OHIO LEGISLATIVE SERVICE COMMISSION

**Bill Analysis**

Erika Padgett

# H.B. 399

132nd General Assembly
(As Introduced)

**Reps.** Henne and Butler, DeVitis, Keller, Hood, Becker, Romanchuk, Sprague, Dean, Goodman, Wiggam

## BILL SUMMARY

### SHARED SAVINGS INCENTIVE PROGRAM

- Requires health plan issuers to create and implement a shared savings incentive program for individuals covered by specified health benefit plans.
- Requires the program to provide incentive payments to insured individuals who elect to receive a shoppable health care service from a health care provider that charges less than the average price paid for the service, if the health plan issuer's savings are more than $50.
- Specifies eight categories of shoppable health care services to which the program can apply.
- Requires incentive payments under the program to equal at least 50% of costs saved by the health plan issuer from the shoppable health care service.
- Permits incentive payments relating to in-network providers to be either provided to the insured individual or used to offset out-of-pocket expenses, and requires incentive payments relating to out-of-network providers to be placed in a health savings account for the insured individual.
- Specifies how to calculate the costs saved and the average price paid for a health care service.
- Requires health plan issuers to annually report to the Superintendent of Insurance information about their shared savings incentive programs.

- Requires the Superintendent to annually report to certain members of the General Assembly the information provided by health plan issuers.

## HEALTH CARE COST ESTIMATES

- Replaces requirements regarding cost estimates that are to be provided to patients before receiving medical services with new cost estimate requirements to be implemented through 2019, and applies the new requirements to both health care providers and health plan issuers.

- For 2018, establishes an interim procedure under which costs estimates are to be provided by health plan issuers directly to patients if a health care provider is seeking precertification or verification of coverage under a health benefit plan.

- Beginning in 2019, requires a health care provider to give a patient a cost estimate before providing a product, service, or procedure, and requires the estimate to be given within 24 hours of the patient making an appointment or presenting for the product, service, or procedure.

- Establishes separate provisions for hospital cost estimates whereby a single comprehensive estimate is to be produced and, if independent contractors are involved, requires the hospital to give all necessary information with time limits of 48 to 72 hours after an appointment is made.

- Requires various state agencies that regulate health care providers to prepare documents specifying the providers' responsibilities to provide cost estimates.

- Requires a health care provider, within 24 hours of receiving a request from a patient, to give the patient all necessary information relative to a health care product, service, or procedure, including the provider's license number and applicable CPT codes.

- Beginning in 2019, requires a health plan issuer to provide cost estimates directly to the individuals enrolled in its health benefit plans.

- Requires each enrollee to choose whether to receive the estimates by electronic mail, a smartphone application, or regular mail, and specifies time limits for sending the estimates based on the type of delivery selected.

- Requires a health plan issuer to generate each cost estimate within five minutes of receiving the necessary information from the health care provider.

- Requires each health plan issuer to establish the following websites to be used for receiving and providing information relative to cost estimates: (1) a website for

health care providers to transmit necessary information, (2) a website that allows a provider to generate a cost estimate on behalf of the issuer, and (3) a website that allows enrollees to search for other providers and generate corresponding cost estimates for comparison.

- Authorizes a health care provider to generate cost estimates on behalf of a health plan issuer for an enrollee by using the issuer's website and complying with the requirements that otherwise would apply to the issuer.

- Excludes emergency services, emergency situations, and office visits from the requirement that a health care provider or health plan issuer provide a cost estimate to a patient or enrollee.

- Grants immunity from civil liability to a health care provider or health plan issuer that acts in good faith when collecting information for an estimate or when providing the estimate.

- Authorizes regulatory agencies to levy monetary penalties, issue cease and desist orders, or impose both of these administrative remedies against health care providers or health plan issuers that have a consistent pattern of violating the cost estimate requirements.

## ADMINISTRATION OF HEALTH CARE SERVICES AND BENEFITS

- By June 30, 2018, requires the Office of Health Transformation to analyze the administrative burdens placed on health care providers, including an assessment of the negative effects on quality of care, time spent with patients, and provider financial stability.

- Requires that a health plan issuer's website for transmission of information by health care providers include a link that they can use to obtain online precertification from the issuer.

- Limits a health plan issuer's use of prior authorization if (1) a prescriber has been in the top 25% of prescribers with approved requests for the past three years, (2) the drug, equipment, procedure, or test involved costs $100 or less, or (3) the drug or equipment has been previously authorized for the same treatment or is for a chronic condition.

- Requires the Office of Health Transformation to create a standardized prior authorization form by January 1, 2019, and prohibits a health plan issuer from requiring a prescriber to use any other form.

- Limits a health plan issuer's use of a step therapy protocol if a patient has already tried in the past five years a drug, test, or procedure in a lower step of the protocol sequence and it was unsuccessful or otherwise inappropriate.

- Requires a health plan issuer, before using any step therapy or prior authorization protocol, to offer a minimum 60-day grace period after enrollment in the issuer's benefit plan if the patient is stabilized on a particular medical treatment or drug regimen.

- Requires a health plan issuer to provide coverage throughout a health benefit plan period for any drug, equipment, procedure, or test that is removed from the issuer's formulary or subject to new restrictions after enrollment, unless it is no longer made available to any patient or is prohibited.

- Limits a utilization review entity by: (1) prohibiting it from requiring a patient to repeat step therapy protocols or retry failed therapies, (2) requiring it to provide updated and patient-specific formularies that include prior authorization and step therapy protocols in electronic health records systems, and (3) requiring it to accept and respond to override requests exclusively through secure electronic transmissions.

- By January 1, 2021, requires a vendor of electronic health records systems to provide updated software that enables health care providers to transmit prior authorization requests or step therapy protocol overrides without having to resubmit the same information

- By January 1, 2021, with respect to health information exchanges, (1) requires the Department of Insurance to ensure that a single exchange exists that a health care provider can use to generate cost estimates and precertifications, regardless of various patients' coverage, and (2) requires health plan issuers to perform medical chart audits electronically through health information exchanges.

- Authorizes rules to be adopted by the appropriate regulatory agencies as necessary to carry out the provisions on health care cost estimates and administration of health care services and benefits.

## TABLE OF CONTENTS

## CONTENT AND OPERATION

### SHARED SAVINGS INCENTIVE PROGRAM

#### Implementation by health plan issuers

The bill requires a health plan issuer to implement a shared savings incentive program for individuals covered by a health benefit plan offered by the health plan issuer. The shared savings incentive program must provide incentive payments to individuals insured under those plans who elect to receive a "shoppable health care service" from a health care provider that charges less than the average price paid for the health care service. The program applies to services from any of the following health care providers:

- A physician, psychologist, nurse practitioner, or other health care practitioner licensed, accredited, or certified to perform health care services consistent with Ohio law;
- An institution providing health care services;
- A health care setting.[1]

Under the shared savings incentive program, a health plan issuer must notify individuals about the availability of the program at plan enrollment and renewal. Shoppable health care services include health care services in the following categories:

- Physical and occupational therapy services;
- Obstetrical and gynecological services;
- Radiology and imaging services;
- Laboratory services;
- Infusion therapy;

[1] R.C. 3966.01(B); R.C. 3701.74, not in the bill.

- Inpatient and outpatient surgical procedures;
- Outpatient nonsurgical diagnostic tests or procedures;
- Any other category determined by the Superintendent of Insurance.[2]

### Covered health plan issuers and health benefit plans

The shared savings incentive program requirement applies to sickness and accident insurers, health insuring corporations, and multiple employer welfare arrangements, as well as nonfederal government insurers. It also applies to third party administrators (such as pharmacy benefit managers) administering a health benefit plan for one of those health plan issuers. The following types of plans are exempt from the requirement:

- A plan that covers only a specified accident, accident only, credit, dental, disability income, long-term care, hospital indemnity, supplemental coverage, specified disease, or vision care;
- Coverage issued as a supplement to liability insurance;
- Workers' compensation insurance;
- Automobile medical payment insurance;
- Insurance under which benefits are payable without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- A Medicare supplement policy;
- Coverage under a plan through Medicare, Medicaid, or the federal employees benefit program;
- Certain U.S. armed services medical and dental care coverage.[3]

[2] R.C. 3966.01(C), (D), and (E), 3966.02(A), and 3966.04; R.C. 3922.01, not in the bill.

[3] R.C. 3966.01(C); R.C. 3922.01, not in the bill.

## Incentive payments

### In-network providers

A health plan issuer can calculate incentive payments under the program for in-network providers in any of the following ways:

- As the difference in price between the shoppable health care service and the average price paid for the service;
- As a flat dollar amount;
- In any other reasonable manner approved by the Superintendent.

The incentive payments must equal at least 50% of the costs saved by the health plan issuer for each shoppable health care service. However, a health plan issuer is not required to provide an incentive payment when its savings are $50 or less.

An insured individual may elect to have the incentive payment applied to offset the cost of any out-of-pocket expenses incurred by the individual under the health benefit plan. The offset must be used during the immediately following three plan years.[4]

### Out-of-network providers

If an insured individual receives a shoppable health care service from an out-of-network health care provider, the health plan issuer must provide the incentive payment to the individual in a health savings account established by the health plan issuer for the individual. The insured individual can access the funds in the health savings account for use toward any cost-sharing requirement under the health benefit plan (such as copayments and deductible amounts). For services provided by out-of-network providers, the incentive payment is calculated generally the same way as for in-network providers, but the savings that are the basis of the incentive payment may be only the difference in price between the shoppable health care service and the average price paid for the service.[5]

### Calculating average price paid

A health plan issuer must calculate the average price paid for a health care service based on the average amount paid by the health plan issuer to a health care provider for the service under a health benefit plan over a 12-month period (occurring

[4] R.C. 3966.02(B).

[5] R.C. 3966.06.

not more than two years before the calculation), adjusted for inflation. The health plan issuer must annually recalculate the average price paid data. However, a health plan issuer may use an alternative methodology for calculating the average price paid if it is approved by the Superintendent.[6]

### Health plan issuer duties

Health plan issuers must make incentive payments without any action on the part of the insured individual. Each health plan issuer must develop and maintain an Internet-based system where insured individuals can track their incentive payments. Additionally, each health plan issuer must establish an interactive mechanism on its public website that enables an insured individual to obtain information on the average price paid by the issuer for a particular health care service to compare costs among providers.[7]

#### Filing with the Superintendent of Insurance

The bill requires a health plan issuer to file with the Superintendent a description of its shared savings incentive program prior to offering the program to insured individuals. The Superintendent must review the filing to ensure the program complies with the shared savings incentive program portions of the bill. Filings are confidential until reviewed by the Superintendent.[8]

Beginning in 2019 and annually thereafter, a health plan issuer must file with the Superintendent certain information from the most recent calendar year about its shared savings incentive program. The information includes:

- The total number and monetary total of all shared savings incentive payments made by the health plan issuer, including a breakdown for each category of shoppable health care services;
- The total savings achieved;
- The total number of individuals who participated.[9]

[6] R.C. 3966.02(C).

[7] R.C. 3966.02(D) and 3966.03.

[8] R.C. 3966.05.

[9] R.C. 3966.08(A).

### Superintendent of Insurance duties

Beginning in 2019 and annually thereafter, the Superintendent must submit an aggregate report of the information described in the reports by health plan issuers. The Superintendent's report must be submitted to the Speaker of the House of Representatives, the President of the Senate, the ranking minority members of the House and Senate, and the standing committees in the House and Senate having jurisdiction over health insurance matters.[10]

The Superintendent may adopt rules in accordance with the Administrative Procedure Act (R.C. Chapter 119.) as necessary to implement the bill's shared savings incentive program provisions.[11]

### Effective date

The bill's shared savings incentive program provisions take effect six months after the bill's effective date.[12]

## HEALTH CARE COST ESTIMATES

## Overview

### 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 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.

---

[10] R.C. 3966.08(B).

[11] R.C. 3966.09.

[12] Section 3.

(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, podiatrists, and limited practitioners, such as massage therapists;
- Dentists;
- Optometrists and dispensing opticians;
- Chiropractors;
- Orthotists, prosthetists, and pedorthists;
- Hearing aid dealers;
- Speech-language pathologists and audiologists;
- Occupational therapists, physical therapists, and athletic trainers;
- Psychologists;
- Professional counselors, social workers, and marriage and family therapists.

The Medicaid Director is required to adopt rules to carry out the cost estimate requirements. To date, however, no rules have been adopted, and the cost estimate requirements have not gone into effect because of pending litigation (see **COMMENT**, below).

### Pending litigation

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 (1) judgment that the statute is unconstitutional and void, and (2) preliminary and permanent injunctions prohibiting enforcement of the statute. The court barred implementation or enforcement of the statute until it rules on the injunction. On February 20, 2018, the court stayed further hearings on the injunction, pending a decision by the 6th District Court of Appeals on an appealed procedural matter.[13]

### New system for providing cost estimates

The bill replaces the cost estimate requirements of current law with a new system that is to be implemented through 2019.[14] The new system establishes requirements that apply not only to health care facilities and professionals, but also to health plan issuers, including the Medicaid program's fee-for-service system, Medicaid managed care organizations, and third-party payers such as entities licensed as administrators.[15]

## In 2018 – cost estimates directly to patients for precertification of coverage

The bill establishes an interim procedure for providing cost estimates during the period beginning on its effective date and ending December 31, 2018.[16] During this interim period, cost estimates are to be provided by health plan issuers directly to patients or their representatives. The estimates must be given only if a health care provider submits to a health plan issuer Current Procedural Terminology (CPT) codes and product identifiers for purposes of obtaining precertification of health benefit plan coverage.

In this interim period, each cost estimate that is provided must contain the same information that is required when an estimate is provided under the general requirement that begins for health care providers in 2019, as described below. However, the estimate must expressly state at the top, in boldface type, both of the following:

(1) That the estimate is being provided only for those health care products, services, and procedures for which the health care provider is requesting verification of

---

[13] Williams County Common Pleas Court, http://pa.wmsco.org/eservices/search.page.3?x=cp2KdLacFmP--gxhyUC4sw, search Case Number 16CI000128 (accessed June 1, 2018).

[14] R.C. Chapter 3962.

[15] R.C. 3962.01 and 5164.65.

[16] R.C. 3962.03.

health benefit plan coverage and that the estimate may not include all products, services, and procedures the patient is scheduled to receive;

(2) That beginning January 1, 2019, an estimate will be provided for all health care products, services, and procedures the patient is to receive, rather than only those for which the provider is requesting verification of health benefit plan coverage, except for office visits.

## Cost estimates from health care providers

Beginning January 1, 2019, the bill requires specified health care facilities and professionals to provide to a patient or the patient's representative a reasonable, good faith estimate of certain costs before a health care product, service, or procedure is provided to the patient. However, the requirement does not apply if an emergency is involved or the only service is an office visit (see "**Exclusions from cost estimate requirements**," below).

The requirement applies to the same types of health care providers that are subject to the existing cost estimate requirements. These include hospitals, nursing homes, physicians, dentists, and the other health professionals identified in current law.[17]

The bill specifies that the cost estimate may be provided verbally, electronically, or in written form. In contrast, cost estimates under current law are to be provided only in writing.

### Content of estimate

Under the bill, each cost estimate from a health care provider must include all of the following:[18]

(1) The total amount the provider will charge the patient or the patient's health plan issuer, inclusive of facility, professional, and other fees, along with a short description and the CPT code published by the American Medical Association for the product, service, or procedure or, if no CPT code exists, another identifier the health plan issuer requires;

(2) If the patient is insured under a health benefit plan, the amount the provider expects to receive from the health plan issuer for each product, service, or procedure.

[17] R.C. 3962.02.

[18] R.C. 3962.02(B).

The amount specified in the estimate must be the amount that the health plan issuer will reimburse the provider under a contract with the provider or the applicable government pay scale, if any.

(3) The difference, if any, that the patient or other party responsible for the patient's care would be required to pay to the provider;

(4) If the patient is not insured under a health benefit plan, the total amount the provider will charge the patient, inclusive of facility, professional, and other fees, along with a short description and the CPT code published by the American Medical Association for the product, service, or procedure or, if no CPT code exists, another identifier the health plan issuer requires. This information must be provided to a patient who is not insured regardless of whether any other requirement or exemption exists under the bill.

### Additional content

In addition to the information described above, the bill requires the cost estimate to contain both of the following:[19]

(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 unknown, unanticipated, or subsequently needed health care products, services, or procedures; changes to the patient's health benefit plan; or other changes. The bill specifies that the provider has discretion in how the disclaimer is expressed.

(2) A notation that a specific health care provider is out-of-network for the patient, but only if the patient is insured and that information is provided by the health plan issuer.

### Basis for the estimate

The cost estimate must be based on information provided at the time an appointment is made or, in the absence of an appointment, at the time the patient initially presents for the health care product, service, or procedure. In addition, the estimate need not take into account any information that subsequently arises, such as unknown, unanticipated, or subsequently needed health care products, services, or procedures provided for any reason after the initial check-in or appointment. Only one estimate is required per visit.[20]

---

[19] R.C. 3962.02(E).

[20] R.C. 3962.02(C).

If specific information, such as the health care provider who will be providing the health care product, service, or procedure, is not readily available at the time the appointment is made, the provider may base the cost estimate on an average estimated charge for the product, service, or procedure.

### 24-hour time limit

The cost estimate must be provided within 24 hours of the date the appointment for the health care product, service, or procedure is made or the time the patient initially presents for the product, service, or procedure, whichever is sooner.[21]

If a health plan issuer does not provide the information necessary to complete the estimate, the health care provider must notify the patient. The provider may note in the estimate that insurance information was not provided as required by law. In this case, the provider may specify only the information regarding the provider's charges and, at the provider's discretion, the amount the provider expects to receive from the health plan issuer. If the information necessary to complete the estimate is subsequently received and an updated estimate can be provided within the 24-hour time limit, the health care provider must provide the updated estimate.

If the estimated amount to be paid by a patient changes by more than 10% before the patient initially presents for the health care product, service, or procedure, the health care provider must update the estimate. The update must be given to the patient within the same 24-hour time limit described above for the initial estimate.[22]

### Hospital-specific estimates and time limits

If a patient is to receive a health care product, service, or procedure in a hospital, the hospital is responsible for providing one comprehensive cost estimate to the patient or the patient's representative. The comprehensive cost estimate must contain information for products, services, or procedures regardless of whether they are to be provided by (1) the hospital or its employees or (2) health care providers who are independent contractors of the hospital.[23]

In the case of an independent contractor, the health care provider must submit to the hospital all CPT codes or other identifiers the hospital needs to fulfill its responsibility to provide the estimate.

---

[21] R.C. 3962.02(D).

[22] R.C. 3962.02(F).

[23] R.C. 3962.02(J).

In the event a hospital must provide the necessary information for one independent contractor, the bill requires the hospital to submit the information not later than 48 hours after the appointment is made. In the event a hospital must provide the necessary information for two or more independent contractors, the bill requires the hospital to submit the information not later than 72 hours after the appointment is made.

### Choice to decline

The bill specifies that a patient may decline to receive a cost estimate from the health care provider.[24]

### Responsibility for payment

The bill specifies that a patient is responsible for payment for an administered health care product, service, or procedure even if the patient does not receive a cost estimate before the product, service, or procedure is received.[25]

### State agency documents on cost estimate responsibilities of providers

The bill requires the Department of Health, the Department of Medicaid, and various professional licensing boards that regulate health care providers to collaborate to publish a document that specifies the responsibilities of health care providers under the bill's general cost estimate requirements. The agency or board with jurisdiction over a health care provider must send a copy of the document to the provider annually. The copy may be sent electronically.[26]

## "Necessary information" to be given to patients

On request of a patient or the patient's representative, the bill requires a health care provider to provide "necessary information" regarding a health care product, service, or procedure directly to the patient.[27] Specifically, the bill requires the following information to be given:[28]

---

[24] R.C. 3962.02(H).

[25] R.C. 3962.02(I).

[26] R.C. 3962.06.

[27] R.C. 3962.05.

[28] R.C. 3962.01.

(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;

(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;

(3) The date that a health care product, service, or procedure is to be provided.

The information must be given not more than 24 hours after the patient or the patient's representative makes an appointment or, in the absence of an appointment, the patient presents for the health care product, service, or procedure.

## Cost estimates from health plan issuers

Beginning January 1, 2019, the bill requires a health plan issuer to provide directly to an individual enrolled in a health benefit plan or the enrollee's representative a reasonable, good faith estimate of the enrollee's costs for a health care product, service, or procedure. The estimate must be provided before the product, service, or procedure is provided. However, the requirement does not apply if an emergency is involved or the only service is an office visit (see "**Exclusions from cost estimate requirements**," below).[29]

The bill provides that the affirmative obligation of a health plan issuer to provide an estimate directly to a patient obviates its other requirements on a health care provider to provide an estimate, unless the provider elects to fulfill the obligation on behalf of the health plan issuer, as described below (see "**Health care providers that provide estimates on behalf of issuers**," below).[30]

### Choice of method to receive estimates; time limits for sending

When an individual is enrolled in a health benefit plan, and during a health plan issuer's open enrollment period, the issuer is required by the bill to ask the enrollee or the enrollee's representative whether that individual would prefer to receive cost estimates by electronic mail, a smartphone application, or regular mail. The health plan issuer must send cost estimates by the means elected.[31]

---

[29] R.C. 3962.10(A) and (B).

[30] R.C. 3962.10(J).

[31] R.C. 3962.10(C).

If the means elected is by electronic mail or smartphone application, the estimate must be sent automatically. It cannot, however, be sent later than five minutes after the health plan issuer has received the necessary information from the health care provider. If the means elected is by regular mail, the estimate must be mailed not later than 24 hours after the health plan issuer has received the necessary information from the health care provider if the procedure will be provided more than two days from the date the estimate is generated.

If no election is made, the estimate must be sent as follows: (1) by electronic mail, if the email address of the enrollee or the enrollee's representative is on file with the health plan issuer, or (2) by regular mail, unless the health care product, service, or procedure will be provided less than two days from the date the estimate is generated.

### Basis for the estimate

The cost estimate from a health plan issuer must be based on information provided at the time an appointment is made or, in the absence of an appointment, at the time the patient initially presents for the health care product, service, or procedure. In addition, the estimate need not take into account any information that subsequently arises, such as unknown, unanticipated, or subsequently needed health care products, services, or procedures provided for any reason after the initial check-in or appointment. Only one estimate is required per visit.

If specific information, such as the provider who will be providing the health care product, service, or procedure, is not readily available at the time the appointment is made or when the enrollee presents for the health care product, service, or procedure, the health care provider may transmit that a provider is unknown as part of the necessary information. In this case, the health plan issuer may base the estimate on an average estimated charge for the product, service, or procedure at that facility or location.

If a health care provider does not supply to the health plan issuer the necessary information to generate the cost estimate, the issuer must send to the enrollee or the enrollee's representative, by the same means used to send estimates, a notice that the provider failed to supply the necessary information as required by law and, consequently, a cost estimate could not be generated. This action must be taken in the event a provider gives the issuer any indication that receipt of a health care product, service, or procedure is scheduled, such as through precertification.

### Additional content

In addition to the information described above, the bill requires the cost estimate to contain both of the following:[32]

(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.

(2) If applicable, a notation that a specific health care provider is out-of-network for the enrollee.

### Format

The estimate required by the bill must be provided in large font and must be easy to understand. Unless the estimate contains more than nine CPT codes or product identifiers, it must be limited to one page.[33]

### Five-minute time limit for generating estimate

A health plan issuer must provide the required estimate within five minutes of receiving the necessary information from the health care provider. If the amount specified in the estimate changes by more than 10% 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 must supply to the enrollee an updated estimate within five minutes of receiving the updated information.[34]

### Choice to decline

The bill specifies that an enrollee may decline to receive a cost estimate from the health plan issuer.[35]

---

[32] R.C. 3962.10(E).

[33] R.C. 3962.10(F).

[34] R.C. 3962.10(G).

[35] R.C. 3962.10(H).

### Responsibility for payment

The bill specifies that 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 before the product, service, or procedure is received.[36]

### Health care provider information to be given to health plan issuers

Not more than 24 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 is required by the bill to provide to a health plan issuer the necessary information through the website that the bill requires each health plan issuer to establish (see "**Websites to be maintained by health plan issuers**," below). The duty of health care providers to give this information begins January 1, 2019, to coincide with the duty of health plan issuers to begin providing cost estimates.[37]

#### Hospital-specific information

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:

(1) All necessary information associated with products, services, or procedures to be provided by the hospital or its employees;

(2) All necessary information associated with products, services, or procedures to be provided by health care providers who are independent contractors of the hospital. A health care provider who is an independent contractor of a hospital must submit to the hospital all CPT codes or other identifiers the hospital needs to fulfill its responsibility.

In the event a hospital must provide the necessary information for one independent contractor, the hospital must submit the necessary information not later than 48 hours after the appointment is made. In the event a hospital must provide the necessary information for two or more independent contractors, the hospital shall submit the necessary information not later than 72 hours after the appointment is made.[38]

---

[36] R.C. 3962.10(I).

[37] R.C. 3962.11(A) and (B).

[38] R.C. 3962.11(C).

### Websites to be maintained by health plan issuers

To facilitate a health care provider's transmission of necessary information and to promote health care price transparency for enrollees, each health plan issuer is required by the bill to create and maintain three websites. Access to each website must be provided free of charge.[39]

Specifically, the bill requires that each of the following websites be created and maintained:

(1) A website for health care providers to transmit necessary information. A health plan issuer must maintain only one website for all of its health benefit plans, including the health benefit plans of its affiliates and related entities, through which providers may enter necessary information without regard to the specific plan offered by the issuer. The website must permit all providers to quickly and easily enter the necessary information for each patient appointment or visit. The issuer cannot require the provider to enter more than the necessary information, such as the patient's particular plan.

(2) A website that can be instantly accessed by a health care provider that elects to provide cost estimates (as described below) through which the provider, upon entering the necessary information, may generate within five minutes a cost estimate that the provider may then give the patient electronically, in writing, or verbally;

(3) A website through which an enrollee or the enrollee's representative, upon entering the necessary information, may search for other health care providers and generate a corresponding cost estimate for the health care product, service, or procedure for the purpose of cost comparison.

Not later than October 15, 2018, each health plan issuer must report to the Superintendent of Insurance the Internet addresses of its three websites. The Superintendent must post those addresses on the website of the Department of Insurance. The Superintendent must monitor the health plan issuers' websites to ensure compliance. The Superintendent may impose a fine or withhold licensure if a health plan issuer fails to create and maintain websites that comply with the bill.

### Health care providers that provide estimates on behalf of issuers

The bill specifies that a health care provider may elect to provide an enrollee or enrollee's representative with a cost estimate by complying with the requirements described above for health plan issuers. If a health care provider elects to provide a cost

[39] R.C. 3962.11(D).

estimate, a health plan issuer must give the provider access to the applicable website created under the bill for this purpose.[40]

On request, and not more than five minutes after all necessary information has been received from a health care provider, a health plan issuer must submit to the health care provider all information that is needed by the provider to generate the cost estimate. The health plan issuer may provide the information either verbally or in electronic form.

A health plan issuer must make itself readily available to provide information to a health care provider to generate the cost estimate. The health plan issuer cannot charge the health care provider for the information.

The bill specifies that a health plan issuer is not required to provide a cost estimate if a health care provider elects to provide the estimate. It also specifies, however, that the health plan issuer may provide a cost estimate at its discretion using the necessary information received from the health care provider.

## Exclusions from cost estimate requirements

### Emergency situations and services

Similar to current law on providing cost estimates, the bill's cost estimate requirements do not apply in an emergency situation or to an emergency service. The bill describes "emergency service" as a service furnished to an individual in an emergency, including when the individual presents for care at an emergency department, is directly admitted to a hospital, or another instance where a health care provider determines that taking the time to provide a cost estimate for a product, service, or procedure or to transmit the necessary information to the patient's health plan issuer to provide the cost estimate would endanger the patient.[41]

### Office visits

The bill's requirements to provide cost estimates do not apply when the only service a health care provider will provide is an office visit. "Office visit" is described by the bill as the family of CPT codes for "Evaluation and Management, Office Visits Established" (codes 99211, 99212, 99213, 99214, and 99215) used for office or other outpatient visits for an established patient.[42]

---

[40] R.C. 3962.12.

[41] R.C. 3962.01 and 3962.02(B).

[42] R.C. 3962.04.

If a patient schedules or presents for health care products, services, or procedures in addition to an office visit but the health care provider is unable to estimate the level of office visit to be provided, the bill permits the provider to enter, and the website the health plan issuer creates under the bill must provide for, a general designation for an unknown level of office visit. The estimate provided through the health care provider or health plan issuer, respectively, must list the general designation and price range for all levels of office visits.

## Immunity from liability

The bill grants qualified immunity from civil liability to a health care provider or health plan issuer that provides a cost estimate under the bill. Specifically, the bill provides that the provider or issuer is not liable in damages in a civil action for injury, death, or loss to person or property that allegedly arises from an act or omission associated with providing the estimate if the provider or issuer made a good faith effort to collect the information required to complete the estimate and a good faith effort to provide the estimate to the patient or enrollee.[43]

## Sanctions for failure to comply

If, after completing an examination involving information collected from a six-month period, the Superintendent of Insurance, Department of Health, or appropriate regulatory board, finds that a health plan issuer or health care provider has committed a series of violations that, taken together, constitute a consistent pattern or practice of violating the bill's requirements to provide cost estimates, the Superintendent, Department, or board may impose administrative remedies on the issuer or provider.[44] In imposing these remedies, the Superintendent, Department, or board may do either or both of the following:

(1) Levy a monetary penalty, calculated as described below;

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

### Opportunity for a hearing

Before imposing an administrative remedy, the Superintendent, Department, or board must give written notice informing the health plan issuer or health care provider of the reasons for the finding, the proposed administrative remedy, and the opportunity

[43] R.C. 3962.16.

[44] R.C. 3962.17.

to submit a written request for an administrative hearing regarding the finding and proposed remedy. If a hearing is requested, it must be conducted in accordance with the Administrative Procedure Act not later than 15 days after receipt of the request.

### Monetary penalty amounts

A finding by the Superintendent, Department, or appropriate regulatory board that a health plan issuer or health care provider has committed a series of violations that, taken together, constitutes a consistent pattern or practice of violating the bill's requirements to provide cost estimates constitutes a single offense for purposes of levying a fine. A fine may be imposed as follows:

--For a first offense, the Superintendent or Department may levy a fine of not more than $100,000. The appropriate regulatory board may levy a fine of not more than $10,000.

--For a second offense that occurs on or earlier than four years after the first offense, the Superintendent or Department may levy a fine of not more than $150,000. The appropriate regulatory board may levy a fine of not more than $15,000.

--For a third or additional offense that occurs on or earlier than seven years after a first offense, the Superintendent or Department may levy a fine of not more than $300,000. The appropriate regulatory board may levy a fine of not more than $30,000.

### Factors in determining amounts

In determining the amount of a fine to be levied within the limits specified above, the Superintendent, Department, or appropriate regulatory board must consider the following factors:

(1) The extent and frequency of the violations;

(2) Whether the violations were due to circumstances beyond the control of the health plan issuer or health care provider;

(3) Any remedial actions taken by the health plan issuer or health care provider;

(4) The actual or potential harm to others resulting from the violations;

(5) If the health plan issuer or health care provider knowingly and willingly committed the violations;

(6) The financial condition of the health plan issuer or health care provider;

(7) Any other factors the Superintendent, Department, or appropriate board considers appropriate.

The amounts collected from levying fines are to be paid into the state treasury to the credit of the General Revenue Fund.

## ADMINISTRATION OF HEALTH CARE SERVICES AND BENEFITS

### Analysis of administrative burdens

Not later than June 30, 2018, the bill requires the Office of Health Transformation, in consultation with the Department of Insurance and Department of Medicaid, to analyze the administrative burdens placed on health care providers. The analysis must assess the extent to which the burdens negatively affect the quality of care that health care providers are able to provide, the amount of time that health care providers are able to spend with patients, and the financial stability of health care providers.[45]

### Online precertification from health plan issuers

Once a health care provider seeking to generate a cost estimate submits CPT codes to a website a health plan issuer has created under bill for that purpose, the website must direct the provider to a link that the provider can use to obtain online precertification from the issuer. Once CPT codes have been submitted to generate a cost estimate, a health plan issuer is prohibited from requiring the provider to submit the codes again for the purpose of precertification.[46]

### Limits on use of prior authorization for prescribers

The bill establishes a number of limitations on the use of prior authorization requirements by health plan issuers in the case of prescribers.[47] The bill specifies that, to the extent possible, a health plan issuer must also comply with current law pertaining to prior authorization.[48] Under that law, "prior authorization" is a practice implemented by a health plan issuer in which coverage of a health care service, drug, or device is dependent upon an insured individual or health care practitioner obtaining prior approval from the issuer. Current law (1) establishes criteria for prior authorization requirements, (2) imposes prior authorization request response deadlines on health

[45] R.C. 121.12.

[46] R.C. 3962.21.

[47] R.C. 3962.22.

[48] R.C. 3962.32.

plan issuers, and (3) requires health plan issuers to honor prior authorizations for specified time periods.[49]

### Previously approved prescribers

Beginning July 1, 2018, a health plan issuer is prohibited by the bill from requiring a prescriber to obtain prior authorization before prescribing a drug or item of medical equipment to a patient or performing a medical procedure or diagnostic test on a patient if that prescriber, within the immediately preceding three-year period before the bill's effective date, was in the top 25% of prescribers who had prior authorization requests approved. A health plan issuer must notify each prescriber who is exempt from the requirement. Every six months thereafter, beginning January 1, 2019, a health plan issuer must make a redetermination of which prescribers qualify for the exemption and notify them. Health plan issuers may combine information they have about prescribers and apply the exemption uniformly.[50]

### Product costs of $100 or less

The bill prohibits a health plan issuer from requiring a prescriber to obtain prior authorization for a drug that costs $100 or less for a 30-day supply or for an item of medical equipment, procedure, or diagnostic test that costs $100 or less.

### Chronic disease treatments

The bill prohibits a health plan issuer from requiring a prescriber to obtain prior authorization for a drug or item of medical equipment that had been the subject of a prior authorization request for the same course of treatment if the drug or item is to treat a chronic disease or medical condition.

### Standardized forms

The bill prohibits a health plan issuer from requiring a prescriber to use a prior authorization form that differs from the standardized prior authorization form created by the Office of Health Transformation. The Office is required to create the form not later than January 1, 2019.[51]

---

[49] R.C. 1751.72, 3923.041, and 5160.32, not in the bill.

[50] R.C. 3962.22(A).

[51] R.C. 191.11.

## Limits on use of step therapy

The bill establishes a number of limitations on the use of step therapy protocols. "Step therapy protocol" is defined by the bill as 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.[52]

A health plan issuer is prohibited from imposing a step therapy protocol on a prescriber who is seeking to prescribe a drug or perform a diagnostic test or medical procedure for treatment of a patient's particular condition that is in a later step of the applicable sequence if both of the following are the case:

(1) The patient has already tried, in the five-year period preceding the date the prescription is to be issued or the test or procedure is to be performed, either of the following: (a) a drug that is in a lower step of the sequence or a drug in the same pharmacologic class or with the same mechanism of action that is in a lower step of the sequence, or (b) a diagnostic test or medical procedure that is in a lower step of the sequence.

(2) With respect to a drug, the drug is determined to lack efficacy or effectiveness, have a diminished effect on the patient's condition, or cause the patient to experience an adverse event. With respect to a diagnostic test or medical procedure, the test or procedure is contraindicated for the patient because it poses a danger to the patient's health.

## Stabilized patients – 60-day grace period after enrollment

The bill requires a health plan issuer to offer a grace period of at least 60 days for any step therapy protocol or prior authorization protocol for a patient who is already stabilized on a particular medical treatment or drug regimen upon enrollment in the issuer's plan. During this period, a medical treatment or drug regimen cannot be interrupted while any utilization management requirements, such as prior authorization, step therapy overrides, or formulary exceptions, are addressed.[53]

## Continued coverage under formularies throughout benefit period

The bill requires a health plan issuer to cover for the entire duration of a health benefit plan period, without restrictions, a drug, item of medical equipment, medical

[52] R.C. 3962.01 and 3962.23.

[53] R.C. 3962.24.

procedure, or diagnostic test that is removed from the issuer's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended. The requirement does not apply, however, if the drug, item, procedure, or test is no longer made available to any patient or is prohibited.[54]

## Limits on utilization review entities

The bill establishes the following limitations on a utilization review entity that is part of a health plan issuer or under contract with an issuer:

(1) It cannot require a patient to repeat step therapy protocols or retry therapies that failed under coverage provided by another health plan issuer before authorizing coverage of a different drug or therapy;[55]

(2) It must provide accurate, patient-specific, and updated formularies that include prior authorization and step therapy protocol requirements in electronic health record systems for use in e-prescribing and other purposes;[56]

(3) If it requires health care providers to adhere to prior authorization protocols, it must accept and respond to prior authorization and step therapy protocol override requests exclusively through secure electronic transmissions using standard electronic transactions for pharmacy and medical services benefits. Facsimile, proprietary payer web-based portals, telephone discussions, and nonstandard electronic forms cannot be considered electronic transmissions.[57]

## Electronic health record software

Not later than January 1, 2021, a vendor of electronic health record systems is required by the bill to provide updated software that enables health care providers to transmit prior authorization requests or step therapy protocol overrides without having to resubmit the same information.[58]

---

[54] R.C. 3962.25.

[55] R.C. 3962.26.

[56] R.C. 3962.27.

[57] R.C. 3962.28.

[58] R.C. 3962.29.

### Health information exchanges

Not later than January 1, 2021, the Department of Insurance is required by the bill to ensure that a single health information exchange exists that a health care provider can use to generate cost estimates and precertifications for patients regardless of each patient's coverage.[59]

Not later than January 1, 2021, health plan issuers are required by the bill to perform medical chart audits electronically through health information exchanges.[60]

### Rule-making authority

The bill authorizes all of the following to adopt any rules necessary to carry out its provisions regarding health care cost estimates and benefits administration:

(1) The Superintendent of Insurance;

(2) The Medicaid Director;

(3) The Director of Health;

(4) Any other relevant department, agency, board, or other entity that regulates, licenses, or certifies a health care provider or health plan issuer.

If adopted, the rules must be adopted in accordance with the Administrative Procedure Act.

## COMMENT

The health care cost estimate requirements of current law, as 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 (1) judgment that the statute is unconstitutional and void, and (2) preliminary and permanent injunctions prohibiting enforcement of the statute. The court barred implementation or enforcement

[59] R.C. 3962.30.

[60] R.C. 3962.31.

of the statute until it rules on the injunction. On February 20, 2018, the court stayed further hearings on the injunction, pending a decision by the 6th District Court of Appeals on an appealed procedural matter.[61]

## HISTORY

| ACTION | DATE |
|---|---|
| Introduced | 10-31-17 |

H0399-I-132.docx/ks

[61] Williams County Common Pleas Court, http://pa.wmsco.org/eservices/search.page.3?x=cp2KdLacFmP--gxhyUC4sw, search Case Number 16CI000128 (accessed June 1, 2018).