OHIO LEGISLATIVE SERVICE COMMISSION

Bill Analysis

Yosef Schiff

H.B. 416

132nd General Assembly
(As Introduced)

Rep. Huffman

BILL SUMMARY

- Requires a health care provider to provide a patient a verbal or written estimate of the cost of scheduled services.
- Requires a health plan issuer to provide a patient a written estimate of the cost of services, including scheduled services, for which the patient's health care provider seeks preauthorization from the health plan issuer.
- Requires the estimates to include certain information.
- Provides that the bill's new estimate provisions take effect on June 1, 2018.
- Provides that a patient is responsible for payment of an administered health care service or procedure even if the patient did not receive an estimate required by the bill.
- Provides that a health care provider or health plan issuer is not liable for damages or subject to criminal prosecution or professional disciplinary action as a result of failure to fulfill the provider's or issuer's duties under the bill unless that failure constitutes willful or wanton misconduct.
- Repeals the existing system for providing cost estimates.

CONTENT AND OPERATION

The bill repeals the existing provisions that require specified health care facilities and professionals to provide a reasonable, good faith estimate of various costs before products, services, or procedures are provided. In their place, the bill enacts a system that requires health care providers to provide reasonable, good faith estimates for

scheduled services and health plan issuers to provide reasonable, good faith estimates for services for which the patient's health care provider seeks preauthorization.

Health care provider estimate for scheduled services

The bill requires a health care provider (see "**Scope of the bill**," below) to provide a reasonable, good faith estimate of the cost for each scheduled service to a patient or the patient's representative upon request of that individual. A scheduled service is a health care service or procedure that a patient or the patient's representative has scheduled at least seven days before the service or procedure is to occur. 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:

- If the patient is insured, the amount the health care provider expects as payment from the patient's health plan issuer for each scheduled service;
- The amount the patient or party responsible for the patient's care must pay to the health care provider for each scheduled service;
- 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 health care items, services, or procedures could change the estimate;
- If applicable and known to the health care provider at the time the estimate is given, a notification that the provider is out-of-network for the patient.[2]

The estimate must be based on information available at the time the estimate is provided and need not take into account any information that subsequently arises, such as unexpected additional services or procedures. A health care provider may state the estimate as a range rather than a specific dollar amount.[3]

The health care provider estimate requirements do not apply in either of the following circumstances:

[1] R.C. 3726.01 and 3726.02(A)(1).

[2] R.C. 3726.02(A)(2).

[3] R.C. 3726.02(B) and (C).

- The patient is insured and the health plan issuer fails to supply the necessary information to the health care provider within 48 hours of the provider's request to the issuer for that information. In that case, the health care provider may notify the patient or the patient's representative of the health plan issuer's failure.

- The scheduled service the patient is to receive requires preauthorization from the patient's health plan issuer. In that case, the requirements in "**Health plan issuer estimate for services requiring preauthorization**" below apply.[4]

The bill's provisions relating to health care provider estimates for scheduled services take effect on June 1, 2018.[5]

Health plan issuer estimate for services requiring preauthorization

The bill similarly requires a health plan issuer (see "**Scope of the bill**," below) to provide to a patient or the patient's representative a reasonable, good faith estimate of the cost for each service, including a scheduled service, for which the patient's health care provider seeks preauthorization from the health plan issuer. The estimate must be in writing and include the same information that the health care provider estimate must include, except, if the patient is insured, the estimate must include the amount the health plan issuer intends to pay rather than the amount the health care provider expects to receive.[6]

Like the provider's estimate, the estimate must be based on information available at the time the estimate is provided. And the health plan issuer may state the estimate as a range rather than a specific dollar amount. The health plan issuer must send the estimate to the patient or the patient's representative immediately upon the issuer's approval of the preauthorization request. The estimate may be sent by regular mail, electronic mail, or text messaging.[7]

The bill's provisions relating to estimates for services requiring preauthorization take effect on June 1, 2018.[8]

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[4] R.C. 3726.02(D).

[5] R.C. 3726.02(A)(1).

[6] R.C. 3726.03(A) and (D).

[7] R.C. 3726.03(B) through (D).

[8] R.C. 3726.03(A).

Payment and liability

Under the bill, a patient is responsible for payment of an administered health care service or procedure even if the patient does not receive an estimate described above before receiving that service or procedure.[9]

A health care provider, health plan issuer, or any employee or contractor of the provider or issuer is not liable for or subject to any of the following for injury, death, or loss to person or property that allegedly arises from any act or omission associated with fulfilling a duty imposed by the bill unless the act or omission constitutes willful or wanton misconduct: damages in a civil action, prosecution in a criminal proceeding, or professional disciplinary action.[10]

Scope of the bill

Health care provider

The bill applies to individuals licensed or certified as one of the following types of health care providers:

- Individuals licensed to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, massage therapists; cosmetic therapists; naprapaths; and mechanotherapists;
- Dentists, dental volunteers, 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, occupational therapy assistants, physical therapists, physical therapist assistants, and athletic trainers;
- Psychologists and school psychologists;

[9] R.C. 3726.04.

[10] R.C. 3726.05.

- Professional clinical counselors, professional counselors, social workers, independent social workers, social work assistants (certificate of registration), and marriage and family therapists.[11]

Note: individuals in the above list who work under the direction of another, such as an assistant, may not actually be subject to the bill's provisions, as the individual may be employed by another who bills the patient.

Health plan issuers

Under the bill, a health plan issuer is an entity subject to Ohio's Insurance Laws, or subject to the jurisdiction of the Superintendent of Insurance, that contracts (or offers to contract) to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including sickness and accident insurers and health insuring corporations.[12] It would also appear to apply to multiple employer welfare arrangements and public employee benefit plans.

Repeal of existing system for providing cost estimates

The bill also repeals the existing system for providing cost estimates. Current law requires specified health care facilities and professionals to 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 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.

(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.

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[11] R.C. 3726.01(A).

[12] R.C. 3726.01(B).

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;
- Individuals licensed to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, massage therapists; cosmetic therapists; naprapaths; and mechanotherapists Physicians, podiatrists, and limited practitioners, such as massage therapists;
- Dentists, dental volunteers, 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 (certificate of registration), and marriage and family therapists.

Note: individuals in the above 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.[13] To date, however, no rules have been adopted. (See **COMMENT**.)

[13] R.C. 5162.80, repealed by the bill.

COMMENT

The cost estimate requirements of current law described above never went into effect because the statute establishing the requirements is the subject of ongoing litigation. By court order, the statute is restrained from enforcement while the lawsuit is pending.

Shortly after the statute's enactment, Community Hospitals and Wellness Centers, the Ohio Hospital Association, and other health care provider groups filed suit in the Williams County Court of Common Pleas. They sought judgment that the statute is unconstitutional and void, and preliminary and permanent injunctions prohibiting enforcement of the statute. The court barred implementation or enforcement of the statute until it rules on the injunction. A hearing on the preliminary injunction is scheduled for March 15, 2018.[14]

HISTORY

ACTION	DATE
Introduced	11-16-17

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[14] Williams County Common Pleas Court, http://pa.wmsco.org/eservices/search.page.3?x=cp2KdLacFmP--gxhyUC4sw, search Case Number 00CI000159 (accessed November 15, 2017).