(122nd General Assembly)
(Substitute House Bill Number 698)

AN ACT

To amend sections 1701.03, 1705.03, 1705.04, 1705.53, 1739.01, 1751.01, 1751.02, 1751.03, 1751.05, 1751.06, 1751.11, 1751.12, 1751.13, 1751.14, 1751.15, 1751.16, 1751.20, 1751.31, 1751.32, 1751.46, 1751.55, 1751.58, 1751.59, 1751.60, 1751.62, 1751.81, 1785.01, 1785.02, 1785.03, 1785.08, 1907.161, 2305.252, 3701.75, 3901.21, 3901.38, 3917.01, 3917.06, 3923.021, 3923.122, 3923.57, 3923.571, 3923.58, 3924.01, 3924.03, 3924.033, 3924.08, 3924.09, 3924.10, 3924.11, 3924.13, 3999.22, 4715.22, 4715.39, 4723.16, 4725.114, 4729.161, 4731.226, 4731.65, 4732.28, 4734.091, 4755.471, 5111.25, 5111.251, 5111.264, 5111.81, 5112.01, 5112.08, 5725.18, and 5729.03, to enact sections 5.2217, 1751.141, 1751.321, 3701.18, 3702.141, and 4503.104, and to repeal sections 3924.05, 5111.75, 5111.77, 5111.771, and 5111.811 of the Revised Code and to amend Section 3 of Am. Sub. S.B. 67 of the 122nd General Assembly, Section 6 of Am. Sub. S.B. 154 of the 122nd General Assembly, and Section 194 of Am. Sub. H.B. 215 of the 122nd General Assembly to conform provisions in the Health Insuring Corporation Law and the Sickness and Accident Insurance Law with the Health Insurance Portability and Accountability Act of 1996, to revise other provisions in these laws, to specify how health insuring corporations are to bring their net worth into compliance with the Health Insuring Corporation Law, to revise the premium tax imposed on domestic and foreign insurance companies that operate a health insuring

corporation as a line of business, to make related revisions in the phase-in schedule for the tax, to authorize a form of group life insurance as conversion coverage for certain former employees and members, to remove the coverage limitation on group term life insurance insuring the spouse and dependent children of an insured employee or member, to add a member to the committee created under Am. Sub. S.B. 154 of the 122nd General Assembly to study the continuing education requirements for insurance agents, to revise the standards for using electronic signatures in records of health care facilities, to specify when certain existing health care facilities are required to improve the structure or fixtures of the facility in order to comply with the safety and quality-of-care standards and quality-of-care data reporting requirements established by the Director of Health, to extend the Department of Health's study of cardiac catheterization performed without an on-site open-heart surgery service, to create the Save Our Sight Fund to support eye health and safety programs for children, to require the Registrar of Motor Vehicles and deputy registrars to request contributions to the fund from applicants for motor vehicle registration and renewal, to require the Department of Health to develop informational materials on eye care and safety, to allow a dentist to authorize a dental hygienist to provide dental hygiene services when the dentist is not physically present if certain conditions are met, to authorize the State Dental Board to adopt rules allowing certified dental assistants to polish the clinical crowns of teeth, to designate June as "Prostate Cancer Awareness Month," to authorize mechanotherapists to engage in their practice with certain other health care

professionals in a combined form of a professional corporation, limited liability company, partnership, or professional association, and to change the manner of determining the amount of the per day, per patient reimbursement that the Department of Human Services pays for the reasonable capital costs of eligible nursing facilities and intermediate care facilities for the mentally retarded, in specified circumstances in which there is a transfer or lease between related parties.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 1701.03, 1705.03, 1705.04, 1705.53, 1739.01, 1751.01, 1751.02, 1751.03, 1751.05, 1751.06, 1751.11, 1751.12, 1751.13, 1751.14, 1751.15, 1751.16, 1751.20, 1751.31, 1751.32, 1751.46, 1751.55, 1751.58, 1751.59, 1751.60, 1751.62, 1751.81, 1785.01, 1785.02, 1785.03, 1785.08, 1907.161, 2305.252, 3701.75, 3901.21, 3901.38, 3917.01, 3917.06, 3923.021, 3923.122, 3923.57, 3923.571, 3923.58, 3924.01, 3924.03, 3924.033, 3924.08, 3924.09, 3924.10, 3924.11, 3924.13, 3999.22, 4715.22, 4715.39, 4723.16, 4725.114, 4729.161, 4731.226, 4731.65, 4732.28, 4734.091, 4755.471, 5111.25, 5111.251, 5111.264, 5111.81, 5112.01, 5112.08, 5725.18, and 5729.03 be amended and sections 5.2217, 1751.141, 1751.321, 3701.18, 3702.141, and 4503.104 of the Revised Code be enacted to read as follows:

Sec. 5.2217. <u>The month of June shall be designated as "Prostate Cancer Awareness Month."</u>

Sec. 1701.03. (A) A corporation may be formed under this chapter for any purpose or combination of purposes for which individuals lawfully may associate themselves, except that, if the Revised Code contains special provisions pertaining to the formation of any designated type of corporation other than a professional association, as defined in section 1785.01 of the Revised Code, a corporation of that type shall be formed in accordance with the special provisions.

(B) On and after July 1, 1994, a corporation may be formed under this chapter for the purpose of carrying on the practice of any profession, including, but not limited to, a corporation for the purpose of providing public accounting or certified public accounting services, a corporation for

the erection, owning, and conducting of a sanitarium for receiving and caring for patients, medical and hygienic treatment of patients, and instruction of nurses in the treatment of disease and in hygiene, a corporation for the purpose of providing architectural, landscape architectural, professional engineering, or surveying services or any combination of those types of services, and a corporation for the purpose of providing a combination of the professional services, as defined in section 1785.01 of the Revised Code, of optometrists authorized under Chapter 4725. of the Revised Code, chiropractors authorized under Chapter 4734. of the Revised Code, psychologists authorized under Chapter 4732. of the Revised Code, registered or licensed practical nurses authorized under Chapter 4723. of the Revised Code, pharmacists authorized under Chapter 4729. of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.53 of the Revised Code, mechanotherapists authorized under section 4731.151 Of the Revised Code, and doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731. of the Revised Code. This chapter does not restrict, limit, or otherwise affect the authority or responsibilities of any agency, board, commission, department, office, or other entity to license, register, and otherwise regulate the professional conduct of individuals or organizations of any kind rendering professional services, as defined in section 1785.01 of the Revised Code, in this state or to regulate the practice of any profession that is within the jurisdiction of the agency, board, commission, department, office, or other entity, notwithstanding that an individual is a director, officer, employee, or other agent of a corporation formed under this chapter and is rendering professional services or engaging in the practice of a profession through a corporation formed under this chapter or that the organization is a corporation formed under this chapter.

(C) Nothing in division (A) or (B) of this section precludes the organization of a professional association in accordance with this chapter and Chapter 1785. of the Revised Code or the formation of a limited liability company under Chapter 1705. of the Revised Code with respect to a business, as defined in section 1705.01 of the Revised Code.

(D) No corporation formed for the purpose of providing a combination of the professional services, as defined in section 1785.01 of the Revised Code, of optometrists authorized under Chapter 4725. of the Revised Code, chiropractors authorized under Chapter 4734. of the Revised Code, psychologists authorized under Chapter 4732. of the Revised Code, registered or licensed practical nurses authorized under Chapter 4723. of the Revised Code, pharmacists authorized under Chapter 4729. of the Revised

Code, physical therapists authorized under sections 4755.40 to 4755.53 of the Revised Code, mechanotherapists authorized under section 4731.151 Of the Revised Code, and doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731. of the Revised Code shall control the professional clinical judgment exercised within accepted and prevailing standards of practice of a licensed, certificated, or otherwise legally authorized optometrist, chiropractor, psychologist, nurse, pharmacist, physical therapist, mechanotherapist, or doctor of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery in rendering care, treatment, or professional advice to an individual patient.

This division does not prevent a hospital, as defined in section 3727.01 of the Revised Code, insurer, as defined in section 3999.36 of the Revised Code, or intermediary organization, as defined in section 1751.01 of the Revised Code, from entering into a contract with a corporation described in this division that includes a provision requiring utilization review, quality assurance, peer review, or other performance or quality standards. Those activities shall not be construed as controlling the professional clinical judgment of an individual practitioner listed in this division.

Sec. 1705.03. (A) A limited liability company may sue and be sued.

(B) Unless otherwise provided in its articles of organization, a limited liability company may take property of any description or any interest in property of any description by gift, devise, or bequest and may make donations for the public welfare or for charitable, scientific, or educational purposes.

(C) In carrying out the purposes stated in its articles of organization or operating agreement and subject to limitations prescribed by law or in its articles of organization or its operating agreement, a limited liability company may do all of the following:

(1) Purchase or otherwise acquire, lease as lessee or lessor, invest in, hold, use, encumber, sell, exchange, transfer, and dispose of property of any description or any interest in property of any description;

(2) Make contracts;

(3) Form or acquire the control of other domestic or foreign limited liability companies;

(4) Be a shareholder, partner, member, associate, or participant in other profit or nonprofit enterprises or ventures;

(5) Conduct its affairs in this state and elsewhere;

(6) Render in this state and elsewhere a professional service, the kinds of professional services authorized under Chapters 4703. and 4733. of the

Revised Code, or a combination of the professional services of optometrists authorized under Chapter 4725. of the Revised Code, chiropractors authorized under Chapter 4734. of the Revised Code, psychologists authorized under Chapter 4732. of the Revised Code, registered or licensed practical nurses authorized under Chapter 4723. of the Revised Code, pharmacists authorized under Chapter 4729. of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.53 of the Revised Code, mechanotherapists authorized under section 4731.151 Of the Revised Code, and doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731. of the Revised Code;

(7) Borrow money;

(8) Issue, sell, and pledge its notes, bonds, and other evidences of indebtedness;

(9) Secure any of its obligations by mortgage, pledge, or deed of trust of all or any of its property;

(10) Guarantee or secure obligations of any person;

(11) Do all things permitted by law and exercise all authority within or incidental to the purposes stated in its articles of organization.

(D) In addition to the authority conferred by division (C) of this section and irrespective of the purposes stated in its articles of organization or operating agreement but subject to any limitations stated in those articles or its operating agreement, a limited liability company may invest funds not currently needed in its business in any securities if the investment does not cause the company to acquire control of another enterprise whose activities and operations are not incidental to the purposes stated in the articles of organization of the company.

(E)(1) No lack of authority or limitation upon the authority of a limited liability company shall be asserted in any action except as follows:

(a) By the state in an action by it against the company;

(b) By or on behalf of the company in an action against a manager, an officer, or any member as a member;

(c) By a member as a member in an action against the company, a manager, an officer, or any member as a member;

(d) In an action involving an alleged improper issue of a membership interest in the company.

(2) Division (E)(1) of this section applies to any action commenced in this state upon any contract made in this state by a foreign limited liability company.

Sec. 1705.04. (A) One or more persons, without regard to residence,

domicile, or state of organization, may form a limited liability company. The company is formed when one or more persons or their authorized representative signs and files with the secretary of state articles of organization that set forth all of the following:

(1) The name of the company;

(2) Except as provided in division (B) of this section, the period of its duration, which may be perpetual;

(3) The address to which interested persons may direct requests for copies of any operating agreement and any bylaws of the company;

(4) Any other provisions that are from the operating agreement or that are not inconsistent with applicable law and that the members elect to set out in the articles for the regulation of the affairs of the company.

(B) If the articles of organization or operating agreement do not set forth the period of the duration of the limited liability company, its duration shall be perpetual.

(C) If a limited liability company is formed under this chapter for the purpose of rendering a professional service, the kinds of professional services authorized under Chapters 4703. and 4733. of the Revised Code, or a combination of the professional services of optometrists authorized under Chapter 4725. of the Revised Code, chiropractors authorized under Chapter 4734. of the Revised Code, psychologists authorized under Chapter 4732. of the Revised Code, registered or licensed practical nurses authorized under Chapter 4723. of the Revised Code, pharmacists authorized under Chapter 4729. of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.53 of the Revised Code, <u>mechanotherapists authorized under section 4731.151 Of the Revised Code,</u> and doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731. of the Revised Code, the following apply:

(1) Each member, employee, or other agent of the company who renders a professional service in this state and, if the management of the company is not reserved to its members, each manager of the company who renders a professional service in this state shall be licensed, certificated, or otherwise legally authorized to render in this state the same kind of professional service; if applicable, the kinds of professional services authorized under Chapters 4703. and 4733. of the Revised Code; or, if applicable, any of the kinds of professional services of optometrists authorized under Chapter 4725. of the Revised Code, chiropractors authorized under Chapter 4734. of the Revised Code, psychologists authorized under Chapter 4732. of the Revised Code, registered or licensed practical nurses authorized under

Chapter 4723. of the Revised Code, pharmacists authorized under Chapter 4729. of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.53 of the Revised Code, mechanotherapists authorized under section 4731.151 Of the Revised Code, or doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731. of the Revised Code.

(2) Each member, employee, or other agent of the company who renders a professional service in another state and, if the management of the company is not reserved to its members, each manager of the company who renders a professional service in another state shall be licensed, certificated, or otherwise legally authorized to render that professional service in the other state.

(D) Except for the provisions of this chapter pertaining to the personal liability of members, employees, or other agents of a limited liability company and, if the management of the company is not reserved to its members, the personal liability of managers of the company, this chapter does not restrict, limit, or otherwise affect the authority or responsibilities of any agency, board, commission, department, office, or other entity to license, certificate, register, and otherwise regulate the professional conduct of individuals or organizations of any kind rendering professional services in this state or to regulate the practice of any profession that is within the jurisdiction of the agency, board, commission, department, office, or other entity, notwithstanding that the individual is a member or manager of a limited liability company and is rendering the professional services or engaging in the practice of the profession through the limited liability company or that the organization is a limited liability company.

(E) No limited liability company formed for the purpose of providing a combination of the professional services, as defined in section 1785.01 of the Revised Code, of optometrists authorized under Chapter 4725. of the Revised Code, chiropractors authorized under Chapter 4734. of the Revised Code, psychologists authorized under Chapter 4732. of the Revised Code, registered or licensed practical nurses authorized under Chapter 4723. of the Revised Code, pharmacists authorized under Chapter 4729. of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.53 of the Revised Code, mechanotherapists authorized under section 4731.151 Of the Revised Code, and doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731. of the Revised Code shall control the professional clinical judgment exercised within accepted and prevailing standards of practice of a licensed, certificated, or otherwise legally authorized optometrist,

chiropractor, psychologist, nurse, pharmacist, physical therapist, mechanotherapist, or doctor of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery in rendering care, treatment, or professional advice to an individual patient.

This division does not prevent a hospital, as defined in section 3727.01 of the Revised Code, insurer, as defined in section 3999.36 of the Revised Code, or intermediary organization, as defined in section 1751.01 of the Revised Code, from entering into a contract with a limited liability company described in this division that includes a provision requiring utilization review, quality assurance, peer review, or other performance or quality standards. Those activities shall not be construed as controlling the professional clinical judgment of an individual practitioner listed in this division.

Sec. 1705.53. Subject to any contrary provisions of the Ohio Constitution, the laws of the state under which a foreign limited liability company is organized govern its organization and internal affairs and the liability of its members. A foreign limited liability company may not be denied a certificate of registration as a foreign limited liability company in this state because of any difference between the laws of the state under which it is organized and the laws of this state. However, a foreign limited liability company that applies for registration under this chapter to render a professional service in this state, as a condition to obtaining and maintaining a certificate of registration, shall comply with the requirements of division (C) of section 1705.04 of the Revised Code and shall comply with the requirements of Chapters 4703. and 4733. of the Revised Code if the kinds of professional services authorized under those chapters are to be rendered or with the requirements of Chapters 4723., 4725., 4729., 4731., 4732., 4734., and 4755. of the Revised Code if a combination of the professional services of optometrists authorized under Chapter 4725. of the Revised Code, chiropractors authorized under Chapter 4734. of the Revised Code, psychologists authorized under Chapter 4732. of the Revised Code, registered or licensed practical nurses authorized under Chapter 4723. of the Revised Code, pharmacists authorized under Chapter 4729. of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.53 of the Revised Code, mechanotherapists authorized under section 4731.151 Of the Revised Code, and doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731. of the Revised Code are to be rendered.

Sec. 1739.01. As used in sections 1739.01 to 1739.22 of the Revised Code:

(A) "Agreement" means a written agreement executed by members of a multiple employer welfare arrangement that establishes an arrangement, provides for its operation, and through which each member agrees to assume and discharge all liability under sections 1739.01 to 1739.22 of the Revised Code relating to or arising out of the operation of the arrangement in proportion to the ratio of the total number of covered employees employed by the member at the time the liability arose to the total number of covered employees employed by all members of the arrangement at the time the liability arose.

(B) "Excess insurance" or "stop-loss insurance" means an insurance policy purchased by a multiple employer welfare arrangement under which it receives reimbursement for benefits it pays in excess of a preset deductible or limit.

(C) "~~Fully-insured~~ Fully insured program" means a program by which benefits are provided to members, employees of members, or the dependents of such members or employees, through the purchase of sickness and accident insurance from an insurance company licensed to do business in this state or health services purchased from a health ~~maintenance organization~~ insuring corporation authorized to do business in this state.

(D) "Group self-insurance program" means a program by which benefits are provided to members, employees of members, or the dependents of such members or employees, other than through sickness and accident insurance purchased from an insurance company licensed to do business in this state or health care services purchased from a health ~~maintenance organization~~ insuring corporation authorized to do business in this state.

(E) "Member" means an individual or an employer that is a member of an organization sponsoring a multiple employer welfare arrangement.

(F) "Multiple employer welfare arrangement" means an employee welfare benefit plan, trust, or any other arrangement, whether such plan, trust, or arrangement is subject to the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 1001, as amended, that is established or maintained for the purpose of offering or providing, through group insurance or group self-insurance programs, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, or death, to the employees, and their dependents, of two or more employers, or to two or more self-employed individuals and their dependents.

(G) "Premium" means any type of consideration paid to a multiple employer welfare arrangement by a member for coverage under the arrangement.

(H) "Surplus" means the total assets of the multiple employer welfare arrangement less its liabilities and reserves as determined in accordance with the requirements of sections 1739.01 to 1739.21 of the Revised Code.

(I) "Third-party administrator" has the same meaning as "administrator" in section 3959.01 of the Revised Code.

Sec. 1751.01. As used in this chapter:

(A) "Basic health care services" means the following services when medically necessary:

(1) Physician's services, except when such services are supplemental under division (B) of this section;

(2) Inpatient hospital services;

(3) Outpatient medical services;

(4) Emergency health services;

(5) Urgent care services;

(6) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;

(7) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care.

"Basic health care services" does not include experimental procedures.

A health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all listed basic health care services. However, this requirement does not apply to the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare ~~risk contract or medicare cost~~ contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the Ohio department of human services under Chapter 5111. of the Revised Code, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

(B) "Supplemental health care services" means any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes:

(1) Services of facilities for intermediate or long-term care, or both;

(2) Dental care services;

(3) Vision care and optometric services including lenses and frames;

(4) Podiatric care or foot care services;

(5) Mental health services including psychological services;

(6) Short-term outpatient evaluative and crisis-intervention mental health services;

(7) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction;

(8) Home health services;

(9) Prescription drug services;

(10) Nursing services;

(11) Services of a dietitian licensed under Chapter 4759. of the Revised Code;

(12) Physical therapy services;

(13) Chiropractic services;

(14) Any other category of services approved by the superintendent of insurance.

(C) "Specialty health care services" means one of the supplemental health care services listed in division (B)(1) to (13) of this section, when provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services.

(D) "Closed panel plan" means a health care plan that requires enrollees to use participating providers.

(E) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.

(F) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.

(G) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state.

(H) "Emergency health services" means those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.

(I) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation.

(J) "Evidence of coverage" means any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage and other rights to which such person is entitled under a health care plan.

(K) "Health care facility" means any facility, except a health care practitioner's office, that provides preventive, diagnostic, therapeutic, acute convalescent, rehabilitation, mental health, mental retardation, intermediate care, or skilled nursing services.

(L) "Health care services" means ~~any~~ basic, supplemental, and specialty health care services ~~involved in or incident to the furnishing of preventive, diagnostic, therapeutic, or rehabilitative care~~.

(M) "Health delivery network" means any group of providers or health care facilities, or both, or any representative thereof, that have entered into an agreement to offer health care services in a panel rather than on an individual basis.

(N) "Health insuring corporation" means a corporation, as defined in division (G) of this section, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

"Health insuring corporation" does not include a limited liability company formed pursuant to Chapter 1705. of the Revised Code, an insurer licensed under Title XXXIX of the Revised Code if that insurer offers only open panel plans under which all providers and health care facilities participating receive their compensation directly from the insurer, a corporation formed by or on behalf of a political subdivision or a department, office, or institution of the state, or a public entity formed by or on behalf of a board of county commissioners, a county board of mental retardation and developmental disabilities, an alcohol and drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, as those terms are used in Chapters 340. and 5126. of the Revised Code. Except as provided by division (D) of section 1751.02 of the Revised Code, or as otherwise provided by law, no board, commission, agency, or other entity under the control of a political subdivision may accept insurance risk in providing for health care services. However, nothing in this division shall be construed as prohibiting such entities from purchasing the services of a health insuring corporation or a third-party administrator licensed under Chapter 3959. of

the Revised Code.

(O) "Intermediary organization" means a health delivery network or other entity that contracts with licensed health insuring corporations or self-insured employers, or both, to provide health care services, and that enters into contractual arrangements with other entities for the provision of health care services for the purpose of fulfilling the terms of its contracts with the health insuring corporations and self-insured employers.

(P) "Intermediate care" means residential care above the level of room and board for patients who require personal assistance and health-related services, but who do not require skilled nursing care.

(Q) "Medical record" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment.

(R)(1) "Open panel plan" means a health care plan that provides incentives for enrollees to use participating providers and that also allows enrollees to use providers that are not participating providers.

(2) No health insuring corporation may offer an open panel plan, unless the health insuring corporation is also licensed as an insurer under Title XXXIX of the Revised Code, the health insuring corporation, on ~~the effective date of this section~~ June 4, 1997, holds a certificate of authority or license to operate under Chapter 1736. or 1740. of the Revised Code, or an insurer licensed under Title XXXIX of the Revised Code is responsible for the out-of-network risk as evidenced by both an evidence of coverage filing under section 1751.11 of the Revised Code and a policy and certificate filing under section 3923.02 of the Revised Code.

(S) "Panel" means a group of providers or health care facilities that have joined together to deliver health care services through a contractual arrangement with a health insuring corporation, employer group, or other payor.

(T) "Person" has the same meaning as in section 1.59 of the Revised Code, and, unless the context otherwise requires, includes any insurance company holding a certificate of authority under Title XXXIX of the Revised Code, any subsidiary and affiliate of an insurance company, and any government agency.

~~(T)~~(U) "Premium rate" means any set fee regularly paid by a subscriber to a health insuring corporation. A "premium rate" does not include a one-time membership fee, an annual administrative fee, or a nominal access fee, paid to a managed health care system under which the recipient of health care services remains solely responsible for any charges accessed for those services by the provider or health care facility.

~~(U)~~(V) "Primary care provider" means a provider that is designated by a health insuring corporation to supervise, coordinate, or provide initial care or continuing care to an enrollee, and that may be required by the health insuring corporation to initiate a referral for specialty care and to maintain supervision of the health care services rendered to the enrollee.

~~(V)~~(W) "Provider" means any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code, provided that nothing in this chapter or other provisions of law shall be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health insuring corporation from employing CERTIFIED nurse practitioners, CERTIFIED NURSE ANESTHETISTS, CLINICAL NURSE SPECIALISTS, CERTIFIED NURSE MIDWIVES, dietitians, physicians' assistants, dental assistants, dental hygienists, optometric technicians, or other allied health personnel who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services.

~~(W)~~(X) "Provider sponsored organization" means a corporation, as defined in division (G) of this section, that is at least eighty per cent owned or controlled by one or more hospitals, as defined in section 3727.01 of the Revised Code, or one or more physicians licensed to practice medicine or surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code, or any combination of such physicians and hospitals. Such control is presumed to exist if at least eighty per cent of the voting rights or governance rights of a provider sponsored organization are directly or indirectly owned, controlled, or otherwise held by any combination of the physicians and hospitals described in this division.

~~(X)~~(Y) "Solicitation document" means the written materials provided to prospective subscribers or enrollees, or both, and used for advertising and marketing to induce enrollment in the health care plans of a health insuring corporation.

~~(Y)~~(Z) "Subscriber" means a person who is responsible for making payments to a health insuring corporation for participation in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health insuring corporation.

~~(Z)~~(AA) "Urgent care services" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may

include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements.

Sec. 1751.02. (A) Notwithstanding any law in this state to the contrary, any corporation, as defined in section 1751.01 of the Revised Code, may apply to the superintendent of insurance for a certificate of authority to establish and operate a health insuring corporation. If the corporation applying for a certificate of authority is a foreign corporation domiciled in a state without laws similar to those of this chapter, the corporation must form a domestic corporation to apply for, obtain, and maintain a certificate of authority under this chapter.

(B) No person shall establish, operate, or perform the services of a health insuring corporation in this state without obtaining a certificate of authority under this chapter.

(C) Except as provided by division (D) of this section, no political subdivision or department, office, or institution of this state, or corporation formed by or on behalf of any political subdivision or department, office, or institution of this state, shall establish, operate, or perform the services of a health insuring corporation. Nothing in this section shall be construed to preclude a board of county commissioners, a county board of mental retardation and developmental disabilities, an alcohol and drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, or a public entity formed by or on behalf of any of these boards, from using managed care techniques in carrying out the board's or public entity's duties pursuant to the requirements of Chapters 307., 329., 340., and 5126. of the Revised Code. However, no such board or public entity may operate so as to compete in the private sector with health insuring corporations holding certificates of authority under this chapter.

(D) A corporation formed by or on behalf of a publicly owned, operated, or funded hospital or health care facility may apply to the superintendent for a certificate of authority under division (A) of this section to establish and operate a health insuring corporation.

(E) A health insuring corporation shall operate in this state in compliance with this chapter and Chapter 1753. of the Revised Code, and with sections 3702.51 to 3702.62 of the Revised Code, and shall operate in conformity with its filings with the superintendent under this chapter, including filings made pursuant to sections 1751.03, 1751.11, 1751.12, and 1751.31 of the Revised Code.

(F) An insurer licensed under Title XXXIX of the Revised Code need

not obtain a certificate of authority as a health insuring corporation to offer an open panel plan as long as the providers and health care facilities participating in the open panel plan receive their compensation directly from the insurer. If the providers and health care facilities participating in the open panel plan receive their compensation from any person other than the insurer, or if the insurer offers a closed panel plan, the insurer must obtain a certificate of authority as a health insuring corporation.

(G) An intermediary organization need not obtain a certificate of authority as a health insuring corporation, regardless of the method of reimbursement to the intermediary organization, as long as a health insuring corporation or a self-insured employer maintains the ultimate responsibility to assure delivery of all health care services required by the contract between the health insuring corporation and the subscriber and the laws of this state or between the self-insured employer and its employees.

Nothing in this section shall be construed to require any health care facility, provider, health delivery network, or intermediary organization that contracts with a health insuring corporation or self-insured employer, regardless of the method of reimbursement to the health care facility, provider, health delivery network, or intermediary organization, to obtain a certificate of authority as a health insuring corporation under this chapter, unless otherwise provided, in the case of contracts with a self-insured employer, by operation of the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 1001, as amended.

(H) Any health delivery network doing business in this state, including any health delivery network that is functioning as an intermediary organization doing business in this state, that is not required to obtain a certificate of authority under this chapter shall certify to the superintendent annually, not later than the first day of July, and shall provide a statement signed by the highest ranking official which includes the following information:

(1) The health delivery network's full name and the address of its principal place of business;

(2) A statement that the health delivery network is not required to obtain a certificate of authority under this chapter to conduct its business.

(I) The superintendent shall not issue a certificate of authority to a health insuring corporation that is a provider sponsored organization unless all health care plans to be offered by the health insuring corporation provide basic health care services. Substantially all of the physicians and hospitals with ownership or control of the provider sponsored organization, as defined in division ~~(W)~~(X) of section 1751.01 of the Revised Code, shall also be

participating providers for the provision of basic health care services for health care plans offered by the provider sponsored organization. If a health insuring corporation that is a provider sponsored organization offers health care plans that do not provide basic health care services, the health insuring corporation shall be deemed, for purposes of section 1751.35 of the Revised Code, to have failed to substantially comply with this chapter.

Except as specifically provided in this division and in division (C) of section 1751.28 of the Revised Code, the provisions of this chapter shall apply to all health insuring corporations that are provider sponsored organizations in the same manner that these provisions apply to all health insuring corporations that are not provider sponsored organizations.

(J) Nothing in this section shall be construed to apply to any multiple employer welfare arrangement operating pursuant to Chapter 1739. of the Revised Code.

(K) Any person who violates division (B) of this section, and any health delivery network that fails to comply with division (H) of this section, is subject to the penalties set forth in section 1751.45 of the Revised Code.

Sec. 1751.03. (A) Each application for a certificate of authority under this chapter shall be verified by an officer or authorized representative of the applicant, shall be in a format prescribed by the superintendent of insurance, and shall set forth or be accompanied by the following:

(1) A certified copy of the applicant's articles of incorporation and all amendments to the articles of incorporation;

(2) A copy of any regulations adopted for the government of the corporation, any bylaws, and any similar documents, and a copy of all amendments to these regulations, bylaws, and documents. The corporate secretary shall certify that these regulations, bylaws, documents, and amendments have been properly adopted or approved.

(3) A list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant, including all members of the board, the principal officers, and the person responsible for completing or filing financial statements with the department of insurance, accompanied by a completed original biographical affidavit and release of information for each of these persons on forms acceptable to the department;

(4) A full and complete disclosure of the extent and nature of any contractual or other financial arrangement between the applicant and any provider or a person listed in division (A)(3) of this section, including, but not limited to, a full and complete disclosure of the financial interest held by any such provider or person in any health care facility, provider, or insurer that has entered into a financial relationship with the health insuring

corporation;

(5) A description of the applicant, its facilities, and its personnel, including, but not limited to, the location, hours of operation, and telephone numbers of all contracted facilities;

(6) The applicant's projected annual enrollee population over a three-year period;

(7) A clear and specific description of the health care plan or plans to be used by the applicant, including a description of the proposed providers, procedures for accessing care, and the form of all proposed and existing contracts relating to the administration, delivery, or financing of health care services;

(8) A copy of each type of evidence of coverage and identification card or similar document to be issued to subscribers;

(9) A copy of each type of individual or group policy, contract, or agreement to be used;

(10) The schedule of the proposed contractual periodic prepayments or premium rates, or both, accompanied by appropriate supporting data;

(11) A financial plan which provides a three-year projection of operating results, including the projected expenses, income, and sources of working capital;

(12) The enrollee complaint procedure to be utilized as required under section 1751.19 of the Revised Code;

(13) A description of the procedures and programs to be implemented on an ongoing basis to assure the quality of health care services delivered to enrollees, including, if applicable, a description of a quality assurance program complying with the requirements of sections 1751.73 to 1751.75 of the Revised Code;

(14) A statement describing the geographic area or areas to be served, by county;

(15) A copy of all solicitation documents;

(16) A balance sheet and other financial statements showing the applicant's assets, liabilities, income, and other sources of financial support;

(17) A description of the nature and extent of any reinsurance program to be implemented, and a demonstration that errors and omission insurance and, if appropriate, fidelity insurance, will be in place upon the applicant's receipt of a certificate of authority;

(18) Copies of all proposed or in force related-party or intercompany agreements with an explanation of the financial impact of these agreements on the applicant. If the applicant intends to enter into a contract for managerial or administrative services, with either an affiliated or an

unaffiliated person, the applicant shall provide a copy of the contract and a detailed description of the person to provide these services. The description shall include that person's experience in managing or administering health care plans, a copy of that person's most recent audited financial statement, and a completed biographical affidavit on a form acceptable to the superintendent for each of that person's principal officers and board members and for any additional employee to be directly involved in providing managerial or administrative services to the health insuring corporation. If the person to provide managerial or administrative services is affiliated with the health insuring corporation, the contract must provide for payment for services based on actual costs.

(19) A statement from the applicant's board that the admitted assets of the applicant have not been and will not be pledged or hypothecated;

(20) A statement from the applicant's board that the applicant will submit monthly financial statements during the first year of operations;

(21) The name and address of the applicant's Ohio statutory agent for service of process, notice, or demand;

(22) Copies of all documents the applicant filed with the secretary of state;

(23) The location of those books and records of the applicant that must be maintained, which books and records shall be maintained in Ohio if the applicant is a domestic corporation, and which may be maintained either in the applicant's state of domicile or in Ohio if the applicant is a foreign corporation;

(24) The applicant's federal identification number, corporate address, and mailing address;

(25) An internal and external organizational chart;

(26) A list of the assets representing the initial net worth of the applicant;

(27) If the applicant has a parent company, the parent company's guaranty, on a form acceptable to the superintendent, that the applicant will maintain Ohio's minimum net worth. If no parent company exists, a statement regarding the availability of future funds if needed.

(28) The names and addresses of the applicant's actuary and external auditors;

(29) If the applicant is a foreign corporation, a copy of the most recent financial statements filed with the insurance regulatory agency in the applicant's state of domicile;

(30) If the applicant is a foreign corporation, a statement from the insurance regulatory agency of the applicant's state of domicile stating that

the regulatory agency has no objection to the applicant applying for an Ohio license and that the applicant is in good standing in the applicant's state of domicile;

(31) Any other information that the superintendent may require.

(B)(1) A health insuring corporation, unless otherwise provided for in this chapter or in section 3901.321 of the Revised Code, shall file a timely notice with the superintendent describing any change to the corporation's articles of incorporation or regulations, or any major modification to its operations as set out in the information required by division (A) of this section that affects any of the following:

(a) The solvency of the health insuring corporation;

(b) The health insuring corporation's continued provision of services that it has contracted to provide;

(c) The manner in which the health insuring corporation conducts its business.

(2) If the change or modification is to be the result of an action to be taken by the health insuring corporation, the notice shall be filed with the superintendent prior to the health insuring corporation taking the action. The action shall be deemed approved if the superintendent does not disapprove it within sixty days of filing.

(3) The filing of a notice pursuant to division (B)(1) or (2) of this section shall also serve as the submission of a notice when required for the Superintendent's review for purposes of section 3901.341 of the Revised Code, if the notice contains all of the information that section 3901.341 of the Revised Code requires for such submissions and a copy of any written agreement. The filing of such a notice, for the purpose of satisfying this division and section 3901.341 of the Revised Code, shall be subject to the sixty-day review period of division (B)(2) of this section.

(C)(1) No health insuring corporation shall expand its approved service area until a copy of the request for expansion, accompanied by documentation of the network of providers, forms of all proposed or existing provider contracts relating to the delivery of health care services, a schedule of proposed contractual periodic prepayments and premium rates for group contracts accompanied by appropriate supporting data, enrollment projections, plan of operation, and any other changes have been filed with the superintendent.

(2) Within ten calendar days after receipt of a complete filing under division (C)(1) of this section, the superintendent shall refer the appropriate jurisdictional issues to the director of health pursuant to section 1751.04 of the Revised Code.

(3) Within seventy-five days after the superintendent's receipt of a complete filing under division (C)(1) of this section, the superintendent shall determine whether the plan for expansion is lawful, fair, and reasonable. The superintendent may not make a determination until the superintendent has received the director's certification of compliance, which the director shall furnish within forty-five days after referral under division (C)(2) of this section. The director shall not certify that the requirements of section 1751.04 of the Revised Code are not met, unless the applicant has been given an opportunity for a hearing as provided in division (D) of section 1751.04 of the Revised Code. The forty-five-day and seventy-five-day review periods provided for in division (C)(3) of this section shall cease to run as of the date on which the notice of the applicant's right to request a hearing is mailed and shall remain suspended until the director issues a final certification.

(4) If the superintendent has not approved or disapproved all or a portion of a service area expansion within the seventy-five-day period provided for in division (C)(3) of this section, the filing shall be deemed approved.

(5) Disapproval of all or a portion of the filing shall be effected by written notice, which shall state the grounds for the order of disapproval and shall be given in accordance with Chapter 119. of the Revised Code.

Sec. 1751.05. (A) The superintendent of insurance shall issue or deny a certificate of authority to establish or operate a health insuring corporation to any corporation filing an application pursuant to section 1751.03 of the Revised Code within forty-five days of the superintendent's receipt of the certification from the director of health under division (C) of section 1751.04 of the Revised Code. A certificate of authority shall be issued upon payment of the application fee prescribed in section 1751.44 of the Revised Code if the superintendent is satisfied that the following conditions are met:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations.

(2) The director certifies, in accordance with division (C) of section 1751.04 of the Revised Code, that the organization's proposed plan of operation meets the requirements of division (B) of that section and sections 3702.51 to 3702.62 of the Revised Code. If, after the director has certified compliance, the application is amended in a manner that affects its approval under section 1751.04 of the Revised Code, the superintendent shall request the director to review and recertify the amended plan of operation. Within forty-five days of receipt of the amended plan from the superintendent, the director shall certify to the superintendent, pursuant to section 1751.04 of

the Revised Code, whether or not the amended plan meets the requirements of section 1751.04 of the Revised Code. The superintendent's forty-five-day review period shall cease to run as of the date on which the amended plan is transmitted to the director and shall remain suspended until the superintendent receives a new certification from the director.

(3) The applicant constitutes an appropriate mechanism to effectively provide or arrange for the provision of the basic health care services, supplemental health care services, or specialty health care services to be provided to enrollees.

(4) The applicant is financially responsible, complies with section 1751.28 of the Revised Code, and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the superintendent may consider:

(a) The financial soundness of the applicant's arrangements for health care services, including the applicant's proposed contractual periodic prepayments or premiums and the use of copayments ~~or deductibles~~;

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a government, or any other person for insuring the payment of the cost of health care services or providing for automatic applicability of an alternative coverage in the event of discontinuance of the health insuring corporation's operations;

(d) Any agreement with providers or health care facilities for the provision of health care services;

(e) Any deposit of securities submitted in accordance with section 1751.27 of the Revised Code as a guarantee that the obligations will be performed.

(5) The applicant has submitted documentation of an arrangement to provide health care services to its enrollees until the expiration of the enrollees' contracts with the applicant if a health care plan or the operations of the health insuring corporation are discontinued prior to the expiration of the enrollees' contracts. An arrangement to provide health care services may be made by using any one, or any combination, of the following methods:

(a) The maintenance of insolvency insurance;

(b) A provision in contracts with providers and health care facilities, but no health insuring corporation shall rely solely on such a provision for more than thirty days;

(c) An agreement with other health insuring corporations or insurers, providing enrollees with automatic conversion rights upon the discontinuation of a health care plan or the health insuring corporation's operations;

(d) Such other methods as approved by the superintendent.

(6) Nothing in the applicant's proposed method of operation, as shown by the information submitted pursuant to section 1751.03 of the Revised Code or by independent investigation, will cause harm to an enrollee or to the public at large, as determined by the superintendent.

(7) Any deficiencies certified by the director have been corrected.

(8) The applicant has deposited securities as set forth in section 1751.27 of the Revised Code.

(B) If an applicant elects to fulfill the requirements of division (A)(5) of this section through an agreement with other health insuring corporations or insurers, the agreement shall require those health insuring corporations or insurers to give thirty days' notice to the superintendent prior to cancellation or discontinuation of the agreement for any reason.

(C) A certificate of authority shall be denied only after compliance with the requirements of section 1751.36 of the Revised Code.

Sec. 1751.06. Upon obtaining a certificate of authority as required under this chapter, a health insuring corporation may do all of the following:

(A) Enroll individuals and their dependents in either of the following circumstances:

(1) The individual resides or lives in the approved service area.

(2) The individual's place of employment is located in the approved service area.

(B) Contract with providers and health care facilities for the health care services to which enrollees are entitled under the terms of the health insuring corporation's health care contracts;

(C) Contract with insurance companies authorized to do business in this state for insurance, indemnity, or reimbursement against the cost of providing emergency and nonemergency health care services for enrollees, subject to the provisions set forth in this chapter and the limitations set forth in the Revised Code;

(D) Contract with any person pursuant to the requirements of division (A)(18) of section 1751.03 of the Revised Code for managerial or administrative services, or for data processing, actuarial analysis, billing services, or any other services authorized by the superintendent of insurance. However, a health insuring corporation shall not enter into a contract for any of the services listed in this division with an insurance company that is not authorized to engage in the business of insurance in this state.

(E) Accept from governmental agencies, private agencies, corporations, associations, groups, individuals, or other persons, payments covering all or

part of the costs of planning, development, construction, and the provision of health care services;

(F) Purchase, lease, construct, renovate, operate, or maintain health care facilities, and their ancillary equipment, and any property necessary in the transaction of the business of the health insuring corporation;

(G) In the employer group market, impose an affiliation period of not more than sixty days, or for late enrollees an affiliation period of not more than ninety days, which period begins on the individual's date of enrollment and runs concurrently with any waiting period imposed under the coverage. For purposes of this division, "affiliation period" means a period of time which, under the terms of the coverage offered, must expire before the coverage becomes effective. No health care services or benefits need to be provided during an affiliation period, and no periodic prepayments can be charged for any coverage during that period.

(H) If a health insuring corporation offers coverage in the small employer group market through a network plan, limit or deny the coverage in accordance with section 3924.031 of the Revised Code;

(I) Refuse to issue coverage in the small employer group market pursuant to section 3924.032 of the Revised Code;

(J) Establish employer contribution rules or group participation rules for the offering of coverage in connection with a group contract in the small employer group market, as provided in division (E)(1) of section 3924.03 of the Revised Code.

Nothing in this section shall be construed as prohibiting a health insuring corporation without other commercial enrollment from contracting solely with federal health care programs regulated by federal regulatory bodies.

Nothing in this section shall be construed to limit the authority of a health insuring corporation to perform those functions not otherwise prohibited by law.

Sec. 1751.11. (A) Every subscriber of a health insuring corporation is entitled to an evidence of coverage for the health care plan under which health care benefits are provided.

(B) Every subscriber of a health insuring corporation that offers basic health care services is entitled to an identification card or similar document that specifies the health insuring corporation's name as stated in its articles of incorporation, and any trade or fictitious names used by the health insuring corporation. The identification card or document shall list at least one telephone number that provides the subscriber with access to health care on a ~~twenty-four-hour-per-day~~ twenty-four-hours-per-day,

~~en-day-per-week~~ seven-days-per-week basis.

(C) No evidence of coverage, or amendment to the evidence of coverage, shall be delivered, issued for delivery, renewed, or used, until the form of the evidence of coverage or amendment has been filed by the health insuring corporation with the superintendent of insurance. If the superintendent does not disapprove the evidence of coverage or amendment within sixty days after it is filed it shall be deemed approved, unless the superintendent sooner gives approval for the evidence of coverage or amendment. With respect to an amendment to an approved evidence of coverage, the superintendent only may disapprove provisions amended or added to the evidence of coverage. If the superintendent determines within the sixty-day period that any evidence of coverage or amendment fails to meet the requirements of this section, the superintendent shall so notify the health insuring corporation and it shall be unlawful for the health insuring corporation to use such evidence of coverage or amendment. At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw an approval, deemed or actual, of any evidence of coverage or amendment on any of the grounds stated in this section. Such disapproval shall be effected by a written order, which shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

(D) No evidence of coverage or amendment shall be delivered, issued for delivery, renewed, or used:

(1) If it contains provisions or statements that are inequitable, untrue, misleading, or deceptive;

(2) Unless it contains a clear, concise, and complete statement of the following:

(a) The health care services and insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

(b) Any exclusions or limitations on the health care services, type of health care services, benefits, or type of benefits to be provided, including copayments ~~or deductibles~~;

(c) The enrollee's personal financial obligation for noncovered services;

(d) Where and in what manner general information and information as to how services may be obtained is available, including the telephone number;

(e) The premium rate with respect to individual and conversion contracts, and relevant copayment provisions with respect to all contracts. The statement of the premium rate, however, may be contained in a separate insert.

(f) The method utilized by the health insuring corporation for resolving enrollee complaints.

(3) Unless it provides for the continuation of an enrollee's coverage, in the event that the enrollee's coverage under the GROUP policy, contract, certificate, or agreement terminates while the enrollee is receiving inpatient care in a hospital. This continuation of coverage shall terminate at the earliest occurrence of any of the following:

(a) The enrollee's discharge from the hospital;

(b) The determination by the enrollee's attending physician that inpatient care is no longer medically indicated for the enrollee; however, nothing in division (D)(3)(b) of this section precludes a health insuring corporation from engaging in utilization review as described in the evidence of coverage.

(c) The enrollee's reaching the limit for contractual benefits;

(d) The effective date of any new coverage.

(4) Unless it contains a provision that states, in substance, that the health insuring corporation is not a member of any guaranty fund, and that in the event of the health insuring corporation's insolvency, the enrollee is protected only to the extent that the hold harmless provision required by section 1751.13 of the Revised Code applies to the health care services rendered;

(5) Unless it contains a provision that states, in substance, that in the event of the insolvency of the health insuring corporation, the enrollee may be financially responsible for health care services rendered by a provider or health care facility that is not under contract to the health insuring corporation, whether or not the health insuring corporation authorized the use of the provider or health care facility.

(E) Notwithstanding ~~division~~ divisions (C) and (D) of this section, a health insuring corporation may use an evidence of coverage that provides for the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare ~~risk contract or medicare cost~~ contract, or an evidence of coverage that provides for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or an evidence of coverage that provides for the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the Ohio department of human services under Chapter 5111. of the Revised Code, or an evidence of coverage that provides for the coverage of beneficiaries under any other federal health

care program regulated by a federal regulatory body, or an evidence of coverage that provides for the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services, if both of the following apply:

(1) The evidence of coverage has been approved by the United States department of health and human services, the United States office of personnel management, ~~or~~ the Ohio department of human services, or the department of administrative services.

(2) The evidence of coverage is filed with the superintendent of insurance prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, ~~or~~ the Ohio department of human services, or the department of administrative services.

Sec. 1751.12. (A)(1) No contractual periodic prepayment and no premium rate for nongroup and conversion policies for health care services, or any amendment to them, may be used by any health insuring corporation at any time until the contractual periodic prepayment and premium rate, or amendment, have been filed with the superintendent of insurance, and shall not be effective until the expiration of sixty days after their filing unless the superintendent sooner gives approval. The filing shall be accompanied by an actuarial certification in the form prescribed by the Superintendent. The superintendent shall disapprove the filing, if the superintendent determines within the sixty-day period that the contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. The superintendent shall notify the health insuring corporation of the disapproval, and it shall thereafter be unlawful for the health insuring corporation to use the contractual periodic prepayment or premium rate, or amendment.

(2) No contractual periodic prepayment for group policies for health care services shall be used until the contractual periodic prepayment has been filed with the superintendent. The filing shall be accompanied by an actuarial certification in the form prescribed by the Superintendent. The superintendent may reject a filing made under division (A)(2) of this section at any time, with at least thirty days' written notice to a health insuring corporation, if the contractual periodic prepayment is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees.

(3) At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw the approval given

under division (A)(1) of this section, deemed or actual, of any contractual periodic prepayment or premium rate, or amendment, based on information that either of the following applies:

(a) The contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles.

(b) The contractual periodic prepayment or premium rate, or amendment, is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees.

(4) Any disapproval under division (A)(1) of this section, any rejection of a filing made under division (A)(2) of this section, or any withdrawal of approval under division (A)(3) of this section, shall be effected by a written notice, which shall state the specific basis for the disapproval, rejection, or withdrawal and shall be issued in accordance with Chapter 119. of the Revised Code.

(B) Notwithstanding division (A) of this section, a health insuring corporation may use a contractual periodic prepayment or premium rate for policies used for the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare risk contract or medicare cost contract, or for policies used for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or for policies used for the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the Ohio department of human services under Chapter 5111. of the Revised Code, or for policies used for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, or for policies used for the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services, if both of the following apply:

(1) The contractual periodic prepayment or premium rate has been approved by the United States department of health and human services, the United States office of personnel management, ~~or~~ the Ohio department of human services, or the department of administrative services.

(2) The contractual periodic prepayment or premium rate is filed with the superintendent prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, ~~or~~ the Ohio department of human services, or the department of administrative services.

(C) The administrative expense portion of all contractual periodic

prepayment or premium rate filings submitted to the superintendent for review must reflect the actual cost of administering the product. The superintendent may require that the administrative expense portion of the filings be itemized and supported.

(D)(1) Copayments ~~and deductibles~~ must be reasonable and must not be a barrier to the necessary utilization of services by enrollees.

(2) A health insuring corporation may not impose copayment charges on basic health care services that exceed thirty per cent of the total cost of providing any single covered health care service, except for physician office visits, emergency health services, and urgent care services. The total cost of providing a health care service is the cost to the health insuring corporation of providing the health care service to its enrollees as reduced by any applicable provider discount. An open panel plan may not impose copayments on out-of-network benefits that exceed fifty per cent of the total cost of providing any single covered health care service.

(3) To ensure that copayments are not a barrier to the utilization of basic health care services, a health insuring corporation may not impose, in any contract year, on any subscriber or enrollee, copayments that exceed two hundred per cent of the total annual premium rate to the subscriber or enrollees. This limitation of two hundred per cent does not include any reasonable copayments that are not a barrier to the necessary utilization of health care services by enrollees and that are imposed on physician office visits, emergency health services, urgent care services, supplemental health care services, or specialty health care services.

(E) A health insuring corporation shall not impose lifetime maximums on basic health care services. However, a health insuring corporation may establish a benefit limit for inpatient hospital services that are provided pursuant to a policy, contract, certificate, or agreement for supplemental health care services.

Sec. 1751.13. (A)(1)(a) A health insuring corporation shall, either directly or indirectly, enter into contracts for the provision of health care services with a sufficient number and types of providers and health care facilities to ensure that all covered health care services will be accessible to enrollees from a contracted provider or health care facility.

(b) A health insuring corporation shall not refuse to contract with a physician for the provision of health care services or refuse to recognize a physician as a specialist on the basis that the physician attended an educational program or a residency program approved or certified by the American Osteopathic Association. A health insuring corporation shall not refuse to contract with a health care facility for the provision of health care

services on the basis that the health care facility is certified or accredited by the American Osteopathic Association or that the health care facility is an osteopathic hospital as defined in section 3702.51 of the Revised Code.

(c) Nothing in division (A)(1)(b) of this section shall be construed to require a health insuring corporation to make a benefit payment under a closed panel plan to a physician or health care facility with which the health insuring corporation does not have a contract, provided that none of the bases set forth in that division are used as a reason for failing to make a benefit payment.

(2) When a health insuring corporation is unable to provide a covered health care service from a contracted provider or health care facility, the health insuring corporation must provide that health care service from a noncontracted provider or health care facility consistent with the terms of the enrollee's policy, contract, certificate, or agreement. The health insuring corporation shall either ensure that the health care service be provided at no greater cost to the enrollee than if the enrollee had obtained the health care service from a contracted provider or health care facility, or make other arrangements acceptable to the superintendent of insurance.

(3) Nothing in this section shall prohibit a health insuring corporation from entering into contracts with out-of-state providers or health care facilities that are licensed, certified, accredited, or otherwise authorized in that state.

(B)(1) A health insuring corporation shall, either directly or indirectly, enter into contracts with all providers and health care facilities through which health care services are provided to its enrollees.

(2) A health insuring corporation, upon written request, shall assist its contracted providers in finding stop-loss or reinsurance carriers.

(C) A health insuring corporation shall file an annual certificate with the superintendent certifying that all provider contracts and contracts with health care facilities through which health care services are being provided contain the following:

(1) A description of the method by which the provider or health care facility will be notified of the specific health care services for which the provider or health care facility will be responsible, including any limitations or conditions on such services;

(2) The specific hold harmless provision specifying protection of enrollees set forth as follows:

"[Provider/Health Care Facility] agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall [~~Provide~~

Provider/Health Care Facility] bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the covered enrollee, for health care services provided pursuant to this agreement. This does not prohibit [Provider/Health Care Facility] from collecting co-insurance~~, deductibles,~~ or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor."

(3) Provisions requiring the provider or health care facility to continue to provide covered health care services to enrollees in the event of the health insuring corporation's insolvency or discontinuance of operations. The provisions shall require the provider or health care facility to continue to provide covered health care services to enrollees as needed to complete any medically necessary procedures commenced but unfinished at the time of the health insuring corporation's insolvency or discontinuance of operations. The completion of a medically necessary procedure shall include the rendering of all covered health care services that constitute medically necessary follow-up care for that procedure. If an enrollee is receiving necessary inpatient care at a hospital, the provisions may limit the required provision of covered health care services relating to that inpatient care in accordance with division (D)(3) of section 1751.11 of the Revised Code, and may also limit such required provision of covered health care services to the period ending thirty days after the health insuring corporation's insolvency or discontinuance of operations.

The provisions required by division (C)(3) of this section shall not require any provider or health care facility to continue to provide any covered health care service after the occurrence of any of the following:

(a) The end of the thirty-day period following the entry of a liquidation order under Chapter 3903. of the Revised Code;

(b) The end of the enrollee's period of coverage for a contractual prepayment or premium;

(c) The enrollee obtains equivalent coverage with another health insuring corporation or insurer, or the enrollee's employer obtains such coverage for the enrollee;

(d) The enrollee or the enrollee's employer terminates coverage under the contract;

(e) A liquidator effects a transfer of the health insuring corporation's obligations under the contract under division (A)(8) of section 3903.21 of

the Revised Code.

(4) A provision clearly stating the rights and responsibilities of the health insuring corporation, and of the contracted providers and health care facilities, with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs;

(5) A provision regarding the availability and confidentiality of those health records maintained by providers and health care facilities to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to enrollees. The provision shall include terms requiring the provider or health care facility to make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of enrollees, and requiring the provider or health care facility to comply with applicable state and federal laws related to the confidentiality of medical or health records.

(6) A provision that states that contractual rights and responsibilities may not be assigned or delegated by the provider or health care facility without the prior written consent of the health insuring corporation;

(7) A provision requiring the provider or health care facility to maintain adequate professional liability and malpractice insurance. The provision shall also require the provider or health care facility to notify the health insuring corporation not more than ten days after the provider's or health care facility's receipt of notice of any reduction or cancellation of such coverage.

(8) A provision requiring the provider or health care facility to observe, protect, and promote the rights of enrollees as patients;

(9) A provision requiring the provider or health care facility to provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the provider or health care facility appropriately does not render services due to limitations arising from the provider's or health care facility's lack of training, experience, or skill, or due to licensing restrictions.

(10) A provision containing the specifics of any obligation on the primary care provider ~~or health care facility~~ to provide, or to arrange for the

provision of, covered health care services twenty-four hours per day, seven days per week;

(11) A provision setting forth procedures for the resolution of disputes arising out of the contract;

(12) A provision stating that the hold harmless provision required by division (C)(2) of this section shall survive the termination of the contract with respect to services covered and provided under the contract during the time the contract was in effect, regardless of the reason for the termination, including the insolvency of the health insuring corporation;

(13) A provision requiring those terms that are used in the contract and that are defined by this chapter, be used in the contract in a manner consistent with those definitions.

this division does not apply to the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare risk contract or medicare cost contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the Ohio department of human services under Chapter 5111. of the Revised Code, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

(D)(1) No health insuring corporation contract with a provider or health care facility shall contain any of the following:

(a) A provision that directly or indirectly offers an inducement to the provider or health care facility to reduce or limit medically necessary health care services to a covered enrollee;

(b) A provision that penalizes a provider or health care facility that assists an enrollee to seek a reconsideration of the health insuring corporation's decision to deny or limit benefits to the enrollee;

(c) A provision that limits or otherwise restricts the provider's or health care facility's ethical and legal responsibility to fully advise enrollees about their medical condition and about medically appropriate treatment options;

(d) A provision that penalizes a provider or health care facility for principally advocating for medically necessary health care services;

(e) A provision that penalizes a provider or health care facility for providing information or testimony to a legislative or regulatory body or

agency. This shall not be construed to prohibit a health insuring corporation from penalizing a provider or health care facility that provides information or testimony that is libelous or slanderous or that discloses trade secrets which the provider or health care facility has no privilege or permission to disclose.

(2) Nothing in this division shall be construed to prohibit a health insuring corporation from doing either of the following:

(a) Making a determination not to reimburse or pay for a particular medical treatment or other health care service;

(b) Enforcing reasonable peer review or utilization review protocols, or determining whether a particular provider or health care facility has complied with these protocols.

(E) Any contract between a health insuring corporation and an intermediary organization shall clearly specify that the health insuring corporation must approve or disapprove the participation of any provider or health care facility with which the intermediary organization contracts.

(F) If an intermediary organization that is not a health delivery network contracting solely with self-insured employers subcontracts with a provider or health care facility, the subcontract with the provider or health care facility shall do all of the following:

(1) Contain the provisions required by divisions (C) and (G) of this section, as made applicable to an intermediary organization, without the inclusion of inducements or penalties described in division (D) of this section;

(2) Acknowledge that the health insuring corporation is a third-party beneficiary to the agreement;

(3) Acknowledge the health insuring corporation's role in approving the participation of the provider or health care facility, pursuant to division (E) of this section.

(G) Any provider contract or contract with a health care facility shall clearly specify the health insuring corporation's statutory responsibility to monitor and oversee the offering of covered health care services to its enrollees.

(H)(1) A health insuring corporation shall maintain its provider contracts and its contracts with health care facilities at one or more of its places of business in this state, and shall provide copies of these contracts to facilitate regulatory review upon written notice by the superintendent of insurance.

(2) Any contract with an intermediary organization <u>that accepts compensation</u> shall include provisions requiring the intermediary

organization to provide the superintendent with regulatory access to all books, records, financial information, and documents related to the provision of health care services to subscribers and enrollees under the contract. The contract shall require the intermediary organization to maintain such books, records, financial information, and documents at its principal place of business in this state and to preserve them for at least three years in a manner that facilitates regulatory review.

(I)(1) A health insuring corporation shall ~~provide notice~~ notify its affected enrollees of the termination of ~~any~~ a contract ~~with~~ for the provision of health care services between the health insuring corporation and a primary care physician or hospital, by mail, within thirty days after the termination of the contract.

(a) Notice shall be given to subscribers of the termination of a contract with a primary care physician if the subscriber, or a dependent covered under the subscriber's health care coverage, has received health care services from the primary care physician within the previous twelve months or if the subscriber or dependent has selected the physician as the subscriber's or dependent's primary care physician within the previous twelve months.

(b) Notice shall be given to subscribers of the termination of a contract with a hospital if the subscriber, or a dependent covered under the subscriber's health care coverage, has received health care services from that hospital within the previous twelve months.

(2) The health insuring corporation shall pay, in accordance with the terms of the contract, for all covered health care services rendered to an enrollee by a primary care physician or hospital between the date of the termination of the contract and five days after the notification of the contract termination is mailed to a subscriber at the subscriber's last known address.

(J) Divisions (A) and (B) of this section do not apply to any health insuring corporation that, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1740. of the Revised Code.

(K) Nothing in this section shall restrict the governing body of a hospital from exercising the authority granted it pursuant to section 3701.351 of the Revised Code.

Sec. 1751.14. (A) Any policy, contract, or agreement for health care services authorized by this chapter that is issued, delivered, or renewed in this state and that provides that coverage of an unmarried dependent child will terminate upon attainment of the limiting age for dependent children specified in the policy, contract, or agreement, shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if the child is and continues to be both:

(1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap;

(2) Primarily dependent upon the subscriber for support and maintenance.

(B) Proof of incapacity and dependence for purposes of division (A) of this section shall be furnished to the health insuring corporation within thirty-one days of the child's attainment of the limiting age. Upon request, but not more frequently than annually, the health insuring corporation may require proof satisfactory to it of the continuance of such incapacity and dependency.

(C) ~~Nothing in this section shall be construed to require a health insuring corporation to cover a dependent child who is mentally retarded or physically handicapped if the policy, contract, or agreement is underwritten on evidence of insurability based on health factors set forth in the application, or if the dependent child does not satisfy the conditions of the policy, contract, or agreement as to any requirement for evidence of insurability or any other provision of the policy, contract, or agreement, satisfaction of which is required for coverage thereunder to take effect. In any such case, the terms of the policy, contract, or agreement shall apply with regard to the coverage or exclusion of the dependent from such coverage.~~

~~(D)~~ This section does not apply to any health insuring corporation~~,~~ policy, contract, or agreement offering only supplemental health care services or specialty health care services.

Sec. 1751.141. A health insuring corporation shall provide coverage, in accordance with the terms of the contract, for a subscriber's dependent children living outside the health insuring corporation's approved service area if a court order requires the subscriber to provide health care coverage to the dependent children.

Sec. 1751.15. (A) After a health insuring corporation has furnished, directly or indirectly, basic health care services for a period of twenty-four months, and if it currently meets the financial requirements set forth in section 1751.28 of the Revised Code and had net income as reported to the superintendent of insurance for at least one of the preceding four calendar quarters, it shall hold an annual open enrollment period of not less than thirty days during its month of licensure for individuals who are not federally eligible individuals at the time they apply for enrollment.

(B) During the open enrollment period described in division (A) of this section, the health insuring corporation shall accept applicants and their dependents in the order in which they apply for enrollment and in

accordance with any of the following:

(1) Up to its capacity, as determined by the health insuring corporation subject to review by the superintendent;

(2) If less than its capacity, one per cent of the health insuring corporation's total number of subscribers residing in this state as of the immediately preceding thirty-first day of December.

(C) Where a health insuring corporation demonstrates to the satisfaction of the superintendent that such open enrollment would jeopardize its economic viability, the superintendent may do any of the following:

(1) Waive the requirement for open enrollment;

(2) Impose a limit on the number of applicants and their dependents that must be enrolled;

(3) Authorize such underwriting restrictions upon open enrollment as are necessary to do any of the following:

(a) Preserve its financial stability;

(b) Prevent excessive adverse selection;

(c) Avoid unreasonably high or unmarketable charges for coverage of health care services.

(D)(1) A request to the superintendent under division (C) of this section for any restriction, limit, or waiver during an open enrollment period must be accompanied by supporting documentation, including financial data. In reviewing the request, the superintendent may consider various factors, including the size of the health insuring corporation, the health insuring corporation's net worth and profitability, the health insuring corporation's delivery system structure, and the effect on profitability of prior open enrollments.

(2) Any action taken by the superintendent under division (C) of this section shall be effective for a period of not more than one year. At the expiration of such time, a new demonstration of the health insuring corporation's need for the restriction, limit, or waiver shall be made before a new restriction, limit, or waiver is granted by the superintendent.

(3) Irrespective of the granting of any restriction, limit, or waiver by the superintendent, a health insuring corporation may reject an applicant or a dependent of the applicant during its open enrollment period if the applicant or dependent:

(a) Was eligible for and was covered under any employer-sponsored health care coverage, or if employer-sponsored health care coverage was available at the time of open enrollment;

(b) Is eligible for continuation coverage under state or federal law;

(c) Is eligible for medicare, and the health insuring corporation does not

have an agreement on appropriate payment mechanisms with the governmental agency administering the medicare program.

(E) A health insuring corporation shall not be required either to enroll applicants or their dependents who are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the health insuring corporation if such applicants or their dependents were enrolled or to make the effective date of benefits for applicants or their dependents enrolled under this section earlier than ninety days after the date of enrollment.

(F) A health insuring corporation shall not be required to cover the fees or costs, or both, for any basic health care service related to a transplant of a body organ if the transplant occurs within one year after the effective date of an enrollee's coverage under this section. This limitation on coverage does not apply to a newly born child who meets the requirements for coverage under section 1751.61 of the Revised Code.

(G) Each health insuring corporation required to hold an open enrollment pursuant to division (A) of this section shall file with the superintendent, not later than sixty days prior to the commencement of the proposed open enrollment period, the following documents:

(1) The proposed public notice of open enrollment;

(2) The evidence of coverage approved pursuant to section 1751.11 of the Revised Code that will be used during open enrollment;

(3) The contractual periodic prepayment and premium rate approved pursuant to section 1751.12 of the Revised Code that will be applicable during open enrollment;

(4) Any solicitation document approved pursuant to section 1751.31 of the Revised Code to be sent to applicants, including the application form that will be used during open enrollment;

(5) A list of the proposed dates of publication of the public notice, and the names of the newspapers in which the notice will appear;

(6) Any request for a restriction, limit, or waiver with respect to the open enrollment period, along with any supporting documentation.

(H)(1) An open enrollment period shall not satisfy the requirements of this section unless the health insuring corporation provides adequate public notice in accordance with divisions (H)(2) and (3) of this section. No public notice shall be used until the form of the public notice has been filed by the health insuring corporation with the superintendent. If the superintendent does not disapprove the public notice within sixty days after it is filed, it shall be deemed approved, unless the superintendent sooner gives approval for the public notice. If the superintendent determines within this sixty-day

period that the public notice fails to meet the requirements of this section, the superintendent shall so notify the health insuring corporation and it shall be unlawful for the health insuring corporation to use the public notice. Such disapproval shall be effected by a written order, which shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

(2) A public notice pursuant to division (H)(1) of this section shall be published in at least one newspaper of general circulation in each county in the health insuring corporation's service area, at least once in each of the two weeks immediately preceding the month in which the open enrollment is to occur and in each week of that month, or until the enrollment limitation is reached, whichever occurs first. The notice published during the last week of open enrollment shall appear not less than five days before the end of the open enrollment period. It shall be at least two newspaper columns wide or two and one-half inches wide, whichever is larger. The first two lines of the text shall be published in not less than twelve-point, boldface type. The remainder of the text of the notice shall be published in not less than eight-point type. The entire public notice shall be surrounded by a continuous black line not less than one-eighth of an inch wide.

(3) The following information shall be included in the public notice provided under division (H)(2) of this section:

(a) The dates that open enrollment will be held and the date coverage obtained under the open enrollment will become effective;

(b) Notice that an applicant or the applicant's dependents will not be denied coverage during open enrollment because of a preexisting health condition, but that some limitations and restrictions may apply;

(c) The address where a person may obtain an application;

(d) The telephone number that a person may call to request an application or to ask questions;

(e) The date the first payment will be due;

(f) The actual rates or range of rates that will be applicable for applicants;

(g) Any limitation granted by the superintendent on the number of applications that will be accepted by the health insuring corporation.

(4) Within thirty days after the end of an open enrollment period, the health insuring corporation shall submit to the superintendent proof of publication for the public notices, and shall report the total number of applicants and their dependents enrolled during the open enrollment period.

(I)(1) No health insuring corporation may employ any scheme, plan, or device that restricts the ability of any person to enroll during open

enrollment.

(2) No health insuring corporation may require enrollment to be made in person. Every health insuring corporation shall permit application for coverage by mail. A representative of the health insuring corporation may visit an applicant who has submitted an application by mail, in order to explain the operations of the health insuring corporation and to answer any questions the applicant may have. Every health insuring corporation shall make open enrollment applications and solicitation documents readily available to any potential applicant who requests such material.

(J) An application postmarked on the last day of an open enrollment period shall qualify as a valid application, regardless of the date on which it is received by the health insuring corporation.

(K) This section does not apply to any health insuring corporation that offers only supplemental health care services or specialty health care services, or to any health insuring corporation that offers plans only through Title XVIII or Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and that has no other commercial enrollment, or to any health insuring corporation that offers plans only through other federal health care programs regulated by federal regulatory bodies and that has no other commercial enrollment, or to any health insuring corporation that offers plans only through contracts covering officers or employees of the state that have been entered into by the department of administrative services and that has no other commercial enrollment.

(L) Each health insuring corporation shall accept federally eligible individuals for open enrollment coverage as provided in section 3923.581 of the Revised Code. A health insuring corporation may reinsure coverage of any federally eligible individual acquired under that section with the open enrollment reinsurance program in accordance with division (G) of section 3924.11 of the Revised Code. Fixed periodic prepayment rates charged for coverage reinsured by the program shall be established in accordance with section 3924.12 of the Revised Code.

(M) As used in this section, "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

Sec. 1751.16. (A) Except as provided in division (F) of this section, every group contract issued by a health insuring corporation shall provide an option for conversion to an individual contract issued on a direct-payment basis to any subscriber covered by the group contract who terminates employment or membership in the group, unless:

(1) Termination of the conversion option or contract is based upon nonpayment of premium after reasonable notice in writing has been given

by the health insuring corporation to the subscriber.

(2) The subscriber is, or is eligible to be, covered for benefits at least comparable to the group contract under any of the following:

(a) Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;

(b) Any act of congress or law under this or any other state of the United States providing coverage at least comparable to the benefits under division (A)(2)(a) of this section;

(c) Any policy of insurance or health care plan providing coverage at least comparable to the benefits under division (A)(2)(a) of this section.

(B)(1) The direct-payment contract offered by the health insuring corporation pursuant to division (A) of this section shall provide the following:

(a) In the case of an individual who is not a federally eligible individual, benefits comparable to benefits in any of the individual contracts then being issued to individual subscribers by the health insuring corporation;

(b) In the case of a federally eligible individual, a basic and standard plan established by the board of directors of the Ohio health reinsurance program or plans substantially similar to the basic and standard plan in benefit design and scope of covered services. For purposes of division (B)(1)(b) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services. The contractual periodic prepayments charged for such plans may not exceed an amount that is two times the midpoint of the standard rate charged any other individual of a group to which the organization is currently accepting new business and for which similar copayments ~~and deductibles~~ are applied.

(2) The direct payment contract offered pursuant to division (A) of this section may include a coordination of benefits provision as approved by the superintendent.

(3) For purposes of division (B) of this section "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

(C) The option for conversion shall be available:

(1) Upon the death of the subscriber, to the surviving spouse with respect to such of the spouse and dependents as are then covered by the group contract;

(2) To a child solely with respect to the child upon the child's attaining the limiting age of coverage under the group contract while covered as a dependent under the contract;

(3) Upon the divorce, dissolution, or annulment of the marriage of the

subscriber, to the divorced spouse, or, in the event of annulment, to the former spouse of the subscriber.

(D) No health insuring corporation shall use age as the basis for refusing to renew a converted contract.

(E) Written notice of the conversion option provided by this section shall be given to the subscriber by the health insuring corporation by mail. The notice shall be sent to the subscriber's address in the records of the employer upon receipt of notice from the employer of the event giving rise to the conversion option. If the subscriber has not received notice of the conversion privilege at least fifteen days prior to the expiration of the thirty-day conversion period, then the subscriber shall have an additional period within which to exercise the privilege. This additional period shall expire fifteen days after the subscriber receives notice, but in no event shall the period extend beyond sixty days after the expiration of the thirty-day conversion period.

(F) This section does not apply to any group contract offering only supplemental health care services or specialty health care services.

Sec. 1751.20. (A) No health insuring corporation, or agent, employee, or representative of a health insuring corporation, shall use any advertisement or solicitation document, or shall engage in any activity, that is unfair, untrue, misleading, or deceptive.

(B) No health insuring corporation shall use a name that is deceptively similar to the name or description of any insurance or surety corporation doing business in this state.

(C) All solicitation documents, advertisements, evidences of coverage, and enrollee identification cards used by a health insuring corporation shall contain the health insuring corporation's name. The use of a trade name, an insurance group designation, the name of a parent company, the name of a division of an affiliated insurance company, a service mark, a slogan, a symbol, or other device, without the name of the health insuring corporation as stated in its articles of incorporation, shall not satisfy this requirement if the usage would have the capacity and tendency to mislead or deceive persons as to the true identity of the health insuring corporation.

(D) No solicitation document or advertisement used by a health insuring corporation shall contain any words, symbols, or physical materials that are so similar in content, phraseology, shape, color, or other characteristic to those used by an agency of the federal government or this state, that prospective enrollees may be led to believe that the solicitation document or advertisement is connected with an agency of the federal government or this state.

(E) A health insuring corporation that provides basic health care services may use the phrase "health maintenance organization" or the abbreviation "HMO" in its marketing name, advertising, solicitation documents, or marketing literature, or in reference to the phrase "doing business as" or the abbreviation "DBA."

(F) This section does not apply to the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare risk contract or medicare cost contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the Ohio department of human services under Chapter 5111. of the Revised Code, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

Sec. 1751.31. (A) Any changes in a health insuring corporation's solicitation document shall be filed with the superintendent of insurance. The superintendent, within sixty days of filing, may disapprove any solicitation document or amendment to it on any of the grounds stated in this section. Such disapproval shall be effected by written notice to the health insuring corporation. The notice shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

(B) The solicitation document shall contain all information necessary to enable a consumer to make an informed choice as to whether or not to enroll in the health insuring corporation. The information shall include a specific description of the health care services to be available and the approximate number and type of full-time equivalent medical practitioners. The information shall be presented in the solicitation document in a manner that is clear, concise, and intelligible to prospective applicants in the proposed service area.

(C) Every potential applicant whose subscription to a health care plan is solicited shall receive, at or before the time of solicitation, a solicitation document approved by the superintendent.

(D) Notwithstanding division (A) of this section, a health insuring corporation may use a solicitation document that the corporation uses in connection with policies for beneficiaries of Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant

to a medicare risk contract or medicare cost contract, or for policies for beneficiaries of the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or for policies for beneficiaries of Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the Ohio department of human services under Chapter 5111. of the Revised Code, or for policies for beneficiaries of any other federal health care program regulated by a federal regulatory body, or for policies for beneficiaries of contracts covering officers or employees of the state entered into by the department of administrative services, if both of the following apply:

(1) The solicitation document has been approved by the United States department of health and human services, the United States office of personnel management, ~~or~~ the Ohio department of human services, or the department of administrative services.

(2) The solicitation document is filed with the superintendent of insurance prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, ~~or~~ the Ohio department of human services, or the department of administrative services.

(E) No health insuring corporation, or its agents or representatives, shall use monetary or other valuable consideration, engage in misleading or deceptive practices, or make untrue, misleading, or deceptive representations to induce enrollment. Nothing in this division shall prohibit incentive forms of remuneration such as commission sales programs for the health insuring corporation's employees and agents.

(F) Any person obligated for any part of a premium rate in connection with an enrollment agreement, in addition to any right otherwise available to revoke an offer, may cancel such agreement within seventy-two hours after having signed the agreement or offer to enroll. Cancellation occurs when written notice of the cancellation is given to the health insuring corporation or its agents or other representatives. A notice of cancellation mailed to the health insuring corporation shall be considered to have been filed on its postmark date.

(G) Nothing in this section shall prohibit healthy lifestyle programs.

Sec. 1751.32. Each health insuring corporation, annually, on or before the first day of March, shall file a report with the superintendent of insurance and the director of health, covering the preceding calendar year.

The report shall be verified by an officer of the health insuring corporation, shall be in the form the superintendent prescribes, and shall include:

(A) A financial statement of the health insuring corporation, including its balance sheet and receipts and disbursements for the preceding year, which reflect, at a minimum:

(1) All premium rate and other payments received for health care services rendered;

(2) Expenditures with respect to all categories of providers, facilities, insurance companies, and other persons engaged to fulfill obligations of the health insuring corporation arising out of its health care policies, contracts, certificates, and agreements;

(3) Expenditures for capital improvements or additions thereto, including, but not limited to, construction, renovation, or purchase of facilities and equipment.

(B) A description of the enrollee population and composition, group and nongroup;

(C) A summary of enrollee written complaints and their disposition;

(D) A statement of the number of subscriber policies, contracts, certificates, and agreements that have been terminated by action of the health insuring corporation, including the number of enrollees affected;

(E) A summary of the information compiled pursuant to division (B)(5) of section 1751.04 of the Revised Code;

(F) A current report of the names and addresses of the persons responsible for the conduct of the affairs of the health insuring corporation as required by section 1751.03 of the Revised Code. Additionally, the report shall include the amount of wages, expense reimbursements, and other payments to these persons for services to the health insuring corporation, and shall include a full disclosure of the financial interests related to the operations of the health insuring corporation acquired by these persons during the preceding year.

(G) ~~An audit report certified by an independent certified public accountant in the form prescribed by the superintendent by rule;~~

~~(H)~~ An actuarial opinion in the form prescribed by the superintendent by rule;

~~(I)~~(H) Any other information relating to the performance of the health insuring corporation that is necessary to enable the superintendent to carry out the superintendent's duties under this chapter.

Sec. 1751.321. Each health insuring corporation, annually, on or before the first day of June, shall file with the superintendent of insurance and the director of health an audit report certified by an independent certified public accountant covering the preceding calendar year. The report shall be verified by an officer of the health insuring corporation and shall be in the form

prescribed by the superintendent by rule.

Sec. 1751.46. (A) The superintendent of insurance and the director of health may contract with qualified persons to make recommendations concerning the determinations required to be made by the superintendent or the director relative to an expansion of a service area pursuant to division (C) of section 1751.03 of the Revised Code, an application for a certificate of authority pursuant to sections 1751.04 and 1751.05 of the Revised Code, a contractual periodic prepayment or premium rate pursuant to section 1751.12 of the Revised Code, and an examination pursuant to division (B) of section 1751.34 of the Revised Code. The recommendations may be accepted in full or in part, or may be rejected, by the superintendent or director.

The total cost of a contract with a qualified person pursuant to this division shall represent the fair market value of the services provided and shall be borne by the health insuring corporation that is the subject of the determination required to be made by the superintendent or the director.

(B) No qualified person placed on contract by the superintendent or the director pursuant to division (A) of this section shall have a conflict of interest with the department of insurance, the department of health, or the health insuring corporation.

Sec. 1751.55. A health insuring corporation policy, contract, or agreement shall not be construed to exclude illness or injury upon the ground that the subscriber might have elected to have such illness or injury covered by workers' compensation under ~~division (A)(3) of section 4123.01~~ Chapter 4123. of the Revised Code unless the policy, contract, or agreement clearly excludes work or occupational related illness or injury, or the policy, contract, or agreement, or a separate writing signed by the subscriber, informs the subscriber that such coverage is excluded and may be available to the subscriber under workers' compensation as the sole proprietor of a business, a member of a partnership, or an officer of a family farm corporation.

Sec. 1751.58. Except as otherwise provided in section 2721 of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as amended, the following conditions apply to all group health insuring corporation contracts that are sold in connection with an employment-related group health care plan and that are not subject to section 3924.03 of the Revised Code:

(A)(1) Except as provided in section 2712(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," if a health insuring corporation offers coverage in the small or large group market in connection

with a group contract, the ~~organization~~ corporation shall renew or continue in force such coverage at the option of the contract holder.

(2) A health insuring corporation may cancel or decide not to renew the coverage of any eligible employee or of a dependent of an eligible employee under the group contract in accordance with division (B) of section 1751.18 Of the Revised Code.

(B) Such group contracts are subject to division ~~(E)(1)~~(A)(3) of section 3924.03 and sections 3924.033 and 3924.27 of the Revised Code.

(C) Such group contracts shall provide for the special enrollment periods described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996."

(D) At least once in every twelve-month period, a health insuring corporation shall provide to all late enrollees, as defined in section 3924.01 of the Revised Code, who are identified by the contract holder, the option to enroll in the group contract. The enrollment option shall be provided for a minimum period of thirty consecutive days. All delays of coverage imposed under the group contract, including any affiliation period, shall begin on the date the health insuring corporation receives notice of the late enrollee's application or request for coverage, and shall run concurrently with each other.

Sec. 1751.59. ~~(A)~~ No individual or group health insuring corporation policy, contract, or agreement that makes family coverage available may be delivered, issued for delivery, or renewed in this state, unless the policy, contract, or agreement covers adopted children of the subscriber on the same basis as other dependents.

~~(B)~~ The coverage required by this section is subject to the requirements and restrictions set forth in section 3924.51 of the Revised Code. ~~Coverage for dependent children living outside the health insuring corporation's approved service area must be provided if a court order requires the subscriber to provide health care coverage.~~

Sec. 1751.60. (A) Except as provided for in divisions (E) and (F) of this section, every provider or health care facility that contracts with a health insuring corporation to provide health care services to the health insuring corporation's enrollees or subscribers shall seek compensation for covered services solely from the health insuring corporation and not, under any circumstances, from the enrollees or subscribers, except for approved ~~deductibles and~~ copayments.

(B) No subscriber or enrollee of a health insuring corporation is liable to any contracting provider or health care facility for the cost of any covered health care services, if the subscriber or enrollee has acted in accordance

with the evidence of coverage.

(C) Except as provided for in divisions (E) and (F) of this section, every contract between a health insuring corporation and provider or health care facility shall contain a provision approved by the superintendent of insurance requiring the provider or health care facility to seek compensation solely from the health insuring corporation and not, under any circumstances, from the subscriber or enrollee, except for approved ~~deductibles and~~ copayments.

(D) Nothing in this section shall be construed as preventing a provider or health care facility from billing the enrollee or subscriber of a health insuring corporation for noncovered services.

(E) Upon application by a health insuring corporation and a provider or health care facility, the superintendent may waive the requirements of divisions (A) and (C) of this section when, in addition to the reserve requirements contained in section 1751.28 of the Revised Code, the health insuring corporation provides sufficient assurances to the superintendent that the provider or health care facility has been provided with financial guarantees. No waiver of the requirements of divisions (A) and (C) of this section is effective as to enrollees or subscribers for whom the health insuring corporation is compensated under a provider agreement or risk contract entered into pursuant to Chapter 5111. or 5115. of the Revised Code.

(F) The requirements of divisions (A) to (C) of this section apply only to health care services provided to an enrollee or subscriber prior to the effective date of a termination of a contract between the health insuring corporation and the provider or health care facility.

Sec. 1751.62. (A) As used in this section, "screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film.

"Screening mammography" does not include diagnostic mammography.

(B) Every individual or group health insuring corporation policy, contract, or agreement providing basic health care services that is delivered, issued for delivery, or renewed in this state shall provide benefits for the expenses of both of the following:

(1) Screening mammography to detect the presence of breast cancer in adult women;

(2) Cytologic screening for the presence of cervical cancer.

(C) The benefits provided under division (B)(1) of this section shall cover expenses in accordance with all of the following:

(1) If a woman is at least thirty-five years of age but under forty years of age, one screening mammography;

(2) If a woman is at least forty years of age but under fifty years of age, either of the following:

(a) One screening mammography every two years;

(b) If a licensed physician has determined that the woman has risk factors to breast cancer, one screening mammography every year.

(3) If a woman is at least fifty years of age but under sixty-five years of age, one screening mammography every year.

(D)(1) The benefits provided under division (B)(1) of this section shall not exceed eighty-five dollars per year unless a lower amount is established pursuant to a provider contract.

(2) The benefit paid in accordance with division (D)(1) of this section shall constitute full payment. No institutional or professional health care provider shall seek or receive remuneration in excess of the payment made in accordance with division (D)(1) of this section, except for approved ~~deductibles and~~ copayments.

(E) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a health care facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(F) The benefits provided under divisions (B)(1) and (2) of this section shall be provided according to the terms of the subscriber contract.

(G) The benefits provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

Sec. 1751.81. (A) As used in this section:

(1) "Enrollee" includes the representative of an enrollee.

(2) "Necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(B) A health insuring corporation shall maintain written procedures for making utilization review determinations and for notifying enrollees, and participating providers and health care facilities acting on behalf of

enrollees, of its determinations.

(C) For initial determinations, a health insuring corporation shall make the determination within two business days after obtaining all necessary information regarding a proposed admission, procedure, or health care service requiring a review determination.

(1) In the case of a determination to certify an admission, procedure, or health care service, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone or facsimile within three business days after making the initial certification~~, and shall provide written or electronic confirmation of the telephone notification to the enrollee and the provider or health care facility within two business days after making the telephone notification~~.

(2) In the case of an adverse determination, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone within three business days after making the adverse determination, and shall provide written or electronic confirmation of the telephone notification to the enrollee and the provider or health care facility within one business day after making the telephone notification.

(D) For concurrent review determinations, a health insuring corporation shall make the determination within one business day after obtaining all necessary information.

(1) In the case of a determination to certify an extended stay or additional health care services, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone or facsimile within one business day after making the certification~~, and shall provide written or electronic confirmation to the enrollee and the provider or health care facility within one business day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days of health care services approved, and the date of admission or initiation of health care services~~.

(2) In the case of an adverse determination, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone within one business day after making the adverse determination, and shall provide written or electronic confirmation to the enrollee and the provider or health care facility within one business day after the telephone notification. The health care service to the enrollee shall be continued, with standard copayments and deductibles, if applicable, until the enrollee has been notified of the determination.

(E) For retrospective review determinations, a health insuring

orporation shall make the determination within thirty business days after receiving all necessary information.

(1) In the case of a certification, the health insuring corporation may notify the enrollee and the provider or health care facility rendering the health care service in writing.

(2) In the case of an adverse determination, the health insuring corporation shall notify the enrollee and the provider or health care facility rendering the health care service, in writing, within five business days after making the adverse determination.

(F) The time frames set forth in divisions (C), (D), and (E) of this section for determinations and notifications shall prevail unless the seriousness of the medical condition of the enrollee otherwise requires a more timely response from the health insuring corporation. The health insuring corporation shall maintain written procedures for making expedited utilization review determinations and notifications of enrollees and providers or health care facilities when warranted by the medical condition of the enrollee.

(G) A written notification of an adverse determination shall include the principal reason or reasons for the determination, instructions for initiating an appeal or reconsideration of the determination, and instructions for requesting a written statement of the clinical rationale used to make the determination. A health insuring corporation shall provide the clinical rationale for an adverse determination in writing to any party who received notice of the adverse determination and who follows the instructions for a request.

(H) A health insuring corporation shall have written procedures to address the failure or inability of a health care facility, provider, or enrollee to provide all necessary information for review. If the health care facility, provider, or enrollee will not release necessary information, the health insuring corporation may deny certification.

Sec. 1785.01. As used in this chapter:

(A) "Professional service" means any type of professional service that may be performed only pursuant to a license, certificate, or other legal authorization issued pursuant to Chapter 4701., 4703., 4705., 4715., 4723., 4725., 4729., 4731., 4732., 4733., 4734., or 4741., sections 4755.01 to 4755.12, or 4755.40 to 4755.56 of the Revised Code to certified public accountants, licensed public accountants, architects, attorneys, dentists, nurses, optometrists, pharmacists, doctors of medicine and surgery, doctors of osteopathic medicine and surgery, doctors of podiatric medicine and surgery, practitioners of the limited branches of medicine or surgery

specified in section 4731.15 of the Revised Code, mechanotherapists, psychologists, professional engineers, chiropractors, veterinarians, occupational therapists, and physical therapists.

(B) "Professional association" means an association organized under this chapter for the sole purpose of rendering one of the professional services authorized under Chapter 4701., 4703., 4705., 4715., 4723., 4725., 4729., 4731., 4732., 4733., 4734., or 4741., sections 4755.01 to 4755.12, or 4755.40 to 4755.56 of the Revised Code, a combination of the professional services authorized under Chapters 4703. and 4733. of the Revised Code, or a combination of the professional services of optometrists authorized under Chapter 4725. of the Revised Code, chiropractors authorized under Chapter 4734. of the Revised Code, psychologists authorized under Chapter 4732. of the Revised Code, registered or licensed practical nurses authorized under Chapter 4723. of the Revised Code, pharmacists authorized under Chapter 4729. of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.53 of the Revised Code, mechanotherapists authorized under section 4731.151 Of the Revised Code, and doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731. of the Revised Code.

Sec. 1785.02. An individual or group of individuals each of whom is licensed, certificated, or otherwise legally authorized to render within this state the same kind of professional service, a group of individuals each of whom is licensed, certificated, or otherwise legally authorized to render within this state the professional service authorized under Chapter 4703. or 4733. of the Revised Code, or a group of individuals each of whom is licensed, certificated, or otherwise legally authorized to render within this state the professional service of optometrists authorized under Chapter 4725. of the Revised Code, chiropractors authorized under Chapter 4734. of the Revised Code, psychologists authorized under Chapter 4732. of the Revised Code, registered or licensed practical nurses authorized under Chapter 4723. of the Revised Code, pharmacists authorized under Chapter 4729. of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.53 of the Revised Code, mechanotherapists authorized under section 4731.151 Of the Revised Code, or doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731. of the Revised Code may organize and become a shareholder or shareholders of a professional association. Any group of individuals described in this section who may be rendering one of the professional services as an organization created otherwise than pursuant to this chapter may incorporate under and pursuant to this chapter by

mending the agreement establishing the organization in a manner that the agreement as amended constitutes articles of incorporation prepared and filed in the manner prescribed in section 1785.08 of the Revised Code and by otherwise complying with the applicable requirements of this chapter.

Sec. 1785.03. A professional association may render a particular professional service only through officers, employees, and agents who are themselves duly licensed, certificated, or otherwise legally authorized to render the professional service within this state. As used in this section, "employee" does not include clerks, bookkeepers, technicians, or other individuals who are not usually and ordinarily considered by custom and practice to be rendering a particular professional service for which a license, certificate, or other legal authorization is required and does not include any other person who performs all of that person's employment under the direct supervision and control of an officer, agent, or employee who renders a particular professional service to the public on behalf of the professional association.

No professional association formed for the purpose of providing a combination of the professional services, as defined in section 1785.01 of the Revised Code, of optometrists authorized under Chapter 4725. of the Revised Code, chiropractors authorized under Chapter 4734. of the Revised Code, psychologists authorized under Chapter 4732. of the Revised Code, registered or licensed practical nurses authorized under Chapter 4723. of the Revised Code, pharmacists authorized under Chapter 4729. of the Revised Code, physical therapists authorized under sections 4755.40 to 4755.53 of the Revised Code, mechanotherapists authorized under section 4731.151 Of the Revised Code, and doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery authorized under Chapter 4731. of the Revised Code shall control the professional clinical judgment exercised within accepted and prevailing standards of practice of a licensed, certificated, or otherwise legally authorized optometrist, chiropractor, psychologist, nurse, pharmacist, physical therapist, mechanotherapist, or doctor of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery in rendering care, treatment, or professional advice to an individual patient.

This division does not prevent a hospital, as defined in section 3727.01 of the Revised Code, insurer, as defined in section 3999.36 of the Revised Code, or intermediary organization, as defined in section 1751.01 of the Revised Code, from entering into a contract with a professional association described in this division that includes a provision requiring utilization review, quality assurance, peer review, or other performance or quality

standards. Those activities shall not be construed as controlling the professional clinical judgment of an individual practitioner listed in this division.

Sec. 1785.08. Chapter 1701. of the Revised Code applies to professional associations, including their organization and the manner of filing articles of incorporation, except that the requirements of division (A) of section 1701.06 of the Revised Code do not apply to professional associations. If any provision of this chapter conflicts with any provision of Chapter 1701. of the Revised Code, the provisions of this chapter shall take precedence. A professional association for the practice of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery or for the combined practice of optometry, chiropractic, psychology, nursing, pharmacy, physical therapy, mechanotherapy, medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery may provide in its articles of incorporation or bylaws that its directors may have terms of office not exceeding six years.

Sec. 1907.161. (A) As used in this section, "health care coverage" means sickness and accident insurance or other coverage of hospitalization, surgical care, major medical care, disability, dental care, eye care, medical care, hearing aids, and prescription drugs or any combination of those benefits or services.

(B) The board of county commissioners, after consultation with the judges of the county court, shall negotiate and contract for, purchase, or otherwise procure group health care coverage for the judges and their spouses and dependents from insurance companies authorized to engage in the business of insurance in this state under Title ~~XXXIA~~ XXXIX of the Revised Code~~, medical care corporations organized under Chapter 1737. of the Revised Code, health care corporations organized under Chapter 1738. of the Revised Code,~~ or health ~~maintenance organizations~~ insuring corporations organized under Chapter ~~1742.~~ 1751. of the Revised Code, except that, if the county provides group health care coverage for its employees, the group health care coverage required by this section shall be provided, if possible, through the policy or plan under which the group health care coverage is provided for the county employees.

(C) The portion of the costs, premiums, or charges for the group health care coverage procured pursuant to division (B) of this section that is not paid by the judges of the county court, or all of the costs, premiums, or charges for the group health care coverage if the judges will not be paying any portion of those costs, premiums, or charges, shall be paid out of the county treasury.

Sec. 2305.252. (A) As used in this section:

(1) "Review board, committee, risk management personnel, or corporation" means any of the following:

(a) A peer review committee of a hospital, a nonprofit health care corporation that is a member of the hospital or of which the hospital is a member, or a community mental health center;

(b) A board or committee of a hospital or of a nonprofit health care corporation that is a member of the hospital or of which the hospital is a member reviewing professional qualifications or activities of the hospital medical staff or applicants for admission to the medical staff;

(c) A utilization committee of a state or local society composed of doctors of medicine or doctors of osteopathic medicine and surgery or doctors of podiatric medicine;

(d) A peer review committee of nursing home providers or administrators, including a corporation engaged in performing the functions of a peer review committee of nursing home providers or administrators, or a corporation engaged in performing the functions of another type of peer review or professional standards review committee;

(e) A peer review committee, professional standards review committee, or arbitration committee of a state or local society composed of doctors of medicine, doctors of osteopathic medicine and surgery, doctors of dentistry, doctors of optometry, doctors of podiatric medicine, psychologists, or registered pharmacists;

(f) A peer review committee of a health ~~maintenance organization~~ insuring corporation that has at least a two-thirds majority of member physicians in active practice and that conducts professional credentialing and quality review activities involving the competence or professional conduct of health care providers, which conduct adversely affects, or could adversely affect, the health or welfare of any patient. For purposes of this division, "health ~~maintenance organization~~ insuring corporation" includes ~~wholly-owned~~ wholly owned subsidiaries of a health ~~maintenance organization~~ insuring corporation.

(g) A peer review committee of any insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state that has at least a two-thirds majority of physicians in active practice and that conducts professional credentialing and quality review activities involving the competence or professional conduct of health care providers, which conduct adversely affects, or could adversely affect, the health or welfare of any patient;

(h) A peer review committee of any insurer authorized under Title

IX of the Revised Code to do the business of sickness and accident insurance in this state that has at least a two-thirds majority of physicians in active practice and that conducts professional credentialing and quality review activities involving the competence or professional conduct of a health care facility that has contracted with the insurer to provide health care services to insureds, which conduct adversely affects, or could adversely affect, the health or welfare of any patient;

(i) A peer review committee of an insurer authorized under Title XXXIX of the Revised Code to do the business of medical professional liability insurance in this state and that conducts professional quality review activities involving the competence or professional conduct of health care providers, which conduct adversely affects, or could affect, the health or welfare of any patient;

(j) A peer review committee of a health care entity.

(2) "Peer review committee" means a utilization review committee, quality assurance committee, quality improvement committee, tissue committee, credentialing committee, and any other committee that conducts professional credentialing and quality review activities involving the competence or professional conduct of health care practitioners.

(3) "Health care entity" means a government entity, a for-profit or nonprofit corporation, a limited liability company, a partnership, a professional corporation, a state or local society as described in division (A)(1)(c) of this section, or other health care organization, including, but not limited to, health care entities described in division (A)(1) of this section, whether acting on its own behalf or on behalf of or in affiliation with other health care entities, that conducts, as part of its purpose, professional credentialing and quality review activities involving the competence or professional conduct of health care practitioners.

(4) "Incident report or risk management report" means a report of an incident involving injury or potential injury to a patient as a result of patient care by a health care entity that is prepared by or for the use of a review board, committee, risk management personnel, or corporation and is within the scope of the functions of that review board, committee, risk management personnel, or corporation.

(5) "Tort action" means a civil action for damages for injury, death, or loss to a patient of a health care entity. "Tort action" includes a product liability claim but does not include a civil action for a breach of contract or another agreement between persons.

(B) Notwithstanding any contrary provision of section 149.43, ~~1742.141~~ 1751.21, 2305.24, 2305.25, 2305.251, or 2305.28 of the Revised Code, an

incident report or risk management report and the contents of an incident report or risk management report are not subject to discovery in, and are not admissible in evidence in the trial of, a tort action. An individual who prepares or has knowledge of the contents of an incident report or risk management report shall not testify and shall not be required to testify in a tort action as to the contents of the report. This division does not prohibit or limit the discovery or admissibility of testimony or evidence relating to patient care that is within a person's personal knowledge.

(C) Except as specified in division (B) of this section, this section does not affect any provision of section ~~1742.141~~ 1751.21, 2305.24, 2305.25, 2305.251, or 2305.28 of the Revised Code that describes, imposes, or confers an immunity from tort or other civil liability, a forfeiture of an immunity from tort or other civil liability, a requirement of confidentiality, a limitation upon the use of information, data, reports, or records, tort or other civil liability, or a limitation upon discovery of matter, introduction into evidence of matter, or testimony pertaining to matter in a tort or other civil action. This section does not affect a privileged communication between an attorney and the attorney's client under section 2317.02 of the Revised Code.

(D) This section shall be considered to be purely remedial in operation and shall be applied in a remedial manner in any civil action in which this section is relevant, whether the civil action is pending in court or commenced on or after ~~the effective date of this section~~ January 27, 1997, regardless of when the cause of action accrued and notwithstanding any other section of the Revised Code or prior rule of law of this state.

Sec. 3701.18. (A) As used in this section:

(1) "Amblyopia" means reduced vision in an eye that has not received adequate use during early childhood.

(2) "501(c) organization" means an organization exempt from federal income taxation pursuant to 26 U.S.C.A. 501(a) and (c).

(B) There is hereby created in the state treasury the save our sight fund. The fund shall consist of voluntary contributions deposited as provided in section 4503.104 of the Revised Code. All investment earnings from the fund shall be credited to the fund.

(C) The director of health shall use the money in the save our sight fund as follows:

(1) To provide support to 501(c) organizations that offer vision services in all counties of the state and have demonstrated experience in the delivery of vision services to do one or more of the following:

(a) Implement a voluntary children's vision screening training and

certification program for volunteers, child day-care providers, nurses, teachers, health care professionals practicing in primary care settings, and others serving children;

(b) Provide materials for the program implemented under division (C)(1)(a) of this section;

(c) Develop and implement a registry and targeted voluntary case management system to determine whether children with amblyopia are receiving professional eye care and to provide their parents with information and support regarding their child's vision care;

(d) Establish a matching grant program for the purchase and distribution of protective eyewear to children;

(e) Provide vision health and safety programs and materials for classrooms.

(2) For the purpose of section 4503.104 Of the Revised Code, to develop and distribute informational materials on the importance of eye care and safety to the registrar of motor vehicles and each deputy registrar;

(3) To pay costs incurred by the director in administering the fund;

(4) To reimburse the bureau of motor vehicles for the administrative costs incurred in performing its duties under section 4503.104 Of the Revised Code.

(D) A 501(c) organization seeking funding from the save our sight fund for any of the projects specified in division (C) of this section shall submit a request for the funding to the director in accordance with rules adopted under division (E) of this section. The director shall determine the appropriateness of and approve or disapprove projects for funding and approve or disapprove the disbursement of money from the save our sight fund.

(E) The public health council shall adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. The rules shall include the parameters of the projects specified in division (C)(1) of this section that may be funded with money in the save our sight fund and procedures for 501(c) organizations to request funding from the fund.

Sec. 3701.75. (A) As used in this section:

(1) "Electronic record" means a record communicated, received, or stored by electronic, magnetic, optical, or similar means for storage in an information system or transmission from one information system to another. "Electronic record" includes a record that is communicated, received, or stored by electronic data interchange, electronic mail, facsimile, telex, or similar methods of communication.

(2) "Electronic signature" means any of the following attached to or

associated with an electronic record by an individual to authenticate the record:

(a) A code consisting of a combination of letters, numbers, characters, or symbols that is adopted or executed by an individual as that individual's electronic signature;

(b) A computer-generated signature code created for an individual;

(c) An electronic image of an individual's handwritten signature created by using a pen computer.

(3) "Health care record" means any document or combination of documents pertaining to a patient's medical history, diagnosis, prognosis, or medical condition that is generated and maintained in the process of the patient's treatment.

(B) ~~Any~~ All notes, orders, and observations entered into a health care record, including any interpretive reports of diagnostic tests or specific treatments, such as radiologic or electrocardiographic reports, operative reports, reports of pathologic examination of tissue, and similar reports, shall be authenticated by the individual who made or authorized the entry. An entry into a health care record may be authenticated by executing handwritten signatures or handwritten initials directly on the entry ~~or by executing an electronic signature~~. An entry that is an electronic ~~signature executed in accordance with an electronic signature system that is certified by the department of health under division (C) of this section shall be considered for all legal purposes to be the same as having executed a handwritten signature or handwritten initials, except when any federal law governing state participation in a federal program requires that entries into health care records~~ record may be authenticated ~~only~~ by ~~handwritten signatures or handwritten initials. The~~ An electronic signature ~~generated by a certified system shall be presumed to be the signature of the individual to whom it is assigned and to be affixed for the purpose of authenticating an entry into a health care record.~~

~~(C)(1) The department of health shall administer a program under which entities that create and maintain health care records may receive certification from the department of their electronic signature systems. The department shall determine the types of entities that are eligible to have their electronic signature systems certified under this section.~~

~~The department shall certify an eligible entity's electronic signature system~~ if all of the following apply:

~~(a)~~(1) The entity responsible for creating and maintaining the health care record adopts a policy that permits the use of electronic signatures on electronic records.

~~(b)~~(2) The entity's electronic signature system utilizes either a two-level access control mechanism that assigns a unique identifier to each user or a biometric access control device.

~~(c)~~(3) The entity takes steps to safeguard against unauthorized access to the system and forgery of electronic signatures.

~~(d)~~(4) The system includes a process to verify that the individual affixing the electronic signature has reviewed the contents of the entry and determined that the entry contains what that individual intended.

~~(e)~~(5) The policy adopted by the entity pursuant to division ~~(C)~~(B)(1)~~(a)~~ of this section prescribes all of the following:

~~(i)~~(a) A procedure by which each user of the system must certify in writing that the user will follow the confidentiality and security policies maintained by the entity for the system;

~~(ii)~~(b) Penalties for misusing the system;

~~(iii)~~(c) Training for all users of the system that includes an explanation of the appropriate use of the system and the consequences for not complying with the entity's confidentiality and security policies.

~~(2) In lieu of making a direct determination of compliance under division (C)(1) of this section, the department may accept the approval of any private or public organization that has reviewed the entity's system, if the department determines that the organization has standards at least as stringent as those specified in division (C)(1) of this section. Organizations with standards for approval of electronic signature systems that the department may accept include the joint commission on accreditation of healthcare organizations, the American osteopathic association, the United States food and drug administration, and the United States health care financing administration. If an entity receives approval of its electronic signature system in this manner, and is subsequently cited by the private or public organization for a violation that involves the entity's system, the entity shall immediately notify the department of the citation and the department shall withdraw its certification.~~

~~(3) The public health council shall adopt rules in accordance with Chapter 119. of the Revised Code as necessary for the department's administration of the program for certifying the electronic signature systems of entities that create and maintain health care records.~~

Sec. 3702.141. (A) As used in this section, "existing health care facility" has the same meaning as in section 3702.51 of the Revised Code.

(B) Section 3702.14 of the Revised Code shall not be construed to require any existing health care facility that is conducting an activity specified in section 3702.11 of the Revised Code, which activity was

initiated on or before March 20, 1997, to alter, upgrade, or otherwise improve the structure or fixtures of the facility in order to comply with any rule adopted under section 3702.11 of the Revised Code relating to that activity, unless one of the following applies:

(1) The facility initiates a construction, renovation, or reconstruction project that involves a capital expenditure of at least fifty thousand dollars, not including expenditures for equipment or staffing or operational costs, and that directly involves the area in which the existing service is conducted.

(2) The facility initiates another activity specified in section 3702.11 of the Revised Code.

(3) The facility initiates a service level designation change for obstetric and newborn care.

(4) The facility proposes to add a cardiac catheterization laboratory to an existing cardiac catheterization service.

(5) The facility proposes to add an open-heart operating room to an existing open-heart surgery service.

(6) The director of health determines, by clear and convincing evidence, that failure to comply with the rule would create an imminent risk to the health and welfare of any patient.

(C) If division (B)(4) or (5) of this section applies, any alteration, upgrade, or other improvement required shall apply only to the proposed addition to the existing service if the cost of the addition is less than the capital expenditure threshold set forth in division (B)(1) of this section.

(D) No person or government entity shall divide or otherwise segment a construction, renovation, or reconstruction project in order to evade application of the capital expenditure threshold set forth in division (B)(1) of this section.

Sec. 3901.21. The following are hereby defined as unfair and deceptive acts or practices in the business of insurance:

(A) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer as shown by the last preceding verified statement made by it to the insurance department of this state, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies

misrepresenting the true nature thereof, or making any misrepresentation or incomplete comparison to any person for the purpose of inducing or tending to induce such person to purchase, amend, lapse, forfeit, change, or surrender insurance.

Any written statement concerning the premiums for a policy which refers to the net cost after credit for an assumed dividend, without an accurate written statement of the gross premiums, cash values, and dividends based on the insurer's current dividend scale, which are used to compute the net cost for such policy, and a prominent warning that the rate of dividend is not guaranteed, is a misrepresentation for the purposes of this division.

(B) Making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station, or in any other way, or preparing with intent to so use, an advertisement, announcement, or statement containing any assertion, representation, or statement, with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.

(C) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating, or preparing with intent to so use, any statement, pamphlet, circular, article, or literature, which is false as to the financial condition of an insurer and which is calculated to injure any person engaged in the business of insurance.

(D) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer.

Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer, or mutilating, destroying, suppressing, withholding, or concealing any of its records.

(E) Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency company stock or other capital stock or benefit certificates or shares in any common-law corporation or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(F) Making or permitting any unfair discrimination among individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(G)(1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities, or other obligations of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

(2) Nothing in division (F) or division (G)(1) of this section shall be construed as prohibiting any of the following practices: (a) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (b) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; (c) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(H) Making, issuing, circulating, or causing or permitting to be made,

issued, or circulated, or preparing with intent to so use, any statement to the effect that a policy of life insurance is, is the equivalent of, or represents shares of capital stock or any rights or options to subscribe for or otherwise acquire any such shares in the life insurance company issuing that policy or any other company.

(I) Making, issuing, circulating, or causing or permitting to be made, issued or circulated, or preparing with intent to so issue, any statement to the effect that payments to a policyholder of the principal amounts of a pure endowment are other than payments of a specific benefit for which specific premiums have been paid.

(J) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any statement to the effect that any insurance company was required to change a policy form or related material to comply with Title XXXIX of the Revised Code or any regulation of the superintendent of insurance, for the purpose of inducing or intending to induce any policyholder or prospective policyholder to purchase, amend, lapse, forfeit, change, or surrender insurance.

(K) Aiding or abetting another to violate this section.

(L) Refusing to issue any policy of insurance, or canceling or declining to renew such policy because of the sex or marital status of the applicant, prospective insured, insured, or policyholder.

(M) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, other than life insurance, or in the benefits payable thereunder, or in underwriting standards and practices or eligibility requirements, or in any of the terms or conditions of such contract, or in any other manner whatever.

(N) Refusing to make available disability income insurance solely because the applicant's principal occupation is that of managing a household.

(O) Refusing, when offering maternity benefits under any individual or group sickness and accident insurance policy, to make maternity benefits available to the policyholder for the individual or individuals to be covered under any comparable policy to be issued for delivery in this state, including family members if the policy otherwise provides coverage for family members. Nothing in this division shall be construed to prohibit an insurer from imposing a reasonable waiting period for such benefits under an individual sickness and accident insurance policy <u>issued to an individual who is not a federally eligible individual or a nonemployer-related group sickness and accident insurance policy</u>, but in no event shall such waiting

period exceed two hundred seventy days.

For purposes of division (O) of this section, "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

(P) Using, or permitting to be used, a pattern settlement as the basis of any offer of settlement. As used in this division, "pattern settlement" means a method by which liability is routinely imputed to a claimant without an investigation of the particular occurrence upon which the claim is based and by using a predetermined formula for the assignment of liability arising out of occurrences of a similar nature. Nothing in this division shall be construed to prohibit an insurer from determining a claimant's liability by applying formulas or guidelines to the facts and circumstances disclosed by the insurer's investigation of the particular occurrence upon which a claim is based.

(Q) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent, or kind of life or sickness and accident insurance or annuity coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated actuarial experience as are sighted persons. Refusal to insure includes, but is not limited to, denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the eyesight of the insured is lost. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such conditions existed at the time the policy was issued. To the extent that the provisions of this division may appear to conflict with any provision of section 3999.16 of the Revised Code, this division applies.

(R)(1) Directly or indirectly offering to sell, selling, or delivering, issuing for delivery, renewing, or using or otherwise marketing any policy of insurance or insurance product in connection with or in any way related to the grant of a student loan guaranteed in whole or in part by an agency or commission of this state or the United States, except insurance that is required under federal or state law as a condition for obtaining such a loan and the premium for which is included in the fees and charges applicable to the loan; or, in the case of an insurer or insurance agent, knowingly permitting any lender making such loans to engage in such acts or practices in connection with the insurer's or agent's insurance business.

(2) Except in the case of a violation of division (G) of this section,

division (R)(1) of this section does not apply to either of the following:

(a) Acts or practices of an insurer, its agents, representatives, or employees in connection with the grant of a guaranteed student loan to its insured or the insured's spouse or dependent children where such acts or practices take place more than ninety days after the effective date of the insurance;

(b) Acts or practices of an insurer, its agents, representatives, or employees in connection with the solicitation, processing, or issuance of an insurance policy or product covering the student loan borrower or the borrower's spouse or dependent children, where such acts or practices take place more than one hundred eighty days after the date on which the borrower is notified that the student loan was approved.

(S) Denying coverage, under any health insurance or health care policy, contract, or plan providing family coverage, to any natural or adopted child of the named insured or subscriber solely on the basis that the child does not reside in the household of the named insured or subscriber.

(T)(1) Using any underwriting standard or engaging in any other act or practice that, directly or indirectly, due solely to any health status-related factor in relation to one or more individuals, does either of the following:

(a) Terminates or fails to renew an existing individual policy, contract, or plan of health benefits, or a health benefit plan issued to an employer, for which an individual would otherwise be eligible;

(b) With respect to a health benefit plan issued to an employer, excludes or causes the exclusion of an individual from coverage under an existing employer-provided policy, contract, or plan of health benefits.

(2) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code for purposes of implementing division (T)(1) of this section.

(3) For purposes of division (T)(1) of this section, "health status-related factor" means any of the following:

(a) Health status;

(b) Medical condition, including both physical and mental illnesses;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence;

(h) Disability.

(U) With respect to a health benefit plan issued to a small employer, as

those terms are defined in section 3924.01 of the Revised Code, negligently or willfully placing coverage for adverse risks with a certain carrier, as defined in section 3924.01 of the Revised Code.

(V) Using any program, scheme, device, or other unfair act or practice that, directly or indirectly, causes or results in the placing of coverage for adverse risks with another carrier, as defined in section 3924.01 of the Revised Code.

(W) Failing to comply with section 3923.23, 3923.231, 3923.232, 3923.233, or 3923.234 of the Revised Code by engaging in any unfair, discriminatory reimbursement practice.

(X) Intentionally establishing an unfair premium for, or misrepresenting the cost of, any insurance policy financed under a premium finance agreement of an insurance premium finance company.

(Y)(1)(a) Limiting coverage under, refusing to issue, canceling, or refusing to renew, any individual policy or contract of life insurance, or limiting coverage under or refusing to issue any individual policy or contract of health insurance, for the reason that the insured or applicant for insurance is or has been a victim of domestic violence;

(b) Adding a surcharge or rating factor to a premium of any individual policy or contract of life or health insurance for the reason that the insured or applicant for insurance is or has been a victim of domestic violence;

(c) Denying coverage under, or limiting coverage under, any policy or contract of life or health insurance, for the reason that a claim under the policy or contract arises from an incident of domestic violence;

(d) Inquiring, directly or indirectly, of an insured under, or of an applicant for, a policy or contract of life or health insurance, as to whether the insured or applicant is or has been a victim of domestic violence, or inquiring as to whether the insured or applicant has sought shelter or protection from domestic violence or has sought medical or psychological treatment as a victim of domestic violence.

(2) Nothing in division (Y)(1) of this section shall be construed to prohibit an insurer from inquiring as to, or from underwriting or rating a risk on the basis of, a person's physical or mental condition, even if the condition has been caused by domestic violence, provided that all of the following apply:

(a) The insurer routinely considers the condition in underwriting or in rating risks, and does so in the same manner for a victim of domestic violence as for an insured or applicant who is not a victim of domestic violence;

(b) The insurer does not refuse to issue any policy or contract of life or

health insurance or cancel or refuse to renew any policy or contract of life insurance, solely on the basis of the condition, except where such refusal to issue, cancellation, or refusal to renew is based on sound actuarial principles or is related to actual or reasonably anticipated experience;

(c) The insurer does not consider a person's status as being or as having been a victim of domestic violence, in itself, to be a physical or mental condition;

(d) The underwriting or rating of a risk on the basis of the condition is not used to evade the intent of division (Y)(1) of this section, or of any other provision of the Revised Code.

(3)(a) Nothing in division (Y)(1) of this section shall be construed to prohibit an insurer from refusing to issue a policy or contract of life insurance insuring the life of a person who is or has been a victim of domestic violence if the person who committed the act of domestic violence is the applicant for the insurance or would be the owner of the insurance policy or contract.

(b) Nothing in division (Y)(2) of this section shall be construed to permit an insurer to cancel or refuse to renew any policy or contract of health insurance in violation of the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a manner that violates or is inconsistent with any provision of the Revised Code that implements the "Health Insurance Portability and Accountability Act of 1996."

(4) An insurer is immune from any civil or criminal liability that otherwise might be incurred or imposed as a result of any action taken by the insurer to comply with division (Y) of this section.

(5) As used in division (Y) of this section, "domestic violence" means any of the following acts:

(a) Knowingly causing or attempting to cause physical harm to a family or household member;

(b) Recklessly causing serious physical harm to a family or household member;

(c) Knowingly causing, by threat of force, a family or household member to believe that the person will cause imminent physical harm to the family or household member.

For the purpose of division (Y)(5) of this section, "family or household member" has the same meaning as in section 2919.25 of the Revised Code.

Nothing in division (Y)(5) of this section shall be construed to require, as a condition to the application of division (Y) of this section, that the act described in division (Y)(5) of this section be the basis of a criminal

prosecution.

With respect to private passenger automobile insurance, no insurer shall charge different premium rates to persons residing within the limits of any municipal corporation based solely on the location of the residence of the insured within those limits.

The enumeration in sections 3901.19 to 3901.26 of the Revised Code of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement this section, or to take action under other sections of the Revised Code.

This section does not prohibit the sale of shares of any investment company registered under the "Investment Company Act of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any policies, annuities, or other contracts described in section 3907.15 of the Revised Code.

As used in this section, "estimate," "statement," "representation," "misrepresentation," "advertisement," or "announcement" includes oral or written occurrences.

Sec. 3901.38. (A) As used in this section and section 3901.381 of the Revised Code:

(1) "Beneficiary" means any policyholder, subscriber, member, employee, or other person who is eligible for benefits under a benefits contract.

(2) "Benefits contract" means a sickness and accident insurance policy providing hospital, surgical, or medical expense coverage, or a health insuring corporation contract or other policy or agreement under which a third-party payer agrees to reimburse for covered health care or dental services rendered to beneficiaries, up to the limits and exclusions contained in the benefits contract.

(3) "Completed claim" means a proof of loss or a claim for payment for health care services which has been submitted to the appropriate claims processing office of the third-party payer accompanied by sufficient documentation for the third-party payer to determine proof of loss and reasonably required by the third-party payer to accept or reject the claim.

(4) "Hospital" has the same meaning set forth in section 3727.01 of the Revised Code.

(5) "Proof of loss" means a claim for payment for health care services which has been submitted to the appropriate claims processing office of the third-party payer accompanied by sufficient documentation for the third-party payer to determine benefits payable under the benefits contract and reasonably required by the third-party payer to accept or reject the

claim.

(6) "Provider" means a hospital, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, or other licensed health care provider entitled to reimbursement by a third-party payer for services rendered to a beneficiary under a benefits contract.

(7) "Reimburse" means indemnify, make payment, or otherwise accept responsibility for payment for health care services rendered to a beneficiary, or arrange for the provision of health care services to a beneficiary.

(8) "Third-party payer" means any of the following:

(a) An insurance company;

(b) A health insuring corporation;

(c) A ~~preferred provider organization;~~

~~(d) A~~ labor organization;

~~(e)~~(d) An employer;

~~(f)~~(e) An intermediary organization, as defined in section 1751.01 of the Revised Code, that is not a health delivery network contracting solely with self-insured employers;

~~(g)~~(f) An administrator subject to sections 3959.01 to 3959.16 of the Revised Code;

~~(h)~~(g) A health delivery network, as defined in section 1751.01 of the Revised Code;

~~(i)~~(h) Any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services rendered to beneficiaries under such contract.

(B)(1) Except as provided in division (B)(2) of this section and in section 3901.381 of the Revised Code, within twenty-four days of the receipt of a completed claim from a provider or a beneficiary for reimbursement for health care services rendered by the provider to a beneficiary, a third-party payer shall, in accordance with division (D) of this section, make payment of any amount due on such claim.

(2) A third-party payer and a provider may, in negotiating a reimbursement contract, agree to any time period by which a third-party payer shall, subject to division (D) of this section, make payment of any amount due on a completed claim. Nothing in this division shall be construed as limiting in any manner the application of the requirements of this section to any benefits or reimbursement contract.

(3) Any provider or beneficiary aggrieved with respect to any act of a third-party payer that such provider or beneficiary believes to be a violation of division (B)(1) or (2) of this section may file a written complaint with the superintendent of insurance. If a series of such complaints is received by the

superintendent with respect to a particular third-party payer and if, after investigation, the superintendent finds that such third-party payer has engaged in a series of such violations which, taken together, constitute a consistent pattern or a practice of such third-party payer to violate division (B)(1) or (2) of this section, the superintendent shall issue an order requiring such third-party payer to cease and desist from engaging in such violations and to pay a late payment penalty as specified in divisions (B)(4) and (5) of this section with respect to the claims the superintendent finds were not timely paid. In the order, the superintendent shall specify the reasons for the superintendent's finding and order and state that a hearing conducted pursuant to Chapter 119. of the Revised Code shall be held within fifteen days after requested in writing by the third-party payer. The provisions of ~~this~~ division (B)(3) of this section are in addition to, and not in lieu of, such other remedies as providers and beneficiaries may otherwise have by law.

(4)(a) The late payment penalty shall be computed based upon the number of days that have elapsed between the date payment is due in accordance with division (B)(1) or (2) of this section and the date payment is actually sent.

(b) The interest rate for determining the amount of the late payment penalty shall be the rate agreed to by the provider and the third-party payer or the rate specified by and determined in accordance with division (A) of section 1343.01 of the Revised Code.

(5) A provider and a third-party payer may enter into a contractual agreement in which the timing of payments by the third-party payer is not directly related to the receipt of a completed claim. Such contractual arrangement may include periodic interim payment arrangements, capitation payment arrangements, or other payment arrangements acceptable to the provider and the third-party payer. Except as agreed to under such contract, this section does not apply to such payment arrangements.

(6) Any late payment penalty due and payable by a third-party payer in accordance with this section shall not be used to reduce benefits or payments otherwise payable under a benefits contract.

(C) No third-party payer shall refuse to process or pay within the time period required under division (B)(1) or (2) of this section a completed claim submitted by a provider on the ground the beneficiary has not been discharged from the hospital or the treatment has not been completed, if the submitted claim covers services actually rendered and charges actually incurred over at least a thirty-day period.

(D)(1) Notwithstanding section ~~1742.10~~ 1751.13 or division (I)(2) of section 3923.04 of the Revised Code, a reimbursement contract entered into

or renewed on or after June 29, 1988, between a third-party payer and a hospital shall provide that reimbursement for any service provided by a hospital pursuant to a reimbursement contract and covered under a benefits contract shall be made directly to the hospital.

(2) If the third-party payer and the hospital have not entered into a contract regarding the provision and reimbursement for covered services, the third-party payer shall accept and honor a completed and validly executed assignment of benefits with a hospital by a beneficiary, except when the third-party payer has notified the hospital in writing of the conditions under which the third-party payer will not accept and honor an assignment of benefits. Such notice shall be made annually.

(3) A third-party payer may not refuse to accept and honor a validly executed assignment of benefits with a hospital pursuant to division (D)(2) of this section for medically necessary hospital services provided on an emergency basis.

(E) A series of violations which taken together, constitute a consistent pattern or a practice of violation of any of the provisions of this section is an unfair and deceptive act pursuant to sections 3901.19 to 3901.23 of the Revised Code and is subject to proceedings pursuant to those sections.

Sec. 3917.01. (A) Group life insurance is that form of life insurance covering not less than ten employees with or without medical examination, written under a policy issued to the employer, or to a trustee of a trust created by such employer, the premium on which is to be paid by the employer, by the employer and employees jointly, or by such trustee out of funds contributed by the employer or by the employer and employees jointly, and insuring only all of the employer's employees or all of any classes thereof, determined by sex, age, or conditions pertaining to the employment, for amounts of insurance based upon some plan which will preclude individual selection, for the benefit of persons other than the employer; but when the premium is to be paid by the employer and employee jointly and the benefits of the policy are offered to all eligible employees, not less than seventy-five per cent of such employees may be so insured. Such group policy may provide that "employees" includes retired employees of the employer and the officers, managers, employees, and retired employees of subsidiary or affiliated corporations and the individual proprietors, partners, employees, and retired employees of affiliated individuals and firms, when the business of such subsidiary or affiliated corporations, firms, or individuals is controlled by the common employer through stock ownership, contract, or otherwise. This section does not define as a group the lives covered by a policy issued on more than one life

which provides for payments upon the death of any one or more or upon the death of each of the lives so insured, and upon which the premium rates charged are computed on the same basis as used by the issuing company on single life policies and upon its regular forms of insurance.

(B) As used in sections 3917.01 to 3917.06 of the Revised Code, the following forms of life insurance are group life insurance:

(1) Life insurance covering the members of one or more companies, batteries, troops, battalions, divisions, or other units of the national guard or naval militia of any state, written under a policy issued to the commanding general of the national guard or commanding officer of the naval militia, who is the employer for the purposes of such sections, the premium on which is to be paid by the members of such units for the benefit of persons other than the employer; provided that when the benefits of the policy are offered to all eligible members of a unit of the national guard or naval militia, not less than seventy-five per cent of the members of such a unit may be insured;

(2) Life insurance covering the members of one or more troops or other units of the state troopers or state police of any state, written under a policy issued to the commanding officer of the state troopers or state police who is the employer for the purposes of such sections, the premium on which is to be paid by the members of such units for the benefit of persons other than the employer; provided that when the benefits of the policy are offered to all eligible members of a unit of the state troopers or state police, not less than seventy-five per cent of the members of such a unit may be insured;

(3) Life insurance covering the members of any labor union, written under a policy issued to such union which is the employer for the purposes of such sections, the premium on which is to be paid by the union or by the union and its members jointly, and insuring only all of its members, who are actively engaged in the same occupation, for amounts of insurance based upon some plan which will preclude individual selection, for the benefit of persons other than the union or its officials; provided that in case the insurance policy is cancellable at the end of any policy year at the option of the insurance company and that the basis of premium rates may be changed by the insurance company at the beginning of any policy year, all members of a labor union may be insured; and provided that when the premium is to be paid by the union and its members jointly and the benefits are offered to all eligible members, not less than seventy-five per cent of such members may be insured; and provided that when members apply and pay for additional amounts of insurance, a smaller percentage of members may be insured for such additional amounts if they pass satisfactory medical

examinations or submit satisfactory evidence of insurability;

(4) Life insurance written under a policy issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements:

(a) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor, excepting that no debtor is eligible unless the indebtedness constitutes an obligation to repay that is binding upon the debtor during the debtor's lifetime at and from the date the insurance becomes effective upon the debtor's life. The policy may provide that "debtors" includes the debtors of one or more subsidiary corporations and the debtors of one or more affiliated corporations, proprietors, or partnerships if the business of the policyholder and of such affiliated corporations, proprietors, or partnerships is under common control through stock ownership, contract, or otherwise.

(b) The premium for the policy shall be paid by the policyholder, either from the creditor's funds, or from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors shall not include debtors under obligations outstanding at its date of issue without evidence of individual insurability unless at least seventy-five per cent of the then eligible debtors elect to pay the required charges. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(c) The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least one hundred persons yearly, or may reasonably be expected to receive at least one hundred new entrants during the first policy year, and continues to receive not less than one hundred new entrants to the group yearly, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five per cent of the new entrants become insured. The policy may exclude from the classes eligible for insurance classes of debtors determined by age.

(d) The amount of insurance on the life of any debtor may be determined by the age of the debtor based upon a plan which will preclude individual selection and shall at no time exceed the amount owed by the debtor that is repayable in installments to the creditor.

(e) The insurance shall be payable to the policyholder. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent

of such payment.

(5) Life insurance covering the members of any duly organized corporation or association of veterans or veteran society or association of the World War veterans, written under a policy issued to such corporation, association, or society which is the employer for the purpose of such sections, the premium on which is to be paid by the corporation, association, society, and its members jointly, and insuring all of its members who are actively engaged in any occupation for amounts of insurance based upon some plan which will preclude individual selection for the benefit of persons other than the corporation, association, or society or its officials; provided that when the premium is to be paid by the corporation, association, or society and its members jointly and the benefits are offered to all eligible members, not less than seventy-five per cent of such members may be insured; and provided that when members apply and pay for additional amounts of insurance, a smaller percentage of members may be insured for such additional amounts if they pass satisfactory medical examinations or submit satisfactory evidence of insurability;

(6) Life insurance covering the members of any organization of agriculturists or horticulturists organized under the co-operative laws of this state, written under a policy issued to such co-operative association which is the employer for the purpose of such sections, the premium on which is to be paid by the association or by the association and its members jointly, and insuring all of its members who are actively engaged in agricultural or horticultural pursuits, for an amount of insurance based upon some plan which will preclude individual selection, and for the benefit of persons other than the association or its officials; provided that when the premium is to be paid by the corporation, association, or society and its members jointly and the benefits are offered to all eligible members, not less than seventy-five per cent of such members may be insured; provided that when members apply and pay for additional amounts of insurance, a smaller percentage of members may be insured for such additional amounts if they pass satisfactory medical examinations or submit satisfactory evidence of insurability;

(7) Life insurance covering employees of a political subdivision or district of this state, or of an educational or other institution supported in whole or in part by public funds, or of any classes thereof, determined by conditions pertaining to employment, or of this state or any department or division thereof, written under a policy issued to such political subdivision, district, or institution, or the proper official or board of this state or of such state department or division thereof, which is the employer for the purpose

of such sections, the premium on which is to be paid by such employees, unless otherwise provided by law, charter, or ordinance, for the benefit of persons other than the employer; provided that when the benefits of the policy are offered to all eligible employees of a political subdivision or district of the state or of an educational or other institution supported in whole, or in part by public funds, or of this state or a state department or division thereof, not less than seventy-five per cent of such employees may be insured; and provided that when employees apply and pay for additional amounts of insurance, a smaller percentage of employees may be insured for such additional amounts if they pass satisfactory medical examinations or submit satisfactory evidence of insurability; and provided that upon acquisition by a political subdivision of any privately owned property or enterprise, the employees of which have been covered by a group policy of life or other insurance as employees of such private employer, such political subdivision and insurance company may continue such contract in force upon similar conditions as the last preceding private employer;

(8) Life insurance covering the members, or the members and the employees of members of any duly organized association, other than an association subject to any other provision of this division, written under a policy issued to such association, which association is the employer for the purpose of such sections, the premium on which is to be paid by the insured members or their employees, insuring members and their employees for amounts of insurance based upon some plan which will preclude individual selection except as provided in this section, for the benefit of persons other than the association; provided the association has been in existence for at least two years immediately preceding the purchase of the insurance; provided that there must be at least fifty insured members in any group; and provided that the association has been organized and is maintained in good faith for purposes other than that of obtaining insurance;

(9) Life insurance issued to trustees of a trust fund established jointly by one or more employers in the same industry, on the one hand, and one or more labor unions representing as bargaining agents employees of such employers, on the other hand, or by two or more employers in the same industry, or by two or more labor unions, which trustees shall be deemed the policyholder to insure employees of the employers or members of unions for the benefit of persons other than the employers or the unions or the trustees, subject to the following requirements:

(a) The persons eligible for such insurance shall be all of the employees of the employers, or all of the members of the unions, or all of any class of such employees determined by sex, age, or conditions pertaining to their

employment, or to membership in the unions, or to any or all of them. The policy may provide that "employees" includes the retired employees of the employer and the officers, managers, employees, and retired employees of subsidiary or affiliated corporations and the individual proprietors, partners, employees, and retired employees of affiliated individuals and firms, when the business of such subsidiary or affiliated corporations, firms, or individuals is controlled by the common employer through stock ownership, contract, or otherwise. The policy may provide that "employees" includes the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that "employees" includes the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(b) The premium for the policy shall be paid by the trustees, either wholly from funds contributed by the employers of the insured persons, or partly from such funds and partly from funds contributed by the insured employees. If part of the premium is to be derived from funds contributed by the insured employees, then such policy may be placed in force only if it covers at least seventy-five per cent of the then eligible employees. A policy on which no part of the premium is derived from funds contributed by the insured employees must insure all eligible employees.

(c) Any policy must insure at least ten persons at date of issue.

(d) The amounts of insurance under the policy must be based upon some plan precluding individual selection by the insured persons or the policyholder or the employers or the unions or the trustees.

(10) Life insurance covering the members of a credit union, which shall be deemed to be the employer for the purposes of this section, the premium on which is to be paid by the credit union or by the credit union and its members jointly, and insuring all of its eligible members for amounts of insurance not in excess of the share balance as to each member, and for the benefit of persons other than the credit union or its officers; provided that in the determination of the eligibility of members there may be classifications and limitations based upon age; provided also that when the premium is to be paid by the credit union and its members jointly and the benefits are offered to all eligible members, not less than seventy-five per cent of such members may be so insured; provided also that in obtaining such insurance, the officers of the credit union shall consider proposals from any licensed insurer; provided also that members may be required to provide evidence of insurability satisfactory to the insurer.

(11) Life insurance covering the members of any duly organized corporation or association of members of the Ohio national guard, the Ohio

naval militia, and the Ohio military reserve, which shall have been in existence for at least two years immediately preceding the purchase of such insurance, written under a policy issued to such corporation or association, which corporation or association is the employer for the purpose of such sections, the premium on which is to be paid by the insured members, insuring members for amounts of insurance based upon some plan which will preclude individual selection, except as provided in this section, for the benefit of persons other than the corporation or association, provided that there must be at least fifty insured members in any group, and provided further that unless seventy-five per cent of all members or one thousand members, whichever is the lesser number, are insured, each member must pass a satisfactory medical examination in order to be insured; and provided that, when members apply and pay for additional amounts of insurance, they may be insured for such additional amounts if they pass satisfactory medical examinations or submit satisfactory evidence of insurability.

(12) Life insurance that is written under a policy issued to a trustee under a trust established by an insurer for the purpose of providing continued group life insurance coverage to those former employees, former members, or former members and the employees of such members, and their spouses and dependent children, previously covered under policies of group life insurance issued by the insurer to employers or trustees pursuant to division (A) of this section, to associations pursuant to division (B)(8) of this section, or to trustees pursuant to division (B)(9) of this section, and that is evidenced by the issuance of a certificate of insurance to such former employees or members; provided that The amount of the continued life insurance coverage made available to a former employee or member and to the employee's or member's spouse and dependents shall not exceed the amount of the group life insurance coverage previously provided to the employee or member and the employee's or member's eligible dependents at the time of the employee's separation from employment or the member's termination of membership.

(C) Any policy issued pursuant to this section, except a policy issued to a creditor pursuant to division (B) (4) of this section, may be extended, in the form of group term life insurance only, to insure the spouse and dependent children of an insured employee or member, or any class or classes thereof, subject to the following requirements:

(1) The premiums for the group term life insurance shall be paid by the policyholder, either from the employer, union or association funds, or from funds contributed by the employer, union, or association, or from funds contributed by the insured employee or member, or from both.

(2) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the insured employee or member or by the policyholder~~, provided that group term life insurance upon the life of a spouse or dependent child shall not exceed the lesser of (a) ten thousand dollars, or (b) one-half of the amount of insurance on the life of the insured employee or member under the group policy~~.

(3) Upon termination of the group term life insurance with respect to the spouse of any insured employee or member by reason of such person's termination of employment or membership or death, the spouse insured pursuant to this section shall have the same conversion rights as to the group term life insurance on the spouse's life as is provided for the insured employee or member.

(4) Only one certificate need be issued for delivery to an insured employee or member if a statement concerning any dependent's coverage is included in such certificate.

Sec. 3917.06. No policy of group life insurance shall be issued or delivered in this state until a copy of its form has been filed with the superintendent of insurance and formally approved by ~~him~~ the superintendent; nor shall such policy be so issued or delivered unless it contains in substance the following provisions:

(A) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premiums due except the first during which grace period the death benefit coverage shall continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy; the policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

(B) A provision that the policy is incontestable after two years from its date of issue, except for nonpayment of premiums and except for violation of the conditions of the policy relating to military or naval service in time of war;

(C) A provision that the policy and the application submitted in connection therewith constitute the entire contract between the parties, and that all statements contained in such application are deemed, in the absence of fraud, representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in a written application;

(D) A provision for the equitable adjustment of the premium or the amount of insurance payable in the event of a misstatement of the age of an

employee or other person whose life is insured under a group life policy;

(E) Except in the case of a policy described in division (B)(4) of section 3917.01 of the Revised Code, a provision that the company will issue to the policyholder for delivery to each person whose life is insured under such policy, an individual certificate setting forth a statement as to the insurance protection to which ~~he~~ the person is entitled, to whom payable, together with provision to the effect that in case of the termination of the employment for any reason or of membership in the classes eligible for insurance under the policy, such person is entitled to have issued to ~~him~~ the person by the company, without evidence of insurability, and upon application made to the company within thirty-one days after such termination, and upon the payment of the premium applicable to the class of risk to which ~~he~~ the person belongs and to the form and amount of the policy at ~~his~~ the person's then attained age, either a policy of life insurance in any one of the forms customarily issued by the company, except term insurance, in any amount not in excess of the amount of ~~his~~ the person's protection under ~~such~~ the group insurance policy at the time of ~~such~~ the termination, as ~~he~~ the person elects or, if applicable, the coverage described in division (B)(12) of section 3917.01 Of the Revised Code;

(F) A provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of such termination whose insurance terminates and who has been so insured for at least five years prior to such termination date is entitled to have issued to ~~him~~ the person by the insurer an individual policy of life insurance, subject to the same conditions as are provided by division (E) of this section, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of (1) the amount of the person's life insurance protection ceasing because of the termination ~~of~~ or amendment of the group policy, less the amount of any life insurance for which ~~he~~ the person is or becomes eligible under any group policy issued or reinstated by the same or another insurer within thirty-one days after such termination, and (2) two thousand dollars;

(G) A provision that if a person insured under the group policy dies during the period within which ~~he~~ the person would have been entitled to have an individual policy issued to ~~him~~ the person in accordance with division (E) or (F) of this section, and before such an individual policy has become effective, the amount of life insurance which ~~he~~ the person would have been entitled to have issued to ~~him~~ the person under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium

therefor has been made;

(H) A provision that to the group or class of persons originally insured there shall be added from time to time all new employees of the employer or other persons eligible to insurance in such group or class;

(I) In the case of a policy issued to a labor union covering all members of the union, a notice that the annual renewable term premium depends upon the attained ages of the members in the group and increases with advancing ages.

Policies of group life insurance, when issued in this state by any company not organized under the laws of this state, may contain, when issued, any provision required by the law of the state, territory, or district of the United States under which the company is organized; and policies issued in other states or countries by companies organized in this state, may contain any provision required or permitted by the laws of the state, territory, district, or country in which the same are issued. Any such policy may be issued or delivered in this state which in the opinion of the superintendent contains provisions on any one or more of the requirements of this section more favorable to the policyholder or to the person whose life is insured under such policy than such requirements.

The group life insurance policy together with any application in connection therewith shall be available for inspection during regular business hours at the office of the policyholder where such policy is on file, by any beneficiary thereunder or by an authorized representative of such beneficiary.

Except as provided in sections 3917.01 to 3917.06~~, inclusive,~~ of the Revised Code, no contract of life insurance shall be made covering a group in this state.

Sec. 3923.021. (A) As used in this section, "benefits provided are not unreasonable in relation to the premium charged" means the rates were calculated in accordance with sound actuarial principles.

(B) With respect to any filing, made pursuant to section 3923.02 of the Revised Code, of any premium rates for any individual policy of sickness and accident insurance or for any indorsement or rider pertaining thereto, the superintendent of insurance may, within thirty days after filing:

(1) Disapprove such filing after finding that the benefits provided are unreasonable in relation to the premium charged. Such disapproval shall be effected by written order of the superintendent, a copy of which shall be mailed to the insurer that has made the filing. In the order, the superintendent shall specify the reasons for the disapproval and state that a hearing will be held within fifteen days after requested in writing by the

insurer. If a hearing is so requested, the superintendent shall also give such public notice as the superintendent considers appropriate. The superintendent, within fifteen days after the commencement of any hearing, shall issue a written order, a copy of which shall be mailed to the insurer that has made the filing, either affirming the prior disapproval or approving such filing after finding that the benefits provided are not unreasonable in relation to the premium charged.

(2) Set a date for a public hearing to commence no later than forty days after the filing. The superintendent shall give the insurer making the filing twenty days' written notice of the hearing and shall give such public notice as the superintendent considers appropriate. The superintendent, within twenty days after the commencement of a hearing, shall issue a written order, a copy of which shall be mailed to the insurer that has made the filing, either approving such filing if the superintendent finds that the benefits provided are not unreasonable in relation to the premium charged, or disapproving such filing if the superintendent finds that the benefits provided are unreasonable in relation to the premium charged. This division does not apply to any insurer organized or transacting the business of insurance under Chapter 3907. or 3909. of the Revised Code.

(3) Take no action, in which case such filing shall be deemed to be approved and shall become effective upon the thirty-first day after such filing, unless the superintendent has previously given to the insurer a written approval.

(C) At any time after any filing has been approved pursuant to this section, the superintendent may, after a hearing of which at least twenty days' written notice has been given to the insurer that has made such filing and for which such public notice as the superintendent considers appropriate has been given, withdraw approval of such filing after finding that the benefits provided are unreasonable in relation to the premium charged. Such withdrawal of approval shall be effected by written order of the superintendent, a copy of which shall be mailed to the insurer that has made the filing, which shall state the ground for such withdrawal and the date, not less than forty days after the date of such order, when the withdrawal or approval shall become effective.

(D) The superintendent may retain at the insurer's expense such attorneys, actuaries, accountants, and other experts not otherwise a part of the superintendent's staff as shall be reasonably necessary to assist in the preparation for and conduct of any public hearing under this section. The expense for retaining such experts and the expenses of the department of insurance incurred in connection with such public hearing shall be assessed

against the insurer in an amount not to exceed one one-hundredth of one per cent of the sum of premiums earned plus net realized investment gain or loss of such insurer as reflected in the most current annual statement on file with the superintendent. Any person retained shall be under the direction and control of the superintendent and shall act in a purely advisory capacity.

~~(E) This section does not apply to any filing of any premium rate or rating formula for individual sickness and accident insurance policies offered in accordance with division (L) of section 3923.58 of the Revised Code, or for any amendment thereto.~~

Sec. 3923.122. (A) Every policy of group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only, and delivered, issued for delivery, or renewed in this state on or after January 1, 1976, shall include a provision giving each insured the option to convert to the following:

(1) In the case of an individual who is not a federally eligible individual, any of the individual policies of hospital, surgical, or medical expense insurance then being issued by the insurer with benefit limits not to exceed those in effect under the group policy;

(2) In the case of a federally eligible individual, a basic or standard plan established by the board of directors of the Ohio health reinsurance program or plans substantially similar to the basic and standard plan in benefit design and scope of covered services. For purposes of division (A)(2) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services.

(B) An option for conversion to an individual policy shall be available without evidence of insurability to every insured, including any person eligible under division (D) of this section, who terminates employment or membership in the group holding the policy after having been continuously insured thereunder for at least one year.

Upon receipt of the insured's written application and upon payment of at least the first quarterly premium not later than thirty-one days after the termination of coverage under the group policy, the insurer shall issue a converted policy on a form then available for conversion. The premium shall be in accordance with the insurer's table of premium rates in effect on the later of the following dates:

(1) The effective date of the converted policy;

(2) The date of application therefor; and shall be applicable to the class of risk to which each person covered belongs and to the form and amount of the policy at the person's then attained age. However, premiums charged

federally eligible individuals may not exceed an amount that is two times the midpoint of the standard rate charged any other individual of a group to which the insurer is currently accepting new business and for which similar copayments and deductibles are applied.

At the election of the insurer, a separate converted policy may be issued to cover any dependent of an employee or member of the group.

Except as provided in division (H) of this section, any converted policy shall become effective as of the day following the date of termination of insurance under the group policy.

Any probationary or waiting period set forth in the converted policy is deemed to commence on the effective date of the insured's coverage under the group policy.

(C) No insurer shall be required to issue a converted policy to any person who is, or is eligible to be, covered for benefits at least comparable to the group policy under:

(1) Title XVIII of the Social Security Act, as amended or superseded;

(2) Any act of congress or law under this or any other state of the United States that duplicates coverage offered under division (C)(1) of this section;

(3) Any policy that duplicates coverage offered under division (C)(1) of this section;

(4) Any other group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only.

(D) The option for conversion shall be available:

(1) Upon the death of the employee or member, to the surviving spouse with respect to such of the spouse and dependents as are then covered by the group policy;

(2) To a child solely with respect to the child upon attaining the limiting age of coverage under the group policy while covered as a dependent thereunder;

(3) Upon the divorce, dissolution, or annulment of the marriage of the employee or member, to the divorced spouse, or former spouse in the event of annulment, of such employee or member, or upon the legal separation of the spouse from such employee or member, to the spouse.

Persons possessing the option for conversion pursuant to this division shall be considered members for the purposes of division (H) of this section.

(E) If coverage is continued under a group policy on an employee following retirement prior to the time the employee is, or is eligible to be, covered by Title XVIII of the Social Security Act, the employee may elect, in lieu of the continuance of group insurance, to have the same conversion

rights as would apply had the employee's insurance terminated at retirement by reason of termination of employment.

(F) If the insurer and the group policyholder agree upon one or more additional plans of benefits to be available for converted policies, the applicant for the converted policy may elect such a plan in lieu of a converted policy.

(G) The converted policy may contain provisions for avoiding duplication of benefits provided pursuant to divisions (C)(1), (2), (3), and (4) of this section or provided under any other insured or noninsured plan or program.

(H) If an employee or member becomes entitled to obtain a converted policy pursuant to this section, and if the employee or member has not received notice of the conversion privilege at least fifteen days prior to the expiration of the thirty-one-day conversion period provided in division (B) of this section, then the employee or member has an additional period within which to exercise the privilege. This additional period shall expire fifteen days after the employee or member receives notice, but in no event shall the period extend beyond sixty days after the expiration of the thirty-one-day conversion period.

Written notice presented to the employee or member, or mailed by the policyholder to the last known address of the employee or member as indicated on its records, constitutes notice for the purpose of this division. In the case of a person who is eligible for a converted policy under division (D)(2) or (D)(3) of this section, a policyholder shall not be responsible for presenting or mailing such notice, unless such policyholder has actual knowledge of the person's eligibility for a converted policy.

If an additional period is allowed by an employee or member for the exercise of a conversion privilege, and if written application for the converted policy, accompanied by at least the first quarterly premium, is made after the expiration of the thirty-one-day conversion period, but within the additional period allowed an employee or member in accordance with this division, the effective date of the converted policy shall be the date of application.

(I) The converted policy may provide~~:~~

~~(1) That~~ that any hospital, surgical, or medical expense benefits otherwise payable with respect to any person may be reduced by the amount of any such benefits payable under the group policy for the same loss after termination of coverage~~;~~

~~(2) For termination of coverage on any person who is, or is eligible to be, covered pursuant to division (C) of this section;~~

~~(3) That the insurer may request information in advance of any premium due date of the policy as to whether the insured is, or is eligible to be, covered pursuant to division (C) of this section. If the insured is, or is eligible to be, covered, and the insured fails to furnish the details of the insured's coverage or eligibility to the insurer within thirty-one days after the date of the request, the benefits payable under the converted policy may be based on the hospital, surgical, or medical expenses actually incurred after excluding expenses to the extent of the amount of benefits for which the insured is, or is eligible to be, covered pursuant to division (C) of this section~~.

(J) The converted policy may contain:

(1) Any exclusion, reduction, or limitation contained in the group policy or customarily used in individual policies issued by the insurer;

(2) Any provision permitted in this section;

(3) Any other provision not prohibited by law.

Any provision required or permitted in this section may be made a part of any converted policy by means of an endorsement or rider.

(K) The time limit specified in a converted policy for certain defenses with respect to any person who was covered by a group policy shall commence on the effective date of such person's coverage under the group policy.

(L) No insurer shall use deterioration of health as the basis for refusing to renew a converted policy.

(M) No insurer shall use age as the basis for refusing to renew a converted policy.

(N) A converted policy made available pursuant to this section shall, if delivery of the policy is to be made in this state, comply with this section. If delivery of a converted policy is to be made in another state, it may be on a form offered by the insurer in the jurisdiction where the delivery is to be made and which provides benefits substantially in compliance with those required in a policy delivered in this state.

(O) As used in this section, "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

Sec. 3923.57. Notwithstanding any provision of this chapter, every individual policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state is subject to the following conditions, as applicable:

(A) Pre-existing conditions provisions shall not exclude or limit coverage for a period beyond twelve months following the policyholder's effective date of coverage and may only relate to conditions during the six

months immediately preceding the effective date of coverage.

(B) In determining whether a pre-existing conditions provision applies to a policyholder or dependent, each policy shall credit the time the policyholder or dependent was covered under a previous policy, contract, or plan if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, exclusive of any applicable service waiting period under the policy.

(C)(1) Except as otherwise provided in division (C) of this section, an insurer that provides an individual sickness and accident insurance policy to an individual shall renew or continue in force such coverage at the option of the individual.

(2) An insurer may nonrenew or discontinue coverage of an individual in the individual market based only on one or more of the following reasons:

(a) The individual failed to pay premiums or contributions in accordance with the terms of the policy or the insurer has not received timely premium payments.

(b) The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the policy.

(c) The insurer is ceasing to offer coverage in the individual market in accordance with division (D) of this section and the applicable laws of this state.

(d) If the insurer offers coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area, or in an area for which the insurer is authorized to do business; provided, however, that such coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(e) If the coverage is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association, on the basis of which the coverage is provided, ceases; provided, however, that such coverage is terminated under division (C)(2)(e) of this section uniformly without regard to any health status-related factor of covered individuals.

An insurer offering coverage to individuals solely through membership in a bona fide association shall not be deemed, by virtue of that offering, to be in the individual market for purposes of sections 3923.58 and 3923.581 of the Revised Code. Such an insurer shall not be required to accept applicants for coverage in the individual market pursuant to sections 3923.58 and 3923.581 of the Revised Code unless the insurer also offers coverage to individuals other than through bona fide associations.

(3) An insurer may cancel or decide not to renew the coverage of a dependent of an individual if the dependent has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to the dependent.

(D)(1) If an insurer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the insurer if the insurer does all of the following:

(a) Provides notice to each individual provided coverage of this type in such market of the discontinuation at least ninety days prior to the date of the discontinuation of the coverage;

(b) Offers to each individual provided coverage of this type in such market, the option to purchase any other individual health insurance coverage currently being offered by the insurer for individuals in that market;

(c) In exercising the option to discontinue coverage of this type and in offering the option of coverage under division (D)(1)(b) of this section, acts uniformly without regard to any health status-related factor of covered individuals or of individuals who may become eligible for such coverage.

(2) If an insurer elects to discontinue offering all health insurance coverage in the individual market in this state, health insurance coverage may be discontinued by the insurer only if both of the following apply:

(a) The insurer provides notice to the department of insurance and to each individual of the discontinuation at least one hundred eighty days prior to the date of the expiration of the coverage.

(b) All health insurance delivered or issued for delivery in this state in such market is discontinued and coverage under that health insurance in that market is not renewed.

(3) In the event of a discontinuation under division (D)(2) of this section in the individual market, the insurer shall not provide for the issuance of any health insurance coverage in the market and this state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(E) ~~Nothwithstanding~~ Notwithstanding divisions (C) and (D) of this section, an insurer may, at the time of coverage renewal, modify the health insurance coverage for a policy form offered to individuals in the individual market if the modification is consistent with the law of this state and effective on a uniform basis among all individuals with that policy form.

(F) Such policies are subject to sections 2743 and 2747 of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-43 and 300gg-47, as amended.

(G) Sections 3924.031 and 3924.032 of the Revised Code shall apply to sickness and accident insurance policies offered in the individual market in the same manner as they apply to health benefit plans offered in the small employer market.

In accordance with 45 C.F.R. 148.102, divisions (C) to (G) of this section also apply to all group sickness and accident insurance policies that are not sold in connection with an employment-related group health plan and that provide more than short-term, limited duration coverage.

In applying divisions (C) to (G) of this section with respect to health insurance coverage that is made available by an insurer in the individual market to individuals only through one or more associations, the term "individual" includes the association of which the individual is a member.

For purposes of this section, any policy issued pursuant to division (C) of section 3923.13 of the Revised Code in connection with a public or private college or university student health insurance program is considered to be issued to a bona fide association ~~and is not subject to divisions (C) to (G) of this section~~.

As used in this section, "bona fide association" has the same meaning as in section 3924.03 of the Revised Code, and "health status-related factor" and "network plan" have the same meanings as in section 3924.031 of the Revised Code.

This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy of no longer than six months, or other policy that offers only supplemental benefits.

Sec. 3923.571. Except as otherwise provided in section 2721 of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as amended, the following conditions apply to all group policies of sickness and accident insurance that are sold in connection with an employment-related group health plan and that are not subject to section 3924.03 of the Revised Code:

(A) Any such policy shall comply with the requirements of division (A) of section 3924.03 and section 3924.033 of the Revised Code.

(B)(1) Except as provided in section 2712(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," if an insurer offers coverage in the small or large group market in connection with a group

policy, the insurer shall renew or continue in force such coverage at the option of the policyholder.

(2) An insurer may cancel or decide not to renew the coverage of an employee or of a dependent of an employee if the employee or dependent, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to the employee or dependent.

As used in division (B)(2) of this section, "health status-related factor" has the same meaning as in section 3924.031 of the Revised Code.

(C)(1) No such policy, or insurer offering health insurance coverage in connection with such a policy, shall require any individual, as a condition of coverage or continued coverage under the policy, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual covered under the policy on the basis of any health status-related factor in relation to the individual or to an individual covered under the policy as a dependent of the individual.

(2) Nothing in division (C)(1) of this section shall be construed to restrict the amount that an employer may be charged for coverage under a group policy, or to prevent a group policy, and an insurer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(D) Such policies shall provide for the special enrollment periods described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996."

(E) At least once in every twelve-month period, an insurer shall provide to all late enrollees, as defined in section 3924.01 of the Revised Code, who are identified by the policyholder, the option to enroll in the group policy. The enrollment option shall be provided for a minimum period of thirty consecutive days. All delays of coverage imposed under the group policy, including any pre-existing condition exclusion period or service waiting period, shall begin on the date the insurer receives notice of the late enrollee's application or request for coverage, and shall run concurrently with each other.

Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of the Revised Code:

(1) "Health benefit plan" and "MEWA" have the same meanings as in section 3924.01 of the Revised Code.

(2) "Insurer" means any sickness and accident insurance company authorized to do business in this state, or MEWA authorized to issue insured health benefit plans in this state. "Insurer" does not include any health insuring corporation that is owned or operated by an insurer.

(3) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received, or a pregnancy existing on the effective date of coverage.

(B) Beginning in January of each year, insurers in the business of issuing individual policies of sickness and accident insurance as contemplated by section 3923.021 of the Revised Code, except individual policies issued pursuant to section 3923.122 of the Revised Code, shall accept applicants for open enrollment coverage, as set forth in this division, in the order in which they apply for coverage and subject to the limitation set forth in division (G) of this section. Insurers shall accept for coverage pursuant to this section individuals to whom both of the following conditions apply:

(1) The individual is not applying for coverage as an employee of an employer, as a member of an association, or as a member of any other group.

(2) The individual is not covered, and is not eligible for coverage, under any other private or public health benefits arrangement, including the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or any other act of congress or law of this or any other state of the United States that provides benefits comparable to the benefits provided under this section, any medicare supplement policy, or any continuation of coverage policy under state or federal law.

(C) An insurer shall offer to any individual accepted under this section the ~~small employer~~ Ohio health care ~~plan~~ basic and standard plans established by the board of directors of the Ohio health reinsurance program under division (A) of section 3924.10 of the Revised Code or ~~a~~ health benefit ~~plan~~ plans that ~~is~~ are substantially similar to the ~~small employer~~ Ohio health care ~~plan~~ basic and standard plans in benefit plan design and scope of covered services.

An insurer may offer other health benefit plans in addition to, but not in lieu of, the ~~plan~~ plans required to be offered under this division. ~~These additional~~ A basic health benefit ~~plans~~ plan shall provide, at a minimum, the coverage provided by the ~~small employer~~ Ohio health care basic plan or any health benefit plan that is substantially similar to the ~~small employer~~ Ohio health care basic plan in benefit plan design and scope of covered services. A standard health benefit plan shall provide, at a minimum, the coverage provided by the Ohio health care standard plan or any health benefit plan that is substantially similar to the Ohio health care standard plan in benefit plan design and scope of covered services.

For purposes of this division, the superintendent of insurance shall determine whether a health benefit plan is substantially similar to the ~~small employer~~ Ohio health care ~~plan~~ BASIC AND STANDARD PLANS in benefit plan design and scope of covered services.

(D) Health benefit plans issued under this section may establish pre-existing conditions provisions that exclude or limit coverage for a period of up to twelve months following the individual's effective date of coverage and that may relate only to conditions during the six months immediately preceding the effective date of coverage.

(E) Premiums charged to individuals under this section may not exceed an amount that is two and one-half times the highest rate charged any other individual to which the insurer is currently accepting new business, and for which similar copayments and deductibles are applied.

(F) In offering health benefit plans under this section, an insurer may require the purchase of health benefit plans that condition the reimbursement of health services upon the use of a specific network of providers.

(G)(1) In no event shall an insurer be required to accept annually under this section individuals who, in the aggregate, would cause the insurer to have a total number of new insureds that is more than one-half per cent of its total number of insured individuals in this state per year, as contemplated by section 3923.021 of the Revised Code, calculated as of the immediately preceding thirty-first day of December and excluding the insurer's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division ~~(M)~~(L) of this section.

(2) An officer of the insurer shall certify to the department of insurance when it has met the enrollment limit set forth in division (G)(1) of this section. Upon providing such certification, the insurer shall be relieved of its open enrollment requirement under this section for the remainder of the

calendar year.

(H) An insurer shall not be required to accept under this section applicants who, at the time of enrollment, are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the insurer if the applicants were accepted, or to make the effective date of benefits for individuals accepted under this section earlier than ninety days after the date of acceptance.

(I) The requirements of this section do not apply to any insurer that is currently in a state of supervision, insolvency, or liquidation. If an insurer demonstrates to the satisfaction of the superintendent that the requirements of this section would place the insurer in a state of supervision, insolvency, or liquidation, the superintendent may waive or modify the requirements of division (B) or (G) of this section. The actions of the superintendent under this division shall be effective for a period of not more than one year. At the expiration of such time, a new showing of need for a waiver or modification by the insurer shall be made before a new waiver or modification is issued or imposed.

(J) No hospital, health care facility, or health care practitioner, and no person who employs any health care practitioner, shall balance bill any individual or dependent of an individual for any health care supplies or services provided to the individual or dependent who is insured under a policy issued under this section. The hospital, health care facility, or health care practitioner, or any person that employs the health care practitioner, shall accept payments made to it by the insurer under the terms of the policy or contract insuring or covering such individual as payment in full for such health care supplies or services.

As used in this division, "hospital" has the same meaning as in section 3727.01 of the Revised Code; "health care practitioner" has the same meaning as in section 4769.01 of the Revised Code; and "balance bill" means charging or collecting an amount in excess of the amount reimbursable or payable under the policy or health care service contract issued to an individual under this section for such health care supply or service. "Balance bill" does not include charging for or collecting copayments or deductibles required by the policy or contract.

(K) An insurer shall pay an agent a commission in the amount of five per cent of the premium charged for initial placement or for otherwise securing the issuance of a policy or contract issued to an individual under this section, and four per cent of the premium charged for the renewal of such a policy or contract. The superintendent may adopt, in accordance with Chapter 119. of the Revised Code, such rules as are necessary to enforce this

division.

(L) ~~Individuals accepted for coverage under this section may be issued contracts and certificates subject to the requirements of section 3923.12 of the Revised Code. The coverage issued to such individuals is not subject to the requirements of section 3923.021 of the Revised Code.~~

~~(M)~~ This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy of no longer than six months, or other policy that offers only supplemental benefits.

Sec. 3924.01. As used in sections 3924.01 to 3924.14 of the Revised Code:

(A) "Actuarial certification" means a written statement prepared by a member of the American academy of actuaries, or by any other person acceptable to the superintendent of insurance, that states that, based upon the person's examination, a carrier offering health benefit plans to small employers is in compliance with sections 3924.01 to 3924.14 of the Revised Code. "Actuarial certification" shall include a review of the appropriate records of, and the actuarial assumptions and methods used by, the carrier relative to establishing premium rates for the health benefit plans.

(B) "Adjusted average market premium price" means the average market premium price as determined by the board of directors of the Ohio health reinsurance program either on the basis of the arithmetic mean of all carriers' premium rates for an ~~SEHC~~ OHC plan sold to groups with similar case characteristics by all carriers selling ~~SEHC~~ OHC plans in the state, or on any other equitable basis determined by the board.

(C) "Base premium rate" means, as to any health benefit plan that is issued by a carrier and that covers at least two but no more than fifty employees of a small employer, the lowest premium rate for a new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any small employer with similar case characteristics.

(D) "Carrier" means any sickness and accident insurance company or health insuring corporation authorized to issue health benefit plans in this state or a MEWA. A sickness and accident insurance company that owns or operates a health insuring corporation, either as a separate corporation or as a line of business, shall be considered as a separate carrier from that health insuring corporation for purposes of sections 3924.01 to 3924.14 of the Revised Code.

(E) "Case characteristics" means, with respect to a small employer, the

geographic area in which the employees work; the age and sex of the individual employees and their dependents; the appropriate industry classification as determined by the carrier; the number of employees and dependents; and such other objective criteria as may be established by the carrier. "Case characteristics" does not include claims experience, health status, or duration of coverage from the date of issue.

(F) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefits plan covering the employee.

(G) "Eligible employee" means an employee who works a normal work week of twenty-five or more hours. "Eligible employee" does not include a temporary or substitute employee, or a seasonal employee who works only part of the calendar year on the basis of natural or suitable times or circumstances.

(H) "Health benefit plan" means any hospital or medical expense policy or certificate or any health plan provided by a carrier, that is delivered, issued for delivery, renewed, or used in this state on or after the date occurring six months after November 24, 1995. "Health benefit plan" does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy of no longer than six months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(I) "Late enrollee" means an eligible employee or dependent who enrolls in a small employer's health benefit plan other than during the first period in which the employee or dependent is eligible to enroll under the plan or during a special enrollment period described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as amended.

(J) "MEWA" means any "multiple employer welfare arrangement" as defined in section 3 of the "Federal Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended, except for any arrangement which is fully insured as defined in division (b)(6)(D) of section 514 of that act.

(K) "Midpoint rate" means, for small employers with similar case characteristics and plan designs and as determined by the applicable carrier for a rating period, the arithmetic average of the applicable base premium

rate and the corresponding highest premium rate.

(L) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's enrollment date as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the enrollment date. Genetic information shall not be treated as such a condition in the absence of a diagnosis of the condition related to such information.

For purposes of this division, "enrollment date" means, with respect to an individual covered under a group health benefit plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.

(M) "Service waiting period" means the period of time after employment begins before an employee is eligible to be covered for benefits under the terms of any applicable health benefit plan offered by the small employer.

(N)(1) "Small employer" means, in connection with a group health benefit plan and with respect to a calendar year and a plan year, an employer who employed an average of at least two but no more than fifty eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

(2) For purposes of division (N)(1) of this section, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected the employer will employ on business days in the current calendar year. Any reference in division (N) of this section to an "employer" includes any predecessor of the employer. Except as otherwise specifically provided, provisions of sections 3924.01 to 3924.14 of the Revised Code that apply to a small employer that has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this division.

(O) "~~SEHC~~ OHC plan" means an Ohio ~~small employer~~ health care plan, which is ~~a health benefit~~ the basic, standard, or carrier reimbursement plan for small ~~individuals and~~ employers and individuals established by the board in accordance with section 3924.10 of the Revised Code.

Sec. 3924.03. Except as otherwise provided in section 2721 of the

"Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as amended, health benefit plans covering small employers are subject to the following conditions, as applicable:

(A)(1) Pre-existing conditions provisions shall not exclude or limit coverage for a period beyond twelve months, or eighteen months in the case of a late enrollee, following the individual's enrollment date and may only relate to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six months immediately preceding the enrollment date.

Division (A)(1) of this section is subject to the exceptions set forth in section 2701(d) of the "Health Insurance Portability and Accountability Act of 1996."

(2) The period of any such pre-existing condition exclusion shall be reduced by the aggregate of the periods of creditable coverage, if any, applicable to the employee or dependent as of the enrollment date.

(3) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health benefit plan, if, after that period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage. Subsections (c)(2) to (4) and (e) of section 2701 of the "Health Insurance Portability and Accountability Act of 1996" apply with respect to crediting previous coverage.

(4) As used in division (A) of this section:

(a) "Creditable coverage" has the same meaning as in section 2701(c)(1) of the "Health Insurance Portability and Accountability Act of 1996."

(b) "Enrollment date" means, with respect to an individual covered under a group health benefit plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.

(B)(1) Except as provided in section 2712(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," if a carrier offers coverage in the small employer market in connection with a group health benefit plan, the carrier shall renew or continue in force such coverage at the option of the plan sponsor of the plan.

(2) A carrier may cancel or decide not to renew the coverage of any eligible employee or of a dependent of an eligible employee if the employee or dependent, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based,

either directly or indirectly, on any health status-related factor in relation to the employee or dependent.

As used in division (B)(2) of this section, "health status-related factor" has the same meaning as in section 3924.031 of the Revised Code.

(C) A carrier shall not exclude any eligible employee or dependent, who would otherwise be covered under a health benefit plan, on the basis of any actual or expected health condition of the employee or dependent.

If, prior to November 24, 1995, a carrier excluded an eligible employee or dependent, other than a late enrollee, on the basis of an actual or expected health condition, the carrier shall, upon the initial renewal of the coverage on or after that date, extend coverage to the employee or dependent if all other eligibility requirements are met.

(D) No health benefit plan issued by a carrier shall limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident, except for pre-existing conditions as permitted under division (A) of this section. If a health benefit plan that is delivered or issued for delivery prior to April 14, 1993, contains such limitations or exclusions, by use of a rider or amendment applicable to a specific individual, the plan shall eliminate the use of such riders or amendments within eighteen months after April 14, 1993.

(E)(1) Except as provided in sections 3924.031 and 3924.032 of the Revised Code, and subject to such rules as may be adopted by the superintendent of insurance in accordance with Chapter 119. of the Revised Code, a carrier shall offer and make available every health benefit plan that it is actively marketing to every small employer that applies to the carrier for such coverage.

Division (E)(1) of this section does not apply to a health benefit plan that a carrier makes available in the small employer market only through one or more bona fide associations.

Division (E)(1) of this section shall not be construed to preclude a carrier from establishing employer contribution rules or group participation rules for the offering of coverage in connection with a group health benefit plan in the small employer market, as allowed under the law of this state. As used in division (E)(1) of this section, "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of employees and dependents and "group participation rule" means a requirement relating to the minimum number of employees or dependents that must be enrolled in relation to a specified percentage or number of eligible individuals or

employees of an employer.

(2) Each health benefit plan, at the time of initial group enrollment, shall make coverage available to all the eligible employees of a small employer without a service waiting period. The decision of whether to impose a service waiting period shall be made by the small employer. Such waiting periods shall not be greater than ninety days.

(3) Each health benefit plan shall provide for the special enrollment periods described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996."

(4) At least once in every twelve-month period, a carrier shall provide to all late enrollees who are identified by the small employer, the option to enroll in the health benefit plan. The enrollment option shall be provided for a minimum period of thirty consecutive days. All delays of coverage imposed under the health benefit plan, including any pre-existing condition exclusion period, affiliation period, or service waiting period, shall begin on the date the carrier receives notice of the late enrollee's application or request for coverage, and shall run concurrently with each other.

(F) The benefit structure of any health benefit plan may, at the time of coverage renewal, be changed by the carrier to make it consistent with the benefit structure contained in health benefit plans being marketed to new small employer groups. If the health benefit plan is available in the small employer market other than only through one or more bona fide associations, the modification must be consistent with the law of this state and effective on a uniform basis among small employer group plans.

(G) A carrier may obtain any facts and information necessary to apply this section, or supply those facts and information to any other third-party payer, without the consent of the beneficiary. Each person claiming benefits under a health benefit plan shall provide any facts and information necessary to apply this section.

For purposes of this section, "bona fide association" means an association that has been actively in existence for at least five years; has been formed and maintained in good faith for purposes other than obtaining insurance; does not condition membership in the association on any health status-related factor, as defined in section 3924.031 of the Revised Code, relating to an individual, including an employee or dependent; makes health insurance coverage offered through the association available to all members regardless of any health status-related factor, as defined in section 3924.031 of the Revised Code, relating to such members or to individuals eligible for coverage through a member; does not make health insurance coverage offered through the association available other than in connection with a

member of the association; and meets any other requirement imposed by the superintendent. To maintain its status as a "bona fide association," each association shall annually certify to the superintendent that it meets the requirements of this paragraph.

Sec. 3924.033. (A) Each carrier, in connection with the offering of a health benefit plan to a small employer, shall disclose to the employer, as part of its solicitation and sales materials, ~~that~~ the ~~information described in division (B) of this section is available upon request.~~

~~(B) A carrier shall provide the~~ following information ~~to a small employer upon request~~:

(1) The provisions of the plan concerning the carrier's right to change premium rates and the factors that may affect changes in premium rates;

(2) The provisions of the plan relating to renewability of coverage;

(3) The provisions of the plan relating to any pre-existing condition exclusion;

(4) The benefits and premiums available under all health benefit plans for which the employer is qualified.

~~(C)~~(B) The information described in division ~~(B)~~(A) of this section shall be provided in a manner determined to be understandable by the average small employer, and in a manner sufficient to reasonably inform a small employer regarding the employer's rights and obligations under the health benefit plan.

~~(D)~~(C) Nothing in this section requires a carrier to disclose any information that is by law proprietary and trade secret information.

Sec. 3924.08. (A) The board of directors of the Ohio health reinsurance program shall consist of nine appointed members who shall serve staggered terms as determined by the initial board for its members and by the plan of operation of the program for members of subsequent boards. Within thirty days after April 14, 1993, the members of the board shall be appointed, as follows:

(1) The chairperson of the senate committee having jurisdiction over insurance shall appoint the following members:

(a) Two member carriers that are small employer carriers;

(b) One member carrier that is a health insuring corporation predominantly in the small employer market;

(c) One representative of providers of health care.

(2) The chairperson of the committee in the house of representatives having jurisdiction over insurance shall appoint the following members:

(a) One member carrier that is a small employer carrier;

(b) One member carrier whose principal health insurance business is in

the large employer market;

(c) One representative of an employer with fifty or fewer employees;

(d) One representative of consumers in this state.

(3) The superintendent of insurance shall appoint a representative of a member carrier operating in the small employer market who is a fellow of the society of actuaries.

The superintendent, a member of the house of representatives appointed by the speaker of the house of representatives, and a member of the senate appointed by the president of the senate, shall be ex-officio members of the board. The membership of all boards subsequent to the initial board shall reflect the distribution described in division (A) of this section.

The chairperson of the initial board and each subsequent board shall represent a small employer member carrier and shall be elected by a majority of the voting members of the board. Each chairperson shall serve for the maximum duration established in the plan of operation.

(B) Within one hundred eighty days after the appointment of the initial board, the board shall establish a plan of operation and, thereafter, any amendments to the plan that are necessary or suitable, to assure the fair, reasonable, and equitable administration of the program. The board shall, immediately upon adoption, provide to the superintendent copies of the plan of operation and all subsequent amendments to it.

(C) The plan of operation shall establish rules, conditions, and procedures for all of the following:

(1) The handling and accounting of assets and moneys of the program and for an annual fiscal reporting to the superintendent;

(2) Filling vacancies on the board;

(3) Selecting an ~~administering insurer, which shall be a carrier as defined in section 3924.01 of the Revised Code~~ administrator of the program, and setting forth the powers and duties of the ~~administering insurer;~~ administrator. The administrator may be a carrier as defined in section 3924.01 of the Revised Code or a person licensed as an administrator under Chapter 3959. of the Revised Code, or the board may, in its sole discretion, choose to serve as administrator of the program.

(4) Reinsuring risks in accordance with sections 3924.07 to 3924.14 of the Revised Code;

(5) Collecting assessments subject to section 3924.13 of the Revised Code from all members to provide for claims reinsured by the program and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(6) Providing protection for carriers from the financial risk associated

with small employers that present poor credit risks;

(7) Establishing standards for the coverage of small employers that have a high turnover of employees;

(8) Establishing an appeals process for carriers to seek relief when a carrier has experienced an unfair share of administrative and credit risks;

(9) Establishing the adjusted average market premium prices for use by the ~~SEHC plan~~ OHC plans for individuals, for groups of two to twenty-five employees, and for groups of twenty-six to fifty employees that are offered in the state;

(10) Establishing participation standards at issue and renewal for reinsured cases;

(11) Reinsuring risks and collecting assessments in accordance with division (G) of section 3924.11 of the Revised Code;

(12) Any additional matters as determined by the board.

Sec. 3924.09. The Ohio health reinsurance program shall have the general powers and authority granted under the laws of the state to insurance companies licensed to transact sickness and accident insurance, except the power to issue insurance. The board of directors of the program also shall have the specific authority to do all of the following:

(A) Enter into contracts as are necessary or proper to carry out the provisions and purposes of sections 3924.07 to 3924.14 of the Revised Code, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions;

(B) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against any program or board member;

(C) Take such legal action as is necessary to avoid the payment of improper claims against the program;

(D) Design the ~~SEHC plan~~ OHC plans which, when offered by a carrier, ~~is~~ are eligible for reinsurance and issue reinsurance policies in accordance with the requirements of sections 3924.07 to 3924.14 of the Revised Code;

(E) Establish rules, conditions, and procedures pertaining to the reinsurance of members' risks by the program;

(F) Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the operation of the program;

(G) Assess members in accordance with division (G) of section 3924.11 and the provisions of section 3924.13 of the Revised Code, and make such

advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.

(H) Appoint members to appropriate legal, actuarial, and other committees if necessary to provide technical assistance with respect to the operation of the program, policy and other contract design, and any other function within the authority of the program;

(I) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

(J) Reinsure risks, collect assessments, and otherwise carry out its duties under division (G) of section 3924.11 of the Revised Code;

(K) Study the operation of the Ohio health reinsurance program and the open enrollment reinsurance program and, based on its findings, make legislative recommendations to the general assembly for improvements in the effectiveness, operation, and integrity of the programs;

(L) Design a basic and standard plan for purposes of sections 1751.16, 3923.122, and 3923.581 of the Revised Code.

Sec. 3924.10. (A) The board of directors of the Ohio health reinsurance program shall design the ~~SEHC plan~~ OHC basic, standard, and carrier reimbursement plans which, when offered by a carrier, ~~is~~ are eligible for reinsurance under the program. The board shall establish the form and level of coverage to be made available by carriers in their ~~SEHC plan~~ OHC plans. In designing the ~~plan~~ plans the board shall also establish benefit levels, deductibles, coinsurance factors, exclusions, and limitations for the ~~plan~~ plans. The forms and levels of coverage established by the board shall specify which components of ~~a~~ health benefit ~~plan~~ plans offered by a carrier may be reinsured. The ~~SEHC plan is~~ OHC plans are subject to division (C) of section 3924.02 of the Revised Code and to the provisions in Chapters 1751., 1753., 3923., and any other chapter of the Revised Code that require coverage or the offer of coverage of a health care service or benefit.

(B) The board shall adopt the ~~SEHC plan~~ OHC plans within one hundred eighty days after ~~its appointment~~ the effective date of this amendment. The ~~plan~~ plans may include cost containment features including any of the following:

(1) Utilization review of health care services, including review of the medical necessity of hospital and physician services;

(2) Case management benefit alternatives;

(3) Selective contracting with hospitals, physicians, and other health

care providers;

(4) Reasonable benefit differentials applicable to participating and nonparticipating providers;

(5) Employee assistance program options that provide preventive and early intervention mental health and substance abuse services;

(6) Other provisions for the cost-effective management of the ~~plan~~ plans.

(C) ~~An SEHC plan~~ OHC plans established for use by health insuring corporations shall be consistent with the basic method of operation of such corporations.

(D) Each carrier shall certify to the superintendent of insurance, in the form and manner prescribed by the superintendent, that the ~~SEHC plan~~ OHC plans filed by the carrier ~~is~~ are in substantial compliance with the provisions of the board ~~SEHC plan~~ OHC plans. Upon receipt by the superintendent of the certification, the carrier may use the certified ~~plan~~ plans.

(E) Each carrier shall, on and after sixty days after the date that the program becomes operational and as a condition of transacting business in this state, renew coverage provided to any individual or group under its ~~SEHC plan~~ OHC plans.

Sec. 3924.11. Any member of the Ohio health reinsurance program may reinsure small employer groups or individuals in accordance with the following conditions and limitations:

(A) ~~With respect to eligible employees and their dependents who are hired subsequent to the commencement of the employer's coverage by a carrier and who are not late enrollees, and with respect to employees of an employer who are otherwise eligible for insurance but were excluded by the carrier's underwriting and who are not late enrollees, coverage may be reinsured in any of the following ways:~~

~~(1) Except in the case of late enrollees, within sixty days after the commencement of their coverage under the plan;~~

~~(2) In the case of late enrollees who were not eligible to enroll during a special enrollment period described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-42, as amended, eighteen months after the date the late enrollee becomes a member of the small employer's plan;~~

~~(3) In the case of late enrollees who were eligible to enroll during a special enrollment period described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996," as amended, within sixty days after the commencement of their coverage under the plan~~ A small

employer group or individual may be reinsured within sixty days after the commencement of the group's or individual's coverage under the plan.

(B)(1) The carrier may reinsure either the entire eligible group or any eligible individual, in accordance with the premium rates established in section 3924.12 of the Revised Code, upon commencement of the coverage.

(2) The carrier may reinsure an eligible employee, or the dependents of an eligible employee, who were previously excluded from group coverage for medical reasons, and shall reinsure such employees or dependents within sixty days after the carrier is required to include them in the group coverage.

(C) With respect to an ~~SEHC~~ OHC plan, the program shall reinsure the level of coverage provided.

(D) With respect to other plans issued to small employers, the program shall reinsure the level of coverage provided up to, but not exceeding, the level of coverage provided in an ~~SEHC~~ OHC carrier reimbursement plan. In the coverage provided to small employers, carriers shall be required to use high-cost care management, hospital precertification techniques, and other cost containment mechanisms established by the program.

(E) A carrier may not reinsure existing business, except pursuant to division (A) of this section.

(F) If an employer group is covered under a plan other than an ~~SEHC~~ OHC carrier reimbursement plan and the carrier chooses to reinsure the group subsequent to the initial coverage period, or if a new individual joins the group and the carrier wants to reinsure that individual, the carrier shall not force the employer to change to an ~~SEHC~~ OHC carrier reimbursement plan. The carrier shall allow the employer to maintain the same benefit plan and reinsure only that portion of the plan that is consistent with an ~~SEHC~~ OHC carrier reimbursement plan.

(G) With respect to coverage provided to an individual acquired under section 3923.58 or a federally eligible individual acquired under section 3923.581 of the Revised Code, the following conditions and limitations apply:

(1) Within sixty days after the commencement of the initial coverage, any carrier may reinsure coverage of such an individual with the open enrollment reinsurance program in accordance with division (G) of this section. Premium rates charged for coverage reinsured by the program shall be established in accordance with section 3924.12 of the Revised Code.

(2) The board of directors of the Ohio health reinsurance program shall establish the open enrollment reinsurance fund for coverage provided under section 3923.58 of the Revised Code and, with respect to federally eligible individuals, coverage provided under section 3923.581 of the Revised Code.

The fund shall be maintained separately from any reinsurance fund established for ~~small employer~~ Ohio health care plans issued pursuant to sections 3924.07 to 3924.14 of the Revised Code. The board shall calculate, on a retrospective basis, the amount needed for maintenance of the open enrollment reinsurance fund and, on the basis of that calculation, shall determine the amount to be assessed each carrier that is required to provide open enrollment coverage.

Assessments shall be apportioned by the board among all carriers participating in the open enrollment reinsurance program in proportion to their respective shares of the total premiums, net of reinsurance premiums paid by a carrier for open enrollment coverage and net of reinsurance premiums paid by the carrier for all other individual health benefit plans, earned in this state from all health benefit plans covering individuals that are issued by all such carriers during the calendar year coinciding with or ending during the fiscal year of the open enrollment program, or on any other equitable basis reflecting coverage of individuals in this state as may be provided in the plan of operation adopted by the board. In no event shall the assessment of any carrier under this section exceed, on an annual basis, three per cent of its Ohio premiums for health benefit plans covering individuals as reported on its most recent annual statement filed with the superintendent of insurance.

The board shall submit its determination of the amount of the assessment to the superintendent for review of the accuracy of the calculation of the assessment. Upon approval by the superintendent, each carrier shall, within thirty days after receipt of the notice of assessment, submit the assessment to the board for purposes of the open enrollment reinsurance fund.

(3) If the assessments made and collected pursuant to division (G)(2) of this section are not sufficient to pay the claims reinsured under division (G) of this section and the allocated administrative expenses, incurred or estimated to be incurred during the period for which the assessment was made, the secretary of the board shall immediately notify the superintendent, and the superintendent shall suspend the operation of open enrollment under section 3923.58 of the Revised Code and, with respect to federally eligible individuals, under section 3923.581 of the Revised Code until the board has collected in subsequent years through assessments made pursuant to division (G)(2) of this section an amount sufficient to pay such claims and administrative expenses.

(4)(a) Any carrier that is subject to open enrollment under section 3923.58 of the Revised Code may elect not to participate in the open

enrollment reinsurance program under division (G) of this section by filing an application with the superintendent and obtaining the superintendent's approval. In determining whether to approve an application, the superintendent shall consider whether the carrier meets all of the following standards:

(i) Demonstration by the carrier of a substantial and established market presence;

(ii) Demonstrated experience in the individual market and history of rating and underwriting individual plans;

(iii) Commitment to comply with the requirements of section 3923.58 of the Revised Code;

(iv) Financial ability to assume and manage the risk of enrolling open enrollment individuals without the need for, or protection of, reinsurance.

(b) A carrier whose application for nonparticipation has been rejected by the superintendent may appeal the decision in accordance with Chapter 119. of the Revised Code. A carrier that has received approval of the superintendent not to participate in the open enrollment reinsurance program shall, on or before the first day of December, annually certify to the superintendent that it continues to meet the standards described in division (G)(4)(a) of this section.

(c) In any year subsequent to the year in which its application not to participate has been approved, a carrier may elect to participate in the open enrollment reinsurance program by giving notice to the superintendent and board on or before the thirty-first day of December. If, after a period of nonparticipation, a carrier elects to participate in the open enrollment reinsurance program, the carrier retains the risks it assumed during the period when it was not participating.

(d) The superintendent may, at any time, authorize a carrier to modify an election not to participate if the risk from the carrier's open enrollment business jeopardizes the financial condition of the carrier. If the superintendent authorizes the carrier to again participate in the open enrollment reinsurance program, the carrier shall retain the risks it assumed during the period of nonparticipation.

(5)(a) The open enrollment reinsurance program shall be operated separately from the Ohio health reinsurance program.

(b) A carrier's election to participate in the open enrollment reinsurance program under division (G) of this section shall not be construed as an election to participate in the Ohio health reinsurance program under section 3924.07 of the Revised Code.

Sec. 3924.13. (A) Following the close of each calendar year, the

~~administering insurer~~ administrator of the Ohio health reinsurance program shall determine the net premiums, the program expenses for administration, and the incurred losses, if any, for the year, taking into account investment income and other appropriate gains and losses. For purposes of this section, health benefit plan premiums earned by MEWAs shall be established by adding paid claim losses and administrative expenses of the MEWA. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board of directors of the program to justify the cost of collection shall not be considered for purposes of determining assessments. For purposes of this division, "net premiums" means health benefit plan premiums, less administrative expense allowances.

(B) Any net loss for the year shall be recouped first by assessments of carriers in accordance with this division. Assessments shall be apportioned by the board among all carriers participating in the program in proportion to their respective shares of the total premiums, net of reinsurance premiums paid for coverage under this program earned in the state from health benefit plans covering small employers that are issued by participating members during the calendar year coinciding with or ending during the fiscal year of the program, or on any other equitable basis reflecting coverage of small employers as may be provided in the plan of operation. An assessment shall be made pursuant to this division against a health insuring corporation that is approved by the secretary of health and human services as a federally qualified health maintenance organization pursuant to the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, subject to an assessment adjustment formula adopted by the board for such health insuring corporations that recognizes the restrictions imposed on the entities by federal law. The adjustment formula shall be adopted by the board prior to the first anniversary of the program's operation. In no event shall the assessment made pursuant to this division exceed, on an annual basis, one per cent of the carrier's Ohio small employer group premium as reported on its most recent annual statement filed with the superintendent of insurance. If an excess is actuarially projected, the superintendent may take any action necessary to lower the assessment to the maximum level of one per cent.

(C) If assessments exceed actual losses and administrative expenses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this division, "future losses" includes reserves for incurred but not reported claims.

(D) Each carrier's proportion of participation in the program shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the carrier with the

board. MEWAs shall report to the board claims payments made and administrative expenses incurred in this state on an annual basis on a form prescribed by the superintendent.

(E) Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(F) A carrier may seek from the superintendent a deferment, in whole or in part, from any assessment issued by the board. The superintendent may defer, in whole or in part, the assessment of a carrier if, in the opinion of the superintendent, payment of the assessment would endanger the carrier's ability to fulfill its contractual obligations.

(G) In the event an assessment against a carrier is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessments set forth in this section. In such event, the other carriers assessed shall have a claim in the amount of the assessment against the carrier receiving the deferment. The carrier receiving the deferment shall remain liable to the program for the amount deferred. The superintendent may attach appropriate conditions to any deferment.

Sec. 3999.22. (A) As used in this section:

(1) "Claim" means any attempt to cause a health care insurer to make payment of a health care benefit.

(2) "Health care benefit" means the right under a contract or a certificate or policy of insurance to have a payment made by a health care insurer for a specified health care service.

(3) "Health care insurer" means any person that is authorized to do the business of sickness and accident insurance~~;~~, any ~~prepaid dental plan, medical care corporation, health care corporation, dental care corporation, or~~ health ~~maintenance organization;~~ insuring corporation, and any legal entity that is self-insured and provides health care benefits to its employees or members.

(B) No person shall knowingly solicit, offer, pay, or receive any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual for the furnishing of health care services or goods for which whole or partial reimbursement is or may be made by a health care insurer, except as authorized by the health care or health insurance contract, policy, or plan. This division does not apply to any of the following:

(1) Deductibles, copayments, or similar amounts owed by the person covered by the health care or health insurance contract, policy, or plan;

(2) Discounts or similar reductions in prices;

(3) Any amount paid within a bona fide legal entity, or within legal entities under common ownership or control, including any amount paid to an employee in a bona fide employment relationship;

(4) Any amount paid as part of a bona fide lease, management, or other business contract.

(C) Nothing in this section shall be construed to apply to any of the following:

(1) A provider who provides goods or services requested by an individual that are not covered by the individual's health care or health insurance contract, policy, or plan;

(2) A provider who, in good faith, provides goods or services ordered by another health care provider;

(3) A provider who, in good faith, resubmits a claim previously submitted that has not been paid or denied within thirty days of the original submission, if the provider notifies the payor or returns any duplicate payment within sixty days after receipt of the duplicate payment;

(4) A provider who, in good faith, makes a diagnosis that differs from the interpretation of a diagnosis reached by a health care insurer in the payment of claims.

(D) Whoever violates this section is guilty of a felony of the fifth degree on a first offense and a felony of the fourth degree on each subsequent offense.

Sec. 4503.104. In addition to the fees collected under sections 4503.10 and 4503.102 of the Revised Code, the registrar of motor vehicles or deputy registrar shall ask each person applying for or renewing a motor vehicle registration whether the person wishes to make a one-dollar voluntary contribution to the save our sight fund established under section 3701.18 of the Revised Code. Every application for registration or renewal notice shall state whether the owner of the motor vehicle wishes to make a one-dollar voluntary contribution to the save our sight fund established under section 3701.18 of the Revised Code. The registrar or deputy registrar shall also make available to each person applying for or renewing a motor vehicle registration informational materials on the importance of eye care and safety provided by the director of health under division (C)(2) of section 3701.18 of the Revised Code.

All donations collected under this section during each calendar quarter shall be forwarded by the registrar to the treasurer of state, who shall deposit them into the save our sight fund.

Sec. 4715.22. (A) As used in this section, "health care facility" means either of the following:

(1) A HOSPITAL REGISTERED UNDER SECTION 3701.07 OF THE REVISED CODE;

(2) A "HOME" AS DEFINED IN SECTION 3721.01 OF THE REVISED CODE.

(B) A licensed dental hygienist ~~may~~ shall practice under the supervision, order, control, and full responsibility of a dentist licensed under this chapter. A dental hygienist may practice in a dental office, public or private school, ~~hospital~~ health care facility, dispensary, or public institution~~, provided the service is rendered under the supervision of a licensed dentist of this state~~. Except as provided in division (C) or (D) of this section, a dental hygienist may not provide dental hygiene services to a patient when the supervising dentist is not physically present at the location where the dental hygienist is practicing.

(C) A dental hygienist may provide, for not more than fifteen consecutive business days, dental hygiene services to a patient when the supervising dentist is not physically present at the location at which the services are provided if all of the following requirements are met:

(1) The dental hygienist has at least two years and a minimum of three thousand hours of experience in the practice of dental hygiene.

(2) The dental hygienist has successfully completed a course approved by the state dental board in the identification and prevention of potential medical emergencies.

(3) The dental hygienist complies with written protocols for emergencies the supervising dentist establishes.

(4) The dental hygienist does not perform, while the supervising dentist is absent from the location, procedures while the patient is anesthetized, definitive root planing, definitive subgingival curettage, or other procedures identified in rules the state dental board adopts.

(5) The supervising dentist has evaluated the dental hygienist's skills.

(6) The supervising dentist examined the patient not more than seven months prior to the date the dental hygienist provides the dental hygiene services to the patient.

(7) The dental hygienist complies with written protocols or written standing orders that the supervising dentist establishes.

(8) The supervising dentist completed and evaluated a medical and dental history of the patient not more than one year prior to the date the dental hygienist provides dental hygiene services to the patient and, except when the dental hygiene services are provided in a health care facility, the supervising dentist determines that the patient is in a medically stable condition.

(9) If the dental hygiene services are provided in a health care facility, a doctor of medicine and surgery or osteopathic medicine and surgery who holds a current certificate issued under Chapter 4731. of the Revised Code or a registered nurse licensed under Chapter 4723. of the Revised Code is present in the health care facility when the services are provided.

(10) In advance of the appointment for dental hygiene services, the patient is notified that the supervising dentist will be absent from the location and that the dental hygienist cannot diagnose the patient's dental health care status.

(11) The dental hygienist is employed by, or under contract with, one of the following:

(a) The supervising dentist;

(b) A dentist licensed under this chapter who is one of the following:

(i) The employer of the supervising dentist;

(ii) A shareholder in a professional association formed under Chapter 1785. of the Revised Code of which the supervising dentist is a shareholder;

(iii) A member or manager of a limited liability company formed under Chapter 1705. of the Revised Code of which the supervising dentist is a member or manager;

(iv) A shareholder in a corporation formed under division (B) of section 1701.03 of the Revised Code of which the supervising dentist is a shareholder;

(v) A partner or employee of a partnership or a limited liability partnership formed under Chapter 1775. of the Revised Code of which the supervising dentist is a partner or employee.

(c) A government entity that employs the dental hygienist to provide dental hygiene services in a public school or in connection with other programs the government entity administers.

(D) A DENTAL HYGIENIST MAY PROVIDE DENTAL HYGIENE SERVICES TO A PATIENT WHEN THE SUPERVISING DENTIST IS NOT PHYSICALLY PRESENT AT THE LOCATION AT WHICH THE SERVICES ARE PROVIDED IF THE SERVICES ARE PROVIDED AS PART OF A DENTAL HYGIENE PROGRAM THAT IS APPROVED BY THE STATE DENTAL BOARD AND all of the following requirements are met:

(1) The program is OPERATED THROUGH A SCHOOL DISTRICT BOARD OF EDUCATION OR THE GOVERNING BOARD OF AN EDUCATIONAL SERVICE CENTER; THE BOARD OF HEALTH OF A CITY OR GENERAL HEALTH DISTRICT OR THE AUTHORITY HAVING THE DUTIES OF A BOARD OF HEALTH UNDER SECTION

3709.05 OF THE REVISED CODE; A NATIONAL, STATE, DISTRICT, OR LOCAL DENTAL ASSOCIATION; OR ANY OTHER PUBLIC OR PRIVATE ENTITY RECOGNIZED BY THE STATE DENTAL BOARD.

(2) THE SUPERVISING DENTIST IS EMPLOYED BY OR A VOLUNTEER FOR, AND THE PATIENTS ARE REFERRED BY, THE ENTITY THROUGH WHICH THE PROGRAM IS OPERATED.

(3) THE SERVICES ARE PERFORMED AFTER EXAMINATION AND DIAGNOSIS BY THE DENTIST AND IN ACCORDANCE WITH THE DENTIST'S WRITTEN TREATMENT PLAN.

(E) No person shall do either of the following:

(1) Practice dental hygiene in a manner that is separate or otherwise independent from the dental practice of a supervising dentist;

(2) Establish or maintain an office or practice that is primarily devoted to the provision of dental hygiene services.

(F) The state dental board shall adopt rules under division (C) of section 4715.03 of the Revised Code identifying procedures a dental hygienist may not perform when practicing in the absence of the supervising dentist pursuant to division (C) or (D) of this section.

Sec. 4715.39. (A) The state dental board may ~~adopt rules, in accordance with Chapter 119. of the Revised Code, defining~~ define the duties ~~which~~ that may be performed by dental assistants and other individuals designated by the board as qualified personnel~~, and may adopt rules establishing~~. If defined, the duties shall be defined in rules adopted in accordance with Chapter 119. of the Revised Code. The rules may include training and practice standards for dental assistants and other qualified personnel~~; such~~. The standards may include examination and issuance of a certificate. If the board issues a certificate, the recipient shall display the certificate in a conspicuous location in any office in which the recipient is employed to perform the duties authorized by the certificate.

The board's rules may allow a dental assistant to polish the clinical crowns of teeth IF all of the following requirements are met:

(1) The dental assistant's polishing activities are limited to the use of a rubber cup attached to a slow-speed rotary dental hand piece.

(2) The dentist supervising the assistant supervises not more than two dental assistants engaging in polishing activities at any given time.

(3) The dental assistant is certified by the dental assisting national board or the Ohio commission on dental assistant certification.

(4) The dental assistant receives a certificate from the board authorizing the assistant to engage in the polishing activities. The board may issue the certificate only if the individual has SUCCESSFULLY COMPLETED

AINING IN THE POLISHING OF CLINICAL CROWNS through A PROGRAM ACCREDITED BY THE COMMISSION ON DENTAL ACCREDITATION OR EQUIVALENT TRAINING APPROVED BY THE BOARD. THE TRAINING SHALL INCLUDE COURSES IN BASIC DENTAL ANATOMY AND INFECTION CONTROL, FOLLOWED BY A COURSE IN CORONAL POLISHING THAT INCLUDES didactic, preclinical, and CLINICAL TRAINING; ANY OTHER training REQUIRED BY THE BOARD; and a skills assessment that includes successful completion of standardized testing.

(B) Subject to the rules of the board, licensed dentists may assign to dental assistants and other qualified personnel dental procedures that do not require the professional competence or skill of the licensed dentist or dental hygienist as the board by rule authorizes ~~such~~ dental assistants and other qualified personnel to perform. The performance of dental procedures by dental assistants and other qualified personnel shall be under direct supervision and full responsibility of the licensed dentist.

(C) Nothing in this section shall be construed by rule of the state dental board or otherwise to ~~authorize "~~ do the following:

(1) Authorize dental assistants or other qualified personnel~~" as that term is used in this section~~ to engage in the practice of dental hygiene as defined by sections 4715.22 and 4715.23 of the Revised Code or to perform the duties of a dental hygienist, including the removal of calcarious deposits or accretions on the crowns and roots of teeth~~, or as authorizing;~~

(2) Authorize the assignment of ~~diagnosis, treatment~~ any of the following:

(a) Diagnosis;

(b) Treatment planning and prescription ~~(~~, including prescription for drugs and medicaments or authorization for restorative, prosthodontic, or orthodontic appliances~~), or surgical~~;

(c) Surgical procedures on hard or soft tissue of the oral cavity, or any other intraoral procedure that contributes to or results in an irremediable alteration of the oral anatomy ~~or the~~;

(d) The making of final impressions from which casts are made to construct any dental restoration.

(D) No dentist shall assign any dental assistant or other individual acting in the capacity of qualified personnel to perform any dental procedure ~~such personnel are~~ that the assistant or other individual is not authorized by board rule to perform. No dental assistant or other individual acting in the capacity of qualified personnel shall perform any dental procedure other than in accordance with board rule or any dental procedure that ~~such personnel are~~

the assistant or other individual is not authorized by board rule to perform.

Sec. 4723.16. (A) An individual whom the board of nursing licenses, certificates, or otherwise legally authorizes to engage in the practice of nursing as a registered nurse or as a licensed practical nurse may render the professional services of a registered or licensed practical nurse within this state through a corporation formed under division (B) of section 1701.03 of the Revised Code, a limited liability company formed under Chapter 1705. of the Revised Code, a partnership, or a professional association formed under Chapter 1785. of the Revised Code. This division does not preclude an individual of that nature from rendering professional services as a registered or licensed practical nurse through another form of business entity, including, but not limited to, a nonprofit corporation or foundation, or in another manner that is authorized by or in accordance with this chapter, another chapter of the Revised Code, or rules of the board of nursing adopted pursuant to this chapter.

(B) A corporation, limited liability company, partnership, or professional association described in division (A) of this section may be formed for the purpose of providing a combination of the professional services of the following individuals who are licensed, certificated, or otherwise legally authorized to practice their respective professions:

(1) Optometrists who are authorized to practice optometry under Chapter 4725. of the Revised Code;

(2) Chiropractors who are authorized to practice chiropractic under Chapter 4734. of the Revised Code;

(3) Psychologists who are authorized to practice psychology under Chapter 4732. of the Revised Code;

(4) Registered or licensed practical nurses who are authorized to practice nursing as registered nurses or as licensed practical nurses under this chapter;

(5) Pharmacists who are authorized to practice pharmacy under Chapter 4729. of the Revised Code;

(6) Physical therapists who are authorized to practice physical therapy under sections 4755.40 to 4755.53 of the Revised Code;

(7) Mechanotherapists who are authorized to practice mechanotherapy under section 4731.151 of the Revised Code;

(8) Doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are licensed, certificated, or otherwise legally authorized for their respective practices under Chapter 4731. of the Revised Code.

This division shall apply notwithstanding a provision of a code of ethics

applicable to a nurse that prohibits a registered or licensed practical nurse from engaging in the practice of nursing as a registered nurse or as a licensed practical nurse in combination with a person who is licensed, certificated, or otherwise legally authorized to practice optometry, chiropractic, psychology, pharmacy, physical therapy, mechanotherapy, medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, but who is not also licensed, certificated, or otherwise legally authorized to engage in the practice of nursing as a registered nurse or as a licensed practical nurse.

Sec. 4725.114. (A) An individual whom the state board of optometry licenses, certificates, or otherwise legally authorizes to engage in the practice of optometry may render the professional services of an optometrist within this state through a corporation formed under division (B) of section 1701.03 of the Revised Code, a limited liability company formed under Chapter 1705. of the Revised Code, a partnership, or a professional association formed under Chapter 1785. of the Revised Code. This division does not preclude an individual of that nature from rendering professional services as an optometrist through another form of business entity, including, but not limited to, a nonprofit corporation or foundation, or in another manner that is authorized by or in accordance with this chapter, another chapter of the Revised Code, or rules of the state board of optometry adopted pursuant to this chapter.

(B) A corporation, limited liability company, partnership, or professional association described in division (A) of this section may be formed for the purpose of providing a combination of the professional services of the following individuals who are licensed, certificated, or otherwise legally authorized to practice their respective professions:

(1) Optometrists who are authorized to practice optometry under Chapter 4725. of the Revised Code;

(2) Chiropractors who are authorized to practice chiropractic under Chapter 4734. of the Revised Code;

(3) Psychologists who are authorized to practice psychology under Chapter 4732. of the Revised Code;

(4) Registered or licensed practical nurses who are authorized to practice nursing as registered nurses or as licensed practical nurses under Chapter 4723. of the Revised Code;

(5) Pharmacists who are authorized to practice pharmacy under Chapter 4729. of the Revised Code;

(6) Physical therapists who are authorized to practice physical therapy under sections 4755.40 to 4755.53 of the Revised Code;

(7) Mechanotherapists who are authorized to practice mechanotherapy under section 4731.151 of the Revised Code;

(8) Doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are authorized for their respective practices under Chapter 4731. of the Revised Code.

This division shall apply notwithstanding a provision of a code of ethics applicable to an optometrist that prohibits an optometrist from engaging in the practice of optometry in combination with a person who is licensed, certificated, or otherwise legally authorized to practice chiropractic, psychology, nursing, pharmacy, physical therapy, mechanotherapy, medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, but who is not also licensed, certificated, or otherwise legally authorized to engage in the practice of optometry.

Sec. 4729.161. (A) An individual registered with the state board of pharmacy to engage in the practice of pharmacy may render the professional services of a pharmacist within this state through a corporation formed under division (B) of section 1701.03 of the Revised Code, a limited liability company formed under Chapter 1705. of the Revised Code, a partnership, or a professional association formed under Chapter 1785. of the Revised Code. This division does not preclude an individual of that nature from rendering professional services as a pharmacist through another form of business entity, including, but not limited to, a nonprofit corporation or foundation, or in another manner that is authorized by or in accordance with this chapter, another chapter of the Revised Code, or rules of the state board of pharmacy adopted pursuant to this chapter.

(B) A corporation, limited liability company, partnership, or professional association described in division (A) of this section may be formed for the purpose of providing a combination of the professional services of the following individuals who are licensed, certificated, or otherwise legally authorized to practice their respective professions:

(1) Optometrists who are authorized to practice optometry under Chapter 4725. of the Revised Code;

(2) Chiropractors who are authorized to practice chiropractic under Chapter 4734. of the Revised Code;

(3) Psychologists who are authorized to practice psychology under Chapter 4732. of the Revised Code;

(4) Registered or licensed practical nurses who are authorized to practice nursing as registered nurses or as licensed practical nurses under Chapter 4723. of the Revised Code;

(5) Pharmacists who are authorized to practice pharmacy under Chapter

4729. of the Revised Code;

(6) Physical therapists who are authorized to practice physical therapy under sections 4755.40 to 4755.53 of the Revised Code;

(7) Mechanotherapists who are authorized to practice mechanotherapy under section 4731.151 of the Revised Code;

(8) Doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are authorized for their respective practices under Chapter 4731. of the Revised Code.

This division shall apply notwithstanding a provision of a code of ethics applicable to a pharmacist that prohibits a pharmacist from engaging in the practice of pharmacy in combination with a person who is licensed, certificated, or otherwise legally authorized to practice optometry, chiropractic, psychology, nursing, physical therapy, mechanotherapy, medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, but who is not also licensed, certificated, or otherwise legally authorized to engage in the practice of pharmacy.

Sec. 4731.226. (A)(1) An individual whom the state medical board licenses, certificates, or otherwise legally authorizes to engage in the practice of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery may render the professional services of a doctor of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery within this state through a corporation formed under division (B) of section 1701.03 of the Revised Code, a limited liability company formed under Chapter 1705. of the Revised Code, a partnership, or a professional association formed under Chapter 1785. of the Revised Code. ~~This division~~ Division (A)(1) of this section does not preclude an individual of that nature from rendering professional services as a doctor of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery through another form of business entity, including, but not limited to, a nonprofit corporation or foundation, or in another manner that is authorized by or in accordance with this chapter, another chapter of the Revised Code, or rules of the state medical board adopted pursuant to this chapter.

(2) An individual whom the state medical board authorizes to engage in the practice of mechanotherapy may render the professional services of a mechanotherapist within this state through a corporation formed under division (B) of section 1701.03 of the Revised Code, a limited liability company formed under Chapter 1705. of the Revised Code, a partnership, or a professional association formed under Chapter 1785. of the Revised Code. Division (A)(2) of this section does not preclude an individual of that nature

from rendering professional services as a mechanotherapist through another form of business entity, including, but not limited to, a nonprofit corporation or foundation, or in another manner that is authorized by or in accordance with this chapter, another chapter of the Revised Code, or rules of the state medical board adopted pursuant to this chapter.

(B) A corporation, limited liability company, partnership, or professional association described in division (A) of this section may be formed for the purpose of providing a combination of the professional services of the following individuals who are licensed, certificated, or otherwise legally authorized to practice their respective professions:

(1) Optometrists who are authorized to practice optometry under Chapter 4725. of the Revised Code;

(2) Chiropractors who are authorized to practice chiropractic under Chapter 4734. of the Revised Code;

(3) Psychologists who are authorized to practice psychology under Chapter 4732. of the Revised Code;

(4) Registered or licensed practical nurses who are authorized to practice nursing as registered nurses or as licensed practical nurses under Chapter 4723. of the Revised Code;

(5) Pharmacists who are authorized to practice pharmacy under Chapter 4729. of the Revised Code;

(6) Physical therapists who are authorized to practice physical therapy under sections 4755.40 to 4755.53 of the Revised Code;

(7) Mechanotherapists who are authorized to practice mechanotherapy under section 4731.151 of the Revised Code;

(8) Doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are authorized for their respective practices under this chapter.

~~This division~~ (C) Division (B) of this section shall apply notwithstanding a provision of a code of ethics described in division (B)(18) of section 4731.22 of the Revised Code that prohibits ~~a~~ either of the following:

(1) A doctor of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery from engaging in the doctor's authorized practice in combination with a person who is licensed, certificated, or otherwise legally authorized to engage in the practice of optometry, chiropractic, psychology, nursing, pharmacy, ~~or~~ physical therapy, or mechanotherapy, but who is not also licensed, certificated, or otherwise legally authorized to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery.

(2) A mechanotherapist from engaging in the practice of mechanotherapy in combination with a person who is licensed, certificated, or otherwise legally authorized to engage in the practice of optometry, chiropractic, psychology, nursing, pharmacy, physical therapy, medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, but who is not also licensed, certificated, or otherwise legally authorized to engage in the practice of mechanotherapy.

Sec. 4731.65. As used in sections 4731.65 to 4731.71 of the Revised Code:

(A)(1) "Clinical laboratory services" means either of the following:

(a) Any examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment or for the assessment of health;

(b) Procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.

(2) "Clinical laboratory services" does not include the mere collection or preparation of specimens.

(B) "Designated health services" means any of the following:

(1) Clinical laboratory services;

(2) Home health care services;

(3) Outpatient prescription drugs.

(C) "Fair market value" means the value in arms-length transactions, consistent with general market value and:

(1) With respect to rentals or leases, the value of rental property for general commercial purposes, not taking into account its intended use;

(2) With respect to a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor if the lessor is a potential source of referrals to the lessee.

(D) "Governmental health care program" means any program providing health care benefits that is administered by the federal government, this state, or a political subdivision of this state, including the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, health care coverage for public employees, health care benefits administered by the bureau of workers' compensation, the medical assistance program established under Chapter 5111. of the Revised Code, and disability assistance medical assistance established under Chapter 5115. of the Revised Code.

(E)(1) "Group practice" means a group of two or more holders of certificates under this chapter legally organized as a partnership,

professional corporation or association, limited liability company, foundation, nonprofit corporation, faculty practice plan, or similar group practice entity, including an organization comprised of a nonprofit medical clinic that contracts with a professional corporation or association of physicians to provide medical services exclusively to patients of the clinic in order to comply with section 1701.03 of the Revised Code and including a corporation, limited liability company, partnership, or professional association described in division (B) of section 4731.226 of the Revised Code formed for the purpose of providing a combination of the professional services of optometrists who are licensed, certificated, or otherwise legally authorized to practice optometry under Chapter 4725. of the Revised Code, chiropractors who are licensed, certificated, or otherwise legally authorized to practice chiropractic under Chapter 4734. of the Revised Code, psychologists who are licensed, certificated, or otherwise legally authorized to practice psychology under Chapter 4732. of the Revised Code, registered or licensed practical nurses who are licensed, certificated, or otherwise legally authorized to practice nursing under Chapter 4723. of the Revised Code, pharmacists who are licensed, certificated, or otherwise legally authorized to practice pharmacy under Chapter 4729. of the Revised Code, physical therapists who are licensed, certificated, or otherwise legally authorized to practice physical therapy under sections 4755.40 to 4755.53 of the Revised Code, mechanotherapists who are licensed, certificated, or otherwise legally authorized to practice mechanotherapy under section 4731.151 of the Revised Code, and ~~of~~ doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are licensed, certificated, or otherwise legally authorized for their respective practices under this chapter, to which all of the following apply:

(a) Each physician who is a member of the group practice provides substantially the full range of services that the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel.

(b) Substantially all of the services of the members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group.

(c) The overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group.

(d) The group practice meets any other requirements that the state medical board applies in rules adopted under section 4731.70 of the Revised Code.

(2) In the case of a faculty practice plan associated with a hospital with a medical residency training program in which physician members may provide a variety of specialty services and provide professional services both within and outside the group, as well as perform other tasks such as research, the criteria in division (E)(1) of this section apply only with respect to services rendered within the faculty practice plan.

(F) "Home health care services" and "immediate family" have the same meanings as in the rules adopted under section 4731.70 of the Revised Code.

(G) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.

(H) A "referral" includes both of the following:

(1) A request by a holder of a certificate under this chapter for an item or service, including a request for a consultation with another physician and any test or procedure ordered by or to be performed by or under the supervision of the other physician;

(2) A request for or establishment of a plan of care by a certificate holder that includes the provision of designated health services.

(I) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code.

Sec. 4732.28. (A) An individual whom the state board of psychology licenses, certificates, or otherwise legally authorizes to engage in the practice of psychology may render the professional services of a psychologist within this state through a corporation formed under division (B) of section 1701.03 of the Revised Code, a limited liability company formed under Chapter 1705. of the Revised Code, a partnership, or a professional association formed under Chapter 1785. of the Revised Code. This division does not preclude an individual of that nature from rendering professional services as a psychologist through another form of business entity, including, but not limited to, a nonprofit corporation or foundation, or in another manner that is authorized by or in accordance with this chapter, another chapter of the Revised Code, or rules of the state board of psychology adopted pursuant to this chapter.

(B) A corporation, limited liability company, partnership, or professional association described in division (A) of this section may be formed for the purpose of providing a combination of the professional services of the following individuals who are licensed, certificated, or otherwise legally authorized to practice their respective professions:

(1) Optometrists who are authorized to practice optometry under Chapter 4725. of the Revised Code;

(2) Chiropractors who are authorized to practice chiropractic under Chapter 4734. of the Revised Code;

(3) Psychologists who are authorized to practice psychology under this chapter;

(4) Registered or licensed practical nurses who are authorized to practice nursing as registered nurses or as licensed practical nurses under Chapter 4723. of the Revised Code;

(5) Pharmacists who are authorized to practice pharmacy under Chapter 4729. of the Revised Code;

(6) Physical therapists who are authorized to practice physical therapy under sections 4755.40 to 4755.53 of the Revised Code;

(7) Mechanotherapists who are authorized to practice mechanotherapy under section 4731.151 of the Revised Code;

(8) Doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are authorized for their respective practices under Chapter 4731. of the Revised Code.

This division shall apply notwithstanding a provision of a code of ethics applicable to a psychologist that prohibits a psychologist from engaging in the practice of psychology in combination with a person who is licensed, certificated, or otherwise legally authorized to practice optometry, chiropractic, nursing, pharmacy, physical therapy, mechanotherapy, medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, but who is not also licensed, certificated, or otherwise legally authorized to engage in the practice of psychology.

Sec. 4734.091. (A) An individual whom the chiropractic examining board licenses, certificates, or otherwise legally authorizes to engage in the practice of chiropractic may render the professional services of a chiropractor within this state through a corporation formed under division (B) of section 1701.03 of the Revised Code, a limited liability company formed under Chapter 1705. of the Revised Code, a partnership, or a professional association formed under Chapter 1785. of the Revised Code. This division does not preclude an individual of that nature from rendering professional services as a chiropractor through another form of business entity, including, but not limited to, a nonprofit corporation or foundation, or in another manner that is authorized by or in accordance with this chapter, another chapter of the Revised Code, or rules of the chiropractic examining board adopted pursuant to this chapter.

(B) A corporation, limited liability company, partnership, or professional association described in division (A) of this section may be formed for the purpose of providing a combination of the professional

ces of the following individuals who are licensed, certificated, or otherwise legally authorized to practice their respective professions:

(1) Optometrists who are authorized to practice optometry, under Chapter 4725. of the Revised Code;

(2) Chiropractors who are authorized to practice chiropractic under this chapter;

(3) Psychologists who are authorized to practice psychology under Chapter 4732. of the Revised Code;

(4) Registered or licensed practical nurses who are authorized to practice nursing as registered nurses or as licensed practical nurses under Chapter 4723. of the Revised Code;

(5) Pharmacists who are authorized to practice pharmacy under Chapter 4729. of the Revised Code;

(6) Physical therapists who are authorized to practice physical therapy under sections 4755.40 to 4755.53 of the Revised Code;

(7) Mechanotherapists who are authorized to practice mechanotherapy under section 4731.151 of the Revised Code;

(8) Doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are authorized for their respective practices under Chapter 4731. of the Revised Code.

This division shall apply notwithstanding a provision of a code of ethics described in division (A)(9) of section 4734.10 of the Revised Code that prohibits an individual from engaging in the practice of chiropractic in combination with a person who is licensed, certificated, or otherwise authorized for the practice of optometry, psychology, nursing, pharmacy, physical therapy, mechanotherapy, medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, but who is not also licensed, certificated, or otherwise legally authorized to engage in the practice of chiropractic.

Sec. 4755.471. (A) An individual whom the physical therapy section of the Ohio occupational therapy, physical therapy, and athletic trainers board licenses, certificates, or otherwise legally authorizes to engage in the practice of physical therapy may render the professional services of a physical therapist within this state through a corporation formed under division (B) of section 1701.03 of the Revised Code, a limited liability company formed under Chapter 1705. of the Revised Code, a partnership, or a professional association formed under Chapter 1785. of the Revised Code. This division does not preclude an individual of that nature from rendering professional services as a physical therapist through another form of business entity, including, but not limited to, a nonprofit corporation or

foundation, or in another manner that is authorized by or in accordance with sections 4755.40 to 4755.53 of the Revised Code, another chapter of the Revised Code, or rules of the Ohio occupational therapy, physical therapy, and athletic trainers board adopted pursuant to sections 4755.40 to 4755.53 of the Revised Code.

(B) A corporation, limited liability company, partnership, or professional association described in division (A) of this section may be formed for the purpose of providing a combination of the professional services of the following individuals who are licensed, certificated, or otherwise legally authorized to practice their respective professions:

(1) Optometrists who are authorized to practice optometry under Chapter 4725. of the Revised Code;

(2) Chiropractors who are authorized to practice chiropractic under Chapter 4734. of the Revised Code;

(3) Psychologists who are authorized to practice psychology under Chapter 4732. of the Revised Code;

(4) Registered or licensed practical nurses who are authorized to practice nursing as registered nurses or as licensed practical nurses under Chapter 4723. of the Revised Code;

(5) Pharmacists who are authorized to practice pharmacy under Chapter 4729. of the Revised Code;

(6) Physical therapists who are authorized to practice physical therapy under sections 4755.40 to 4755.53 of the Revised Code;

(7) Mechanotherapists who are authorized to practice mechanotherapy under section 4731.151 of the Revised Code;

(8) Doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are authorized for their respective practices under Chapter 4731. of the Revised Code.

This division shall apply notwithstanding a provision of a code of ethics applicable to a physical therapist that prohibits a physical therapist from engaging in the practice of physical therapy in combination with a person who is licensed, certificated, or otherwise legally authorized to practice optometry, chiropractic, psychology, nursing, pharmacy, mechanotherapy, medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, but who is not also licensed, certificated, or otherwise legally authorized to engage in the practice of physical therapy.

Sec. 5111.25. (A) The department of human services shall pay each eligible nursing facility a per resident per day rate for its reasonable capital costs established prospectively each fiscal year for each facility. Except as otherwise provided in sections 5111.20 to 5111.32 of the Revised Code, the

rate shall be based on the facility's capital costs for the calendar year preceding the fiscal year in which the rate will be paid. The rate shall equal the sum of divisions (A)(1) to (3) of this section:

(1) The lesser of the following:

(a) Eighty-eight and sixty-five one-hundredths per cent of the facility's desk-reviewed, actual, allowable, per diem cost of ownership and eighty-five per cent of the facility's actual, allowable, per diem cost of nonextensive renovation determined under division (F) of this section;

(b) Eighty-eight and sixty-five one-hundredths per cent of the following limitation:

(i) For the fiscal year beginning July 1, 1993, sixteen dollars per resident day;

(ii) For the fiscal year beginning July 1, 1994, sixteen dollars per resident day, adjusted to reflect the rate of inflation for the twelve-month period beginning July 1, 1992, and ending June 30, 1993, using the consumer price index for shelter costs for all urban consumers for the north central region, published by the United States bureau of labor statistics;

(iii) For subsequent fiscal years, the limitation in effect during the previous fiscal year, adjusted to reflect the rate of inflation for the twelve-month period beginning on the first day of July for the calendar year preceding the calendar year that precedes the fiscal year and ending on the following thirtieth day of June, using the consumer price index for shelter costs for all urban consumers for the north central region, published by the United States bureau of labor statistics.

(2) Any efficiency incentive determined under division (D) of this section;

(3) Any amounts for return on equity determined under division (H) of this section.

Buildings shall be depreciated using the straight line method over forty years or over a different period approved by the department. Components and equipment shall be depreciated using the straight-line method over a period designated in rules adopted by the department in accordance with Chapter 119. of the Revised Code, consistent with the guidelines of the American hospital association, or over a different period approved by the department. Any rules adopted under this division that specify useful lives of buildings, components, or equipment apply only to assets acquired on or after July 1, 1993. Depreciation for costs paid or reimbursed by any government agency shall not be included in cost of ownership or renovation unless that part of the payment under sections 5111.20 to 5111.32 of the Revised Code is used to reimburse the government agency.

(B) The capital cost basis of nursing facility assets shall be determined in the following manner:

(1) For purposes of calculating the rate to be paid for the fiscal year beginning July 1, 1993, for facilities with dates of licensure on or before June 30, 1993, the capital cost basis shall be equal to the following:

(a) For facilities that have not had a change of ownership during the period beginning January 1, 1993 and ending June 30, 1993, the desk-reviewed, actual, allowable capital cost basis that is listed on the facility's cost report for the cost reporting period ending December 31, 1992, plus the actual, allowable capital cost basis of any assets constructed or acquired after December 31, 1992, but before July 1, 1993, if the aggregate capital costs of those assets would increase the facility's rate for capital costs by twenty or more cents per resident per day.

(b) For facilities that have a date of licensure or had a change of ownership during the period beginning January 1, 1993, and ending June 30, 1993, the actual, allowable capital cost basis of the person or government entity that owns the facility on June 30, 1993.

Capital cost basis shall be calculated as provided in division (B)(1) of this section subject to approval by the United States health care financing administration of any necessary amendment to the state plan for providing medical assistance.

The department shall include the actual, allowable capital cost basis of assets constructed or acquired during the period beginning January 1, 1993, and ending June 30, 1993, in the calculation for the facility's rate effective July 1, 1993, if the aggregate capital costs of the assets would increase the facility's rate by twenty or more cents per resident per day and the facility provides the department with sufficient documentation of the costs before June 1, 1993. If the facility provides the documentation after that date, the department shall adjust the facility's rate to reflect the costs of the assets one month after the first day of the month after the department receives the documentation.

(2) Except as provided in division (B)(4) of this section, for purposes of calculating the rates to be paid for fiscal years beginning after June 30, 1994, for facilities with dates of licensure on or before June 30, 1993, the capital cost basis of each asset shall be equal to the desk-reviewed, actual, allowable, capital cost basis that is listed on the facility's cost report for the calendar year preceding the fiscal year during which the rate will be paid.

(3) For facilities with dates of licensure after June 30, 1993, the capital cost basis shall be determined in accordance with the principles of the medicare program established under Title XVIII of the "Social Security

Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, except as otherwise provided in sections 5111.20 to 5111.32 of the Revised Code.

(4) ~~If~~ Except as provided in division (B)(5) of this section, if a provider transfers an interest in a facility to another provider after June 30, 1993, there shall be no increase in the capital cost basis of the asset if the providers are related parties. If the providers are not related parties or if they are related parties and division (B)(5) of this section requires the adjustment of the capital cost basis under this division, the basis of the asset shall be adjusted by the lesser of the following:

(a) One-half of the change in construction costs during the time that the transferor held the asset, as calculated by the department of human services using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time that the transferor held the asset.

(5) If a provider transfers an interest in a facility to another provider who is a related party, the capital cost basis of the asset shall be adjusted as specified in division (B)(4) of this section for a transfer to a provider that is not a related party if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) The provider making the transfer retains no ownership interest in the facility;

(c) The United States internal revenue service has issued a ruling that the transfer is an arm's length transaction for purposes of federal income taxation;

(d) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was adjusted most recently under division (B)(5) of this section or actual, allowable cost of ownership was determined most recently under division (C)(9) of this section.

(C) As used in this division, "lease expense" means lease payments in the case of an operating lease and depreciation expense and interest expense in the case of a capital lease. As used in this division, "new lease" means a lease, to a different lessee, of a nursing facility that previously was operated under a lease.

(1) Subject to the limitation specified in division (A)(1) of this section, for a lease of a facility that was effective on May 27, 1992, the entire lease

expense is an actual, allowable cost of ownership during the term of the existing lease. The entire lease expense also is an actual, allowable cost of ownership if a lease in existence on May 27, 1992, is renewed under either of the following circumstances:

(a) The renewal is pursuant to a renewal option that was in existence on May 27, 1992;

(b) The renewal is for the same lease payment amount and between the same parties as the lease in existence on May 27, 1992.

(2) Subject to the limitation specified in division (A)(1) of this section, for a lease of a facility that was in existence but not operated under a lease on May 27, 1992, actual, allowable cost of ownership shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the lessor's entire historical capital asset cost basis, adjusted by the lesser of the following amounts:

(a) One-half of the change in construction costs during the time the lessor held each asset until the beginning of the lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease.

(3) Subject to the limitation specified in division (A)(1) of this section, for a lease of a facility with a date of licensure on or after May 27, 1992, that is initially operated under a lease, actual, allowable cost of ownership shall include the annual lease expense if there was a substantial commitment of money for construction of the facility after December 22, 1992, and before July 1, 1993. If there was not a substantial commitment of money after December 22, 1992, and before July 1, 1993, actual, allowable cost of ownership shall include the lesser of the annual lease expense or the sum of the following:

(a) The annual depreciation expense that would be calculated at the inception of the lease using the lessor's entire historical capital asset cost basis;

(b) The greater of the lessor's actual annual amortization of financing costs and interest expense at the inception of the lease or the imputed interest expense calculated at the inception of the lease using seventy per cent of the lessor's historical capital asset cost basis.

(4) Subject to the limitation specified in division (A)(1) of this section,

for a lease of a facility with a date of licensure on or after May 27, 1992, that was not initially operated under a lease and has been in existence for ten years, actual, allowable cost of ownership shall include the lesser of the annual lease expense or the annual depreciation expense and imputed interest expense that would be calculated at the inception of the lease using the entire historical capital asset cost basis of the lessor, adjusted by the lesser of the following:

(a) One-half of the change in construction costs during the time the lessor held each asset until the beginning of the lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, during the time the lessor held each asset until the beginning of the lease.

(5) Subject to the limitation specified in division (A)(1) of this section, for a new lease of a facility that was operated under a lease on May 27, 1992, actual, allowable cost of ownership shall include the lesser of the annual new lease expense or the annual old lease payment. If the old lease was in effect for ten years or longer, the old lease payment from the beginning of the old lease shall be adjusted by the lesser of the following:

(a) One-half of the change in construction costs from the beginning of the old lease to the beginning of the new lease, as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, from the beginning of the old lease to the beginning of the new lease.

(6) Subject to the limitation specified in division (A)(1) of this section, for a new lease of a facility that was not in existence or that was in existence but not operated under a lease on May 27, 1992, actual, allowable cost of ownership shall include the lesser of annual new lease expense or the annual amount calculated for the old lease under division (C)(2), (3), (4), or (6) of this section, as applicable. If the old lease was in effect for ten years or longer, the lessor's historical capital asset cost basis shall be adjusted by the lesser of the following for purposes of calculating the annual amount under division (C)(2), (3), (4), or (6) of this section:

(a) One-half of the change in construction costs from the beginning of the old lease to the beginning of the new lease, as calculated by the

artment using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift;

(b) One-half of the change in the consumer price index for all items for all urban consumers, as published by the United States bureau of labor statistics, from the beginning of the old lease to the beginning of the new lease.

In the case of a lease under division (C)(3) of this section of a facility for which a substantial commitment of money was made after December 22, 1992, and before July 1, 1993, the old lease payment shall be adjusted for the purpose of determining the annual amount.

(7) For any revision of a lease described in division (C)(1), (2), (3), (4), (5), or (6) of this section, or for any subsequent lease of a facility operated under such a lease, other than execution of a new lease, the portion of actual, allowable cost of ownership attributable to the lease shall be the same as before the revision or subsequent lease.

(8) Except as provided in division (C)(9) of this section, if a provider leases an interest in a facility to another provider who is a related party, the related party's actual, allowable cost of ownership shall include the lesser of the annual lease expense or the reasonable cost to the lessor.

(9) If a provider leases an interest in a facility to another provider who is a related party, regardless of the date of the lease, the related party's actual, allowable cost of ownership shall include the annual lease expense, subject to the limitations specified in divisions (C)(1) to (7) of this section, if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) If the lessor retains an ownership interest, it is in only the real property and any improvements on the real property;

(c) The United States internal revenue service has issued a ruling that the lease is an arm's length transaction for purposes of federal income taxation;

(d) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was adjusted most recently under division (B)(5) of this section or actual, allowable cost of ownership was determined most recently under division (C)(9) of this section.

(10) This division does not apply to leases of specific items of equipment.

(D)(1) Subject to division (D)(2) of this section, the department shall pay each nursing facility an efficiency incentive that is equal to fifty per cent

of the difference between the following:

(a) Eighty-eight and sixty-five one-hundredths per cent of the facility's desk-reviewed, actual, allowable, per diem cost of ownership;

(b) The applicable amount specified in division (E) of this section.

(2) The efficiency incentive paid to a nursing facility shall not exceed the greater of the following:

(a) The efficiency incentive the facility was paid during the fiscal year ending June 30, 1994;

(b) Three dollars per resident per day, adjusted annually for rates paid beginning July 1, 1994, for the inflation rate for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year for which the efficiency incentive is determined and ending on the thirtieth day of the following June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(3) For purposes of calculating the efficiency incentive, depreciation for costs that are paid or reimbursed by any government agency shall be considered as costs of ownership, and renovation costs that are paid under division (F) of this section shall not be considered costs of ownership.

(E) The following amounts shall be used to calculate efficiency incentives for nursing facilities under this section:

(1) For facilities with dates of licensure prior to January 1, 1958, four dollars and twenty-four cents per patient day;

(2) For facilities with dates of licensure after December 31, 1957, but prior to January 1, 1968:

(a) Five dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or more per bed;

(b) Four dollars and twenty-four cents per patient day if the cost of construction was less than three thousand five hundred dollars per bed.

(3) For facilities with dates of licensure after December 31, 1967, but prior to January 1, 1976:

(a) Six dollars and twenty-four cents per patient day if the cost of construction was five thousand one hundred fifty dollars or more per bed;

(b) Five dollars and twenty-four cents per patient day if the cost of construction was less than five thousand one hundred fifty dollars per bed, but exceeded three thousand five hundred dollars per bed;

(c) Four dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(4) For facilities with dates of licensure after December 31, 1975, but prior to January 1, 1979:

(a) Seven dollars and twenty-four cents per patient day if the cost of construction was six thousand eight hundred dollars or more per bed;

(b) Six dollars and twenty-four cents per patient day if the cost of construction was less than six thousand eight hundred dollars per bed but exceeded five thousand one hundred fifty dollars per bed;

(c) Five dollars and twenty-four cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less per bed, but exceeded three thousand five hundred dollars per bed;

(d) Four dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(5) For facilities with dates of licensure after December 31, 1978, but prior to January 1, 1981:

(a) Seven dollars and seventy-four cents per patient day if the cost of construction was seven thousand six hundred twenty-five dollars or more per bed;

(b) Seven dollars and twenty-four cents per patient day if the cost of construction was less than seven thousand six hundred twenty-five dollars per bed but exceeded six thousand eight hundred dollars per bed;

(c) Six dollars and twenty-four cents per patient day if the cost of construction was six thousand eight hundred dollars or less per bed but exceeded five thousand one hundred fifty dollars per bed;

(d) Five dollars and twenty-four cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less but exceeded three thousand five hundred dollars per bed;

(e) Four dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(6) For facilities with dates of licensure in 1981 or any year thereafter prior to December 22, 1992, the following amount:

(a) For facilities with construction costs less than seven thousand six hundred twenty-five dollars per bed, the applicable amounts for the construction costs specified in divisions (E)(5)(b) to (e) of this section;

(b) For facilities with construction costs of seven thousand six hundred twenty-five dollars or more per bed, six dollars per patient day, provided that for 1981 and annually thereafter prior to December 22, 1992, department shall do both of the following to the six-dollar amount:

(i) Adjust the amount for fluctuations in construction costs calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift, using 1980 as the base year;

(ii) Increase the amount, as adjusted for inflation under division

)(b)(i) of this section, by one dollar and seventy-four cents.

(7) For facilities with dates of licensure on or after January 1, 1992, seven dollars and ninety-seven cents, adjusted for fluctuations in construction costs between 1991 and 1993 as calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift, and then increased by one dollar and seventy-four cents.

For the fiscal year that begins July 1, 1994, each of the amounts listed in divisions (E)(1) to (7) of this section shall be increased by twenty-five cents. For the fiscal year that begins July 1, 1995, each of those amounts shall be increased by an additional twenty-five cents. For subsequent fiscal years, each of those amounts, as increased for the prior fiscal year, shall be adjusted to reflect the rate of inflation for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year and ending on the following thirtieth day of June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

If the amount established for a nursing facility under this division is less than the amount that applied to the facility under division (B) of former section 5111.25 of the Revised Code, as the former section existed immediately prior to December 22, 1992, the amount used to calculate the efficiency incentive for the facility under division (D)(2) of this section shall be the amount that was calculated under division (B) of the former section.

(F) Beginning July 1, 1993, regardless of the facility's date of licensure or the date of the nonextensive renovations, the rate for the costs of nonextensive renovations for nursing facilities shall be eighty-five per cent of the desk-reviewed, actual, allowable, per diem, nonextensive renovation costs. This division applies to nonextensive renovations regardless of whether they are made by an owner or a lessee. If the tenancy of a lessee that has made nonextensive renovations ends before the depreciation expense for the renovation costs has been fully reported, the former lessee shall not report the undepreciated balance as an expense.

(1) For a nonextensive renovation made after July 1, 1993, to qualify for payment under this division, both of the following conditions must be met:

(a) At least five years have elapsed since the date of licensure of the portion of the facility that is proposed to be renovated, except that this condition does not apply if the renovation is necessary to meet the requirements of federal, state, or local statutes, ordinances, rules, or policies.

(b) The provider has obtained prior approval from the department of

human services, and if required the director of health has granted a certificate of need for the renovation under section 3702.52 of the Revised Code. The provider shall submit a plan that describes in detail the changes in capital assets to be accomplished by means of the renovation and the timetable for completing the project. The time for completion of the project shall be no more than eighteen months after the renovation begins. The department of human services shall adopt rules in accordance with Chapter 119. of the Revised Code that specify criteria and procedures for prior approval of renovation projects. No provider shall separate a project with the intent to evade the characterization of the project as a renovation or as an extensive renovation. No provider shall increase the scope of a project after it is approved by the department of human services unless the increase in scope is approved by the department.

(2) The payment provided for in this division is the only payment that shall be made for the costs of a nonextensive renovation. Nonextensive renovation costs shall not be included in costs of ownership, and a nonextensive renovation shall not affect the date of licensure for purposes of calculating the efficiency incentive under divisions (D) and (E) of this section.

(G) The owner of a nursing facility operating under a provider agreement shall provide written notice to the department of human services at least forty-five days prior to entering into any contract of sale for the facility or voluntarily terminating participation in the medical assistance program. After the date on which a transaction of sale is closed, the owner shall refund to the department the amount of excess depreciation paid to the facility by the department for each year the owner has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the facility has received payment. If a nursing facility is sold after five or fewer years of operation under a provider agreement, the refund to the department shall be equal to the excess depreciation paid to the facility. If a nursing facility is sold after more than five years but less than ten years of operation under a provider agreement, the refund to the department shall equal the excess depreciation paid to the facility multiplied by twenty per cent, multiplied by the difference between ten and the number of years that the facility was operated under a provider agreement. If a nursing facility is sold after ten or more years of operation under a provider agreement, the owner shall not refund any excess depreciation to the department. The owner of a facility that is sold or that voluntarily terminates participation in the medical assistance program also shall refund any other amount that the department properly finds to be due

after the audit conducted under this division. For the purposes of this division, "depreciation paid to the facility" means the amount paid to the nursing facility for cost of ownership pursuant to this section less any amount paid for interest costs, amortization of financing costs, and lease expenses. For the purposes of this division, "excess depreciation" is the nursing facility's depreciated basis, which is the owner's cost less accumulated depreciation, subtracted from the purchase price net of selling costs but not exceeding the amount of depreciation paid to the facility.

A cost report shall be filed with the department within ninety days after the date on which the transaction of sale is closed or participation is voluntarily terminated. The report shall show the accumulated depreciation, the sales price, and other information required by the department. The amount of the last two monthly payments to a nursing facility made pursuant to division (A)(1) of section 5111.22 of the Revised Code before a sale or termination of participation shall be held in escrow by a bank, trust company, or savings and loan association, except that if the amount the owner will be required to refund under this section is likely to be less than the amount of the last two monthly payments, the department shall take one of the following actions instead of withholding the amount of the last two monthly payments:

(1) In the case of an owner that owns other facilities that participate in the medical assistance program, obtain a promissory note in an amount sufficient to cover the amount likely to be refunded;

(2) In the case of all other owners, withhold the amount of the last monthly payment to the nursing facility.

The department shall, within ninety days following the filing of the cost report, audit the cost report and issue an audit report to the owner. The department also may audit any other cost report that the facility has filed during the previous three years. In the audit report, the department shall state its findings and the amount of any money owed to the department by the nursing facility. The findings shall be subject to adjudication conducted in accordance with Chapter 119. of the Revised Code. No later than fifteen days after the owner agrees to a settlement, any funds held in escrow less any amounts due to the department shall be released to the owner and amounts due to the department shall be paid to the department. If the amounts in escrow are less than the amounts due to the department, the balance shall be paid to the department within fifteen days after the owner agrees to a settlement. If the department does not issue its audit report within the ninety-day period, the department shall release any money held in escrow to the owner. For the purposes of this section, a transfer of corporate

stock, the merger of one corporation into another, or a consolidation does not constitute a sale.

If a nursing facility is not sold or its participation is not terminated after notice is provided to the department under this division, the department shall order any payments held in escrow released to the facility upon receiving written notice from the owner that there will be no sale or termination. After written notice is received from a nursing facility that a sale or termination will not take place, the facility shall provide notice to the department at least forty-five days prior to entering into any contract of sale or terminating participation at any future time.

(H) The department shall pay each eligible proprietary nursing facility a return on the facility's net equity computed at the rate of one and one-half times the average interest rate on special issues of public debt obligations issued to the federal hospital insurance trust fund for the cost reporting period, except that no facility's return on net equity shall exceed one dollar per patient day.

When calculating the rate for return on net equity, the department shall use the greater of the facility's inpatient days during the applicable cost reporting period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.

(I) If a nursing facility would receive a lower rate for capital costs for assets in the facility's possession on July 1, 1993, under this section than it would receive under former section 5111.25 of the Revised Code, as the former section existed immediately prior to December 22, 1992, the facility shall receive for those assets the rate it would have received under the former section for each fiscal year beginning on or after July 1, 1993, until the rate it would receive under this section exceeds the rate it would have received under the former section. Any facility that receives a rate calculated under the former section 5111.25 of the Revised Code for assets in the facility's possession on July 1, 1993, also shall receive a rate calculated under this section for costs of any assets it constructs or acquires after July 1, 1993.

Sec. 5111.251. (A) The department of human services shall pay each eligible intermediate care facility for the mentally retarded for its reasonable capital costs, a per resident per day rate established prospectively each fiscal year for each intermediate care facility for the mentally retarded. Except as otherwise provided in sections 5111.20 to 5111.32 of the Revised Code, the rate shall be based on the facility's capital costs for the calendar year preceding the fiscal year in which the rate will be paid. The rate shall equal the sum of the following:

(1) The facility's desk-reviewed, actual, allowable, per diem cost of ownership for the preceding cost reporting period, limited as provided in divisions (C) and (F) of this section;

(2) Any efficiency incentive determined under division (B) of this section;

(3) Any amounts for renovations determined under division (D) of this section;

(4) Any amounts for return on equity determined under division (I) of this section.

Buildings shall be depreciated using the straight line method over forty years or over a different period approved by the department. Components and equipment shall be depreciated using the straight line method over a period designated by the department in rules adopted in accordance with Chapter 119. of the Revised Code, consistent with the guidelines of the American hospital association, or over a different period approved by the department of human services. Any rules adopted under this division that specify useful lives of buildings, components, or equipment apply only to assets acquired on or after July 1, 1993. Depreciation for costs paid or reimbursed by any government agency shall not be included in costs of ownership or renovation unless that part of the payment under sections 5111.20 to 5111.32 of the Revised Code is used to reimburse the government agency.

(B) The department of human services shall pay to each intermediate care facility for the mentally retarded an efficiency incentive equal to fifty per cent of the difference between any desk-reviewed, actual, allowable cost of ownership and the applicable limit on cost of ownership payments under division (C) of this section. For purposes of computing the efficiency incentive, depreciation for costs paid or reimbursed by any government agency shall be considered as a cost of ownership, and the applicable limit under division (C) of this section shall apply both to facilities with more than eight beds and facilities with eight or fewer beds. The efficiency incentive paid to a facility with eight or fewer beds shall not exceed three dollars per patient day, adjusted annually for the inflation rate for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year for which the efficiency incentive is determined and ending on the thirtieth day of the following June, using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(C) Cost of ownership payments to intermediate care facilities for the

mentally retarded with more than eight beds shall not exceed the following limits:

(1) For facilities with dates of licensure prior to January 1, l958, not exceeding two dollars and fifty cents per patient day;

(2) For facilities with dates of licensure after December 31, l957, but prior to January 1, l968, not exceeding:

(a) Three dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or more per bed;

(b) Two dollars and fifty cents per patient day if the cost of construction was less than three thousand five hundred dollars per bed.

(3) For facilities with dates of licensure after December 31, l967, but prior to January 1, l976, not exceeding:

(a) Four dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or more per bed;

(b) Three dollars and fifty cents per patient day if the cost of construction was less than five thousand one hundred fifty dollars per bed, but exceeds three thousand five hundred dollars per bed;

(c) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(4) For facilities with dates of licensure after December 31, l975, but prior to January 1, l979, not exceeding:

(a) Five dollars and fifty cents per patient day if the cost of construction was six thousand eight hundred dollars or more per bed;

(b) Four dollars and fifty cents per patient day if the cost of construction was less than six thousand eight hundred dollars per bed but exceeds five thousand one hundred fifty dollars per bed;

(c) Three dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less per bed, but exceeds three thousand five hundred dollars per bed;

(d) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(5) For facilities with dates of licensure after December 31, l978, but prior to January 1, l980, not exceeding:

(a) Six dollars per patient day if the cost of construction was seven thousand six hundred twenty-five dollars or more per bed;

(b) Five dollars and fifty cents per patient day if the cost of construction was less than seven thousand six hundred twenty-five dollars per bed but exceeds six thousand eight hundred dollars per bed;

(c) Four dollars and fifty cents per patient day if the cost of construction was six thousand eight hundred dollars or less per bed but exceeds five

thousand one hundred fifty dollars per bed;

(d) Three dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less but exceeds three thousand five hundred dollars per bed;

(e) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.

(6) For facilities with dates of licensure after December 31, 1979, but prior to January 1, 1981, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Six dollars per patient day if the beds were originally licensed as nursing home beds by the department of health.

(7) For facilities with dates of licensure after December 31, 1980, but prior to January 1, 1982, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Six dollars and forty-five cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(8) For facilities with dates of licensure after December 31, 1981, but prior to January 1, 1983, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Six dollars and seventy-nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(9) For facilities with dates of licensure after December 31, 1982, but prior to January 1, 1984, not exceeding:

(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(10) For facilities with dates of licensure after December 31, 1983, but prior to January 1, 1985, not exceeding:

(a) Twelve dollars and twenty-four cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and twenty-three cents per patient day if the beds were

originally licensed as nursing home beds by the department of health.

(11) For facilities with dates of licensure after December 31, 1984, but prior to January 1, 1986, not exceeding:

(a) Twelve dollars and fifty-three cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and forty cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(12) For facilities with dates of licensure after December 31, 1985, but prior to January 1, 1987, not exceeding:

(a) Twelve dollars and seventy cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and fifty cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(13) For facilities with dates of licensure after December 31, 1986, but prior to January 1, 1988, not exceeding:

(a) Twelve dollars and ninety-nine cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and sixty-seven cents per patient day if the beds were originally licensed as nursing home beds by the department of health.

(14) For facilities with dates of licensure after December 31, 1987, but prior to January 1, 1989, not exceeding thirteen dollars and twenty-six cents per patient day;

(15) For facilities with dates of licensure after December 31, 1988, but prior to January 1, 1990, not exceeding thirteen dollars and forty-six cents per patient day;

(16) For facilities with dates of licensure after December 31, 1989, but prior to January 1, 1991, not exceeding thirteen dollars and sixty cents per patient day;

(17) For facilities with dates of licensure after December 31, 1990, but prior to January 1, 1992, not exceeding thirteen dollars and forty-nine cents per patient day;

(18) For facilities with dates of licensure after December 31, 1991, but prior to January 1, 1993, not exceeding thirteen dollars and sixty-seven cents per patient day;

(19) For facilities with dates of licensure after December 31, 1992, not exceeding fourteen dollars and twenty-eight cents per patient day.

(D) Beginning January 1, 1981, regardless of the original date of

licensure, the department of human services shall pay a rate for the per diem capitalized costs of renovations to intermediate care facilities for the mentally retarded made after January 1, l981, not exceeding six dollars per patient day using 1980 as the base year and adjusting the amount annually until June 30, 1993, for fluctuations in construction costs calculated by the department using the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift. The payment provided for in this division is the only payment that shall be made for the capitalized costs of a nonextensive renovation of an intermediate care facility for the mentally retarded. Nonextensive renovation costs shall not be included in cost of ownership, and a nonextensive renovation shall not affect the date of licensure for purposes of division (C) of this section. This division applies to nonextensive renovations regardless of whether they are made by an owner or a lessee. If the tenancy of a lessee that has made renovations ends before the depreciation expense for the renovation costs has been fully reported, the former lessee shall not report the undepreciated balance as an expense.

For a nonextensive renovation to qualify for payment under this division, both of the following conditions must be met:

(1) At least five years have elapsed since the date of licensure or date of an extensive renovation of the portion of the facility that is proposed to be renovated, except that this condition does not apply if the renovation is necessary to meet the requirements of federal, state, or local statutes, ordinances, rules, or policies.

(2) The provider has obtained prior approval from the department of human services. The provider shall submit a plan that describes in detail the changes in capital assets to be accomplished by means of the renovation and the timetable for completing the project. The time for completion of the project shall be no more than eighteen months after the renovation begins. The department of human services shall adopt rules in accordance with Chapter 119. of the Revised Code that specify criteria and procedures for prior approval of renovation projects. No provider shall separate a project with the intent to evade the characterization of the project as a renovation or as an extensive renovation. No provider shall increase the scope of a project after it is approved by the department of human services unless the increase in scope is approved by the department.

(E) The amounts specified in divisions (C) and (D) of this section shall be adjusted beginning July 1, 1993, for the estimated inflation for the twelve-month period beginning on the first day of July of the calendar year preceding the calendar year that precedes the fiscal year for which rate will be paid and ending on the thirtieth day of the following June, using the

consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(F)(1) For facilities of eight or fewer beds that have dates of licensure or have been granted project authorization by the department of mental retardation and developmental disabilities before July 1, 1993, and for facilities of eight or fewer beds that have dates of licensure or have been granted project authorization after that date if the facilities demonstrate that they made substantial commitments of funds on or before that date, cost of ownership shall not exceed eighteen dollars and thirty cents per resident per day. The eighteen-dollar and thirty-cent amount shall be increased by the change in the "Dodge building cost indexes, northeastern and north central states," published by Marshall and Swift, during the period beginning June 30, 1990, and ending July 1, 1993, and by the change in the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics, annually thereafter.

(2) For facilities with eight or fewer beds that have dates of licensure or have been granted project authorization by the department of mental retardation and developmental disabilities on or after July 1, 1993, for which substantial commitments of funds were not made before that date, cost of ownership payments shall not exceed the applicable amount calculated under division (F)(1) of this section, if the department of human services gives prior approval for construction of the facility. If the department does not give prior approval, cost of ownership payments shall not exceed the amount specified in division (C) of this section.

(3) Notwithstanding divisions (D) and (F)(1) and (2) of this section, the total payment for cost of ownership, cost of ownership efficiency incentive, and capitalized costs of renovations for an intermediate care facility for the mentally retarded with eight or fewer beds shall not exceed the sum of the limitations specified in divisions (C) and (D) of this section.

(G) Notwithstanding any provision of this section or section 5111.24 of the Revised Code, the department of human services may adopt rules in accordance with Chapter 119. of the Revised Code that provide for a calculation of a combined maximum payment limit for indirect care costs and cost of ownership for intermediate care facilities for the mentally retarded with eight or fewer beds.

(H) After June 30, 1980, the owner of an intermediate care facility for the mentally retarded operating under a provider agreement shall provide written notice to the department of human services at least forty-five days prior to entering into any contract of sale for the facility or voluntarily

terminating participation in the medical assistance program. After the date on which a transaction of sale is closed, the owner shall refund to the department the amount of excess depreciation paid to the facility by the department for each year the owner has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the facility has received payment. If an intermediate care facility for the mentally retarded is sold after five or fewer years of operation under a provider agreement, the refund to the department shall be equal to the excess depreciation paid to the facility. If an intermediate care facility for the mentally retarded is sold after more than five years but less than ten years of operation under a provider agreement, the refund to the department shall equal the excess depreciation paid to the facility multiplied by twenty per cent, multiplied by the number of years less than ten that a facility was operated under a provider agreement. If an intermediate care facility for the mentally retarded is sold after ten or more years of operation under a provider agreement, the owner shall not refund any excess depreciation to the department. For the purposes of this division, "depreciation paid to the facility" means the amount paid to the intermediate care facility for the mentally retarded for cost of ownership pursuant to this section less any amount paid for interest costs. For the purposes of this division, "excess depreciation" is the intermediate care facility for the mentally retarded's depreciated basis, which is the owner's cost less accumulated depreciation, subtracted from the purchase price but not exceeding the amount of depreciation paid to the facility.

A cost report shall be filed with the department within ninety days after the date on which the transaction of sale is closed or participation is voluntarily terminated for an intermediate care facility for the mentally retarded subject to this division. The report shall show the accumulated depreciation, the sales price, and other information required by the department. The amount of the last two monthly payments to an intermediate care facility for the mentally retarded made pursuant to division (A)(1) of section 5111.22 of the Revised Code before a sale or voluntary termination of participation shall be held in escrow by a bank, trust company, or savings and loan association, except that if the amount the owner will be required to refund under this section is likely to be less than the amount of the last two monthly payments, the department shall take one of the following actions instead of withholding the amount of the last two monthly payments:

(1) In the case of an owner that owns other facilities that participate in the medical assistance program, obtain a promissory note in an amount

sufficient to cover the amount likely to be refunded;

(2) In the case of all other owners, withhold the amount of the last monthly payment to the intermediate care facility for the mentally retarded.

The department shall, within ninety days following the filing of the cost report, audit the report and issue an audit report to the owner. The department also may audit any other cost reports for the facility that have been filed during the previous three years. In the audit report, the department shall state its findings and the amount of any money owed to the department by the intermediate care facility for the mentally retarded. The findings shall be subject to an adjudication conducted in accordance with Chapter 119. of the Revised Code. No later than fifteen days after the owner agrees to a settlement, any funds held in escrow less any amounts due to the department shall be released to the owner and amounts due to the department shall be paid to the department. If the amounts in escrow are less than the amounts due to the department, the balance shall be paid to the department within fifteen days after the owner agrees to a settlement. If the department does not issue its audit report within the ninety-day period, the department shall release any money held in escrow to the owner. For the purposes of this section, a transfer of corporate stock, the merger of one corporation into another, or a consolidation does not constitute a sale.

If an intermediate care facility for the mentally retarded is not sold or its participation is not terminated after notice is provided to the department under this division, the department shall order any payments held in escrow released to the facility upon receiving written notice from the owner that there will be no sale or termination of participation. After written notice is received from an intermediate care facility for the mentally retarded that a sale or termination of participation will not take place, the facility shall provide notice to the department at least forty-five days prior to entering into any contract of sale or terminating participation at any future time.

(I) The department of human services shall pay each eligible proprietary intermediate care facility for the mentally retarded a return on the facility's net equity computed at the rate of one and one-half times the average of interest rates on special issues of public debt obligations issued to the federal hospital insurance trust fund for the cost reporting period. No facility's return on net equity paid under this division shall exceed one dollar per patient day.

In calculating the rate for return on net equity, the department shall use the greater of the facility's inpatient days during the applicable cost reporting period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.

(J)(1) Except as provided in division (J)(2) of this section, if a provider leases or transfers an interest in a facility to another provider who is a related party, the related party's allowable cost of ownership shall include the lesser of the following:

(a) The annual lease expense or actual cost of ownership, whichever is applicable;

(b) The reasonable cost to the lessor or provider making the transfer.

(2) If a provider leases or transfers an interest in a facility to another provider who is a related party, regardless of the date of the lease or transfer, the related party's allowable cost of ownership shall include the annual lease expense or actual cost of ownership, whichever is applicable, subject to the limitations specified in divisions (B) to (I) of this section, if all of the following conditions are met:

(a) The related party is a relative of owner;

(b) In the case of a lease, if the lessor retains any ownership interest, it is in only the real property and any improvements on the real property;

(c) In the case of a transfer, the provider making the transfer retains no ownership interest in the facility;

(d) The United States internal revenue service has issued a ruling that the lease or transfer is an arm's length transaction for purposes of federal income taxation;

(e) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a lessor or provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, allowable cost of ownership was determined most recently under this division.

Sec. 5111.264. ~~The~~ Except as provided in section 5111.25 or 5111.251 Of the Revised Code, the costs of goods, services, and facilities, furnished to a provider by a related party are includable in the allowable costs of the provider at the reasonable cost to the related party.

Sec. 5111.81. (A) There is hereby established the pharmacy and therapeutics committee of the department of human services. The committee shall consist of eight members and shall be appointed by the director of human services. The membership of the committee shall include: two pharmacists licensed under Chapter 4729. of the Revised Code; two doctors of medicine and two doctors of osteopathy licensed under Chapter 4731. of the Revised Code; a registered nurse licensed under Chapter 4723. of the Revised Code; and a pharmacologist who has a doctoral degree. The committee shall elect one of its members as chairperson.

(B) In the absence of fraud or bad faith, neither the pharmacy and

therapeutics committee nor a current or former member, agent, representative, employee, or independent contractor of the committee shall be held liable in damages to a person as the result of an act, omission, proceeding, conduct, or decision relating to the official duties undertaken or performed pursuant to this section~~, section 5111.811 of the Revised Code,~~ or rules promulgated pursuant to section 111.15 or Chapter 119. of the Revised Code. If a current or former member, agent, representative, employee, or independent contractor of the committee requests the state to defend the current or former member, agent, representative, employee, or independent contractor against a claim or in an action arising out of an act, omission, proceeding, conduct, or decision relating to official duties undertaken or performed, if the request is made in writing at a reasonable time before the trial of the claim or in the action, and if the person requesting the defense cooperates in good faith in the defense of the claim or action, the state shall provide and pay for the defense of the claim or action and shall pay any resulting judgment, compromise, or settlement. The state shall not pay that part of a claim or judgment that is for punitive or exemplary damages.

Sec. 5112.01. As used in sections 5112.02 to 5112.21 of the Revised Code:

(A)(1) "Hospital" means a nonfederal hospital to which either of the following applies:

(a) The hospital is registered under section 3701.07 of the Revised Code as a general medical and surgical hospital or a pediatric general hospital, and provides inpatient hospital services, as defined in 42 C.F.R. 440.10;

(b) The hospital is recognized under the medicare program established by Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, as a cancer hospital and is exempt from the medicare prospective payment system.

"Hospital" does not include a hospital operated by a health ~~maintenance organization~~ insuring corporation that has been issued a certificate of authority under section ~~1742.05~~ 1751.05 of the Revised Code or a hospital that does not charge patients for services.

(2) "Disproportionate share hospital" means a hospital that meets the definition of a disproportionate share hospital in rules adopted under section 5112.03 of the Revised Code.

(B) "Bad debt," "charity care," "courtesy care," and "contractual allowances" have the same meanings given these terms in regulations adopted under Title XVIII of the "Social Security Act."

(C) "Cost reporting period" means the twelve-month period used by a hospital in reporting costs for purposes of Title XVIII of the "Social

Security Act."

(D) "Governmental hospital" means a county hospital with more than five hundred registered beds or a state-owned and -operated hospital with more than five hundred registered beds.

(E) "Indigent care pool" means the sum of the following:

(1) The total of assessments to be paid in a program year by all hospitals under section 5112.06 of the Revised Code, less the assessments deposited into the legislative budget services fund under section 5112.19 of the Revised Code;

(2) The total amount of intergovernmental transfers required to be made in the same program year by governmental hospitals under section 5112.07 of the Revised Code, less the amount of transfers deposited into the legislative budget services fund under section 5112.19 of the Revised Code;

(3) The total amount of federal matching funds that will be made available in the same program year as a result of payments the department of human services makes to hospitals under section 5112.08 of the Revised Code.

(F) "Intergovernmental transfer" means any transfer of money by a governmental hospital under section 5112.07 of the Revised Code.

(G) "Medical assistance program" means the program of medical assistance established under section 5111.01 of the Revised Code and Title XIX of the "Social Security Act."

(H) "Program year" means a period beginning the first day of October, or a later date designated in rules adopted under section 5112.03 of the Revised Code, and ending the thirtieth day of September, or an earlier date designated in rules adopted under that section.

(I) "Registered beds" means the total number of hospital beds registered with the department of health, as reported in the most recent "directory of registered hospitals" published by the department of health.

(J) "Total facility costs" means the total costs for all services rendered to all patients, including the direct, indirect, and overhead cost to the hospital of all services, supplies, equipment, and capital related to the care of patients, regardless of whether patients are enrolled in a health ~~maintenance organization~~ insuring corporation, excluding costs associated with providing skilled nursing services in distinct-part nursing facility units, as shown on the hospital's cost report filed under section 5112.04 of the Revised Code. Effective October 1, 1993, if rules adopted under section 5112.03 of the Revised Code so provide, "total facility costs" may exclude costs associated with providing care to recipients of any of the governmental programs listed in division (B) of that section.

(K) "Uncompensated care" means bad debt and charity care.

Sec. 5112.08. The director of human services shall adopt rules under section 5112.03 of the Revised Code establishing a methodology to pay hospitals that is sufficient to expend all money in the indigent care pool. Under the rules:

(A) The department of human services shall classify similar hospitals into groups and allocate funds for distribution within each group.

(B) The department shall establish a method of allocating funds to each group of hospitals, taking into consideration the relative amount of indigent care provided by each group. The amount to be allocated to each group shall be based on any combination of the following indicators of indigent care that the director considers appropriate:

(1) Total costs, volume, or proportion of services to recipients of the medical assistance program, including recipients enrolled in health ~~maintenance organizations~~ insuring corporations;

(2) Total costs, volume, or proportion of services to low-income patients in addition to recipients of the medical assistance program, which may include recipients of Title V of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, general assistance established under Chapter 5113. of the Revised Code, and disability assistance established under Chapter 5115. of the Revised Code;

(3) The amount of uncompensated care provided by the hospitals;

(4) Other factors that the director considers to be appropriate indicators of indigent care.

(C) The department shall distribute funds to hospitals in each group in a manner that first may provide for an additional payment to individual hospitals that provide a high proportion of indigent care in relation to the total care provided by the hospital or in relation to other hospitals. The department shall establish a formula to distribute the remainder of the funds allocated to the group to all hospitals in the group. The formula shall be consistent with section 1923 of the "Social Security Act," 42 U.S.C.A. 1396r-4, as amended, and shall be based on any combination of the indicators of indigent care listed in division (B) of this section that the director considers appropriate.

(D) The department shall make payments to each hospital in installments not later than ten working days after the deadline established in rules for each hospital to pay an installment on its assessment under section 5112.06 of the Revised Code. In the case of a governmental hospital that makes intergovernmental transfers, the department shall pay an installment under this section not later than ten working days after the earlier of that

deadline or the deadline established in rules for the governmental hospital to pay an installment on its intergovernmental transfer. If the amount in the hospital care assurance program fund and the hospital care assurance match fund created under section 5112.18 of the Revised Code is insufficient to make the total payments for which hospitals are eligible to receive in any period, the department shall reduce the amount of each payment by the percentage by which the amount is insufficient. The department shall pay hospitals any amounts not paid in the period in which they are due as soon as moneys are available in the funds.

Sec. 5725.18. (A) An annual franchise tax on the privilege of being an insurance company is hereby levied on each domestic insurance company. In the month of May, annually, the treasurer of state shall charge for collection from each domestic insurance company a franchise tax in the amount computed in accordance with the following, as applicable:

(1) With respect to a domestic insurance company that is a health insuring corporation, one per cent of all premium rate payments received, exclusive of payments received under the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or pursuant to the medical assistance program established under Chapter 5111. of the Revised Code, as reflected in its annual report for the preceding calendar year;

(2) With respect to a domestic insurance company that is not a health insuring corporation, one and four-tenths per cent of the gross amount of premiums received from policies covering risks within this state, exclusive of premiums received under the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or pursuant to the medical assistance program established under Chapter 5111. of the Revised Code, as reflected in its annual statement for the preceding calendar year, and, if the company operates a health insuring corporation as a line of business, one per cent of all premium rate payments received from that line of business, exclusive of payments received under the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or pursuant to the medical assistance program established under Chapter 5111. of the Revised Code, as reflected in its annual statement for the preceding calendar year.

(B) The gross amount of premium rate payments or premiums used to compute the applicable tax in accordance with division (A) of this section is subject to the deductions prescribed by section 5729.03 of the Revised Code for foreign insurance companies. The objects of such tax are those declared in section 5725.24 of the Revised Code, to which only such tax shall be

applied.

(C) In no case shall such tax be less than two hundred fifty dollars.

Sec. 5729.03. (A) If the superintendent of insurance finds the annual statement required by section 5729.02 of the Revised Code to be correct, the superintendent shall compute the following amount, as applicable, of the balance of such gross amount, after deducting such return premiums and considerations received for reinsurance, and charge such amount to such company as a tax upon the business done by it in this state for the period covered by such annual statement:

(1) If the company is a health insuring corporation, one per cent of the balance of premium rate payments received, exclusive of payments received under the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or pursuant to the medical assistance program established under Chapter 5111. of the Revised Code, as reflected in its annual report;

(2) If the company is not a health insuring corporation, one and four-tenths per cent of the balance of premiums received, exclusive of premiums received under the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or pursuant to the medical assistance program established under Chapter 5111. of the Revised Code, as reflected in its annual statement, and, if the company operates a health insuring corporation as a line of business, one per cent of the balance of premium rate payments received from that line of business, exclusive of payments received under the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or pursuant to the medical assistance program established under Chapter 5111. of the Revised Code, as reflected in its annual statement.

(B) Any insurance policies that were not issued in violation of Title XXXIX of the Revised Code and that were issued prior to April 15, 1967, by a life insurance company organized and operated without profit to any private shareholder or individual, exclusively for the purpose of aiding educational or scientific institutions organized and operated without profit to any private shareholder or individual, are not subject to the tax imposed by this section. All taxes collected pursuant to this section shall be credited to the general revenue fund.

(C) In no case shall the tax imposed under this section be less than two hundred fifty dollars.

SECTION 2. That existing sections 1701.03, 1705.03, 1705.04, 1705.53,

1739.01, 1751.01, 1751.02, 1751.03, 1751.05, 1751.06, 1751.11, 1751.12, 1751.13, 1751.14, 1751.15, 1751.16, 1751.20, 1751.31, 1751.32, 1751.46, 1751.55, 1751.58, 1751.59, 1751.60, 1751.62, 1751.81, 1785.01, 1785.02, 1785.03, 1785.08, 1907.161, 2305.252, 3701.75, 3901.21, 3901.38, 3917.01, 3917.06, 3923.021, 3923.122, 3923.57, 3923.571, 3923.58, 3924.01, 3924.03, 3924.033, 3924.08, 3924.09, 3924.10, 3924.11, 3924.13, 3999.22, 4715.22, 4715.39, 4723.16, 4725.114, 4729.161, 4731.226, 4731.65, 4732.28, 4734.091, 4755.471, 5111.25, 5111.251, 5111.264, 5111.81, 5112.01, 5112.08, 5725.18, and 5729.03 and sections 3924.05, 5111.75, 5111.77, 5111.771, and 5111.811 of the Revised Code are hereby repealed.

SECTION 3. That Section 3 of Am. Sub. S.B. 67 of the 122nd General Assembly be amended to read as follows:

"Sec. 3. (A) The certificate of authority of every prepaid dental plan organization, health care corporation, dental care corporation, and health maintenance organization licensed to operate under Chapter 1736., 1738., 1740., or 1742. of the Revised Code, respectively, shall renew, by operation of law, on January 1, 1998, as a certificate of authority to operate under Chapter 1751. of the Revised Code. All assets and liabilities of the prepaid dental plan organization, health care corporation, dental care corporation, or health maintenance organization, including all obligations under subscriber contracts delivered, issued for delivery, or renewed prior to ~~the effective date of this section~~ June 4, 1997, shall be assumed by the successor entity. Except as otherwise provided in division (B) of this section, such entity shall, no later than January 1, 1998, comply with Chapter 1751. of the Revised Code.

(B)(1) Each entity described in division (A) of this section shall do both of the following:

(a) Comply with sections 1751.19 and 1751.26 of the Revised Code no later than six months after ~~the effective date of this section~~ June 4, 1997.

(b) Comply with section 1751.28 of the Revised Code by ~~making annual deposits with the Superintendent of Insurance, no later than the first day of January of each year, for up to three years, beginning the first day of January immediately following the effective date of this section~~ INCREASING the entity's net worth, on the first day of JANUARY IN EACH OF THE YEARS 1998, 1999, AND 2000, by AN AMOUNT EQUAL TO AT LEAST ONE-THIRD OF any difference between the entity's net worth as of June 4, 1997, and the NET WORTH REQUIRED BY SECTION 1751.28 OF THE REVISED CODE. Each entity shall attain the NET WORTH REQUIRED BY SECTION 1751.28 OF THE REVISED

CODE NO LATER THAN JANUARY 1, 2000.

(2) Every contract delivered, issued for delivery, or renewed by an entity described in division (A) of this section prior to ~~the effective date of this section~~ June 4, 1997, shall comply with section 1751.13 of the Revised Code no later than the contract's first renewal date after the first day of January immediately following ~~the effective date of this section~~ June 4, 1997.

(3) Every contract delivered, issued for delivery, or renewed by an entity described in division (A) of this section prior to ~~the effective date of this section~~ June 4, 1997, shall comply with section 1751.31 of the Revised Code no later than three months after ~~the effective date of this section~~ June 4, 1997.

(4) An entity described in division (A) of this section may comply with section 1751.27 of the Revised Code by making annual deposits with the Superintendent of Insurance, not later than the first day of January of each year, for up to three years beginning the first day of January immediately following ~~the effective date of this section~~ June 4, 1997. An equal amount shall be deposited each year until the total amount required under section 1751.27 of the Revised Code has been deposited."

SECTION 4. That existing Section 3 of Am. Sub. S.B. 67 of the 122nd General Assembly is hereby repealed.

SECTION 5. That Section 6 of Am. Sub. S.B. 154 of the 122nd General Assembly be amended to read as follows:

SECTION 6 OF AM. SUB. S.B. 154/122nd GA

"Sec. 6. The Insurance Agent Education Advisory Council operating pursuant to section 3905.483 of the Revised Code shall create a temporary committee to conduct a special study of the continuing education requirements for insurance agents as set forth in the Revised Code and the Administrative Code. The committee shall be composed of the eleven members of the Insurance Agent Education Advisory Council appointed by the Superintendent of Insurance pursuant to section 3905.483 of the Revised Code; a representative, appointed by the Governor, of the Association of Fraternal Insurance Counselors; a representative, appointed by the Governor, of private entities engaged in the business of providing continuing education to agents; a representative, appointed by the Governor, of financial institutions; two members of the House of Representatives, one from each party, appointed by the Speaker of the House of Representatives;

and two members of the Senate, one from each party, appointed by the President of the Senate. The Superintendent or the Superintendent's designee shall serve on the committee as a nonvoting member.

The committee shall hold an organizational meeting within thirty days after ~~the effective date of this section~~ June 30, 1998. At the organizational meeting, the voting members of the committee shall elect a chairperson and a vice-chairperson for the committee. The committee shall meet at the call of the chairperson.

The committee shall study all aspects of the continuing education requirements for insurance agents as set forth in the Revised Code and the Administrative Code, and shall be charged with providing findings and recommendations on how any aspect of these requirements may be improved.

The study shall include, but is not limited to, an examination of issues related to the following questions:

(A) Will a reduction in the biennial continuing education requirement satisfy the continuing education requirements imposed by other states on nonresident agents?

(B) What are the best methods for assuring the quality of continuing education courses and programs of study?

(C) Is the Superintendent of Insurance's annual approval of a continuing education course or program of study necessary if there is no change in the course'sor program's curriculum, or could a course or program of study be approved for a longer period of time?

(D) Could the process of approval for continuing education courses and programs of study be streamlined, to provide for a more timely and efficient process of approval?

(E) Should an agent receive continuing education credit for completing courses or programs of study that pertain to subjects outside of the agent's area of practice or licensure?

(F) What is the optimal number of hours of instruction a statutory continuing education requirement should require agents to complete?

(G) Should continuing education requirements include a minimum number of hours of courses or programs of study on ethics?

(H) Should the completion of a correspondence course, which course requires the successful completion of a test on the course material, be an optional method for an agent's fulfillment of continuing education requirements?

(I) Should minimum requirements be established for instructors of continuing education courses, such as minimum industry experience and a

current agent's license?

(J) Should an agent be limited as to the number of hours of continuing education credit that the agent may earn from private providers and associations or from insurance companies, as a percentage of the total number of hours of continuing education credit that the agent earns, or is permitted to earn, during a single compliance period?

(K) Should an agent receive continuing education credit for completing sales-related courses or programs of study?

(L) Should an agent's receipt of any special designation exempt the agent from the completion of further continuing education requirements?

(M) Has the continuing education requirement improved the quality of licensed insurance agents?

(N) Would a system in which agents certified their compliance with continuing education requirements to the Superintendent, which system included a program of random verification of agent compliance by the Department of Insurance, be a feasible alternative to the current system of continuing education compliance verification?

The committee shall hold a sufficient number of public hearings outside of Franklin County to provide interested parties throughout the state a chance to voice their opinions and make recommendations with regard to the continuing education requirements for insurance agents.

The committee shall issue an interim report within nine months after ~~the effective date of this section~~ June 30, 1998. The committee shall issue its final report within eighteen months after ~~the effective date of this section~~ June 30, 1998. Copies of the interim and the final reports shall be submitted, at the time of their issuance, to the Speaker of the House of Representatives, to the President of the Senate, to the Governor, to the chair of the House committee having primary jurisdiction over insurance legislation, to the chair of the Senate committee having primary jurisdiction over insurance legislation, to the Superintendent of Insurance, and to the Insurance Agent Education Advisory Council. The committee may request staff assistance from the Legislative Service Commission as needed for the completion of the reports. Upon the issuance of its final report, the committee shall cease to exist."

SECTION 6. That existing Section 6 of Am. Sub. S.B. 154 of the 122nd General Assembly is hereby repealed.

SECTION 7. That Section 194 of Am. Sub. H.B. 215 of the 122nd

ral Assembly be amended to read as follows:

"Sec. 194. Insurance Tax Phase-in Schedules

Sections 1731.07, 5725.18, 5725.181, 5729.03, and 5729.031 of the Revised Code, as amended or enacted by ~~this act~~ Am. Sub. H.B. 215 or Sub. H.B. 698 of the 122nd General Assembly, shall first apply to tax year 1999 and shall be implemented according to the following schedule:

(A) For tax years 1999 through 2002, the tax imposed under section 5729.03 of the Revised Code on ~~the gross premiums of~~ foreign insurance companies that are not health insuring corporations shall ~~be~~ equal the sum of the amounts computed under divisions (A)(1) and (2) of this section.

(1) With respect to the gross premiums of the company, exclusive of premiums received under Medicare or Medicaid, the amount computed using the following rates:

For Tax Year	The percentage of premiums is
1999	2.3%
2000	2.09%
2001	1.84%
2002	1.62%

(2) With respect to premium rate payments received by the company, exclusive of payments received under Medicare or Medicaid, if the company operates a health insuring corporation as a line of business, the amount computed using the following rates:

For Tax Year	The percentage of premium rate payments is
1999	.21%
2000	.42%
2001	.60%
2002	.80%

(B) For tax years 1999 through 2002, the tax imposed under section 5725.18 of the Revised Code on domestic insurance companies that are not health insuring ~~corportaions~~ corporations shall equal the sum of the amounts computed under ~~division~~ divisions (B)(1) and (2) of this section.

(1) The tax computed according to the method prescribed in section 5725.181 of the Revised Code, as enacted by ~~this act~~ Am. Sub. H.B. 215 of the 122nd General Assembly, multiplied by the percentage prescribed as follows:

For Tax Year	Multiply the tax under section 5725.181 of the Revised Code by

1999	79%
2000	58%
2001	40%
2002	20%

(2) The tax computed ~~using~~ according to the ~~percentage of gross premiums~~ method prescribed ~~by~~ in section 5725.18 of the Revised Code, as amended by ~~this act~~ Sub. H.B. 698 of the 122nd General Assembly, multiplied by the percentage prescribed as follows:

For Tax Year	Multiply the tax under amended section 5725.18 of the Revised Code by
1999	21%
2000	42%
2001	60%
2002	80%

(C) For tax years 1999 through 2002, the tax imposed under sections 5725.18 and 5729.03 of the Revised Code on domestic and foreign insurance companies that are health insuring corporations shall be computed using the following rates:

For Tax Year	The percentage of premium rate payments is
1999	.21%
2000	.42%
2001	.60%
2002	.80%

(D) For tax years 1999 through 2002, the minimum tax for domestic insurance companies taxed under sections 5725.18 and 5725.181 of the Revised Code, the minimum tax for foreign insurance companies taxed under section 5729.03 of the Revised Code, and the minimum tax for companies that are health insuring corporations taxed under those sections shall equal the amount prescribed as follows:

For Tax Year	The minimum tax is
1999	$50
2000	$100
2001	$150
2002	$200

(E) For tax years 1999 through 2002, the credit available under section 5729.031 of the Revised Code may be claimed against the tax imposed on foreign insurance companies as computed under division (A) of this section,

against the tax imposed on domestic insurance companies as computed under division (B) of this section, or against the tax imposed on companies that are health insuring corporations as computed under division (C) of this section. The credit shall equal a percentage of the amount computed under division (C) of section 5729.031 of the Revised Code according to the following schedule:

For Tax Year	Percentage of credit allowed
1999	20%
2000	40%
2001	60%
2002	80%

As used in this section, "health insuring corporation" has the same meaning as in section 1751.01 of the Revised Code, and "tax year" means the calendar year in which the tax imposed on the insurance company or health insuring corporation is charged."

SECTION 8. That existing Section 194 of Am. Sub. H.B. 215 of the 122nd General Assembly is hereby repealed.

SECTION 9. Pursuant to the authority granted under section 3905.29 of the Revised Code, the Superintendent of Insurance shall modify the forms on which annual financial statements are submitted by domestic and foreign insurance companies to include, as a separate item, the amount of premium rate payments received, exclusive of payments received under Medicare or Medicaid, by any such insurance company that operates a health insuring corporation as a line of business.

SECTION 10. (A) Until November 1, 1999, the Director of Health shall not adopt any rule, whether by adopting, amending, or rescinding a rule or by submitting a rule for review under section 119.032 of the Revised Code, that has the effect of allowing cardiac catheterization to be performed without an on-site open-heart surgery service.

(B) In 1999, the Director of Health shall appear three times before the standing committee of the House of Representatives that primarily deals with health matters and the standing committee of the Senate that primarily deals with health matters to report on the progress of the Department of Health in collecting statewide and national data on the outcomes of cardiac

catheterization performed without an on-site open-heart surgery service. The first appearance before each committee shall be made not later than April 1, 1999. The second appearance shall be made not sooner than 30 days after the first appearance, but not later than June 1, 1999. The third appearance shall be made not sooner than 30 days after the second appearance, but not later than October 1, 1999. At the third appearance, the Director shall make a final report on the Department's findings. The Director shall submit a written copy of the report to the Speaker of the House of Representatives and the President of the Senate.

SECTION 11. For purposes of determining whether a dental hygienist has met the experience requirements specified in division (C)(1) of section 4715.22 of the Revised Code, as amended by this act, all experience that the dental hygienist obtained prior to the effective date of this act shall be counted.

SECTION 12. Sections 3701.18 and 4503.104 of the Revised Code, as enacted by this act, shall take effect on the first day of the month that follows the month that includes the day that is the ninetieth day after the effective of this act.

SECTION 13. The amendment of sections 5112.01 and 5112.08 of the Revised Code by this act is not intended to supersede the repeal of those sections effective July 1, 1999.

SECTION 14. The repeal of sections 5111.75, 5111.77, 5111.771, and 5111.811 of the Revised Code is intended to confirm that such repeal was the result intended by the General Assembly in enacting Am. Sub. S.B. 62 and Am. Sub. S.B. 150 of the 121st General Assembly. The earlier of the two acts, Am. Sub. S.B. 62, repealed the sections in pursuance of its specific purpose of abolishing the Legislative Committee on Medicaid Oversight. The later of the two acts, Am. Sub. S.B. 150, purportedly amended the sections as they related to its general purpose of revising the health care and insurance laws. The later act, Am. Sub. S.B. 150, did not have a purpose sufficiently independent from that of Am. Sub. S.B. 62 such as to revive the sections.

SECTION 15. Section 3901.21 of the Revised Code is presented in this act as a composite of the section as amended by both Sub. H.B. 374 and Am. Sub. S.B. 70 of the 122nd General Assembly, with the language of neither of the acts shown in capital letters. Section 3924.08 of the Revised Code is presented in this act as a composite of the section as amended by both Sub. H.B. 374 and Am. Sub. S.B. 67 of the 122nd General Assembly, with the new language of neither of the acts shown in capital letters. This is in recognition of the principle stated in division (B) of section 1.52 of the Revised Code that such amendments are to be harmonized where not substantively irreconcilable and constitutes a legislative finding that such is the resulting version in effect prior to the effective date of this act.

_____

Speaker _____ of the House of Representatives.

_____

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

_____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

_____

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

_____

Secretary of State.

File No. _____ Effective Date _____