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# Bill Analysis

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**Primary Sponsor:** Rep. Holmes

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## SUMMARY

### Health care price transparency

- Adds to current health care price transparency requirements that apply to health care products, services, and procedures.
- Generally requires that certain health care providers and health plan issuers provide to patients or their representatives a cost estimate for nonemergency health care products, services, or procedures before each is provided.
- Requires that cost estimates be provided within certain time limits and in accordance with all laws pertaining to the privacy of patient-identifying information.
- Grants qualified immunity from civil liability to a health care provider or health plan issuer that provides cost estimates in accordance with the bill.
- Authorizes the Superintendent of Insurance, the Department of Health, the Department of Medicaid, or the relevant regulatory board to impose administrative remedies on a health plan issuer or health care provider who fails to comply with the bill's health care price transparency provisions.
- Specifies that a contract clause prohibiting a health care provider or health plan issuer from providing patients with quality or cost information is invalid and unenforceable.
- Authorizes any member of the General Assembly to intervene in litigation that challenges the bill's health care price transparency provisions or the existing law pertaining to price transparency.
- Specifies that it is the General Assembly's intent in enacting the bill's health care price transparency provisions to provide patients with the information they need to make informed choices regarding their health care, to maximize health care cost savings for all Ohio residents, and to reduce the burden of health care expenditures on government entities, including Medicaid.

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# DETAILED ANALYSIS

## Health care price transparency

### Cost estimate requirement

The bill generally requires that a patient or the patient's representative be given a reasonable, good faith cost estimate for each health care product, service, or procedure the patient is to receive from a health care provider. This requirement does not apply when a patient seeks emergency services, a health care provider believes that a delay in care associated with fulfilling this requirement could harm the patient (see "**Delay in care**," below), or if any of the following are the case:

- When the only service a health care provider will provide is an office visit;
- When the patient was scheduled for only an office visit but during the visit it was determined that the patient needs a product, service, or procedure during that single visit; or
- When the patient seeks care without an appointment and without a prescription or order from another provider.[1]

In the event 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, or when a patient seeks care without an appointment, the provider may enter a general designation for an unknown level of office visit. The estimate must list the general designation and price range for all levels of office visits.[2]

The bill's requirements concerning price transparency apply notwithstanding current law[3] requiring specified health care facilities and professionals to provide a reasonable, good faith estimate of various costs before nonemergency products, services, or procedures are provided.

### Scope

The bill's requirements concerning price transparency apply to health care providers and health plan issuers. "Health care provider" is any individual or facility licensed, certified, or accredited under the following laws:

- Nursing Home and Residential Care Facility Law;
- Hospital Law;
- Dentist and Dental Hygienist Law;

[1] R.C. 3962.03(B) and 3962.08(B).

[2] R.C. 3962.08(C).

[3] R.C. 5162.80.

- Optometrist and Optical Dispenser Law;
- Physician and Limited Practitioner Law;
- Psychologist Law;
- Chiropractor Law;
- Hearing Aid Dealer Law;
- Speech-Language Pathologist and Audiologist Law;
- Occupational Therapist, Physical Therapist, and Athletic Trainer Law;
- Counselor, Social Worker, and Marriage and Family Therapist Law; and
- Orthotist, Prosthetist, and Pedorthist Law.[4]

Hospitals that are members of multi-hospital networks are subject to the bill's requirements beginning on the bill's effective date. Health care providers that are members of a multi-hospital network are subject to the requirements beginning on September 1, 2022. All other health care providers are subject to the requirements beginning on July 1, 2023.[5]

"Health plan issuer" is an entity that is subject to Ohio insurance laws and rules or to the jurisdiction of the Superintendent of Insurance and 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 a sickness and accidence insurance company and a health insuring corporation.[6]

## Who provides a cost estimate

Under the bill, a health care provider must provide the cost estimate if the patient is uninsured. If the patient is insured, the health care provider may elect to provide the estimate or defer to the patient's health plan issuer to provide the estimate. In any case, the provider must notify the patient or the patient's representative who will provide the cost estimate. The provision of a cost estimate by the provider does not preclude the issuer from also providing a cost estimate to the patient or the patient's representative.[7]

Each health care provider or health plan issuer that provides a cost estimate must ensure that the estimate is provided in a manner that complies with all applicable state and federal laws pertaining to the privacy of patient-identifying information.[8]

[4] R.C. 3962.01(D).

[5] R.C. 3962.03(A).

[6] R.C. 3962.01(C).

[7] R.C. 3962.03(C).

[8] R.C. 3962.03(E).

## When cost estimate is provided by the health care provider

### Content

The bill requires a cost estimate provided by a health care provider to contain all of the following:

- Total amount to be charged: The total amount the provider will charge the patient (if the patient is paying out-of-pocket) or the patient's health plan issuer for each health care product, service, or procedure the patient is to receive, inclusive of facility, professional, and other fees, along with a short description and the applicable CPT code[9] for the product, service, or procedure or, if no CPT code exists, another identifier the health plan issuer requires;
- Reimbursement from health plan issuer: If the patient is insured under a health benefit plan, both of the following:
  - A notation of whether the provider is in-network or out-of-network for the patient;
  - The amount the health care provider expects to receive from the health plan issuer for the product, service, or procedure.
- Patient's responsibility: The difference, if any, that the patient or other party responsible for the patient's care would be required to pay to the provider for the product, service, or procedure.[10]

However, 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 within the applicable time frame (see "**Timing**," below). The comprehensive cost estimate must contain all of the above-specified information associated with products, services, or procedures to be provided by the hospital or its employees, as well as by providers who are independent contractors of the hospital. A health care provider who is an independent contractor must submit to the hospital all CPT codes or other identifiers the hospital needs to fulfill its responsibility to provide a cost estimate.[11]

The bill also requires that a cost estimate be based on information provided at the time the appointment is made for the health care product, service, or procedure. The bill defines "the time that an appointment is made" as generally meaning any of the following:

- The point in time that an appointment for a health care product, service, or procedure is made;

[9] "CPT code" stands for "current procedural terminology code," which is the code assigned to a product, service, or procedure and published by the American Medical Association in its CPT code set.

[10] R.C. 3962.04(A).

[11] R.C. 3962.04(B).

- The point in time that a health care provider receives a prescription or order from another provider to provide a health care product, service, or procedure to the patient; or
- The point in time that a patient, pursuant to a prescription or order from the patient's health care provider, presents at the office or facilities of another provider to receive, on a walk-in basis, the product, service, or procedure.

(If, however, the point in time in which an event described above occurs is before 9 a.m. on a particular business day, the point in time may, instead, be considered to be 9 a.m. that same day. If the point in time in which an event described above occurs is after 5 p.m. on a particular business day, or occurs on a day that is not a business day, the point in time must, instead, be considered to be 9 a.m. on the next business day.)

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 appointment. Only one estimate is required per visit.

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 total amount to be charged on either (a) an average estimated charge for the product, service, or procedure that is submitted to the patient's health plan issuer or (b) the average out-of-pocket price for the product, service, or procedure paid by patients who are uninsured.[12]

### Timing

The bill requires that a cost estimate be provided to an uninsured patient not later than 24 hours after the time the appointment for the health care product, service, or procedure is made.[13] For an insured patient, the cost estimate must be provided not later than 24 hours after the health care provider receives the necessary information from the health plan issuer.

If, however, the health care product, service, or procedure is to be provided by one or more independent contractors of the provider, the cost estimate must be provided:

- Not less than 36 hours from the time the appointment is made, for an uninsured patient;
- Not less than 36 hours from the time the provider receives the necessary information from the health plan issuer, for an insured patient; or

[12] R.C. 3962.04(C) and 3962.011.

[13] "The time that an appointment is made" has a specific meaning that is defined in R.C. 3962.011 (see "**Content**," above).

- If the appointment is to be provided less than three days after the time the appointment is made, at the time the patient presents for the product, service, or procedure.

A provider may elect to send the cost estimate to the patient or the patient's representative by regular mail if the health care product, service, or procedure will be provided more than three days from the time the estimate is generated. If this election is made, the provider must mail the cost estimate not later than the above timeframes.[14]

### Transmission of necessary information to the health plan issuer

If the patient is insured, the bill requires that the health care provider, not later than 24 hours after an appointment is made, transmit to the patient's health plan issuer all of the following: the patient's name; the patient's identification number (if one is assigned); the CPT code or other identifier the issuer requires for each health care product, service, or procedure the patient is to receive; the provider's identification number; the provider's charge for each product, service, or procedure the patient has scheduled that will be delivered by a provider who is not in-network for the patient's health benefit plan; notification that the provider is providing the cost estimate to the patient or the patient's representative; and any other information the issuer requires from the provider.

If the provider is to provide a product, service, or procedure pursuant to a prescription or order from another provider, the provider who received the prescription or order must transmit the information described above to the patient's health plan issuer not later than 24 hours after the receiving the prescription or order or, if received when the provider's office or facility is closed, 24 hours after the office or facility reopens.[15]

### Health plan issuer's responsibility to respond to the provider

The bill requires a health plan issuer to give to the provider all information the provider needs to generate a cost estimate not later than five minutes after receiving the information transmitted from the provider, if the provider transmitted the information to the issuer electronically. Until September 1, 2022, if the health care provider transmitted the information to the health plan issuer in a means other than electronic, the issuer must give the needed information within 24 hours after receiving the request. However, under those circumstances, if the provider made the request within 72 hours before the health care product, service, or procedure is to be delivered, a cost estimate is not required.

If a health plan issuer does not provide the necessary information, the health care provider must notify the patient of this fact. The provider may note in the estimate that health plan issuer information was not provided as required by law. In this case, the provider may specify only the total amount to be charged and, at the provider's discretion, the reimbursement from health plan issuer, as well as the amount to be paid to the provider as

[14] R.C. 3962.04.

[15] R.C. 3962.04(E)(1) and (2).

specified in the contract entered into between the health plan issuer and the provider or, if a government pay scale applies, the amount specified in the applicable scale. If the information necessary to complete the estimate is subsequently received and an updated estimate can be provided within the applicable time limit (see "**Timing**," above), the provider must provide the updated estimate.[16]

### Disclaimer

Under the bill, the cost estimate must contain 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 information does not take into account secondary or other insurance the patient possesses that may affect the patient's out-of-pocket responsibility.

The provider has discretion in how the disclaimer is expressed.[17]

### Updated estimate

If the patient's responsibility or the uninsured out-of-pocket rate changes by more than 10% before the patient initially presents for the health care product, service, or procedure, the health care provider must supply to the patient an updated estimate within the applicable time limit (see "**Timing**," above). This requirement does not apply if the patient's health benefit plan failed to transmit to the health care provider the information necessary to generate the cost estimate.[18]

### Form

A cost estimate may be provided verbally or in electronic or written form and must be easy to understand. If the estimate is provided in electronic or written form, all of the following apply:

- It must be provided in large font;
- Unless the estimate contains more than nine CPT codes or other identifiers, it must be limited to one page; and
- The subject line of the communication containing the estimate must state, "Your Ohio Healthcare Price Transparency Estimate."[19]

[16] R.C. 3962.04(E)(3) and (4).

[17] R.C. 3962.04(F).

[18] R.C. 3962.04(G).

[19] R.C. 3962.04(H).

### Option to decline

The bill authorizes a patient to decline to receive a cost estimate from a health care provider.[20]

### Patient's responsibility for payment

The bill specifies that none of the price transparency provisions prohibit a health care provider or health plan issuer from collecting payment from a patient for an administered health care product, service, or procedure regardless of whether the patient does or does not receive a cost estimate before the product, service, or procedure is received.[21]

## Election for health plan issuer to provide estimate

Beginning September 1, 2022, if a health care provider elects for a patient's health plan issuer to provide the cost estimate in lieu of the provider, the provider must notify the issuer of this election through the issuer's portal required by existing law or other similar means.[22] In addition, the provider generally must also transmit to the health plan issuer through the appropriate portal all of the following:

- The patient's name;
- The patient's identification number, if one has been assigned;
- The CPT code or other identifier the health plan issuer requires for each health care product, service, or procedure the patient is to receive;
- The provider's identification number;
- The charge for each product, service, or procedure the patient has scheduled that will be delivered by a provider who is out-of-network for the patient's health benefit plan; and
- Any other information the health plan issuer requires from the provider.

The portal must also be able to transmit a copy of this information directly to the patient to whom the information pertains. (By September 1, 2022, a health plan issuer must modify its portal as necessary to accommodate the information transmission.) Generally, the transmission must occur not later than 24 hours after the time the appointment for the health care product, service, or procedure is made. If, however, the product, service, or procedure is to be provided by one or more independent contractors of the provider, the transmission must occur not later than 36 hours after the time the appointment is made.

[20] R.C. 3962.03(D).

[21] R.C. 3962.03(F).

[22] R.C. 1751.72, 3923.041, or 5160.34, not in the bill.

If a health care provider is unable to transmit information through a health plan issuer's portal, the bill authorizes the provider to transmit the information by facsimile or telephone.[23]

## When cost estimate is provided by the health plan issuer

### Content

When a health care provider elects to have the patient's health plan issuer provide a cost estimate to the patient or the patient's representative, that cost estimate must contain (1) the same information that is to be included in a cost estimate provided by a provider (see "**When cost estimate is provided by the health care provider**," "**Content**," above) and (2) the average rate the health plan issuer reimburses in-network providers for the same health care product, service, or procedure. The cost estimate must be provided not later than 48 hours after the health plan issuer receives the request from the health care provider. The cost estimate must be based on information provided at the time the appointment is made. 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 appointment. Only one estimate is required per visit.

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 transmit that a provider is unknown and the health plan issuer may base the estimate on an average estimated charge submitted to the health plan issuer for the product, service, or procedure at that facility or location.

Beginning September 1, 2022, if the health care provider does not transmit to the health plan issuer the information necessary to generate the cost estimate, the health plan issuer shall send a notice to the patient that the provider failed to transmit the necessary information and a cost estimate could not be generated. This action must be taken if the health care provider gives an indication to the health plan issuer that a health care product, service, or procedure is scheduled on a specific date.[24]

### Form

The bill requires the health plan issuer to ask the patient or the patient's representative whether the patient would prefer to receive cost estimates by electronic mail or other electronic means or by regular mail. The issuer must send cost estimates by the means elected.

The cost estimate must be provided in large font, be easy to understand, and, unless the estimate contains more than nine CPT codes or other identifiers, be limited to one page. The

[23] R.C. 3962.05.

[24] R.C. 3962.06(A) and (C).

subject line of the communication containing the estimate must state, "Your Ohio Healthcare Price Transparency Estimate."[25]

### Timing

If the patient or the patient's representative elects to receive cost estimates by electronic mail or other electronic means, the estimate must be sent automatically, but not later than five minutes after the health plan issuer has received the necessary information from the health care provider. If the means selected is by regular mail, the estimate must be mailed not later than 48 hours after the issuer has received the necessary information from the health care provider if the health care product, service, or procedure will be provided more than three days from the time the estimate is generated. For purposes of calculating the 48 hours, hours on a Saturday, Sunday, or legal holiday are excluded. If the health care product, service, or procedure will be provided less than three days from the time the cost estimate is generated, the health plan issuer must send the estimate by electronic means unless there is no method of sending the estimate electronically. If there is no such method, the health plan issuer is not required to provide a cost estimate.

The bill specifies that a health plan issuer must be held harmless if the electronic mail address of the patient or the patient's representative on file with the issuer is incorrect, invalid, or no longer used.[26]

### Health care provider's responsibility to respond to the issuer

The bill specifies that if a health care provider does not transmit to the health plan issuer the information necessary to generate the cost estimate, the issuer must send to the patient or the patient's representative, by the same means used to send estimates, a notice that the provider failed to transmit 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 on a specific date.

### Disclaimer

A cost estimate must contain both of the following:

- 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 patient's health benefit plan. (The health plan issuer has discretion in how the disclaimer is expressed.)

[25] R.C. 3962.06(F).

[26] R.C. 3962.06(B).

- If applicable, a notation that a specific health care provider is out-of-network for the enrollee.[27]

### Updated estimate

If the amount in a cost estimate changes by more than 10% before the patient presents for the health care product, service, or procedure, the health plan issuer must supply to the patient or patient's representative an updated estimate by the means the patient or the patient's representative has elected and within the applicable time limit (see "**Timing**," above). The health plan issuer is not required to send an updated estimate if there are less than three days from the time of the change in the cost estimate and the time that the health care product, service, or procedure is to be provided and the health plan issuer has no electronic means to send the updated estimate.[28]

## CPT codes and charge information

The bill requires a health care provider, regardless of who provides the cost estimate to the patient or the patient's representative, to give the patient or representative the CPT code or other identifier the patient's health plan issuer requires for each health care product, service, or procedure the patient is to receive along with the total amount to be charged associated with each code or other identifier. The provider has the following options for fulfilling this requirement:

- The provider may send this information to the patient or the patient's representative through electronic means.
- The provider may send this information to the patient or the patient's representative by regular mail if the health care product, service, or procedure will be provided more than three days from the time the appointment for the product, service, or procedure is made.
- The provider may provide to the patient or the patient's representative a website address where that individual may enter each code or identifier and retrieve the charge information. If this option is elected and the provider transmits the codes or identifiers to the patient's health plan issuer through the issuer's portal, the provider may have the portal generate an automatic electronic mail message to the individual with instructions on how to retrieve charge information through the website. By September 1, 2022, each health plan issuer must ensure that its portal is able to generate such a message.
- If the product, service, or procedure is to be provided less than three days from the time the appointment for the product, service, or procedure was made, the provider may give the information to the patient or the patient's representative at the time the patient presents for the product, service, or procedure to be received.

[27] R.C. 3962.06(D).

[28] R.C. 3962.06(E).

Regardless of the manner in which the provider has elected to fulfill this requirement, the provider must fulfill the requirement in accordance with all applicable state and federal laws pertaining to the privacy of patient-identifying information.

The bill requires that the CPT codes or other identifiers and charge information generally be given to the patient or the patient's representative not later than 24 hours after the time the appointment is made or, if the product, service, or procedure is to be provided less than 24 hours after the appointment is made, at the time the patient presents to receive the product, service, or procedure.

If, however, the health care product, service, or procedure is to be provided by one or more independent contractors of the provider, the CPT codes or other identifiers and charge information must be given to the patient or the patient's representative not later than 36 hours after the time the appointment for the product, service, or procedure is made or, if that item is to be provided less than 36 hours after the appointment is made, at the time the patient presents to receive the product, service, or procedure.[29]

## Delay in care

In the event a health care provider believes that a delay in care associated with fulfilling the cost estimate requirement could harm the patient, the bill requires the provider to inform the patient or the patient's representative of this fact and provide the health care product, service, or procedure to the patient without a cost estimate. After the product, service, or procedure is provided, the provider must submit to the applicable licensing board a report, in the form and manner prescribed by the board, detailing why the provider believed that a delay in care could harm the patient. Annually, each board that receives such reports must analyze the reports and prepare a summary of findings. Each summary must be submitted to the Governor and General Assembly.[30]

## Qualified immunity

The bill specifies that a health care provider or health plan issuer that provides a cost estimate in accordance with the bill's price transparency provisions is not liable 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 necessary to generate the estimate and a good faith effort to provide the estimate to the patient or the patient's representative.[31]

[29] R.C. 3962.07.

[30] R.C. 3962.09.

[31] R.C. 3962.10.

## Sanctions for noncompliance

### Alternatives

If, after completing an examination, the Superintendent of Insurance, Department of Health, Department of Medicaid, or appropriate regulatory board, as applicable, 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 to patients or their representatives, the bill permits the Superintendent or relevant department or board to levy a monetary penalty in a certain amount (see "**Fine amounts**," below), order the issuer or provider to cease and desist from engaging in violations, or both.

An examination of a health plan issuer may occur beginning on May 1, 2023. An examination of hospitals that are members of a multi-hospital network may occur beginning May 1, 2023. An examination of health care providers that are members of a multi-hospital network may occur beginning on September 1, 2023. An investigation of all other health care providers may occur beginning on June 1, 2024.[32]

Before imposing an administrative remedy, the Superintendent or relevant department or board must give written notice to the issuer or provider informing that party of the reasons for the finding, the administrative remedy that is proposed, and the opportunity to submit a written request for an administrative hearing regarding the finding and proposed remedy. If a hearing is requested, the Superintendent or relevant department or board must conduct it in accordance with the Administrative Procedure Act.[33]

### Fine amounts

The bill specifies that each finding by the Superintendent or relevant department or 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 to patients or their representatives constitutes a single offense for purposes of levying fines.[34]

[32] R.C. 3962.111.

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

[34] R.C. 3962.11(C)(1).

| Fine Amounts for Cost Estimate Violations[35] | | |
|---|---|---|
| | When Imposed by Superintendent or Department | When Imposed by a Regulatory Board |
| First Offense | Not more than $100,000 | Not more than $10,000 |
| Second Offense | Not more than $150,000 | Not more than $15,000 |
| Third or Subsequent Offense | Not more than $300,000 | Not more than $30,000 |

In determining the amount of a fine to be levied within the limits specified in the table, the Superintendent or relevant department or board must consider the following factors:

- The extent and frequency of the violations;
- Whether the violations were due to circumstances beyond the control of the health plan issuer or health care provider;
- Any remedial actions taken by the health plan issuer or health care provider;
- The actual or potential harm to others resulting from the violations;
- If the health plan issuer or health care provider knowingly and willingly committed the violations;
- The financial condition of the health plan issuer or health care provider;
- Any other factors the Superintendent or relevant department or board considers appropriate.

The amounts collected from levying fines must be paid into the state treasury to the credit of the General Revenue Fund.[36]

## Invalid and unenforceable contract clauses

The bill specifies that a contract clause that does any of the following is invalid and unenforceable:

- Prohibits a health care provider or health plan issuer from providing a patient with information that facilitates the patient's ability to choose a health care provider based on quality or cost, including providing a patient with cost and quality information for alternative providers when the patient demonstrates an intention to see a particular provider;

[35] R.C. 3962.11(C)(2).

[36] R.C. 3962.11(C)(3) and (D).

- Prohibits a health plan issuer from excluding any particular health care provider from a list or other resource that ranks providers based on quality or cost and is intended to help patients make decisions regarding their care; or
- Restricts patient access to quality or cost information provided by a health care provider or health plan issuer.[37]

## Rules

The bill authorizes all of the following to adopt rules necessary to carry out the bill's price transparency provisions:

- The Superintendent of Insurance;
- The Director of Health;
- The Medicaid Director; and
- Any other relevant department, agency, board, or other entity that regulates, licenses, or certifies a health care provider or health plan issuer.

All rules must be adopted in accordance with the Administrative Procedure Act.[38]

## Applicability to Medicaid

Beginning on April 1, 2024, the bill requires the Medicaid program to comply with the bill's price transparency provisions in the same manner as a health plan issuer. This requirement extends to all health care providers, covered under the bill, who are either Medicaid providers or otherwise seek payment through the Medicaid program or Medicaid managed care organizations for providing health care products, services, or procedures to Medicaid recipients.[39]

## Intent

The bill specifies that it is the General Assembly's intent, in enacting the bill's price transparency provisions, to do the following:

1. Provide patients with the information they need to make informed choices regarding their health care;
2. Maximize health care cost savings for all residents of Ohio; and
3. Reduce the burden of health care expenditures on government entities, including Medicaid costs.[40]

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[37] R.C. 3962.12.

[38] R.C. 3962.13.

[39] R.C. 5164.65.

[40] R.C. 3962.15.

## Intervening in litigation

The bill authorizes any member of the General Assembly to intervene in litigation that challenges the bill's price transparency provisions as well as provisions on price transparency in existing law (R.C. 5162.80).[41] The existing law requirements never went into effect because the statute establishing the requirements has been the subject of ongoing litigation.[42]

# HISTORY

| Action | Date |
|---|---|
| Introduced | 03-02-21 |

H0160-I-134/ts

[41] R.C. 3962.14 and 5162.801.

[42] See Kaitlyn Schroeder, "State Appeals Judge's Decision to Block Health Price Law," *Dayton Daily News* (March 18, 2019), available at https://www.daytondailynews.com/news/state-appeals-judge-decision-block-health-price-law/rmm2FzohEvSZpXTcS37ELK/.