

**As Introduced**

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

**H. B. No. 160**

**Representative Holmes**

**Cosponsors: Representatives Click, Gross, Jones, Lanese, Loychik, Riedel, Stein,  
McClain, Zeltwanger**

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**A BILL**

To enact sections 3962.01, 3962.011, 3962.02, 1  
3962.03, 3962.04, 3962.05, 3962.06, 3962.07, 2  
3962.08, 3962.09, 3962.10, 3962.11, 3962.111, 3  
3962.12, 3962.13, 3962.14, 3962.15, 5162.801, 4  
and 5164.65 of the Revised Code regarding the 5  
provision of health care cost estimates. 6

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

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

**Sec. 3962.01.** As used in this chapter: 12

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Before a health care provider may provide a health care product, service, or procedure to a patient, the patient or the patient's representative shall receive a reasonable, good faith cost estimate for the product, service, or procedure, except that the cost estimate requirement does not apply in any of the following cases: 74  
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(1) When a patient seeks emergency services, as defined in section 1753.28 of the Revised Code; 80  
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(2) When a health care provider believes that a delay in care associated with fulfilling the requirement could harm the patient; 82  
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(3) When a circumstance described in section 3962.08 of the Revised Code occurs. 85  
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(C) A health care provider may elect to provide the cost estimate in the manner described in section 3962.04 of the Revised Code or, if the patient is insured under a health benefit plan, may elect to have the patient's health plan issuer provide the cost estimate after the provider has transmitted information to the issuer in accordance with section 3962.05 of the Revised Code. The health care provider shall notify the patient or the patient's representative of the provider's decision regarding the party that will provide the cost estimate. 87  
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The provision of a cost estimate by a health care provider does not preclude a health plan issuer from also providing a cost estimate to a patient or the patient's representative. 97  
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(D) A patient or the patient's representative may decline to receive the cost estimate required by this section. 100  
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(E) Each health care provider or health plan issuer that 102

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

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

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

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

<u>issuers to process claims for that product, service, or</u>	133
<u>procedure.</u>	134
<u>(2) If the patient is insured under a health benefit plan,</u>	135
<u>the cost estimate shall include both of the following:</u>	136
<u>(a) A notation regarding whether the health care provider</u>	137
<u>is in-network or out-of-network for the patient's health benefit</u>	138
<u>plan;</u>	139
<u>(b) The amount the health care provider expects to receive</u>	140
<u>from the health plan issuer for the health care product,</u>	141
<u>service, or procedure based on the information the issuer gives</u>	142
<u>to the provider under division (E) (3) of this section.</u>	143
<u>(3) The cost estimate shall identify the difference, if</u>	144
<u>any, between the amount that will be charged and the amount that</u>	145
<u>the patient or other party responsible for the patient's care</u>	146
<u>will be required to pay to the health care provider for the</u>	147
<u>health care product, service, or procedure.</u>	148
<u>(B) (1) If a patient is to receive a health care product,</u>	149
<u>service, or procedure in a hospital, the hospital is responsible</u>	150
<u>for providing one comprehensive cost estimate to the patient or</u>	151
<u>the patient's representative within the applicable time frame</u>	152
<u>specified in division (D) of this section. The comprehensive</u>	153
<u>cost estimate shall include all information specified in</u>	154
<u>division (A) of this section associated with the health care</u>	155
<u>product, service, or procedure.</u>	156
<u>(2) A hospital's responsibility to provide a comprehensive</u>	157
<u>cost estimate applies in both of the following circumstances:</u>	158
<u>(a) When the health care product, service, or procedure is</u>	159
<u>to be provided by the hospital or its employees;</u>	160

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

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

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

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

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

frames is applicable: 191

(a) If the patient is insured under a health benefit plan and division (D) (1) (c) of this section does not apply, the cost estimate shall be provided not later than twenty-four hours after the health care provider receives from the health plan issuer, pursuant to division (E) (3) of this section, the information the provider needs to generate the cost estimate. 192  
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(b) If the patient is not insured under a health benefit plan and division (D) (1) (c) of this section does not apply, the cost estimate shall be provided not later than twenty-four hours after the time the appointment for the health care product, service, or procedure is made, as specified under any of the circumstances described in division (A) of section 3962.011 of the Revised Code. 198  
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(c) If the health care product, service, or procedure is to be provided less than three days after the time the appointment for the health care product, service, or procedure is made, as specified under any of the circumstances described in division (A) of section 3962.011 of the Revised Code, the cost estimate shall be provided at the time the patient presents to receive the product, service, or procedure. 205  
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(2) In the case of a health care product, service, or procedure that is to be provided by one or more independent contractors of a health care provider, a cost estimate provided under this section shall be provided in accordance with whichever of the following time frames is applicable: 212  
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(a) If the patient is insured under a health benefit plan and division (D) (2) (c) of this section does not apply, the cost estimate shall be provided not later than thirty-six hours after 217  
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the health care provider receives from the health plan issuer, 220  
pursuant to division (E) (3) of this section, the information the 221  
provider needs to generate the cost estimate. 222

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

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

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

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

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

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

(a) The patient's name; 254

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The patient's name; 372

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

of this section constitutes a single offense. 717

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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