

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

To amend section 5162.80; to amend for the purpose 1
of adopting a new section number as indicated in 2
parentheses, section 5162.80 (3962.02); and to 3
enact sections 191.11, 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 Revised Code to enact the Ohio 11
Right to Shop Act to require health insurers to 12
establish shared savings incentive programs for 13
enrollees. 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
endanger the patient. 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
plan issuer" includes all of the following: 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
fee-for-service basis; 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 relevant health plan issuer typically requires, of the health care provider who will provide a health care product, service, or procedure; 76
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(2) The applicable CPT code published by the American medical association for a health care product, service, or procedure or, if no CPT code exists, another identifier the relevant health plan issuer requires; 80
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(3) The date that a health care product, service, or procedure is to be provided. 84
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(F) "Prescriber" has the same meaning as in section 4729.01 of the Revised Code, except that it excludes a veterinarian licensed under Chapter 4741. of the Revised Code. 86
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(G) "Step therapy protocol" means a protocol or program that establishes a specific sequence in which prescription drugs, items of medical equipment, diagnostic tests, or medical procedures that are for a medical condition and are medically necessary for a particular patient are covered by a health plan issuer. 89
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Sec. ~~5162.80~~ 3962.02. (A) A-This section applies on and after January 1, 2019. 95
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(B) Except as provided in section 3962.04 of the Revised Code and in emergency situations, a health care provider of- medical services licensed, accredited, or certified under Chapter ~~3721., 3727., 4715., 4725., 4731., 4732., 4734., 4747., 4753., 4755., 4757., or 4779.~~ of the Revised Code shall provide in writing to a patient or the patient's representative, before products, services, or procedures are a health care product, service, or procedure that is not an emergency service is 97
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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 ~~consumer's~~ patient's health plan issuer for the product, 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 ~~consumer's~~ patient's care would 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
contain both of the following: 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
issuer. 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

<u>division (D) of this section.</u>	194
<u>(G) The cost estimate required by this section may be</u>	195
<u>provided verbally or in electronic or written form.</u>	196
<u>(H) A patient may decline to receive a cost estimate under</u>	197
<u>this section.</u>	198
<u>(I) A patient is responsible for payment for an</u>	199
<u>administered health care product, service, or procedure even if</u>	200
<u>the patient does not receive a cost estimate under this section</u>	201
<u>before the product, service, or procedure is received.</u>	202
<u>(J) (1) If a patient is to receive a health care product,</u>	203
<u>service, or procedure in a hospital, the hospital is responsible</u>	204
<u>for providing one comprehensive cost estimate to the patient or</u>	205
<u>the patient's representative. The comprehensive cost estimate</u>	206
<u>shall contain both of the following:</u>	207
<u>(a) All information in division (B) of this section</u>	208
<u>associated with products, services, or procedures to be provided</u>	209
<u>by the hospital or its employees;</u>	210
<u>(b) All information in division (B) of this section</u>	211
<u>associated with products, services, or procedures to be provided</u>	212
<u>by health care providers who are independent contractors of the</u>	213
<u>hospital.</u>	214
<u>(2) A health care provider who is an independent</u>	215
<u>contractor of a hospital shall submit to the hospital all CPT</u>	216
<u>codes or other identifiers the hospital needs to fulfill its</u>	217
<u>responsibility under division (J) (1) (b) of this section.</u>	218
<u>(3) In the event a hospital must provide the necessary</u>	219
<u>information for one independent contractor, the hospital shall</u>	220
<u>submit the information not later than forty-eight hours after</u>	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
December 31, 2018. 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
established patient. 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
care provider will provide is an office visit. 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
follows: 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 based on facts available at the time it was prepared and that the amounts estimated could change as a result of other factors; unknown, unanticipated, or subsequently needed health care products, services, or procedures; or changes to the enrollee's health benefit plan. The health plan issuer has discretion in how the disclaimer is expressed. 370
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(2) If applicable, a notation that a specific health care provider is out-of-network for the enrollee. 377
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(F) The estimate required by this section shall be provided in large font, be easy to understand, and, unless the estimate contains more than nine CPT codes or product identifiers, be limited to one page. 379
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(G) (1) A health plan issuer shall provide the estimate required by this section within five minutes of receiving the necessary information from the health care provider pursuant to section 3962.11 of the Revised Code. 383
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(2) If the amount in the estimate required by this section changes by more than ten per cent from the time an appointment is made to the time the enrollee presents for the health care product, service, or procedure, the health plan issuer shall supply to the enrollee an updated estimate within five minutes of receiving the updated information. 387
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(H) An enrollee may decline to receive a cost estimate under this section. 393
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(I) An enrollee is responsible for payment for an administered health care product, service, or procedure even if the enrollee does not receive a cost estimate under this section before the product, service, or procedure is received. 395
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(J) The affirmative obligation of a health plan issuer to provide an estimate directly to a patient as required by this section obviates the requirements on a health care provider to provide an estimate pursuant to section 3962.02 of the Revised Code unless the provider elects to fulfill the obligation pursuant to section 3962.12 of the Revised Code. 399
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Sec. 3962.11. (A) This section applies on and after January 1, 2019. 405
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(B) Not more than twenty-four hours after an enrollee or the enrollee's representative makes an appointment or, in the absence of an appointment, the enrollee presents for a health care product, service, or procedure, a health care provider shall provide to a health plan issuer the necessary information through the web site described in division (D) (1) (a) of this section. 407
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(C) (1) If an enrollee is to receive a health care product, service, or procedure in a hospital, the hospital is responsible for providing to a health plan issuer the necessary information, including both of the following: 414
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(a) All necessary information associated with products, services, or procedures to be provided by the hospital or its employees; 418
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(b) All necessary information associated with products, services, or procedures to be provided by health care providers who are independent contractors of the hospital. 421
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(2) A health care provider who is an independent contractor of a hospital shall submit to the hospital all CPT codes or other identifiers the hospital needs to fulfill its responsibility under division (C) (1) (b) of this section. 424
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(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
cost estimate. 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
enrollee. 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
provider; 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
case: 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

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

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
following categories: 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
insurance. 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

individual, 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
program: 822

(1) The total number of shared savings incentive payments 823
made by the issuer; 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
individuals and entities: 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
insurance matters. 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

Section 2. That existing section 5162.80 of the Revised	861
Code is hereby repealed.	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