OHIO LEGISLATIVE SERVICE COMMISSION

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S.B. 97*
133rd General Assembly

Bill Analysis

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Version: As Reported by House Health

Primary Sponsor: Sen. S. Huffman

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SUMMARY

- Generally requires a hospital to provide a patient with a verbal or written cost estimate for each health care service scheduled at least seven days in advance.
- Exempts a hospital from the cost estimate requirement when a health plan issuer fails to timely provide the information necessary to generate the estimate.
- Specifies that a patient remains responsible for the cost of a health care service even if an estimate is not received.
- Requires a health plan issuer to provide cost estimates to covered persons to the same extent required by federal law.
- Requires a hospital's standard charges list, which must be established under federal law, to be published on the hospital's website.
- Authorizes the Director of Health to seek an injunction against a hospital for failing to comply with the cost estimate and standard charges list requirements.
- Repeals previously enacted law governing cost estimates, which encompassed a number of other health care providers and health care insurers, but was permanently enjoined from enforcement in February 2019.

DETAILED ANALYSIS

The bill repeals existing law that requires specified health care facilities and professionals to provide a reasonable, good faith estimate of various costs before products,

* This analysis was prepared before the report of the House Health Committee appeared in the House Journal. Note that the legislative history may be incomplete

services, or procedures are provided. Instead, the bill creates a system that requires only hospitals to provide reasonable, good faith estimates for services scheduled at least seven days in advance. The bill also establishes in Ohio law the following requirements in relation to federal law: (1) that health plan issuers provide cost estimates to their insureds to the same extent required by federal law and (2) that hospitals publish on their websites their standard charges list required by federal law.

Hospital cost estimates for scheduled services

Content

The bill requires a hospital, on request, to provide a patient or the patient's representative a reasonable, good faith estimate of the cost for each health care service that has been scheduled at least seven days before the service is to be provided. The estimate may be written or verbal. A written estimate may be given in electronic form.[1]

The estimate must include all of the following:[2]

- The amount that the patient or party responsible for the patient's care must pay to the hospital for each scheduled service;
- If applicable, a notice that the professional services of physicians or other health care providers will be billed separately;
- A disclaimer that the information provided is only an estimate based on facts available at the time the estimate was prepared and that other required services could change the estimate;
- If known to the hospital at the time the estimate is provided and the patient is insured, a notification that the hospital or health care provider who will treat the patient is not in-network for the patient's health benefit plan; and
- The website address where the hospital publishes its standard charges list (see "**Standard charges list**," below).

The estimate must be based on information available at the time the estimate is prepared and does not have to take into account any information that subsequently arises, such as unexpected additional services. A hospital may state the estimate as a range rather than a specific dollar amount.[3]

[1] R.C. 3727.40(B).

[2] R.C. 3727.40(C)(1).

[3] R.C. 3727.40(C)(2) and (3).

The cost estimate requirement does not apply if the patient is insured and the health plan issuer fails to supply the necessary information needed to prepare the estimate within 48 hours of the hospital's request for that information.[4]

The bill specifies that its requirements relating to hospital cost estimates for scheduled services will begin January 1, 2021.[5] At this point in time, however, the bill's requirements will not become operative until a later date, which will be established by the date that the bill takes effect. Since the bill does not contain an emergency clause or an appropriation, or levy a tax, the bill's effective date will be the default effective date the Ohio Constitution has established for laws passed by the General Assembly. Accordingly, the bill's effective date will be the 91st day after the Governor files the signed act with the Secretary of State.[6]

Payment responsibility

Under the bill, a patient remains responsible for the cost of a health care service that is provided even if the patient did not receive an estimate from the hospital before receiving the service.[7]

Health plan issuer estimates

The bill requires a health plan issuer to provide to its covered persons and their representatives estimates of the costs of health care services to at least the same extent that the health plan issuer is required to do so under federal law.[8] The Superintendent of Insurance is prohibited from taking any disciplinary action or enforcement action against a health plan issuer for failure to comply with this requirement.[9]

On November 15, 2019, the U.S. Department of Health and Human Services (through the Centers for Medicare and Medicaid Services (CMS)), U.S. Department of Labor, and U.S. Department of the Treasury issued proposed rules directed at group health plans and health insurance issuers intended to improve price and quality transparency.[10] The final rules were issued on October 29, 2020.[11]

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[4] R.C. 3727.40(D).

[5] R.C. 3727.40(B).

[6] Ohio Constitution, Article II, Section 1c.

[7] R.C. 3727.40(E).

[8] R.C. 3902.32(B).

[9] R.C. 3902.32(C).

[10] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Transparency in Coverage Proposed Rule (CMS-9915-P)*, available at https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-proposed-rule-cms-9915-p.

[11] U.S. Centers for Medicare & Medicaid Services, *CMS Completes Historic Price Transparency Initiative*, available at https://www.cms.gov/newsroom/press-releases/cms-completes-historic-price-transparency-initiative.

According to a press release issued by CMS, the final rules include two approaches to make health care price information accessible to consumers and other stakeholders, allowing for easy comparison shopping.[12]

1. **Most nongrandfathered group health plans and health insurance issuers offering nongrandfathered health insurance[13] in the individual and group markets will be required to make available to participants, beneficiaries, and enrollees (or their authorized representatives) personalized out-of-pocket cost information, and the underlying negotiated rates, for all covered health care items and services, including prescription drugs, through an internet-based self-service tool and in paper form upon request.**

Most consumers will be able to get real-time estimates of their cost-sharing liability for health care items and services from different providers. An initial list of 500 shoppable services as determined by the departments will be required to be available through the internet-based self-service tool for plan years that begin on or after January 1, 2023. The remainder of all items and services will be required for these self-service tools for plan years that begin on or after January 1, 2024.

2. **Most nongrandfathered group health plans or health insurance issuers offering nongrandfathered health insurance coverage in the individual and group markets will be required to make available to the public, including stakeholders such as consumers, researchers, employers, and third-party developers, three separate machine-readable files that include detailed price information.**

The first file will show negotiated rates for all covered items and services between the plan or issuer and in-network providers. The second file will show both the historical payments to, and billed charges from, out-of-network providers. Historical payments must have a minimum of 20 entries in order to protect consumer privacy. The third file will detail the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level. Plans and issuers will display these data files in a standardized format and will provide monthly updates. These files are required to be made public for plan years that begin on or after January 1, 2022.

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[12] U.S. Centers for Medicare & Medicaid Services, *Transparency in Coverage Final Rule Fact Sheet (CMS-9915-F)*, available at https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f.

[13] Grandfathered health plans are health plans that were in existence as of March 23, 2010, the date of enactment of the Patient Protection and Affordable Care Act (ACA), and that are subject to only certain provisions of the ACA, as long as they maintain status as grandfathered health plans under the applicable rules. *See Id*.

Standard charges list

The bill requires a hospital to publish on its website the list of the hospital's standard charges for items and services provided by the hospital, as that list is established and updated in accordance with federal law. The website address where the list is published must be made readily available for purposes of public access and inclusion on the cost estimates provided by hospitals.[14]

Federal law, effective January 1, 2019, requires hospitals to make available online a list of their current standard charges in a machine-readable format and to update this information at least annually, or more often as appropriate.[15]

Rules

The bill authorizes the Director of Health to adopt rules in accordance with the Administrative Procedure Act[16] to implement the bill's provisions requiring hospitals to issue cost estimates and publish standard charges online.[17]

Enforcement

The bill authorizes the Director of Health to seek a temporary or permanent injunction restraining a hospital from failing to comply with the bill's requirements on cost estimates and publishing standard charges online.[18]

Repeal of existing system for providing cost estimates

The bill repeals the existing law governing providing cost estimates. Under that law, specified health care facilities and professionals must provide a reasonable, good faith estimate of various costs before products, services, or procedures are provided. The requirement does not apply in the case of an emergency. The estimate must be provided in writing and include all of the following information:

1. The amount the provider will charge the patient or the consumer's health plan issuer for the product, service, or procedure.
2. The amount the health plan issuer intends to pay for the product, service, or procedure. For this purpose, current law applies to health insuring corporations, sickness and accident insurers, and other entities subject to Ohio's insurance laws or the jurisdiction of the Superintendent of Insurance. It also applies to the Medicaid program and Medicaid managed care organizations.

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[14] R.C. 3727.41.

[15] 42 United States Code 300gg-18(e). *See* 83 Fed.Reg. 41686 *et. seq.*, available at https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/FR-2018-08-17.pdf.

[16] R.C. Chapter 119, not in the bill.

[17] R.C. 3727.44.

[18] R.C. 3727.45.

3. The difference, if any, that the consumer or other party responsible for the consumer's care would be required to pay to the provider for the product, service, or procedure.

The existing requirement to provide cost estimates applies to the following types of licensed, accredited, or certified health care facilities and professionals:

- Hospitals;
- Nursing homes and residential care facilities;
- Physicians, massage therapists, cosmetic therapists, naprapaths, and mechanotherapists;
- Dentists and dental hygienists;
- Optometrists and dispensing opticians;
- Chiropractors;
- Orthotists, prosthetists, and pedorthists;
- Hearing aid dealers and hearing aid fitters;
- Speech-language pathologists and audiologists;
- Occupational therapists, physical therapists, and athletic trainers;
- Psychologists and school psychologists;
- Professional clinical counselors, professional counselors, social workers, independent social workers, social work assistants, and marriage and family therapists.

Individuals in the list who work under the direction of another, such as an assistant, may not actually be subject to the provision's requirements, as the individual may be employed by another who bills the patient.

The Medicaid Director is required to adopt rules to carry out the cost estimate requirements.[19] To date, however, no rules have been adopted. (See **COMMENT**.)

COMMENT

The cost estimate requirements in current law described above never went into effect because the statute establishing the requirements has been the subject of ongoing litigation. Shortly after the statute's enactment, Community Hospitals and Wellness Centers, the Ohio Hospital Association, and other health care providers sued to prevent its enforcement, arguing that it was unconstitutional.

[19] R.C. 5162.80, repealed.

By court order, the statute was temporarily restrained from enforcement while the lawsuit was pending. On February 13, 2019, the court issued a permanent injunction preventing the statute from being implemented. The court struck down the statute on procedural, constitutional grounds – finding that the General Assembly's passage of the law violated the Ohio Constitution's "single-subject" and "three-readings" rules.[20] On February 7, 2020, the appellate court affirmed the trial court's decision.[21]

On July 18, 2019, the Governor vetoed provisions of H.B. 166 of the 133rd General Assembly, the main appropriations act for fiscal years 2020 and 2021, that would have added a separate price transparency process to the existing price transparency provisions.[22] On the same day as his veto message, the Governor signed an executive order directing state agencies, boards, and commissions to seek to adopt or implement the rules, regulations, and recommendations that result from an executive order issued by President Trump on June 24, 2019, regarding price transparency.[23] The proposed rules described previously result from President Trump's executive order (see "**Health plan issuer estimates**," above).

On November 15, 2019, CMS issued a final rule pertaining to price transparency requirements for hospitals. According to a CMS press release, the final rule (1) implements section 2718(e) of the Public Health Service Act and (2) improves upon prior agency guidance that required hospitals to make public their standard charges on request starting in 2015 and subsequently online in a machine-readable format starting in 2019. Section 2718(e) requires each hospital operating in the U.S. to establish, update, and make public a yearly list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.[24]

In December 2019, the American Hospital Association and other hospital and health system groups challenged the CMS regulations, contending that the statute only allows CMS to

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[20] Williams County Court of Common Pleas, http://pa.wmsco.org/eservices/search.page.3?x=cp2KdLacFmP--gxhyUC4sw, search Case Number 16CI000128 (accessed November 2, 2020); Academy of Medicine of Cleveland and Northern Ohio, Permanent Injunction Issued in Price Transparency Case, available at http://amcno.org/index.php?id=1515.

[21] *Community Hosps. & Wellness Ctrs. v. State*, 2020-Ohio-401, 151 N.E.3d 1113 (6th Dist.).

[22] *See* Office of the Governor, *Statement of the Reasons for the Veto of Items in Am. Sub. H.B. 166* (July 18, 2019), Item Number 3: "Health Care Price Transparency," available at https://rb.gy/7e5e4e. *See* also Executive Order 2019-18D, available at https://governor.ohio.gov/wpsportal/gov/governor/media/executive-orders/2019-18d.

[23] Presidential Executive Order 13877 of June 24, 2019, 84 Fed. Reg. 30850 (Thursday, June 27, 2019), available at https://www.govinfo.gov/content/pkg/FR-2019-06-27/pdf/2019-13945.pdf.

[24] U.S. Centers for Medicare & Medicaid Services, *CY 2020 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes: Hospital Price Transparency Requirements (CMS-1717-F2)*, available at https://www.cms.gov/newsroom/fact-sheets/cy-2020-hospital-outpatient-prospective-payment-system-opps-policy-changes-hospital-price.

require disclosure of standard list prices, not "custom" negotiated prices. In June 2020, the U.S. District Court for the District of Columbia ruled in CMS's favor, finding that the new regulations are a reasonable interpretation of "standard charges," and the Affordable Care Act (ACA) authorizes the imposition of penalties. The district court also found that the regulations do not violate the hospitals' First Amendment right to free speech because the requirements are reasonably related to the government's interests in "providing consumers with factual price information to facilitate more informed health care decisions" and "lowering healthcare costs." [25] The hospitals and health system groups appealed to the D.C. Circuit Court of Appeals, which heard oral arguments on October 15, 2020.[26] Media reports made after oral arguments predict that the nation's second most powerful court seemed likely to uphold the rule.[27]

The Kaiser Family Foundation opined that the U.S. Supreme Court could eventually hear the case. The Trump Administration has argued that the regulations could lead to lower costs for consumers. However, if the Supreme Court accepts the Trump Administration's argument in *California v. Texas*[28] that the entire ACA is invalid, Congress would need to pass new legislation before any price transparency regulations could be adopted.[29]

HISTORY

Action	Date
Introduced	03-11-19
Reported, S. Health, Human Services & Medicaid	10-07-19
Passed Senate (32-0)	10-09-19
Reported, H. Health	--

S0097-RH-133/ts

[25] *AHA v. Azar*, Civil Action No. 1:19-cv-03619 (CJN), 2020 U.S. Dist. LEXIS 110130 (D.D.C. June 23, 2020).

[26] Kaiser Family Foundation, *A Reconfigured U.S. Supreme Court: Implications for Health Policy*, available at https://www.kff.org/health-reform/issue-brief/a-reconfigured-u-s-supreme-court-implications-for-health-policy/.

[27] *See* Bloomberg Law, *Judges Signal Support for Hospital Pricing Disclosure Rule*, available at https://news.bloomberglaw.com/health-law-and-business/judges-signal-support-for-hospital-pricing-disclosure-rule; Healthcare Financial Management Association, *Hospitals' Challenge to New Transparency Rule Draws Skepticism from Appeals Court*, available at https://www.hfma.org/topics/news/2020/10/hospitals--challenge-to-new-transparency-rule-draws-skepticism-f.html.

[28] No. 19-840, https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/19-840.html. The case has been consolidated with *Texas v. California*, No. 19-1019, https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/19-1019.html.

[29] *Id*.