(127th General Assembly)
(Substitute House Bill Number 125)

AN ACT

To amend sections 1751.13, 1753.01, 1753.07, 1753.09, 2317.54, 3701.741, 3702.51, and 5111.17, to enact sections 3721.042, 3963.01 to 3963.11, and to repeal sections 1753.03, 1753.04, 1753.05, and 1753.08 of the Revised Code to establish certain uniform contract provisions between health care providers and contracting entities, to establish standardized credentialing, to require the Department of Job and Family Services to allow managed care plans to use providers to render care, to modify the fees for electronic copies of certain medical records and allow an authorized person to obtain one copy of a patient's medical record without charge, to exempt a nursing home that is a converted county or district home from administrative rules regarding the toilet rooms and dining and recreation areas of nursing homes if certain other requirements are met, to create a Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts, and to create an Advisory Committee on Eligibility and Real Time Claim Adjudication.

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

SECTION 1. That sections 1751.13, 1753.01, 1753.07, 1753.09, 2317.54, 3701.741, 3702.51, and 5111.17 be amended and sections 3721.042, 3963.01, 3963.02, 3963.03, 3963.04, 3963.05, 3963.06, 3963.07, 3963.08, 3963.09, 3963.10, and 3963.11 of the Revised Code be enacted to read as follows:

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 [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 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 department of job and family 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.

(f) A provision that violates Chapter 3963. of the Revised Code.

(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 that accepts compensation 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 notify its affected enrollees of the termination of a contract 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. 1753.01. As used in this chapter~~:~~

~~(A) "Economic profiling" means a health insuring corporation's use of economic performance data and economic information in determining whether to contract with a provider for the provision of covered health care services to enrollees as a participating provider.~~

~~(B) "Basic~~, "basic health care services," "enrollee," "health care facility," "health care services," "health insuring corporation," "medical record," "person," "primary care provider," "provider," "specialty health care services," "subscriber," and "supplemental health care services" have the same meanings as in section 1751.01 of the Revised Code.

Sec. 1753.07. (A)(1) Prior to entering into a participation contract with a provider under section 1751.13 of the Revised Code, a health insuring corporation shall disclose basic information regarding its programs and procedures to the provider~~, upon the provider's request~~. The information shall include all of the following:

~~(1)~~(a) How a participating provider is reimbursed for the participating provider's services, including the range and structure of any financial risk sharing arrangements, a description of any incentive plans, and, if reimbursed according to a type of fee-for-service arrangement, the level of reimbursement for the participating provider's services;

~~(2)~~(b) Insofar as division (A)(1) of section 3963.03 of the Revised Code is applicable, all of the information that is described in that division and is not included in division (A)(1)(a) of this section.

(2) Prior to entering into a participation contract with a provider under section 1751.13 of the Revised Code, a health insuring corporation shall disclose the following information upon the provider's request:

(a) How referrals to other participating providers or to nonparticipating providers are made;

~~(3)~~(b) The availability of dispute resolution procedures and the potential for cost to be incurred;

~~(4)~~(c) How a participating provider's name and address will be used in marketing materials.

(B) A health insuring corporation shall provide all of the following to a participating provider:

(1) Any material incorporated by reference into the participation contract, that is not otherwise available as a public record, if such material affects the participating provider;

(2) Administrative manuals related to provider participation, if any;

(3) Insofar as division (B) of section 3963.03 of the Revised Code is

applicable, the summary disclosure form with the disclosures required under that division;

(4) A signed and dated copy of the final participation contract.

(C) Nothing in this section requires a health insuring corporation providing specialty health care services or supplemental health care services to disclose the health insuring corporation's aggregate maximum allowable fee table used to determine providers' fees or fee schedules.

Sec. 1753.09. (A) Except as provided in division (D) of this section, prior to terminating the participation of a provider on the basis of the participating provider's failure to meet the health insuring corporation's standards for quality or utilization in the delivery of health care services, a health insuring corporation shall give the participating provider notice of the reason or reasons for its decision to terminate the provider's participation and an opportunity to take corrective action. The health insuring corporation shall develop a performance improvement plan in conjunction with the participating provider. If after being afforded the opportunity to comply with the performance improvement plan, the participating provider fails to do so, the health insuring corporation may terminate the participation of the provider.

(B)(1) A participating provider whose participation has been terminated under division (A) of this section may appeal the termination to the appropriate medical director of the health insuring corporation. The medical director shall give the participating provider an opportunity to discuss with the medical director the reason or reasons for the termination.

(2) If a satisfactory resolution of a participating provider's appeal cannot be reached under division (B)(1) of this section, the participating provider may appeal the termination to a panel composed of participating providers who have comparable or higher levels of education and training than the participating provider making the appeal. A representative of the participating provider's specialty shall be a member of the panel, if possible. This panel shall hold a hearing, and shall render its recommendation in the appeal within thirty days after holding the hearing. The recommendation shall be presented to the medical director and to the participating provider.

(3) The medical director shall review and consider the panel's recommendation before making a decision. The decision rendered by the medical director shall be final.

(C) A provider's status as a participating provider shall remain in effect during the appeal process set forth in division (B) of this section unless the termination was based on any of the reasons listed in division (D) of this section.

(D) Notwithstanding division (A) of this section, a provider's participation may be immediately terminated if the participating provider's conduct presents an imminent risk of harm to an enrollee or enrollees; or if there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, or loss of authority to practice in the participating provider's field; or if a governmental action has impaired the participating provider's ability to practice.

(E) Divisions (A) to (D) of this section apply only to providers who are natural persons.

(F)(1) Nothing in this section prohibits a health insuring corporation from rejecting a provider's application for participation, or from terminating a participating provider's contract, if the health insuring corporation determines that the health care needs of its enrollees are being met and no need exists for the provider's or participating provider's services.

(2) Nothing in this section shall be construed as prohibiting a health insuring corporation from terminating a participating provider who does not meet the terms and conditions of the participating provider's contract.

(3) Nothing in this section shall be construed as prohibiting a health insuring corporation from terminating a participating provider's contract pursuant to any provision of the contract described in division (E)(2) of section 3963.02 of the Revised Code, except that, notwithstanding any provision of a contract described in that division, this section applies to the termination of a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of this section.

(G) The superintendent of insurance may adopt rules as necessary to implement and enforce sections ~~1753.04 to~~ 1753.06, 1753.07, and 1753.09 of the Revised Code. Such rules shall be adopted in accordance with Chapter 119. of the Revised Code. The director of health may make recommendations to the superintendent for rules necessary to implement and enforce sections ~~1753.04 to~~ 1753.06, 1753.07, and 1753.09 of the Revised Code. In adopting any rules pursuant to this division, the superintendent shall consider the recommendations of the director.

Sec. 2317.54. No hospital, home health agency, ambulatory surgical facility, or provider of a hospice care program shall be held liable for a physician's failure to obtain an informed consent from the physician's patient prior to a surgical or medical procedure or course of procedures, unless the physician is an employee of the hospital, home health agency, ambulatory surgical facility, or provider of a hospice care program.

Written consent to a surgical or medical procedure or course of

procedures shall, to the extent that it fulfills all the requirements in divisions (A), (B), and (C) of this section, be presumed to be valid and effective, in the absence of proof by a preponderance of the evidence that the person who sought such consent was not acting in good faith, or that the execution of the consent was induced by fraudulent misrepresentation of material facts, or that the person executing the consent was not able to communicate effectively in spoken and written English or any other language in which the consent is written. Except as herein provided, no evidence shall be admissible to impeach, modify, or limit the authorization for performance of the procedure or procedures set forth in such written consent.

(A) The consent sets forth in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks, and, except in emergency situations, sets forth the names of the physicians who shall perform the intended surgical procedures.

(B) The person making the consent acknowledges that such disclosure of information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner.

(C) The consent is signed by the patient for whom the procedure is to be performed, or, if the patient for any reason including, but not limited to, competence, ~~infancy~~ minority, or the fact that, at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances, including either of the following:

(1) The parent, whether the parent is an adult or a minor, of the parent's minor child;

(2) An adult whom the parent of the minor child has given written authorization to consent to a surgical or medical procedure or course of procedures for the parent's minor child.

Any use of a consent form that fulfills the requirements stated in divisions (A), (B), and (C) of this section has no effect on the common law rights and liabilities, including the right of a physician to obtain the oral or implied consent of a patient to a medical procedure, that may exist as between physicians and patients on July 28, 1975.

As used in this section the term "hospital" has the same meaning as in section 2305.113 of the Revised Code; "home health agency" has the same meaning as in section 5101.61 of the Revised Code; "ambulatory surgical facility" has the meaning as in division (A) of section 3702.30 of the Revised Code; and "hospice care program" has the same meaning as in

section 3712.01 of the Revised Code. The provisions of this division apply to hospitals, doctors of medicine, doctors of osteopathic medicine, and doctors of podiatric medicine.

Sec. 3701.741. (A) ~~Through December 31, 2008, each~~ Each health care provider and medical records company shall provide copies of medical records in accordance with this section.

(B) Except as provided in divisions (C) and (E) of this section, a health care provider or medical records company that receives a request for a copy of a patient's medical record shall charge not more than the amounts set forth in this section.

(1) If the request is made by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

(a) ~~With~~ Except as provided in division (B)(1)(b) of this section, with respect to data recorded on paper or electronically, the following amounts:

(i) Two dollars and ~~fifty~~ seventy-four cents per page for the first ten pages;

(ii) ~~Fifty-one~~ Fifty-seven cents per page for pages eleven through fifty;

(iii) ~~Twenty~~ Twenty-three cents per page for pages fifty-one and higher;

(b) With respect to data resulting from an x-ray, magnetic resonance imaging (MRI), or computed axial tomography (CAT) scan and recorded ~~other than~~ on paper or film, one dollar and ~~seventy~~ eighty-seven cents per page;

(c) The actual cost of any related postage incurred by the health care provider or medical records company.

(2) If the request is made other than by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

(a) An initial fee of ~~fifteen~~ sixteen dollars and ~~thirty-five~~ eighty-four cents, which shall compensate for the records search;

(b) ~~With~~ Except as provided in division (B)(2)(c) of this section, with respect to data recorded on paper or electronically, the following amounts:

(i) One dollar and ~~two~~ eleven cents per page for the first ten pages;

(ii) ~~Fifty-one~~ Fifty-seven cents per page for pages eleven through fifty;

(iii) ~~Twenty~~ Twenty-three cents per page for pages fifty-one and higher.

(c) With respect to data resulting from an x-ray, magnetic resonance imaging (MRI), or computed axial tomography (CAT) scan and recorded ~~other than~~ on paper or film, one dollar and ~~seventy~~ eighty-seven cents per page;

(d) The actual cost of any related postage incurred by the health care

provider or medical records company.

(C)(1) ~~A~~ On request, a health care provider or medical records company shall provide one copy of the patient's medical record and one copy of any records regarding treatment performed subsequent to the original request, not including copies of records already provided, without charge to the following:

(a) The bureau of workers' compensation, in accordance with Chapters 4121. and 4123. of the Revised Code and the rules adopted under those chapters;

(b) The industrial commission, in accordance with Chapters 4121. and 4123. of the Revised Code and the rules adopted under those chapters;

(c) The department of job and family services or a county department of job and family services, in accordance with Chapters 5101. and 5111. of the Revised Code and the rules adopted under those chapters;

(d) The attorney general, in accordance with sections 2743.51 to 2743.72 of the Revised Code and any rules that may be adopted under those sections;

(e) A patient ~~or,~~ patient's personal representative, or authorized person if the medical record is necessary to support a claim under Title II or Title XVI of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 401 and 1381, as amended, and the request is accompanied by documentation that a claim has been filed.

(2) Nothing in division (C)(1) of this section requires a health care provider or medical records company to provide a copy without charge to any person or entity not listed in division (C)(1) of this section.

(D) Division (C) of this section shall not be construed to supersede any rule of the bureau of workers' compensation, the industrial commission, or the department of job and family services.

(E) A health care provider or medical records company may enter into a contract with either of the following for the copying of medical records at a fee other than as provided in division (B) of this section:

(1) A patient, a patient's personal representative, or an authorized person;

(2) An insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state or health insuring corporations holding a certificate of authority under Chapter 1751. of the Revised Code.

(F) This section does not apply to medical records the copying of which is covered by section 173.20 of the Revised Code or by 42 C.F.R. 483.10.

Sec. 3702.51. As used in sections 3702.51 to 3702.62 of the Revised

Code:

(A) "Applicant" means any person that submits an application for a certificate of need and who is designated in the application as the applicant.

(B) "Person" means any individual, corporation, business trust, estate, firm, partnership, association, joint stock company, insurance company, government unit, or other entity.

(C) "Certificate of need" means a written approval granted by the director of health to an applicant to authorize conducting a reviewable activity.

(D) "Health service area" means a geographic region designated by the director of health under section 3702.58 of the Revised Code.

(E) "Health service" means a clinically related service, such as a diagnostic, treatment, rehabilitative, or preventive service.

(F) "Health service agency" means an agency designated to serve a health service area in accordance with section 3702.58 of the Revised Code.

(G) "Health care facility" means:

(1) A hospital registered under section 3701.07 of the Revised Code;

(2) A nursing home licensed under section 3721.02 of the Revised Code, or by a political subdivision certified under section 3721.09 of the Revised Code;

(3) A county home or a county nursing home as defined in section 5155.31 of the Revised Code that is certified under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;

(4) A freestanding dialysis center;

(5) A freestanding inpatient rehabilitation facility;

(6) An ambulatory surgical facility;

(7) A freestanding cardiac catheterization facility;

(8) A freestanding birthing center;

(9) A freestanding or mobile diagnostic imaging center;

(10) A freestanding radiation therapy center.

A health care facility does not include the offices of private physicians and dentists whether for individual or group practice, residential facilities licensed under section 5123.19 of the Revised Code, or an institution for the sick that is operated exclusively for patients who use spiritual means for healing and for whom the acceptance of medical care is inconsistent with their religious beliefs, accredited by a national accrediting organization, exempt from federal income taxation under section 501 of the Internal Revenue Code of 1986, 100 Stat. 2085, 26 U.S.C.A. 1, as amended, and providing twenty-four hour nursing care pursuant to the exemption in

division (E) of section 4723.32 of the Revised Code from the licensing requirements of Chapter 4723. of the Revised Code.

(H) "Medical equipment" means a single unit of medical equipment or a single system of components with related functions that is used to provide health services.

(I) "Third-party payer" means a health insuring corporation licensed under Chapter 1751. of the Revised Code, a health maintenance organization as defined in division (K) of this section, an insurance company that issues sickness and accident insurance in conformity with Chapter 3923. of the Revised Code, a state-financed health insurance program under Chapter 3701., 4123., or 5111. of the Revised Code, or any self-insurance plan.

(J) "Government unit" means the state and any county, municipal corporation, township, or other political subdivision of the state, or any department, division, board, or other agency of the state or a political subdivision.

(K) "Health maintenance organization" means a public or private organization organized under the law of any state that is qualified under section 1310(d) of Title XIII of the "Public Health Service Act," 87 Stat. 931 (1973), 42 U.S.C. 300e-9.

(L) "Existing health care facility" means either of the following:

(1) A health care facility that is licensed or otherwise authorized to operate in this state in accordance with applicable law, including a county home or a county nursing home that is certified as of February 1, 2008, under Title XVIII or Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, is staffed and equipped to provide health care services, and is actively providing health services;

(2) A health care facility that is licensed or otherwise authorized to operate in this state in accordance with applicable law, including a county home or a county nursing home that is certified as of February 1, 2008, under Title XVIII or Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended, or that has beds registered under section 3701.07 of the Revised Code as skilled nursing beds or long-term care beds and has provided services for at least three hundred sixty-five consecutive days within the twenty-four months immediately preceding the date a certificate of need application is filed with the director of health.

(M) "State" means the state of Ohio, including, but not limited to, the general assembly, the supreme court, the offices of all elected state officers, and all departments, boards, offices, commissions, agencies, institutions, and other instrumentalities of the state of Ohio. "State" does not include

political subdivisions.

(N) "Political subdivision" means a municipal corporation, township, county, school district, and all other bodies corporate and politic responsible for governmental activities only in geographic areas smaller than that of the state to which the sovereign immunity of the state attaches.

(O) "Affected person" means:

(1) An applicant for a certificate of need, including an applicant whose application was reviewed comparatively with the application in question;

(2) The person that requested the reviewability ruling in question;

(3) Any person that resides or regularly uses health care facilities within the geographic area served or to be served by the health care services that would be provided under the certificate of need or reviewability ruling in question;

(4) Any health care facility that is located in the health service area where the health care services would be provided under the certificate of need or reviewability ruling in question;

(5) Third-party payers that reimburse health care facilities for services in the health service area where the health care services would be provided under the certificate of need or reviewability ruling in question;

(6) Any other person who testified at a public hearing held under division (B) of section 3702.52 of the Revised Code or submitted written comments in the course of review of the certificate of need application in question.

(P) "Osteopathic hospital" means a hospital registered under section 3701.07 of the Revised Code that advocates osteopathic principles and the practice and perpetuation of osteopathic medicine by doing any of the following:

(1) Maintaining a department or service of osteopathic medicine or a committee on the utilization of osteopathic principles and methods, under the supervision of an osteopathic physician;

(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians;

(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members.

(Q) "Ambulatory surgical facility" has the same meaning as in section 3702.30 of the Revised Code.

(R) Except as otherwise provided in division (T) of this section, and until the termination date specified in section 3702.511 of the Revised Code, "reviewable activity" means any of the following:

(1) The addition by any person of any of the following health services,

regardless of the amount of operating costs or capital expenditures:

(a) A heart, heart-lung, lung, liver, kidney, bowel, pancreas, or bone marrow transplantation service, a stem cell harvesting and reinfusion service, or a service for transplantation of any other organ unless transplantation of the organ is designated by public health council rule not to be a reviewable activity;

(b) A cardiac catheterization service;

(c) An open-heart surgery service;

(d) Any new, experimental medical technology that is designated by rule of the public health council.

(2) The acceptance of high-risk patients, as defined in rules adopted under section 3702.57 of the Revised Code, by any cardiac catheterization service that was initiated without a certificate of need pursuant to division (R)(3)(b) of the version of this section in effect immediately prior to April 20, 1995;

(3)(a) The establishment, development, or construction of a new health care facility other than a new long-term care facility or a new hospital;

(b) The establishment, development, or construction of a new hospital or the relocation of an existing hospital;

(c) The relocation of hospital beds, other than long-term care, perinatal, or pediatric intensive care beds, into or out of a rural area.

(4)(a) The replacement of an existing hospital;

(b) The replacement of an existing hospital obstetric or newborn care unit or freestanding birthing center.

(5)(a) The renovation of a hospital that involves a capital expenditure, obligated on or after June 30, 1995, of five million dollars or more, not including expenditures for equipment, staffing, or operational costs. For purposes of division (R)(5)(a) of this section, a capital expenditure is obligated:

(i) When a contract enforceable under Ohio law is entered into for the construction, acquisition, lease, or financing of a capital asset;

(ii) When the governing body of a hospital takes formal action to commit its own funds for a construction project undertaken by the hospital as its own contractor;

(iii) In the case of donated property, on the date the gift is completed under applicable Ohio law.

(b) The renovation of a hospital obstetric or newborn care unit or freestanding birthing center that involves a capital expenditure of five million dollars or more, not including expenditures for equipment, staffing, or operational costs.

(6) Any change in the health care services, bed capacity, or site, or any other failure to conduct the reviewable activity in substantial accordance with the approved application for which a certificate of need was granted, if the change is made prior to the date the activity for which the certificate was issued ceases to be a reviewable activity;

(7) Any of the following changes in perinatal bed capacity or pediatric intensive care bed capacity:

(a) An increase in bed capacity;

(b) A change in service or service-level designation of newborn care beds or obstetric beds in a hospital or freestanding birthing center, other than a change of service that is provided within the service-level designation of newborn care or obstetric beds as registered by the department of health;

(c) A relocation of perinatal or pediatric intensive care beds from one physical facility or site to another, excluding the relocation of beds within a hospital or freestanding birthing center or the relocation of beds among buildings of a hospital or freestanding birthing center at the same site.

(8) The expenditure of more than one hundred ten per cent of the maximum expenditure specified in a certificate of need;

(9) Any transfer of a certificate of need issued prior to April 20, 1995, from the person to whom it was issued to another person before the project that constitutes a reviewable activity is completed, any agreement that contemplates the transfer of a certificate of need issued prior to that date upon completion of the project, and any transfer of the controlling interest in an entity that holds a certificate of need issued prior to that date. However, the transfer of a certificate of need issued prior to that date or agreement to transfer such a certificate of need from the person to whom the certificate of need was issued to an affiliated or related person does not constitute a reviewable transfer of a certificate of need for the purposes of this division, unless the transfer results in a change in the person that holds the ultimate controlling interest in the certificate of need.

(10)(a) The acquisition by any person of any of the following medical equipment, regardless of the amount of operating costs or capital expenditure:

(i) A cobalt radiation therapy unit;

(ii) A linear accelerator;

(iii) A gamma knife unit.

(b) The acquisition by any person of medical equipment with a cost of two million dollars or more. The cost of acquiring medical equipment includes the sum of the following:

(i) The greater of its fair market value or the cost of its lease or

purchase;

(ii) The cost of installation and any other activities essential to the acquisition of the equipment and its placement into service.

(11) The addition of another cardiac catheterization laboratory to an existing cardiac catheterization service.

(S) Except as provided in division (T) of this section, "reviewable activity" also means any of the following activities, none of which are subject to a termination date:

(1) The establishment, development, or construction of a new long-term care facility;

(2) The replacement of an existing long-term care facility;

(3) The renovation of a long-term care facility that involves a capital expenditure of two million dollars or more, not including expenditures for equipment, staffing, or operational costs;

(4) Any of the following changes in long-term care bed capacity:

(a) An increase in bed capacity;

(b) A relocation of beds from one physical facility or site to another, excluding the relocation of beds within a long-term care facility or among buildings of a long-term care facility at the same site;

(c) A recategorization of hospital beds registered under section 3701.07 of the Revised Code from another registration category to skilled nursing beds or long-term care beds.

(5) Any change in the health services, bed capacity, or site, or any other failure to conduct the reviewable activity in substantial accordance with the approved application for which a certificate of need concerning long-term care beds was granted, if the change is made within five years after the implementation of the reviewable activity for which the certificate was granted;

(6) The expenditure of more than one hundred ten per cent of the maximum expenditure specified in a certificate of need concerning long-term care beds;

(7) Any transfer of a certificate of need that concerns long-term care beds and was issued prior to April 20, 1995, from the person to whom it was issued to another person before the project that constitutes a reviewable activity is completed, any agreement that contemplates the transfer of such a certificate of need upon completion of the project, and any transfer of the controlling interest in an entity that holds such a certificate of need. However, the transfer of a certificate of need that concerns long-term care beds and was issued prior to April 20, 1995, or agreement to transfer such a certificate of need from the person to whom the certificate was issued to an

affiliated or related person does not constitute a reviewable transfer of a certificate of need for purposes of this division, unless the transfer results in a change in the person that holds the ultimate controlling interest in the certificate of need.

(T) "Reviewable activity" does not include any of the following activities:

(1) Acquisition of computer hardware or software;

(2) Acquisition of a telephone system;

(3) Construction or acquisition of parking facilities;

(4) Correction of cited deficiencies that are in violation of federal, state, or local fire, building, or safety laws and rules and that constitute an imminent threat to public health or safety;

(5) Acquisition of an existing health care facility that does not involve a change in the number of the beds, by service, or in the number or type of health services;

(6) Correction of cited deficiencies identified by accreditation surveys of the joint commission on accreditation of healthcare organizations or of the American osteopathic association;

(7) Acquisition of medical equipment to replace the same or similar equipment for which a certificate of need has been issued if the replaced equipment is removed from service;

(8) Mergers, consolidations, or other corporate reorganizations of health care facilities that do not involve a change in the number of beds, by service, or in the number or type of health services;

(9) Construction, repair, or renovation of bathroom facilities;

(10) Construction of laundry facilities, waste disposal facilities, dietary department projects, heating and air conditioning projects, administrative offices, and portions of medical office buildings used exclusively for physician services;

(11) Acquisition of medical equipment to conduct research required by the United States food and drug administration or clinical trials sponsored by the national institute of health. Use of medical equipment that was acquired without a certificate of need under division (T)(11) of this section and for which premarket approval has been granted by the United States food and drug administration to provide services for which patients or reimbursement entities will be charged shall be a reviewable activity.

(12) Removal of asbestos from a health care facility.

Only that portion of a project that meets the requirements of division (T) of this section is not a reviewable activity.

(U) "Small rural hospital" means a hospital that is located within a rural

area, has fewer than one hundred beds, and to which fewer than four thousand persons were admitted during the most recent calendar year.

(V) "Children's hospital" means any of the following:

(1) A hospital registered under section 3701.07 of the Revised Code that provides general pediatric medical and surgical care, and in which at least seventy-five per cent of annual inpatient discharges for the preceding two calendar years were individuals less than eighteen years of age;

(2) A distinct portion of a hospital registered under section 3701.07 of the Revised Code that provides general pediatric medical and surgical care, has a total of at least one hundred fifty registered pediatric special care and pediatric acute care beds, and in which at least seventy-five per cent of annual inpatient discharges for the preceding two calendar years were individuals less than eighteen years of age;

(3) A distinct portion of a hospital, if the hospital is registered under section 3701.07 of the Revised Code as a children's hospital and the children's hospital meets all the requirements of division (V)(1) of this section.

(W) "Long-term care facility" means any of the following:

(1) A nursing home licensed under section 3721.02 of the Revised Code or by a political subdivision certified under section 3721.09 of the Revised Code;

(2) The portion of any facility, including a county home or county nursing home, that is certified as a skilled nursing facility or a nursing facility under Title XVIII or XIX of the "Social Security Act";

(3) The portion of any hospital that contains beds registered under section 3701.07 of the Revised Code as skilled nursing beds or long-term care beds.

(X) "Long-term care bed" means a bed in a long-term care facility.

(Y) "Perinatal bed" means a bed in a hospital that is registered under section 3701.07 of the Revised Code as a newborn care bed or obstetric bed, or a bed in a freestanding birthing center.

(Z) "Freestanding birthing center" means any facility in which deliveries routinely occur, regardless of whether the facility is located on the campus of another health care facility, and which is not licensed under Chapter 3711. of the Revised Code as a level one, two, or three maternity unit or a limited maternity unit.

(AA)(1) "Reviewability ruling" means a ruling issued by the director of health under division (A) of section 3702.52 of the Revised Code as to whether a particular proposed project is or is not a reviewable activity.

(2) "Nonreviewability ruling" means a ruling issued under that division

that a particular proposed project is not a reviewable activity.

(BB)(1) "Metropolitan statistical area" means an area of this state designated a metropolitan statistical area or primary metropolitan statistical area in United States office of management and budget bulletin ~~No.~~ no. 93-17, June 30, 1993, and its attachments.

(2) "Rural area" means any area of this state not located within a metropolitan statistical area.

(CC) "County nursing home" has the same meaning as in section 5155.31 of the Revised Code.

Sec. 3721.042. The director of health may not deny a nursing home license to a facility seeking a license under this chapter as a nursing home on the grounds that the facility does not satisfy a requirement established in rules adopted under section 3721.04 of the Revised Code regarding the toilet rooms and dining and recreational areas of nursing homes if all of the following requirements are met:

(A) The facility seeks a license under this chapter because it is a county home or district home being sold under section 5155.31 of the Revised Code to a person who may not operate the facility without a nursing home license under this chapter.

(B) The requirement would not have applied to the facility had the facility been a nursing home first licensed under this chapter before October 20, 2001.

(C) The facility was a nursing facility, as defined in section 5111.20 of the Revised Code, on the date immediately preceding the date the facility is sold to the person seeking the license.

Sec. 3963.01. As used in this chapter:

(A) "Affiliate" means any person or entity that has ownership or control of a contracting entity, is owned or controlled by a contracting entity, or is under common ownership or control with a contracting entity.

(B) "Basic health care services" has the same meaning as in division (A) of section 1751.01 of the Revised Code, except that it does not include any services listed in that division that are provided by a pharmacist or nursing home.

(C) "Contracting entity" means any person that has a primary business purpose of contracting with participating providers for the delivery of health care services.

(D) "Credentialing" means the process of assessing and validating the qualifications of a provider applying to be approved by a contracting entity to provide basic health care services, specialty health care services, or supplemental health care services to enrollees.

(E) "Edit" means adjusting one or more procedure codes billed by a participating provider on a claim for payment or a practice that results in any of the following:

(1) Payment for some, but not all of the procedure codes originally billed by a participating provider;

(2) Payment for a different procedure code than the procedure code originally billed by a participating provider;

(3) A reduced payment as a result of services provided to an enrollee that are claimed under more than one procedure code on the same service date.

(F) "Electronic claims transport" means to accept and digitize claims or to accept claims already digitized, to place those claims into a format that complies with the electronic transaction standards issued by the United States department of health and human services pursuant to the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as those electronic standards are applicable to the parties and as those electronic standards are updated from time to time, and to electronically transmit those claims to the appropriate contracting entity, payer, or third-party administrator.

(G) "Enrollee" means any person eligible for health care benefits under a health benefit plan, including an eligible recipient of medicaid under Chapter 5111. of the Revised Code, and includes all of the following terms:

(1) "Enrollee" and "subscriber" as defined by section 1751.01 of the Revised Code;

(2) "Member" as defined by section 1739.01 of the Revised Code;

(3) "Insured" and "plan member" pursuant to Chapter 3923. of the Revised Code;

(4) "Beneficiary" as defined by section 3901.38 of the Revised Code.

(H) "Health care contract" means a contract entered into, materially amended, or renewed between a contracting entity and a participating provider for the delivery of basic health care services, specialty health care services, or supplemental health care services to enrollees.

(I) "Health care services" means basic health care services, specialty health care services, and supplemental health care services.

(J) "Material amendment" means an amendment to a health care contract that decreases the participating provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or adds a new product. A material amendment does not include any of the following:

(1) A decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the contract;

(2) A decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract;

(3) An administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract;

(4) Changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase the provider's administrative expense;

(5) Changes to an edit program or to specific edits if the participating provider is provided notice of the changes pursuant to division (A)(1) of section 3963.04 of the Revised Code and the notice includes information sufficient for the provider to determine the effect of the change;

(6) Changes to a health care contract described in division (B) of section 3963.04 of the Revised Code.

(K) "Participating provider" means a provider that has a health care contract with a contracting entity and is entitled to reimbursement for health care services rendered to an enrollee under the health care contract.

(L) "Payer" means any person that assumes the financial risk for the payment of claims under a health care contract or the reimbursement for health care services provided to enrollees by participating providers pursuant to a health care contract.

(M) "Primary enrollee" means a person who is responsible for making payments 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 care plan.

(N) "Procedure codes" includes the American medical association's current procedural terminology code, the American dental association's current dental terminology, and the centers for medicare and medicaid services health care common procedure coding system.

(O) "Product" means one of the following types of categories of coverage for which a participating provider may be obligated to provide health care services pursuant to a health care contract:

(1) A health maintenance organization or other product provided by a health insuring corporation;

(2) A preferred provider organization;

(3) Medicare;

(4) Medicaid or the children's buy-in program established under section 5101.5211 to 5101.5216 of the Revised Code;

(5) Workers' compensation.

(P) "Provider" means a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, physician assistant, advanced practice nurse, occupational therapist, massage therapist, physical therapist, professional counselor, professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts. "Provider" does not mean a pharmacist, pharmacy, nursing home, or a provider organization or physician-hospital organization that leases the provider organization's or physician-hospital organization's network to a third party or contracts directly with employers or health and welfare funds.

(Q) "Specialty health care services" has the same meaning as in section 1751.01 of the Revised Code, except that it does not include any services listed in division (B) of section 1751.01 of the Revised Code that are provided by a pharmacist or a nursing home.

(R) "Supplemental health care services" has the same meaning as in division (B) of section 1751.01 of the Revised Code, except that it does not include any services listed in that division that are provided by a pharmacist or nursing home.

Sec. 3963.02. (A)(1) No contracting entity shall sell, rent, or give a third party the contracting entity's rights to a participating provider's services pursuant to the contracting entity's health care contract with the participating provider unless one of the following applies:

(a) The third party accessing the participating provider's services under the health care contract is an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract with the contracting entity or its affiliate for the administration or processing of claims for payment for services provided pursuant to the health care contract with the participating provider.

(b) The third party accessing the participating provider's services under the health care contract either is an affiliate or subsidiary of the contracting entity or is providing administrative services to, or receiving administrative services from, the contracting entity or an affiliate or subsidiary of the contracting entity.

(c) The health care contract specifically provides that it applies to

network rental arrangements and states that one purpose of the contract is selling, renting, or giving the contracting entity's rights to the services of the participating provider, including other preferred provider organizations, and the third party accessing the participating provider's services is any of the following:

(i) A payer or a third-party administrator or other entity responsible for administering claims on behalf of the payer;

(ii) A preferred provider organization or preferred provider network that receives access to the participating provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the participating provider that is in compliance with division (A)(1)(c) of this section, and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the participating provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

(iii) An entity that is engaged in the business of providing electronic claims transport between the contracting entity and the payer or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the participating provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

(2) The contracting entity that sells, rents, or gives the contracting entity's rights to the participating provider's services pursuant to the contracting entity's health care contract with the participating provider as provided in division (A)(1) of this section shall do both of the following:

(a) Maintain a web page that contains a listing of third parties described in divisions (A)(1)(b) and (c) of this section with whom a contracting entity contracts for the purpose of selling, renting, or giving the contracting entity's rights to the services of participating providers that is updated at least every six months and is accessible to all participating providers, or maintain a toll-free telephone number accessible to all participating providers by means of which participating providers may access the same listing of third parties;

(b) Require that the third party accessing the participating provider's services through the participating provider's health care contract is obligated to comply with all of the applicable terms and conditions of the contract, including, but not limited to, the products for which the participating provider has agreed to provide services, except that a payer receiving administrative services from the contracting entity or its affiliate shall be

solely responsible for payment to the participating provider.

(3) Any information disclosed to a participating provider under this section shall be considered proprietary and shall not be distributed by the participating provider.

(4) Except as provided in division (A)(1) of this section, no entity shall sell, rent, or give a contracting entity's rights to the participating provider's services pursuant to a health care contract.

(B)(1) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider provide services for all of the products offered by the contracting entity.

(2) Division (B)(1) of this section shall not be construed to do any of the following:

(a) Prohibit any participating provider from voluntarily accepting an offer by a contracting entity to provide health care services under all of the contracting entity's products;

(b) Prohibit any contracting entity from offering any financial incentive or other form of consideration specified in the health care contract for a participating provider to provide health care services under all of the contracting entity's products;

(c) Require any contracting entity to contract with a participating provider to provide health care services for less than all of the contracting entity's products if the contracting entity does not wish to do so.

(3)(a) Notwithstanding division (B)(2) of this section, no contracting entity shall require, as a condition of contracting with the contracting entity, that the participating provider accept any future product offering that the contracting entity makes.

(b) If a participating provider refuses to accept any future product offering that the contracting entity makes, the contracting entity may terminate the health care contract based on the participating provider's refusal upon written notice to the participating provider no sooner than one hundred eighty days after the refusal.

(4) Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the financial incentive or other form of consideration that is specified in the health care contract pursuant to division (B)(2)(b) of this section is the financial incentive or other form of consideration that was offered by the contracting entity to induce the participating provider to enter into the contract.

(C) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider waive or forego any right or benefit expressly conferred upon a participating provider by state or

federal law. However, this division does not prohibit a contracting entity from restricting a participating provider's scope of practice for the services to be provided under the contract.

(D) No health care contract shall do any of the following:

(1) Prohibit any participating provider from entering into a health care contract with any other contracting entity;

(2) Prohibit any contracting entity from entering into a health care contract with any other provider;

(3) Preclude its use or disclosure for the purpose of enforcing this chapter or other state or federal law, except that a health care contract may require that appropriate measures be taken to preserve the confidentiality of any proprietary or trade-secret information.

(E)(1) In addition to any other lawful reasons for terminating a health care contract, a health care contract may only be terminated under the circumstances described in division (A)(3) of section 3963.04 of the Revised Code.

(2) If the health care contract provides for termination for cause by either party, the health care contract shall state the reasons that may be used for termination for cause, which terms shall be reasonable. Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the reasons stated in the health care contract for termination for cause by either party are reasonable. Subject to division (E)(3) of this section, the health care contract shall state the time by which the parties must provide notice of termination for cause and to whom the parties shall give the notice.

(3) Nothing in divisions (E)(1) and (2) of this section shall be construed as prohibiting any health insuring corporation from terminating a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code. Notwithstanding any provision in a health care contract pursuant to division (E)(2) of this section, section 1753.09 of the Revised Code applies to the termination of a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code.

(4) Subject to sections 3963.01 to 3963.11 of the Revised Code, nothing in this section prohibits the termination of a health care contract without cause if the health care contract otherwise provides for termination without cause.

(F)(1) Disputes among parties to a health care contract that only concern the enforcement of the contract rights conferred by section 3963.02,

divisions (A) and (D) of section 3963.03, and section 3963.04 of the Revised Code are subject to a mutually agreed upon arbitration mechanism that is binding on all parties. The arbitrator may award reasonable attorney's fees and costs for arbitration relating to the enforcement of this section to the prevailing party.

(2) The arbitrator shall make the arbitrator's decision in an arbitration proceeding having due regard for any applicable rules, bulletins, rulings, or decisions issued by the department of insurance or any court concerning the enforcement of the contract rights conferred by section 3963.02, divisions (A) and (D) of section 3963.03, and section 3963.04 of the Revised Code.

(3) A party shall not simultaneously maintain an arbitration proceeding as described in division (F)(1) of this section and pursue a complaint with the superintendent of insurance to investigate the subject matter of the arbitration proceeding. However, if a complaint is filed with the department of insurance, the superintendent may choose to investigate the complaint or, after reviewing the complaint, advise the complainant to proceed with arbitration to resolve the complaint. The superintendent may request to receive a copy of the results of the arbitration. If the superintendent of insurance notifies an insurer or a health insuring corporation in writing that the superintendent has initiated a market conduct examination into the specific subject matter of the arbitration proceeding pending against that insurer or health insuring corporation, the arbitration proceeding shall be stayed at the request of the insurer or health insuring corporation pending the outcome of the market conduct investigation by the superintendent.

Sec. 3963.03. (A) Each health care contract shall include all of the following information:

(1)(a) Information sufficient for the participating provider to determine the compensation or payment terms for health care services, including all of the following, subject to division (A)(1)(b) of this section:

(i) The manner of payment, such as fee-for-service, capitation, or risk;

(ii) The fee schedule of procedure codes reasonably expected to be billed by a participating provider's specialty for services provided pursuant to the health care contract and the associated payment or compensation for each procedure code. A fee schedule may be provided electronically. Upon request, a contracting entity shall provide a participating provider with the fee schedule for any other procedure codes requested and a written fee schedule, that shall not be required more frequently than twice per year excluding when it is provided in connection with any change to the schedule. This requirement may be satisfied by providing a clearly understandable, readily available mechanism, such as a specific web site

address, that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted.

(iii) The effect, if any, on payment or compensation if more than one procedure code applies to the service also shall be stated. This requirement may be satisfied by providing a clearly understandable, readily available mechanism, such as a specific web site address, that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted.

(b) If the contracting entity is unable to include the information described in division (A)(1)(a)(ii) and (iii) of this section, the contracting entity shall include both of the following types of information instead:

(i) The methodology used to calculate any fee schedule, such as relative value unit system and conversion factor or percentage of billed charges. If applicable, the methodology disclosure shall include the name of any relative value unit system, its version, edition, or publication date, any applicable conversion or geographic factor, and any date by which compensation or fee schedules may be changed by the methodology as anticipated at the time of contract.

(ii) The identity of any internal processing edits , including the publisher, product name, version, and version update of any editing software.

(c) If the contracting entity is not the payer and is unable to include the information described in division (A)(1)(a) or (b) of this section, then the contracting entity shall provide by telephone a readily available mechanism, such as a specific web site address, that allows the participating provider to obtain that information from the payer.

(2) Any product or network for which the participating provider is to provide services;

(3) The term of the health care contract;

(4) A specific web site address that contains the identity of the contracting entity or payer responsible for the processing of the participating provider's compensation or payment;

(5) Any internal mechanism provided by the contracting entity to resolve disputes concerning the interpretation or application of the terms and conditions of the contract. A contracting entity may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as a specific web site address or an appendix, that allows a participating provider to determine the procedures for the internal mechanism to resolve those disputes.

(6) A list of addenda, if any, to the contract.

(B)(1) Each contracting entity shall include a summary disclosure form with a health care contract that includes all of the information specified in division (A) of this section. The information in the summary disclosure form shall refer to the location in the health care contract, whether a page number, section of the contract, appendix, or other identifiable location, that specifies the provisions in the contract to which the information in the form refers.

(2) The summary disclosure form shall include all of the following statements:

(a) That the form is a guide to the health care contract and that the terms and conditions of the health care contract constitute the contract rights of the parties;

(b) That reading the form is not a substitute for reading the entire health care contract;

(c) That by signing the health care contract, the participating provider will be bound by the contract's terms and conditions;

(d) That the terms and conditions of the health care contract may be amended pursuant to section 3963.04 of the Revised Code and the participating provider is encouraged to carefully read any proposed amendments sent after execution of the contract;

(e) That nothing in the summary disclosure form creates any additional rights or causes of action in favor of either party.

(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate shall be subject to a civil action for damages or to binding arbitration based on the summary disclosure form. Division (B)(3) of this section does not impair or affect any power of the department of insurance to enforce any applicable law.

(4) The summary disclosure form described in divisions (B)(1) and (2) of this section shall be in substantially the following form:

"SUMMARY DISCLOSURE FORM

(1) Compensation terms

(a) Manner of payment

[ ] Fee for service

[ ] Capitation

[ ] Risk

[ ] Other ..... See .....

(b) Fee schedule available at .....

(c) Fee calculation schedule available at .....

(d) Identity of internal processing edits available at .....

(e) Information in (c) and (d) is not required if information in (b) is provided.

(2) List of products or networks covered by this contract

[ ] .....
[ ] .....
[ ] .....
[ ] .....
[ ] .....

(3) Term of this contract .....

(4) Contracting entity or payer responsible for processing payment available at .....

(5) Internal mechanism for resolving disputes regarding contract terms available at .....

(6) Addenda to contract

	Title	Subject
(a)		
(b)		
(c)		
(d)		

(7) Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the information in (1) through (6) from the payer.

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01(G) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties.

Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Health Care Contract.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party."

(C) When a contracting entity presents a proposed health care contract for consideration by a provider, the contracting entity shall provide in writing or make reasonably available the information required in division (A)(1) of this section.

(D) The contracting entity shall identify any utilization management,

quality improvement, or a similar program that the contracting entity uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The contracting entity shall disclose the policies, procedures, or guidelines of such a program applicable to a participating provider upon request by the participating provider within fourteen days after the date of the request.

(E) Nothing in this section shall be construed as preventing or affecting the application of section 1753.07 of the Revised Code that would otherwise apply to a contract with a participating provider.

(F) The requirements of division (C) of this section do not prohibit a contracting entity from requiring a reasonable confidentiality agreement between the provider and the contracting entity regarding the terms of the proposed health care contract. If either party violates the confidentiality agreement, a party to the confidentiality agreement may bring a civil action to enjoin the other party from continuing any act that is in violation of the confidentiality agreement, to recover damages, to terminate the contract, or to obtain any combination of relief.

Sec. 3963.04. (A)(1) If an amendment to a health care contract is not a material amendment, the contracting entity shall provide the participating provider notice of the amendment at least fifteen days prior to the effective date of the amendment. The contracting entity shall provide all other notices to the participating provider pursuant to the health care contract.

(2) A material amendment to a health care contract shall occur only if the contracting entity provides to the participating provider the material amendment in writing and notice of the material amendment not later than ninety days prior to the effective date of the material amendment. The notice shall be conspicuously entitled "Notice of Material Amendment to Contract."

(3) If within fifteen days after receiving the material amendment and notice described in division (A)(2) of this section, the participating provider objects in writing to the material amendment, and there is no resolution of the objection, either party may terminate the health care contract upon written notice of termination provided to the other party not later than sixty days prior to the effective date of the material amendment.

(4) If the participating provider does not object to the material amendment in the manner described in division (A)(3) of this section, the material amendment shall be effective as specified in the notice described in division (A)(2) of this section.

(B)(1) Division (A) of this section does not apply if the delay caused by compliance with that division could result in imminent harm to an enrollee,

if the material amendment of a health care contract is required by state or federal law, rule, or regulation, or if the provider affirmatively accepts the material amendment in writing and agrees to an earlier effective date than otherwise required by division (A)(2) of this section.

(2) This section does not apply under any of the following circumstances:

(a) The participating provider's payment or compensation is based on the current medicaid or medicare physician fee schedule, and the change in payment or compensation results solely from a change in that physician fee schedule.

(b) A routine change or update of the health care contract is made in response to any addition, deletion, or revision of any service code, procedure code, or reporting code, or a pricing change is made by any third party source.

For purposes of division (B)(2)(b) of this section:

(i) "Service code, procedure code, or reporting code" means the current procedural terminology (CPT), current dental terminology (CDT), the healthcare common procedure coding system (HCPCS), the international classification of diseases (ICD), or the drug topics redbook average wholesale price (AWP).

(ii) "Third party source" means the American medical association, American dental association, the centers for medicare and medicaid services, the national center for health statistics, the department of health and human services office of the inspector general, the Ohio department of insurance, or the Ohio department of job and family services.

(C) Notwithstanding divisions (A) and (B) of this section, a health care contract may be amended by operation of law as required by any applicable state or federal law, rule, or regulation. Nothing in this section shall be construed to require the renegotiation of a health care contract that is in existence before the effective date of this section, until the time that the contract is renewed or materially amended.

Sec. 3963.05. (A) The department of insurance shall prescribe the credentialing application form used by the council for affordable quality healthcare (CAQH) in electronic or paper format for physicians. The department of insurance also shall prepare the standard credentialing form for all other providers and shall make the standard credentialing form as simple, straightforward, and easy to use as possible, having due regard for those credentialing forms that are widely in use in the state by contracting entities and that best serve these goals.

(B) No contracting entity shall fail to use the applicable standard

credentialing form described in division (A) of this section when initially credentialing or recredentialing providers in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services.

(C) No contracting entity shall require a provider to provide any information in addition to the information required by the applicable standard credentialing form described in division (A) of this section in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services.

(D) The credentialing process described in this section does not prohibit a contracting entity from limiting the scope of any participating provider's basic health care services, specialty health care services, or supplemental health care services.

(E) The requirement that the department of insurance prepare the standard credentialing form for all other providers does not include preparing the standard credentialing form for a hospital.

Sec. 3963.06. (A) If a provider, upon the oral or written request of a contracting entity to submit a credentialing form, submits a credentialing form that is not complete, the contracting entity that receives the form shall notify the provider of the deficiency electronically, by facsimile, or by certified mail, return receipt requested, not later than twenty-one days after the contracting entity receives the form.

(B) If a contracting entity receives any information that is inconsistent with the information given by the provider in the credentialing form, the contracting entity may request the provider to submit a written clarification of the inconsistency. The contracting entity shall send the request described in this division electronically, by facsimile, or by certified mail, return receipt requested.

(C)(1) Except as otherwise provided in division (C)(2) of this section, the credentialing process under this section starts when a provider initially submits a credentialing form upon the oral or written request of a contracting entity, and the provider shall submit the credentialing form to the contracting entity electronically, by facsimile, or by certified mail, return receipt requested. Subject to division (C)(3) of this section, a contracting entity shall complete the credentialing process not later than ninety days after the contracting entity receives that credentialing form from the provider. The contracting entity shall allow the provider to submit a credentialing application prior to the provider's employment. A contracting entity that does not complete the credentialing process within the ninety-day

period specified in this division is liable for either a civil penalty payable to the provider in the amount of five hundred dollars per day, including weekend days, starting at the expiration of that ninety-day period until the provider's credentialing application is granted or denied or retroactive reimbursement to the provider according to the terms of the contract for any basic health care services, specialty health care services, or supplemental health care services the provider provided to enrollees starting at the expiration of that ninety-day period until the provider's credentialing application is granted or denied. When the credentialing process of the contracting entity exceeds the ninety-day period, the contracting entity shall select the liability to which the contracting entity is subject and shall inform the provider of the contracting entity's selection.

(2) The credentialing process for a medicaid managed care plan starts when the provider submits a credentialing form and the provider's national provider number issued by the centers for medicare and medicaid services.

(3) The requirement that the credentialing process be completed within the ninety-day period specified in division (C)(1) of this section does not apply to a contracting entity if a provider that submits a credentialing form to the contracting entity under that division is a hospital.

(D) Any communication between the provider and the contracting entity shall be electronically, by facsimile, or by certified mail, return receipt requested.

(E) If the state medical board or its agent has primary source verified the medical education, graduate medical education, and examination history of the physician, or the status of the physician with the educational commission for foreign medical graduates, if applicable, the contracting entity may accept the documentation of primary source verification from the state medical board's web site or from its agent and is not required to perform primary source verification of the medical education, graduate medical education, and examination history of the physician or the status of the physician with the educational commission for foreign medical graduates, if applicable, as a condition for initially credentialing or recredentialing the physician.

Sec. 3963.07. (A) All remittance notices sent by a payer, whether written or electronic, shall include both of the following:

(1) The name of the payer issuing the payment to the participating provider;

(2) The name of the contracting entity through which the payment rate and any discount are claimed, if the contracting entity is different from the payer.

(B) Division (A) of this section takes effect March 31, 2009.

Sec. 3963.08. The superintendent of insurance shall adopt any rules necessary for the implementation of this chapter.

Sec. 3963.09. (A) A series of violations of this chapter by any person regulated by the department of insurance under Title XVII or Title XXXIX of the Revised Code that, taken together, constitute a pattern or practice of violating this chapter may be defined as an unfair and deceptive insurance practice under sections 3901.19 to 3901.26 of the Revised Code.

(B) The superintendent of insurance may conduct a market conduct examination of any person regulated by the department of insurance under Title XVII or Title XXXIX of the Revised Code to determine whether any violation of this chapter has occurred. When conducting that type of examination, the superintendent of insurance may assess the costs of the examination against the person examined. The superintendent may enter into a consent agreement to impose any administrative assessment or fine for conduct discovered that may be a violation of this chapter. All costs, assessments, and fines collected under this section shall be deposited to the credit of the department of insurance operating fund.

Sec. 3963.10. This chapter does not apply with respect to any of the following:

(A) A contract or provider agreement between a provider and the state or federal government, a state agency, or federal agency for health care services provided through a program for medicaid or medicare;

(B) A contract for payments made to providers for rendering health care services to claimants pursuant to claims made under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;

(C) An exclusive contract between a health insuring corporation and a single group of providers in a specific geographic area to provide or arrange for the provision of health care services.

Sec. 3963.11. (A) No contracting entity shall do any of the following:

(1) Offer to a provider other than a hospital a health care contract that includes a most favored nation clause;

(2) Enter into a health care contract with a provider other than a hospital that includes a most favored nation clause;

(3) Amend an existing health care contract previously entered into with a provider other than a hospital to include a most favored nation clause.

(B) This section shall not go into effect until three years after the effective date of this section.

(C) As used in this section:

(1) "Contracting entity," "health care contract," "health care services,"

"participating provider," and "provider" have the same meanings as in section 3963.01 of the Revised Code.

(2) "Most favored nation clause" means a provision in a health care contract that does any of the following:

(a) Prohibits, or grants a contracting entity an option to prohibit, the participating provider from contracting with another contracting entity to provide health care services at a lower price than the payment specified in the contract;

(b) Requires, or grants a contracting entity an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

(c) Requires, or grants a contracting entity an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

(d) Requires the participating provider to disclose the participating provider's contractual reimbursement rates with other contracting entities.

Sec. 5111.17. (A) The department of job and family services may enter into contracts with managed care organizations, including health insuring corporations, under which the organizations are authorized to provide, or arrange for the provision of, health care services to medical assistance recipients who are required or permitted to obtain health care services through managed care organizations as part of the care management system established under section 5111.16 of the Revised Code.

(B) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

(C) The department of job and family services shall allow managed care plans to use providers to render care upon completion of the managed care plan's credentialing process.

SECTION 2. That existing sections 1751.13, 1753.01, 1753.07, 1753.09, 2317.54, 3701.741, 3702.51, and 5111.17 and sections 1753.03, 1753.04, 1753.05, and 1753.08 of the Revised Code are hereby repealed.

SECTION 3. Sections 3963.01 to 3963.11 of the Revised Code, as enacted by this act, shall apply only to contracts that are delivered, issued for delivery, or renewed or materially amended in this state on or after the

effective date of this act. A health insuring corporation having fewer than fifteen thousand enrollees shall comply with the provisions of this section within twelve months after the effective date of this act.

SECTION 4. Section 3963.06 of the Revised Code, as enacted by this act, takes effect ninety days after the effective date of this act.

SECTION 5. (A) As used in this section and Section 6 of this act:

(1) "Most favored nation clause" means a provision in a health care contract that does any of the following:

(a) Prohibits, or grants a contracting entity an option to prohibit, the participating provider from contracting with another contracting entity to provide health care services at a lower price than the payment specified in the contract;

(b) Requires, or grants a contracting entity an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

(c) Requires, or grants a contracting entity an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

(d) Requires the participating provider to disclose the participating provider's contractual reimbursement rates with other contracting entities.

(2) "Contracting entity," "health care contract," "health care services," "participating provider," and "provider" have the same meanings as in section 3963.01 of the Revised Code, as enacted by this act.

(B) No health care contract that includes a most favored nation clause shall be entered into, and no health care contract at the instance of a contracting entity shall be amended or renewed to include a most favored nation clause, for a period of two years after the effective date of this act, subject to extension as provided in Section 6 of this act. This section does not apply to and does not prohibit the continued use of a most favored nation clause in a health care contract that is between a contracting entity and a hospital and that is in existence on the effective date of this act even if the health care contract is materially amended with respect to any provision of the health care contract other than the most favored nation clause during the two-year period specified in this section or during any extended period of time as provided in Section 6 of this act.

SECTION 6. (A) There is hereby created the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts consisting of seventeen members as follows:

(1) The Superintendent of Insurance;

(2) Two members of the House of Representatives, one representing the majority party and one representing the minority party;

(3) Two members of the Senate, one representing the majority party and one representing the minority party;

(4) Three providers who are individuals;

(5) Two representatives of hospitals;

(6) Two representatives of contracting entities regulated by the Department of Insurance under Title XVII of the Revised Code;

(7) Two representatives of contracting entities regulated by the Department of Insurance under Title XXXIX of the Revised Code;

(8) One representative of an employer that pays for the health insurance coverage of its employees;

(9) A licensed attorney with an expertise in antitrust law who represents providers;

(10) A licensed attorney with an expertise in antitrust law who represents contracting entities that have used most favored nation clauses in their health care contracts and that are regulated by the Department of Insurance under either Title XVII or Title XXXIX of the Revised Code.

(B) The members of the Commission shall be appointed as follows:

(1) The Speaker of the House of Representatives shall appoint the two members of the House specified in division (A)(2) of this section.

(2) The President of the Senate shall appoint the two members of the Senate specified in division (A)(3) of this section.

(3) The Speaker of the House of Representatives and the President of the Senate jointly shall appoint the remaining members specified in divisions (A)(4) to (10) of this section.

(C) Initial appointments to the Commission shall be made within thirty days after the effective date of this act. The appointments shall be for the term of the Commission as provided in division (F)(2) of this section. Vacancies shall be filled in the same manner provided for original appointments.

(D)(1) The Superintendent of Insurance shall be the Chairperson of the Commission. Meetings of the Commission shall be at the call of the Chairperson. All of the members of the Commission shall be voting members. Meetings of the Commission shall be held pursuant to section

121.22 of the Revised Code.

(2) The Department of Insurance shall provide office space or other facilities, any administrative or other technical, professional, or clerical employees, and any necessary supplies for the work of the Commission.

(3) The Chairperson of the Commission shall keep the records of the Commission. Upon submission of the Commission's final report to the General Assembly under division (F) of this section, the Chairperson shall deliver all of the Commission's records to the General Assembly.

(E)(1) The Commission shall study the following areas pertaining to health care contracts:

(a) The procompetitive and anticompetitive aspects of most favored nation clauses;

(b) The impact of most favored nation clauses on health care costs and on the availability of and accessibility to quality health care;

(c) The costs associated with the enforcement of most favored nation clauses;

(d) Other state laws and rules pertaining to most favored nation clauses in their health care contracts;

(e) Matters determined by the Department of Insurance as relevant to the study of most favored nation clauses;

(f) Any other matters that the Commission considers appropriate to determine the effectiveness of most favored nation clauses.

(2) The Commission may take testimony from experts or interested parties on the areas of its study as described in division (E)(1) of this section.

(F)(1) Not less than ninety days prior to the expiration of the two-year period specified in Section 5 of this act, the Commission shall report its preliminary findings to the General Assembly and a recommendation of whether to extend that two-year period for one additional year. If the General Assembly does not grant the extension, the Commission shall submit its final report to the General Assembly not later than three months after the expiration of the two-year period specified in Section 5 of this act. If the General Assembly grants the extension, the extension shall be for not more than one year after the expiration of the two-year period specified in Section 5 of this act, and the Commission shall submit its final report to the General Assembly not later than six months prior to the expiration of the one-year extension.

(2) The final report of the Commission shall include its findings and recommendations on whether state law should prohibit or restrict most favored nation clauses in health care contracts. The Commission shall cease

to exist upon the submission of its final report to the General Assembly.

SECTION 7. (A) There is hereby created the Advisory Committee on Eligibility and Real Time Claim Adjudication to study and recommend mechanisms or standards that will enable providers to send to and receive from payers sufficient information to enable a provider to determine at the time of the enrollee's visit the enrollee's eligibility for services covered by the payer as well as real time adjudication of provider claims for services.

(B) The Superintendent of Insurance or the Superintendent's designee shall be a member of the Advisory Committee and shall appoint at least one representative from each of the following groups or entities:

(1) Persons eligible for health care benefits under a health benefit plan;

(2) Physicians;

(3) Hospitals;

(4) Health benefit plan issuers;

(5) Other health care providers;

(6) Health care administrators;

(7) Payers of health care benefits, including employers;

(8) Preferred provider networks;

(9) Health care technology vendors;

(10) The Office of Information Technology.

(C) Initial appointments to the Advisory Committee shall be made within thirty days after the effective date of this act. The appointments shall be for the term of the Advisory Committee as provided in division (I) of this section. Vacancies shall be filled in the same manner provided for original appointments. Members of the Advisory Committee shall serve without compensation.

(D)(1) The Superintendent of Insurance shall be the Chairperson of the Advisory Committee. Meetings of the Advisory Committee shall be at the call of the Chairperson. All of the members of the Advisory Committee shall be voting members. Meetings of the Advisory Committee shall be held pursuant to section 121.22 of the Revised Code.

(2) The Department of Insurance shall provide office space or other facilities, any administrative or other technical, professional, or clerical employees, and any necessary supplies for the work of the Advisory Committee.

(E)(1) The Advisory Committee shall advise the Superintendent of Insurance on both of the following:

(a) The technical aspects of using the transaction standards mandated by the "Health Insurance Portability and Accountability Act of 1996," 110 Stat.

1955, 42 U.S.C. 1320d, et seq., and the transaction standards and rules of the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange to require health benefit plan issuers and administrators to provide access to information technology that will enable physicians and other health care providers to generate a request for eligibility information at the point of service that is compliant with those transaction standards;

(b) The data elements that health benefit plan issuers and administrators are required to make available, using, to the extent possible, the framework adopted by the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange.

(2) The Advisory Committee shall consider including the following data elements in the information that must be made available in eligibility and real time adjudication transactions:

(a) The name, date of birth, member identification number, and coverage status of the patient;

(b) The identification of the payer, insurer, issuer, and administrator, as applicable;

(c) The name and telephone number of the payer's contact person;

(d) The payer's address;

(e) The name and address of the subscriber;

(f) The patient's relationship to the subscriber;

(g) The type of service;

(h) The type of health benefit plan or product;

(i) The effective date of the health care coverage;

(j) For professional services:

(i) The amount of any copayment;

(ii) The amount of an individual deductible;

(iii) The amount of a family deductible;

(iv) Benefit limitations and maximums.

(k) For facility services:

(i) The amount of any copayment or coinsurance;

(ii) The amount of an individual deductible;

(iii) The amount of a family deductible;

(iv) Benefit limitations and maximums.

(l) Precertification or prior authorization requirements;

(m) Policy maximum limits;

(n) Patient liability for a proposed service;

(o) The health benefit plan coverage amount for a proposed service.

(F) The Advisory Committee shall make recommendations regarding all

of the following:

(1) The use of internet web site technologies, smart card technologies, magnetic strip technologies, biometric technologies, or other information technologies to facilitate the generation of a request for eligibility information that is compliant with the transaction standards and rules of the Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange;

(2) Time frames for the implementation of the recommendations in division (F)(1) of this section;

(3) When a provider may rely upon the eligibility information transmitted by a payer regarding a service provided to an enrollee for purposes of allocating responsibility for payment for services rendered by the provider. The Advisory Committee shall further recommend how disputes over enrollee eligibility for services received shall be resolved taking into consideration the legal relationship between the provider, the enrollee, and the payer.

(G) The recommendations made by the Advisory Committee shall not endorse or otherwise limit the choice of products or services available to health care payers, purchasers, or providers.

(H) Not later than January 1, 2009, the Advisory Committee shall provide the General Assembly with a report of its findings and recommendations for legislative action to standardize eligibility and real time adjudication transactions between providers and payers. The transaction standards adopted by the General Assembly shall, at a minimum, comply with the standards mandated by the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as further defined in Title 45, part 162 of the Code of Federal Regulations to the extent that the "Health Insurance Portability and Accountability Act of 1996" applies to the transaction.

(I) The Advisory Committee shall cease to exist upon the submission of its report and recommendations to the General Assembly.

_____

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 _____