limit established by	193

division (D) of this section.	194
(G) The cost estimate required by this section may be	195
provided verbally or in electronic or written form.	196
(H) A patient may decline to receive a cost estimate under	197
this section.	198
(I) A patient is responsible for payment for an	199
administered health care product, service, or procedure even if	200
the patient does not receive a cost estimate under this section	201
before the product, service, or procedure is received.	202
(J)(1) If a patient is to receive a health care product,	203
service, or procedure in a hospital, the hospital is responsible	204
for providing one comprehensive cost estimate to the patient or	205
the patient's representative. The comprehensive cost estimate	206
shall contain both of the following:	207
(a) All information in division (B) of this section	208
associated with products, services, or procedures to be provided	209
by the hospital or its employees;	210
(b) All information in division (B) of this section	211
associated with products, services, or procedures to be provided	212
by health care providers who are independent contractors of the	213
hospital.	214
(2) A health care provider who is an independent	215
contractor of a hospital shall submit to the hospital all CPT	216
codes or other identifiers the hospital needs to fulfill its	217
responsibility under division (J)(1)(b) of this section.	218
(3) In the event a hospital must provide the necessary	219
information for one independent contractor, the hospital shall	220
submit the information not later than forty-eight hours after	221

the appointment is made. In the event a hospital must provide	222
the necessary information for two or more independent	223
contractors, the hospital shall submit the information not later	224
than seventy-two hours after the appointment is made.	225
(B) Any health plan issuer contacted by a provider-	226
described in division (A) of this section in order for the-	227
provider to obtain information so that the provider can comply-	228
with division (A) of this section shall provide such information	229
to the provider within a reasonable time of the provider's-	230
request.	231
(C) As used in this section, "health plan issuer" means an	232
entity subject to the insurance laws and rules of this state, or	233
subject to the jurisdiction of the superintendent of insurance,	234
that contracts, or offers to contract, to provide, deliver,	235
arrange for, pay for, or reimburse any of the costs of health	236
care services under a health benefit plan, including a sickness-	237
and accident insurance company and a health insuring	238
corporation. "Health plan issuer" also includes a managed care-	239
organization under contract with the department of medicaid and,	240
if the services are to be provided on a fee-for-service basis,	241
the Medicaid program.	242
(D) The medicaid director shall adopt rules, in accordance	243
with Chapter 119. of the Revised Code, to carry out this	244
section.	245
Sec. 3962.03. (A) This section applies during the period	246
beginning on the effective date of this section and ending	247
<u>December 31, 2018.</u>	248
(B) In the case of health care products, services, and	249
procedures for which a health care provider submits to a health	250

plan issuer CPT codes and product identifiers for purposes of	251
obtaining precertification of health benefit plan coverage, the	252
health plan issuer shall provide cost estimates directly to	253
patients or their representatives. Each estimate shall contain	254
the same information that is required when an estimate is	255
provided under section 3962.02 of the Revised Code, but shall	256
expressly state at the top of the estimate, in boldface type,	257
both of the following:	258
(1) That the estimate is being provided only for those	259
health care products, services, and procedures for which the	260
health care provider is requesting verification of health	261
benefit plan coverage and that the estimate may not include all	262
products, services, and procedures the patient is scheduled to	263
receive;	264
(2) That beginning January 1, 2019, an estimate will be	265
provided for all health care products, services, and procedures	266
the patient is to receive rather than only those for which the	267
provider is requesting verification of health benefit plan	268
coverage, except for office visits as provided in section	269
3962.04 of the Revised Code.	270
Sec. 3962.04. (A) As used in this section, "office visit"	271
means the family of CPT codes for "Evaluation and Management,	272
Office Visits Established" (codes 99211, 99212, 99213, 99214,	273
and 99215) used for office or other outpatient visits for an	274
<pre>established patient.</pre>	275
(B) The requirements in sections 3962.02 and 3962.10 of	276
the Revised Code do not apply when the only service a health	277
<pre>care provider will provide is an office visit.</pre>	278
(C) In the event a patient schedules or presents for	279

health care products, services, or procedures in addition to an	280
office visit but the health care provider is unable to estimate	281
the level of office visit to be provided, the provider may	282
enter, and the web site the health plan issuer creates under	283
division (D)(1)(a) of section 3962.11 of the Revised Code shall	284
provide for, a general designation for an unknown level of	285
office visit. The estimate provided through the health care	286
provider or health plan issuer under section 3962.02 or 3962.10	287
of the Revised Code, respectively, shall list the general	288
designation and price range for all levels of office visits.	289
Sec. 3962.05. On request of a patient or the patient's	290
representative, a health care provider shall provide the	291
necessary information pertaining to a health care product,	292
service, or procedure directly to the patient not more than	293
twenty-four hours after the patient or the patient's	294
representative makes an appointment or, in the absence of an	295
appointment, the patient presents for the health care product,	296
service, or procedure.	297
Sec. 3962.06. The department of health, the department of	298
medicaid, and the licensing boards created under Title XLVII of	299
the Revised Code that regulate health care providers shall	300
collaborate to publish a document that specifies the	301
responsibilities of health care providers under section 3962.02	302
of the Revised Code. The agency or board with jurisdiction over	303
a health care provider shall send a copy of the document to the	304
provider annually. The copy may be sent by electronic means.	305
Sec. 3962.10. (A) This section applies on and after	306
January 1, 2019.	307
(B) Except as provided in section 3962.04 of the Revised	308
Code and in emergency situations, a health plan issuer shall	309

directly provide to an enrollee or the enrollee's representative	310
a reasonable, good faith estimate of the amounts specified in	311
divisions (B)(1) to (3) of section 3962.02 of the Revised Code.	312
The cost estimate shall be provided before any health care	313
product, service, or procedure that is not an emergency service	314
is provided to the enrollee.	315
(C) When an individual is enrolled in a health benefit	316
plan, and during a health plan issuer's open enrollment period,	317
the issuer shall ask the enrollee or the enrollee's	318
representative whether that individual would prefer to receive	319
cost estimates by electronic mail, a smartphone application, or	320
regular mail. The health plan issuer shall send cost estimates	321
by the means elected. If the means elected is by electronic mail	322
or smartphone application, the estimate shall be sent	323
automatically, but not later than five minutes after the health	324
plan issuer has received the necessary information from the	325
health care provider. If the means elected is by regular mail,	326
the estimate shall be mailed not later than twenty-four hours	327
after the health plan issuer has received the necessary	328
information from the health care provider if the procedure will	329
be provided more than two days from the date the estimate is	330
generated. If no election is made, the estimate shall be sent as	331
<pre>follows:</pre>	332
(1) By electronic mail, if the email address of the	333
enrollee or the enrollee's representative is on file with the	334
health plan issuer;	335
(2) By regular mail, unless the health care product,	336
service, or procedure will be provided less than two days from	337
the date the estimate is generated.	338
(D)(1) The cost estimate required by this section shall be	339

based on information provided at the time an appointment is made	340
or, in the absence of an appointment, at the time the patient	341
initially presents for the health care product, service, or	342
procedure. In addition, the estimate need not take into account	343
any information that subsequently arises, such as unknown,	344
unanticipated, or subsequently needed health care products,	345
services, or procedures provided for any reason after the	346
initial check-in or appointment. Only one estimate is required	347
per visit.	348
(2) If specific information, such as the provider who will	349
be providing the health care product, service, or procedure, is	350
not readily available at the time the appointment is made or	351
when the enrollee presents for the health care product, service,	352
or procedure, the health care provider may transmit that a	353
provider is unknown as part of the necessary information and the	354
health plan issuer may base the estimate on an average estimated	355
charge for the product, service, or procedure at that facility	356
or location.	357
(3) If a health care provider does not supply to the	358
health plan issuer the necessary information to generate the	359
cost estimate, the issuer shall send to the enrollee or the	360
enrollee's representative, by the same means used to send	361
estimates, a notice that the provider failed to supply the	362
necessary information as required by law and, consequently, a	363
cost estimate could not be generated. This action shall be taken	364
in the event a provider gives the issuer any indication that	365
receipt of a health care product, service, or procedure is	366
scheduled, such as through precertification.	367
(E) The estimate required by this section shall contain	368
both of the following:	369

(1) A disclaimer that the information is only an estimate	370
based on facts available at the time it was prepared and that	371
the amounts estimated could change as a result of other factors;	372
unknown, unanticipated, or subsequently needed health care	373
products, services, or procedures; or changes to the enrollee's	374
health benefit plan. The health plan issuer has discretion in	375
how the disclaimer is expressed.	376
(2) If applicable, a notation that a specific health care	377
<pre>provider is out-of-network for the enrollee.</pre>	378
(F) The estimate required by this section shall be	379
provided in large font, be easy to understand, and, unless the	380
estimate contains more than nine CPT codes or product	381
identifiers, be limited to one page.	382
(G)(1) A health plan issuer shall provide the estimate	383
required by this section within five minutes of receiving the	384
necessary information from the health care provider pursuant to	385
section 3962.11 of the Revised Code.	386
(2) If the amount in the estimate required by this section	387
changes by more than ten per cent from the time an appointment	388
is made to the time the enrollee presents for the health care	389
product, service, or procedure, the health plan issuer shall	390
supply to the enrollee an updated estimate within five minutes	391
of receiving the updated information.	392
(H) An enrollee may decline to receive a cost estimate	393
under this section.	394
(I) An enrollee is responsible for payment for an	395
administered health care product, service, or procedure even if	396
the enrollee does not receive a cost estimate under this section	397
before the product, service, or procedure is received	398

(J) The affirmative obligation of a health plan issuer to	399
provide an estimate directly to a patient as required by this	400
section obviates the requirements on a health care provider to	401
provide an estimate pursuant to section 3962.02 of the Revised	402
Code unless the provider elects to fulfill the obligation	403
pursuant to section 3962.12 of the Revised Code.	404
Sec. 3962.11. (A) This section applies on and after	405
January 1, 2019.	406
(B) Not more than twenty-four hours after an enrollee or	407
the enrollee's representative makes an appointment or, in the	408
absence of an appointment, the enrollee presents for a health	409
care product, service, or procedure, a health care provider	410
shall provide to a health plan issuer the necessary information	411
through the web site described in division (D)(1)(a) of this	412
section.	413
(C)(1) If an enrollee is to receive a health care product,	414
service, or procedure in a hospital, the hospital is responsible	415
for providing to a health plan issuer the necessary information,	416
<pre>including both of the following:</pre>	417
(a) All necessary information associated with products,	418
services, or procedures to be provided by the hospital or its	419
<pre>employees;</pre>	420
(b) All necessary information associated with products,	421
services, or procedures to be provided by health care providers	422
who are independent contractors of the hospital.	423
(2) A health care provider who is an independent	424
contractor of a hospital shall submit to the hospital all CPT	425
codes or other identifiers the hospital needs to fulfill its	426
responsibility under division (C)(1)(b) of this section.	427

(3) In the event a hospital must provide the necessary	428
information for one independent contractor, the hospital shall	429
submit the necessary information not later than forty-eight	430
hours after the appointment is made. In the event a hospital	431
must provide the necessary information for two or more	432
independent contractors, the hospital shall submit the necessary	433
information not later than seventy-two hours after the	434
appointment is made.	435
(D)(1) To facilitate a health care provider's transmission	436
of the necessary information and to promote health care price	437
transparency for enrollees, each health plan issuer shall create	438
and maintain all of the following:	439
(a) A web site for health care providers to transmit the	440
necessary information. A health plan issuer shall maintain only	441
one web site for all of its and its affiliates' and related	442
entities' health benefit plans through which providers may enter	443
necessary information without regard to the specific plan	444
offered by the issuer. The web site shall permit all providers	445
to quickly and easily enter the necessary information for each	446
patient appointment or visit. The issuer shall not require the	447
provider to enter more than the necessary information, such as	448
the patient's particular plan.	449
(b) A web site that can be instantly accessed by a health	450
care provider that elects to provide cost estimates pursuant to	451
section 3962.12 of the Revised Code through which the provider,	452
upon entering the necessary information, may generate within	453
five minutes a cost estimate that the provider may then give the	454
patient electronically, in writing, or verbally;	455
(c) A web site through which an enrollee or the enrollee's	456
representative, upon entering the necessary information, may	457

search for other health care providers and generate a	458
corresponding cost estimate for a health care product, service,	459
or procedure for the purpose of cost comparison.	460
(2) Access to a web site created and maintained in	461
accordance with this section shall be provided free of charge.	462
(3) Not later than October 15, 2018, each health plan	463
issuer shall report to the superintendent of insurance the	464
internet addresses of its web sites that comply with this	465
section. The superintendent shall post those addresses on the	466
web site of the department of insurance. The superintendent	467
shall monitor the health plan issuers' web sites to ensure	468
compliance with this section. The superintendent may impose a	469
fine or withhold licensure if an issuer fails to create and	470
maintain web sites that comply with this section.	471
Sec. 3962.12. (A) A health care provider may elect to	472
provide an enrollee or enrollee's representative with a cost	473
estimate by complying with section 3962.10 of the Revised Code	474
as if the provider were a health plan issuer. If a health care	475
provider elects to provide a cost estimate under this section, a	476
health plan issuer shall give the provider access to the web	477
site created under division (D)(1)(b) of section 3962.11 of the	478
Revised Code.	479
On request, and not more than five minutes after all	480
necessary information has been received from a health care	481
provider, a health plan issuer shall submit to the health care	482
provider all information that is needed by the provider to	483
generate the cost estimate. The health plan issuer may provide	484
the information either verbally or in electronic form. The	485
health plan issuer shall not charge a health care provider for	486
the information.	487

A health plan issuer shall make itself readily available	488
to provide information to a health care provider to generate the	489
<pre>cost estimate.</pre>	490
(B) A health plan issuer is not required to provide a cost	491
estimate pursuant to section 3962.10 of the Revised Code if a	492
health care provider elects to provide the estimate under this	493
section, but the health plan issuer may provide a cost estimate	494
at its discretion using the necessary information received from	495
the health care provider.	496
Sec. 3962.16. A health care provider or health plan issuer	497
that provides a cost estimate under this chapter is not liable	498
in damages in a civil action for injury, death, or loss to	499
person or property that allegedly arises from an act or omission	500
associated with providing the estimate if the health care	501
provider or health plan issuer made a good faith effort to	502
collect the information required to complete the estimate and a	503
good faith effort to provide the estimate to the patient or	504
<pre>enrollee.</pre>	505
Sec. 3962.17. (A) If, after completing an examination	506
involving information collected from a six-month period, the	507
superintendent of insurance, department of health, or	508
appropriate regulatory board, as applicable, finds that a health	509
plan issuer or health care provider has committed a series of	510
violations that, taken together, constitute a consistent pattern	511
or practice of violating the requirements of this chapter to	512
provide cost estimates to patients or enrollees, the	513
superintendent, department, or board may impose on the issuer or	514
provider any of the administrative remedies specified in	515
division (B) of this section.	516
Before imposing an administrative remedy, the	517

superintendent, department, or board shall give written notice	518
to the health plan issuer or health care provider informing that	519
party of the reasons for the finding, the administrative remedy	520
that is proposed, and the opportunity to submit a written	521
request for an administrative hearing regarding the finding and	522
proposed remedy. If a hearing is requested, the superintendent,	523
department, or board shall conduct the hearing in accordance	524
with Chapter 119. of the Revised Code not later than fifteen	525
days after receipt of the request.	526
(B) In imposing administrative remedies under this	527
section, the superintendent, department, or appropriate	528
regulatory board may do either or both of the following:	529
(1) Levy a monetary penalty in an amount determined in	530
accordance with division (C) of this section;	531
(2) Order the health plan issuer or health care provider	532
to cease and desist from engaging in the violations.	533
(C)(1) A finding by the superintendent, department, or	534
appropriate regulatory board that a health plan issuer or health	535
care provider has committed a series of violations that, taken	536
together, constitutes a consistent pattern or practice of	537
violating the requirements of this chapter to provide cost	538
estimates to patients or enrollees, shall constitute a single	539
offense for purposes of levying a fine as described in division	540
(B) (1) of this section.	541
(2) For a first offense, the superintendent or department	542
may levy a fine of not more than one hundred thousand dollars;	543
the appropriate regulatory board may levy a fine of not more	544
than ten thousand dollars. For a second offense that occurs on	545
or earlier than four years after the first offense, the	546

superintendent or department may levy a fine of not more than	547
one hundred fifty thousand dollars; the appropriate regulatory	548
board may levy a fine of not more than fifteen thousand dollars.	549
For a third or additional offense that occurs on or earlier than	550
seven years after a first offense, the superintendent or	551
department may levy a fine of not more than three hundred	552
thousand dollars; the appropriate regulatory board may levy a	553
fine of not more than thirty thousand dollars.	554
(3) In determining the amount of a fine to be levied	555
within the limits specified in division (C)(2) of this section,	556
the superintendent, department, or appropriate regulatory board	557
shall consider the following factors:	558
(a) The extent and frequency of the violations;	559
(b) Whether the violations were due to circumstances	560
beyond the control of the health plan issuer or health care	561
<pre>provider;</pre>	562
(c) Any remedial actions taken by the health plan issuer	563
or health care provider;	564
(d) The actual or potential harm to others resulting from	565
the violations;	566
(e) If the health plan issuer or health care provider	567
knowingly and willingly committed the violations;	568
(f) The financial condition of the health plan issuer or	569
health care provider;	570
(g) Any other factors the superintendent, department, or	571
appropriate board considers appropriate.	572
(D) The amounts collected from levying fines under this	573
section shall be paid into the state treasury to the credit of	574

the general revenue fund.	575
Sec. 3962.21. Once a health care provider seeking to	576
generate a cost estimate submits CPT codes to a web site a	577
health plan issuer has created under division (D)(1)(a) of	578
section 3962.11 of the Revised Code, the web site shall direct	579
the provider to a link that the provider can use to obtain	580
online precertification from the issuer. Once CPT codes are	581
submitted for the purpose of generating a cost estimate, a	582
health plan insurer shall not require the provider to submit the	583
codes again for the purpose of precertification.	584
Sec. 3962.22. (A) Beginning July 1, 2018, a health plan	585
issuer shall not require a prescriber to obtain prior	586
authorization before prescribing a drug or item of medical	587
equipment to a patient or performing a medical procedure or	588
diagnostic test on a patient if that prescriber, within the	589
immediately preceding three-year period before the effective	590
date of this section, was in the top twenty-five per cent of	591
prescribers who had prior authorization requests approved. A	592
health plan issuer shall notify each prescriber who is exempt	593
from the requirement. Every six months thereafter, beginning	594
January 1, 2019, a health plan issuer shall make a	595
redetermination of which prescribers qualify for the exemption	596
and notify them. Health plan issuers may combine information	597
they have about prescribers and apply the exemption uniformly.	598
(B) A health plan issuer shall not require a prescriber to	599
obtain prior authorization for a drug that costs one hundred	600
dollars or less for a thirty-day supply or for an item of	601
medical equipment, procedure, or diagnostic test that costs one	602
hundred dollars or less.	603
(C) A health plan issuer shall not require a prescriber to	604

obtain prior authorization for a drug or item of medical	605
equipment that had been the subject of a prior authorization	606
request for the same course of treatment if the drug or item is	607
to treat a chronic disease or medical condition.	608
(D) A health plan issuer shall not require a prescriber to	609
use a prior authorization form that differs from the	610
standardized prior authorization form created by the office of	611
health transformation under section 191.11 of the Revised Code.	612
Sec. 3962.23. A health plan issuer shall not impose a step	613
therapy protocol on a prescriber who is seeking to prescribe a	614
drug or perform a diagnostic test or medical procedure for	615
treatment of a patient's particular condition that is in a later	616
step of the applicable sequence if both of the following are the	617
<pre>case:</pre>	618
(A) The patient has already tried, in the five-year period	619
preceding the date the prescription is to be issued or the test	620
or procedure is to be performed, either of the following:	621
(1) A drug that is in a lower step of the sequence or a	622
drug in the same pharmacologic class or with the same mechanism	623
of action that is in a lower step of the sequence;	624
(2) A diagnostic test or medical procedure that is in a	625
lower step of the sequence.	626
(B) With respect to a drug, the drug is determined to lack	627
efficacy or effectiveness, have a diminished effect on the	628
patient's condition, or cause the patient to experience an	629
adverse event. With respect to a diagnostic test or medical	630
procedure, the test or procedure is contraindicated for the	631
patient because it poses a danger to the patient's health.	632
Sec. 3962.24. A health plan issuer shall offer a grace	633

period of at least sixty days for any step therapy protocol or	634
prior authorization protocol for a patient who is already	635
stabilized on a particular medical treatment or drug regimen	636
upon enrollment in the issuer's plan. During this period, a	637
medical treatment or drug regimen shall not be interrupted while	638
any utilization management requirements, such as prior	639
authorization, step therapy overrides, or formulary exceptions,	640
are addressed.	641
Sec. 3962.25. A health plan issuer shall cover for the	642
entire duration of a health benefit plan period, without	643
restrictions, a drug, item of medical equipment, medical	644
procedure, or diagnostic test that is removed from the issuer's	645
formulary or is subject to new coverage restrictions after the	646
beneficiary enrollment period has ended unless the drug, item,	647
procedure, or test is no longer made available to any patient or	648
is prohibited.	649
Sec. 3962.26. A utilization review entity that is part of	650
a health plan issuer, or under contract with an issuer, shall	651
not require a patient to repeat step therapy protocols or retry	652
therapies that failed under coverage provided by another health	653
plan issuer before authorizing coverage of a different drug or	654
therapy.	655
Sec. 3962.27. A utilization review entity that is part of	656
a health plan issuer, or under contract with a health plan	657
issuer, shall provide accurate, patient-specific, and updated	658
formularies that include prior authorization and step therapy	659
protocol requirements in electronic health record systems for	660
use in e-prescribing and other purposes.	661
Sec. 3962.28. A utilization review entity that is part of	662
a health plan issuer, or under contract with a health plan	663

issuer, that requires health care providers to adhere to prior	664
authorization protocols shall accept and respond to prior	665
authorization and step therapy protocol override requests	666
exclusively through secure electronic transmissions using	667
standard electronic transactions for pharmacy and medical	668
services benefits. Facsimile, proprietary payer web-based	669
portals, telephone discussions, and nonstandard electronic forms	670
shall not be considered electronic transmissions.	671
Sec. 3962.29. Not later than January 1, 2021, a vendor of	672
electronic health record systems shall provide updated software	673
that enables health care providers to transmit prior	674
authorization requests or step therapy protocol overrides	675
without having to resubmit the same information.	676
Sec. 3962.30. Not later than January 1, 2021, the	677
department of insurance shall ensure that a single health	678
information exchange exists that a health care provider can use	679
to generate cost estimates and precertifications for patients	680
regardless of each patient's coverage.	681
Sec. 3962.31. Not later than January 1, 2021, health plan	682
issuers shall perform medical chart audits electronically	683
through health information exchanges.	684
Sec. 3962.32. To the extent possible, in complying with	685
sections 3962.22 to 3962.30 of the Revised Code, a health plan	686
issuer shall also comply with sections 1751.72, 3923.041, and	687
5160.34 of the Revised Code, as applicable, regarding prior	688
authorizations.	689
Sec. 3962.35. (A) All of the following may adopt any rules	690
necessary to carry out this chapter:	691
(1) The superintendent of insurance;	692

(2) The medicaid director;	693
(3) The director of health;	694
(4) Any other relevant department, agency, board, or other	695
entity that regulates, licenses, or certifies a health care	696
provider or health plan issuer.	697
(B) Any rules adopted under this section shall be adopted	698
in accordance with Chapter 119. of the Revised Code.	699
Sec. 3966.01. As used in this chapter:	700
(A) "Allowed amount" means the contractually agreed upon	701
amount paid by a health plan issuer to a health care provider	702
for covered health care services provided to a patient under a	703
health benefit plan.	704
(B) "Health care provider" has the same meaning as in	705
section 3701.74 of the Revised Code.	706
(C) "Health benefit plan" and "health plan issuer" have	707
the same meanings as in section 3922.01 of the Revised Code.	708
(D) "Shared savings incentive program" means a program	709
established by a health plan issuer in accordance with section	710
3966.05 of the Revised Code under which the health plan issuer	711
provides to an individual covered under a health benefit plan	712
offered by the issuer a shared savings incentive payment for	713
utilizing a shoppable health care service.	714
(E) "Shoppable health care service" means a health care	715
service for which a health plan issuer offers a shared savings	716
incentive payment under a shared savings incentive program.	717
Sec. 3966.02. (A) Except as provided in section 3966.06 of	718
the Revised Code, a health plan issuer shall develop and	719

implement a shared savings incentive program for individuals	720
covered under a health benefit plan offered by the issuer. The	721
program shall provide incentive payments to insured individuals	722
who elect to receive a shoppable health care service from a	723
health care provider that charges less than the average price	724
paid by the issuer for that health care service. Shoppable	725
health care services shall include health care services in the	726
<pre>following categories:</pre>	727
(1) Physical and occupational therapy services;	728
(2) Obstetrical and gynecological services;	729
(3) Radiology and imaging services;	730
(4) Laboratory services;	731
(5) Infusion therapy;	732
(6) Inpatient and outpatient surgical procedures;	733
(7) Outpatient nonsurgical diagnostic tests or procedures;	734
(8) Any other category determined by the superintendent of	735
<u>insurance.</u>	736
(B)(1) A health plan issuer may calculate incentives	737
offered under the program in any of the following manners:	738
(a) As the difference in price between the shoppable	739
health care service and the average price paid by the issuer for	740
that service;	741
(b) As a flat dollar amount;	742
(c) By any other reasonable methodology approved by the	743
superintendent of insurance.	744
(2) The shared savings incentive program shall provide	745

insured individuals with at least fifty per cent of the issuer's	746
saved costs for each shoppable health care service. An issuer is	747
not required to provide a payment or credit to an insured	748
individual if the issuer's saved costs is fifty dollars or less.	749
An insured individual may elect to have the health plan	750
issuer apply the balance of any shared savings incentive payment	751
due to the individual to offset the cost of any out-of-pocket	752
expenses incurred by the individual under the health benefit	753
plan. An incentive payment may be used as an offset in this	754
manner during the three plan years immediately following the	755
plan year during which the incentive payment is credited to the	756
individual.	757
(C) A health plan issuer shall calculate the average price	758
paid for a health care service based on the average amount paid	759
by the issuer to a health care provider in this state for the	760
service under the health benefit plan over a twelve-month period	761
occurring not earlier than two calendar years before the	762
calculation, adjusted for inflation using the price index for	763
personal consumption expenditures by function: health, published	764
by the United States bureau of labor statistics or its successor	765
index. A health plan issuer annually shall recalculate the	766
average price paid data. An issuer may use an alternative	767
methodology for calculating the average price for a health care	768
service if the methodology is approved by the superintendent.	769
(D) A health plan issuer shall issue any shared savings	770
incentive payments due to an insured individual under this	771
section without any action or request on the part of the insured	772
individual. Each health plan issuer shall develop and maintain	773
an internet-based system by which an insured individual can	774
track the individual's current shared savings incentive payments	775

and incentive payment history.	776
Sec. 3966.03. A health plan issuer shall establish an	777
interactive mechanism on its public web site that enables an	778
insured individual to request and obtain from the issuer	779
information on the average price paid by the issuer to a	780
participating health care provider for a particular health care	781
service, as calculated under division (C) of section 3966.02 of	782
the Revised Code. The interactive mechanism shall allow an	783
insured individual to compare costs among network providers.	784
Sec. 3966.04. A health plan issuer shall make its shared	785
savings incentive program available under all health benefit	786
plans offered in this state by the issuer. The issuer shall	787
annually, at enrollment or renewal, provide to an insured	788
individual notice about the availability of the program.	789
Sec. 3966.05. (A) Prior to offering a shared savings	790
incentive program to an insured individual, a health plan issuer	791
shall file a description of the program with the superintendent	792
of insurance in the manner determined by the superintendent.	793
(B) The superintendent shall review a filing made by a	794
health plan issuer pursuant to this section to ensure the	795
program complies with the requirements of this chapter.	796
(C) Filings and any supporting documentation made under	797
this section are confidential until the filing has been reviewed	798
by the superintendent.	799
Sec. 3966.06. If an insured individual elects to receive a	800
shoppable health care service from a health care provider that	801
is out-of-network under the individual's health benefit plan,	802
the health plan issuer shall provide to the individual, in a	803
health savings account established by the issuer for the	804

<u>individual</u> , a shared savings incentive payment equal to fifty	805
per cent of the savings to the issuer. The savings shall be	806
calculated as the difference in price between the shoppable	807
health care service and the average price paid by the issuer for	808
that service, as described in section 3966.02 of the Revised	809
Code. The insured individual may access the funds in the health	810
savings account for use toward any cost sharing requirement	811
specified for the service under the plan, as if the service was	812
provided by an in-network provider or other medical services.	813
Sec. 3966.07. A shared savings incentive payment made by a	814
health plan issuer to an insured individual under a shared	815
savings incentive program is not an administrative expense of	816
the issuer for rate development or rate filing purposes.	817
Sec. 3966.08. (A) Beginning in 2019 and annually	818
thereafter, a health plan issuer shall file with the	819
superintendent of insurance the following information from the	820
most recent calendar year about its shared savings incentive	821
<pre>program:</pre>	822
(1) The total number of shared savings incentive payments	823
<pre>made by the issuer;</pre>	824
(2) The monetary total of all shared savings incentive	825
payments made by the issuer;	826
(3) The total number of shared savings incentive payments	827
made by the issuer for each category of shoppable health care	828
services described in division (A) of section 3966.02 of the	829
Revised Code;	830
(4) The average monetary total of shared savings incentive	831
payments made by the issuer for each category of shoppable	832
health care service described in division (A) of section 3966.02	833

of the Revised Code;	834
(5) The total savings achieved for all shoppable health	835
care services as compared to the average prices for those	836
services;	837
(6) The total number of insured individuals who	838
participated in the program;	839
(7) The percentage of individuals insured by the issuer	840
who participated in the program.	841
(B) Beginning in 2019 and annually thereafter, the	842
superintendent shall submit an aggregate report for all health	843
plan issuers filing information under division (A) of this	844
section. The report shall be submitted to all of the following	845
<pre>individuals and entities:</pre>	846
(1) The speaker of the house of representatives;	847
(2) The president of the senate;	848
(3) The ranking minority members of the house of	849
representatives and the senate;	850
(4) The standing committees in the house of	851
representatives and the senate having jurisdiction over health	852
<pre>insurance matters.</pre>	853
Sec. 3966.09. The superintendent of insurance may adopt	854
rules in accordance with Chapter 119. of the Revised Code as	855
necessary to implement the provisions of this chapter.	856
Sec. 5164.65. In accordance with the definition of "health	857
plan issuer" established under section 3962.01 of the Revised	858
Code, the medicaid program shall comply with Chapter 3962. of	859
the Revised Code as a health plan issuer.	860

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Section 2. That existing section 5162.80 of the Revised Code is hereby repealed.	861 862
Section 3. Sections 3966.01 to 3966.09 of the Revised	863
Code, as enacted by this act, shall take effect six months after	864
the effective date of this act.	865