As Introduced

127th General Assembly Regular Session 2007-2008

H. B. No. 456

Representative Raussen

Cosponsors: Representatives Huffman, Peterson, Wolpert, Blessing, Widowfield

A BILL

То	amend sections 9.901, 1731.03, 1731.05, 1731.09,	1
	1751.14, 1751.15, 1751.16, 3313.814, 3901.386,	2
	3923.05, 3923.122, 3923.24, 3923.58, 3923.581,	3
	3924.01, 3924.02, 3924.06, 3924.73, 4121.44,	4
	4121.441, 4123.29, 4715.22, 4715.23, 4715.39,	5
	4715.64, 5111.162, 5112.08, 5725.24, 5729.03,	6
	5747.01, 5747.08, and 5747.98; to enact sections	7
	185.01, 185.02, 185.03, 185.04, 185.05, 185.06,	8
	185.07, 185.08, 185.09, 185.10, 1753.281,	9
	3314.181, 3702.302, 3702.303, 3702.304, 3702.305,	10
	3727.51, 3923.241, 3923.641, 3923.651, 3923.80,	11
	3923.85, 3923.86, 3923.87, 3923.88, 3923.89,	12
	3923.90, 3923.91, 3923.92, 4123.292, 4715.221,	13
	4715.222, 4715.223, 4715.224, 4715.225, 4715.226,	14
	4715.227, 4715.228, 4715.229, 4715.2210, 5101.90,	15
	5101.91, 5101.92, 5101.93, 5101.94, 5101.95,	16
	5120.052, 5139.031, and 5747.81; and to repeal	17
	sections 3923.59, 3924.07, 3924.08, 3924.09,	18
	3924.10, 3924.11, 3924.111, 3924.12, 3924.13, and	19
	3924.14 of the Revised Code to establish Ohio CARE	20
	and to amend section 5112.08 of the Revised Code	21
	to limit or deny funds under the Hospital Care	22

H. B. No. 456	Page 2
As Introduced	

Assurance Program to a hospital that fails to	23
contract with Medicaid managed care organizations	24
and to provide that these provisions of this act	25
terminate on October 16, 2009, when section	26
5112.08 of the Revised Code is repealed on that	27
date.	28

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 9.901, 1731.03, 1731.05, 1731.09,	29
1751.14, 1751.15, 1751.16, 3313.814, 3901.386, 3923.05, 3923.122,	30
3923.24, 3923.58, 3923.581, 3924.01, 3924.02, 3924.06, 3924.73,	31
4121.44, 4121.441, 4123.29, 4715.22, 4715.23, 4715.39, 4715.64,	32
5111.162, 5112.08, 5725.24, 5729.03, 5747.01, 5747.08, and 5747.98	33
be amended and sections 185.01, 185.02, 185.03, 185.04, 185.05,	34
185.06, 185.07, 185.08, 185.09, 185.10, 1753.281, 3314.181,	35
3702.302, 3702.303, 3702.304, 3702.305, 3727.51, 3923.241,	36
3923.641, 3923.651, 3923.80, 3923.85, 3923.86, 3923.87, 3923.88,	37
3923.89, 3923.90, 3923.91, 3923.92, 4123.292, 4715.221, 4715.222,	38
4715.223, 4715.224, 4715.225, 4715.226, 4715.227, 4715.228,	39
4715.229, 4715.2210, 5101.90, 5101.91, 5101.92, 5101.93, 5101.94,	40
5101.95, 5120.052, 5139.031, and 5747.81 of the Revised Code be	41
enacted to read as follows:	42

Sec. 9.901. (A)(1) All health care benefits provided to 43 persons employed by the public school districts of this state 44 shall be provided by health care plans that contain best practices 45 established pursuant to this section by the school employees 46 health care board. Twelve months after the release of best 47 practices by the board all policies or contracts for health care 48 benefits provided to public school district employees that are 49 issued or renewed after the expiration of any applicable 50 collective bargaining agreement must contain best practices 51

established pursuant to this section by the board. Any or all of	52
the health care plans that contain best practices specified by the	53
board may be self-insured. As used in this section, a "public	54
school district" means a city, local, exempted village, or joint	55
vocational school district, and includes the educational service	56
centers associated with those districts but not charter schools.	57
(2) The board shall determine what strategies are used by the	58
existing medical plans to manage health care costs and shall study	59
the potential benefits of state or regional consortiums of public	60
schools offering multiple health care plans. As used in this	61
section:	62
(a) A "health care plan" includes group policies, contracts,	63
and agreements that provide hospital, surgical, or medical expense	64
coverage, including self-insured plans. A "health care plan" does	65
not include an individual plan offered to the employees of a	66
public school district, or a plan that provides coverage only for	67
specific disease or accidents, or a hospital indemnity, medicare	68
supplement, or other plan that provides only supplemental	69
benefits, paid for by the employees of a public school district.	70
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(b) A "health plan sponsor" means a public school district, a	72
consortium of public school districts, or a council of	73
governments.	74
(B) The school employees health care board is hereby created.	75
The school employees health care board shall consist of the	76
following twelve members and shall include individuals with	77
experience with public school district benefit programs, health	78
care industry providers, and health care plan beneficiaries:	79
(1) Four members appointed by the governor, one of whom shall	80
be representative of nonadministrative public school district	81

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employees;

(2) Four members appointed by the president of the senate,	83
one of whom shall be representative of nonadministrative public	84
school district employees;	85
(3) Four members appointed by the speaker of the house of	86
representatives, one of whom shall be representative of	87
nonadministrative public school district employees.	88
A member of the school employees health care board shall not	89
be employed by, represent, or in any way be affiliated with a	90
private entity that is providing services to the board, an	91
individual school district, employers, or employees in the state	92
of Ohio.	93
(C)(1) Members of the school employees health care board	94
shall serve four-year terms, but may be reappointed, except as	95
otherwise specified in division (B) of this section.	96
A member shall continue to serve subsequent to the expiration	97
of the member's term until a successor is appointed. Any vacancy	98
occurring during a member's term shall be filled in the same	99
manner as the original appointment, except that the person	100
appointed to fill the vacancy shall be appointed to the remainder	101
of the unexpired term.	102
(2) Members shall receive compensation fixed pursuant to	103
division (J) of section 124.15 of the Revised Code and shall be	104
reimbursed from the school employees health care fund for actual	105
and necessary expenses incurred in the performance of their	106
official duties as members of the board.	107
(3) Members may be removed by their appointing authority for	108
misfeasance, malfeasance, incompetence, dereliction of duty, or	109
other just cause.	110

(D)(1) At the first meeting of the board after the first day

chairperson and may elect members to other positions on the board

of January of each calendar year, the board shall elect a

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as the board considers necessary or appropriate. The board shall	114
meet at least nine times each calendar year and shall also meet at	115
the call of the chairperson or four or more board members. The	116
chairperson shall provide reasonable advance notice of the time	117
and place of board meetings to all members.	118
(2) A majority of the board constitutes a quorum for the	119
transaction of business at a board meeting. A majority vote of the	120
members present is necessary for official action.	121
(E) The school employees health care board shall conduct its	122
business at open meetings; however, the records of the board are	123
not public records for purposes of section 149.43 of the Revised	124
Code.	125
(F) The school employees health care fund is hereby created	126
in the state treasury. The board shall use all funds in the school	127
employees health care fund solely to carry out the provisions of	128
this section and related administrative costs.	129
(G) The school employees health care board shall do all of	130
the following:	131
(1) Include disease management and consumer education	132
programs, which programs shall include, but are not limited to,	133
wellness programs and other measures designed to encourage the	134
wise use of medical plan coverage. These programs are not services	135
or treatments for purposes of section 3901.71 of the Revised Code.	136
	137
(2) Adopt and release a set of standards that shall be	138
considered the best practices to which public school districts	139
shall adhere in the selection and implementation of health care	140
plans.	141
(2)(3) Include in the standards adopted under division $(G)(2)$	142
of this section a requirement that the provision of pharmacy	143

benefit management services and the payment and reimbursement for

prescription drugs must be in accordance with contracts negotiated	145
and entered into by the office of pharmaceutical purchasing	146
coordination under Chapter 185. of the Revised Code, or in	147
accordance with the lower pricing as may otherwise be established	148
by the school district pursuant to section 185.06 of the Revised	149
Code;	150
(4) Require that the plans the health plan sponsors	151
administer make readily available to the public all cost and	152
design elements of the plan;	153
$\frac{(3)}{(5)}$ Work with health plan sponsors through educational	154
outlets and consultation;	155
$\frac{(4)(6)}{(6)}$ Maintain a commitment to transparency and public	156
access of its meetings and activity pursuant to division (E) of	157
this section;	158
$\frac{(5)}{(7)}$ Promote cooperation among all organizations affected	159
by this section in identifying the elements for the successful	160
implementation of this section;	161
$\frac{(6)}{(8)}$ Promote cost containment measures aligned with	162
patient, plan, and provider management strategies in developing	163
and managing health care plans;	164
$\frac{(7)(9)}{(9)}$ Prepare and disseminate to the public an annual report	165
on the status of health plan sponsors' effectiveness in making	166
progress to reduce the rate of increase in insurance premiums and	167
employee out of pocket expenses, as well as progress in improving	168
the health status of school district employees and their families.	169
(H) The sections in Chapter 3923. of the Revised Code	170
regulating public employee benefit plans are not applicable to the	171
health care plans designed pursuant to this section.	172
(I) The board may contract with one or more independent	173
consultants to analyze costs related to employee health care	174

benefits provided by existing public school district plans in this 175 state. The consultants may evaluate the benefits offered by 176 existing health care plans, the employees' costs, and the 177 cost-sharing arrangements used by public school districts either 178 participating in a consortium or by other means. The consultants 179 may evaluate what strategies are used by the existing health care 180 plans to manage health care costs and the potential benefits of 181 state or regional consortiums of public schools offering multiple 182 health care plans. Based on the findings of the analysis, the 183 consultants may submit written recommendations to the board for 184 the development and implementation of successful best practices 185 and programs for improving school districts' purchasing power for 186 the acquisition of employee health care plans. 187

(J) The public schools health care advisory committee is 188 hereby created under the school employees health care board. The 189 committee shall make recommendations to the school employees 190 health care board related to the board's accomplishment of the 191 duties assigned to the board under this section. The committee 192 shall consist of eighteen members. The governor shall appoint two 193 representatives each from the Ohio education association, the Ohio 194 school boards association, and a health insuring corporation 195 licensed to do business in Ohio and recommended by the Ohio 196 association of Health Plans health plans. The speaker shall 197 appoint two representatives each from the Ohio association of 198 school business officials, the Ohio federation of teachers, and 199 the buckeye association of school administrators. The president of 200 the senate shall appoint two representatives each from the Ohio 201 association of health underwriters, an existing health care 202 consortium serving public schools, and the Ohio association of 203 public school employees. The initial appointees shall serve until 204 December 31, 2007; subsequent two-year appointments, to commence 205 on the first day of January of each year thereafter, and shall be 206 made in the same manner. A member shall continue to serve 207

subsequent to the expiration of the member's term until the	208
member's successor is appointed. Any vacancy occurring during a	209
member's term shall be filled in the same manner as the original	210
appointment, except that the person appointed to fill the vacancy	211
shall be appointed to the remainder of the unexpired term. The	212
advisory committee shall elect a chairperson at its first meeting	213
after the first day of January each year who shall call the time	214
and place of future committee meetings in addition to the meetings	215
that are to be held jointly with the school employees health care	216
board. Committee members are not subject to the conditions for	217
eligibility set by division (B) of this section for members of the	218
school employees health care board.	219

- (K) The board may adopt rules for the enforcement of health 220 plan sponsors' compliance with the best practices standards 221 adopted by the board pursuant to this section. 222
- (L) Any districts providing health care plan coverage for the employees of public school districts shall provide nonidentifiable 224 aggregate claims data for the coverage to the school employees 225 health care board, without charge, within sixty days after 226 receiving a written request from the board. The claims data shall 227 include data relating to employee group benefit sets, 228 demographics, and claims experience. 229
- (M)(1) The school employees health care board may contract 230 with other state agencies for services as the board deems 231 necessary for the implementation and operation of this section, 232 based on demonstrated experience and expertise in administration, 233 management, data handling, actuarial studies, quality assurance, 234 or for other needed services. The school employees health care 235 board may contract with the department of administrative services 236 for central services until such time the board deems itself able 237 to obtain such services from its own staff or from other sources. 238 The board shall reimburse the department of administrative 239

H. B. No. 456 As Introduced	Page 9
services for the reasonable cost of those services.	240
(2) The board shall hire staff as necessary to provide	241
administrative support to the board and the public school employee	242
health care plan program established by this section.	243
(N) Not more than ninety days before coverage begins for	244
public school district employees under health care plans	245
containing best practices prescribed by the school employees	246
health care board, a public school district's board of education	247
shall provide detailed information about the health care plans to	248
the employees.	249
(0) Nothing in this section shall be construed as prohibiting	250
public school districts from consulting with and compensating	251
insurance agents and brokers for professional services.	252
	253
(P) Pursuant to Chapter 117. of the Revised Code, the	254
auditor of state shall conduct all necessary and required audits	255
of the board. The auditor of state, upon request, also shall	256
furnish to the board copies of audits of public school districts	257
or consortia performed by the auditor of state.	258
Sec. 185.01. As used in this chapter:	259
"Participant" means the director of job and family services,	260
each managed care organization that contracts with the department	261
of job and family services under section 5111.17 of the Revised	262
Code, the administrator of workers' compensation, each state	263
retirement system, and the board of education of each school	264
district in this state.	265
"Prescription drug" means a drug that may not be dispensed	266
without a prescription from a licensed health professional	267
authorized to prescribe drugs.	268
"School district" means a city, local, exempted village, or	269

compensable claims filed under Chapters 4121., 4123., 4127., or

4131. of the Revised Code;

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(C) Claims for prescription drugs made under a contract or	299
policy established under section 145.58, 742.45, 3307.39, 3309.69,	300
or 5505.28 of the Revised Code or pursuant to a plan established	301
under section 145.81, 3307.81, or 3309.81 of the Revised Code;	302
(D) Claims for prescription drugs made under insurance or	303
coverage procured or paid for by school districts.	304
Sec. 185.04. (A) In furtherance of the purpose of the office	305
of pharmaceutical purchasing coordination stated in section 185.03	306
of the Revised Code, the office shall do both of the following:	307
	308
(1) Conduct a review of the pharmacy benefit management	309
programs, if any, the participants maintained on or immediately	310
prior to the effective date of this section. The review shall	311
consider, at a minimum, the cost and value of formularies,	312
application of rebates, medication therapy and chronic disease	313
management programs, and electronic prescribing.	314
(2) Except as provided in section 185.07 of the Revised Code,	315
negotiate and enter into one or more contracts on behalf of each	316
participant with a person under which the person provides pharmacy	317
benefits management services on behalf of the participant for the	318
claims described in section 185.03 of the Revised Code. The	319
provision of pharmacy benefit management services shall include,	320
at a minimum, both of the following:	321
(a) The negotiation of prices charged for prescription drugs;	322
(b) Unless a significant negative cost impact can be	323
demonstrated, the maintenance of one or more multiple or regional	324
pharmacy benefit management programs.	325
(B) Not later than one year after the effective date of this	326
section, the office shall submit a report to the governor and	327
general assembly that summarizes the results of the review	328

in the director's sole discretion and by the date established by

the director, that the participant is able to secure lower

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reimbursement rates for claims it pays that are described in	359
section 185.03 of the Revised Code without being included in a	360
contract negotiated by the office.	361
(B) If the director of job and family services chooses to	362
submit written evidence to the director of administrative services	363
under division (A) of this section, this evidence may include any	364
or all of the following:	365
(1) Subject to division (C) of this section, the value of	366
rebates paid by drug manufacturers to the department of job and	367
family services in accordance with a rebate agreement required by	368
42 U.S.C. 1396r-8;	369
(2) The value of supplemental rebates, if any, paid by drug	370
manufacturers to the department of job and family services in	371
accordance with the supplemental drug program the department is	372
permitted to establish under section 5111.081 of the Revised Code;	373
(3) The savings achieved by the department's establishment of	374
the maximum allowable cost program required by section 5111.082 of	375
the Revised Code.	376
(C) If the director of job and family services chooses to	377
submit the information described in division (B)(1) of this	378
section, the information shall be submitted in a manner that does	379
not disclose the identity of a specific manufacturer or wholesaler	380
as prohibited under 42 U.S.C. 1396r-8(b)(3)(D).	381
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Sec. 185.08. The director of health shall provide information	382
to the office of pharmaceutical purchasing coordination, on the	383
office's request, regarding prescription drugs or other scientific	384
<u>matters.</u>	385
Sec. 185.09. The director of job and family services shall	386
determine whether a waiver of federal medicaid requirements is	387
necessary to fulfill the requirements in this chapter. If the	388

director determines a waiver is necessary, the director of job and	389
family services shall notify the office of pharmaceutical	390
purchasing coordination of this fact and apply to the United	391
States secretary of health and human services for the waiver.	392
Sec. 185.10. The director of administrative services shall	393
adopt rules in accordance with Chapter 119. of the Revised Code,	394
as necessary, to implement this chapter.	395
Sec. 1731.03. (A) A small employer health care alliance may	396
do any of the following:	397
(1) Negotiate and enter into agreements with one or more	398
insurers for the insurers to offer and provide one or more health	399
benefit plans to small employers for their employees and retirees,	400
and the dependents and members of the families of such employees	401
and retirees, which coverage may be made available to enrolled	402
small employers without regard to industrial, rating, or other	403
classifications among the enrolled small employers under an	404
alliance program, except as otherwise provided under the alliance	405
program, and for the alliance to perform, or contract with others	406
for the performance of, functions under or with respect to the	407
alliance program;	408
(2) Contract with another alliance for the inclusion of the	409
small employer members of one in the alliance program of the	410
other;	411
(3) Provide or cause to be provided to small employers	412
information concerning the availability, coverage, benefits,	413
premiums, and other information regarding an alliance program and	414
promote the alliance program;	415
(4) Provide, or contract with others to provide, enrollment,	416
record keeping, information, premium billing, collection and	417

transmittal, and other services under an alliance program;

(5) Receive reports and information from the insurer and	419
negotiate and enter into agreements with respect to inspection and	420
audit of the books and records of the insurer;	421
(6) Provide services to and on behalf of an alliance program	422
sponsored by another alliance, including entering into an	423
agreement described in division (B) of section 1731.01 of the	424
Revised Code on behalf of the other alliance;	425
(7) If it is a nonprofit corporation created under Chapter	426
1702. of the Revised Code, exercise all powers and authority of	427
such corporations under the laws of the state, or, if otherwise	428
constituted, exercise such powers and authority as apply to it	429
under the applicable laws, and its articles, regulations,	430
constitution, bylaws, or other relevant governing instruments.	431
(B) A small employer health care alliance is not and shall	432
not be regarded for any purpose of law as an insurer, an offeror	433
or seller of any insurance, a partner of or joint venturer with	434
any insurer, an agent of, or solicitor for an agent of, or	435
representative of, an insurer or an offeror or seller of any	436
insurance, an adjuster of claims, or a third-party administrator,	437
and will not be liable under or by reason of any insurance	438
coverage or other health benefit plan provided or not provided by	439
any insurer or by reason of any conditions or restrictions on	440
eligibility or benefits under an alliance program or any insurance	441
or other health benefit plan provided under an alliance program or	442
by reason of the application of those conditions or restrictions.	443
(C) The promotion of an alliance program by an alliance or by	444
an insurer is not and shall not be regarded for any purpose of law	445
as the offer, solicitation, or sale of insurance.	446
(D)(1) No alliance shall adopt, impose, or enforce medical	447

underwriting rules or underwriting rules requiring a small

employer to have more than a minimum number of employees for the

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purpose of determining whether an alliance member is eligible to	450
purchase a policy, contract, or plan of health insurance or health	451
benefits from any insurer in connection with the alliance health	452
care program.	453
(2) No alliance shall reject any applicant for membership in	454
the alliance based on the health status of the applicant's	455
employees or their dependents or because the small employer does	456
not have more than a minimum number of employees.	457
(3) A violation of division (D)(1) or (2) of this section is	458
deemed to be an unfair and deceptive act or practice in the	459
business of insurance under sections 3901.19 to 3901.26 of the	460
Revised Code.	461
(4) Nothing in division $(D)(1)$ or (2) of this section shall	462
be construed as inhibiting or preventing an alliance from	463
adopting, imposing, and enforcing rules, conditions, limitations,	464
or restrictions that are based on factors other than the health	465
status of employees or their dependents or the size of the small	466
employer for the purpose of determining whether a small employer	467
is eligible to become a member of the alliance. Division (D)(1) of	468
this section does not apply to an insurer that sells health	469
coverage to an alliance member under an alliance health care	470
program.	471
(E) Except as otherwise specified in section 1731.09 of the	472
Revised Code, health benefit plans offered and sold to alliance	473
members that are small employers as defined in section 3924.01 of	474
the Revised Code are subject to sections 3924.01 to 3924.14	475
3924.06 of the Revised Code.	476
(F) Any person who represents an alliance in bargaining or	477
negotiating a health benefit plan with an insurer shall disclose	478

to the governing board of the alliance any direct or indirect

financial relationship the person has or had during the past two

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years with the insurer.	481
Sec. 1731.05. If a qualified alliance, or an alliance that,	482
based upon evidence of interest satisfactory to the superintendent	483
of insurance, will be a qualified alliance within a reasonable	484
time, submits a request for a proposal on a health benefit plan to	485
at least three insurers and does not receive at least one	486
reasonably responsive proposal within ninety days from the date	487
the last such request is submitted, the superintendent, at the	488
request of such alliance, may require that insurers offer	489
proposals to such alliance for health benefit plans for the small	490
employers within such alliance. Such proposals shall include such	491
coverage and benefits for such premiums, as shall take into	492
account the functions provided by the alliance and the economies	493
of scale, and have other terms and provisions as are approved by	494
the superintendent, consistent with the purposes and standards set	495
forth in section 1731.02 of the Revised Code. In making the	496
determination as to which insurers shall be asked to submit	497
proposals under this section, the superintendent shall apply the	498
following standards set forth in division (C)(4)(a) of section	499
3924.11 of the Revised Code:	500
(A) Demonstration by the carrier of a substantial and	501
established market presence;	502
(B) Demonstrated experience in the individual market and	503
history of rating and underwriting individual plans;	504
	F 0 F
(C) Commitment to comply with the requirements of section	505
3923.58 of the Revised Code;	506
(D) Financial ability to assume and manage the risk of	507
enrolling open enrollment individuals. Any insurer that does not	508
submit a proposal when required to do so by the superintendent	509
hereunder, shall be deemed to be in violation of section 3901.20	510
of the Revised Code and shall be subject to all of the provisions	511

of section 3901.22 of the Revised Code, including division (D)(1)	512
of section 3901.22 of the Revised Code as if it provided that the	513
superintendent may suspend or revoke an insurer's license to	514
engage in the business of insurance.	515
Nothing in this section shall be construed as requiring an	516
insurer to enter into an agreement with an alliance under	517
contractual terms that are not acceptable to the insurer or to	518
authorize the superintendent to require an insurer to enter into	519
an agreement with an alliance under contractual terms that are not	520
acceptable to the insurer.	521
This section applies beginning eighteen months after its	522
effective date.	523
Sec. 1731.09. (A) Nothing contained in this chapter is	524
intended to or shall inhibit or prevent the application of the	525
provisions of Chapter 3924. of the Revised Code to any health	526
benefit plan or insurer to which they would otherwise apply in the	527
absence of this chapter, except as otherwise specified in	528
divisions (B) and (C) of this section or unless such application	529
conflicts with the provisions of section 1731.05 of the Revised	530
Code.	531
(B) An insurer may establish one or more separate classes of	532
business solely comprised of one or more alliances. All of the	533
following shall apply to health plans covering small employers in	534
each class of business established pursuant to this division:	535
(1) The premium rate limitations set forth in section 3924.04	536
of the Revised Code apply to each class of business separate and	537
apart from the insurer's other business;	538
(2) For purposes of applying sections 3924.01 to 3924.14	539
3924.06 of the Revised Code to a class of business, the base	540

premium rate and midpoint rate shall be determined with respect to

each class of business separate and apart from the insurer's other	542
business.	543
(3) The midpoint rate for a class of business shall not	544
exceed the midpoint rate for any other class of business or the	545
insurer's non-alliance business by more than fifteen per cent.	546
(4) The insurer annually shall file with the superintendent	547
of insurance an actuarial certification consistent with section	548
3924.06 of the Revised Code for each class of business	549
demonstrating that the underwriting and rating methods of the	550
insurer do all of the following:	551
(a) Comply with accepted actuarial practices;	552
(b) Are uniformly applied to health benefit plans covering	553
small employers within the class of business;	554
(c) Comply with the applicable provisions of this section and	555
sections 3924.01 to 3924.14 <u>3924.06</u> of the Revised Code.	556
(5) An insurer shall apply sections 3924.01 to 3924.14	557
3924.06 of the Revised Code to the insurer's non-alliance business	558
and coverage sold through alliances not established as a separate	559
class of business.	560
(6) An insurer shall file with the superintendent a	561
notification identifying any alliance or alliances to be treated	562
as a separate class of business at least sixty days prior to the	563
date the rates for that class of business take effect.	564
(7) Any application for a certificate of authority filed	565
pursuant to section 1731.021 of the Revised Code shall include a	566
disclosure as to whether the alliance will be underwritten or	567
rated as part of a separate class of business.	568
(C) As used in this section:	569
(1) "Class of business" means a group of small employers, as	570

defined in section 3924.01 of the Revised Code, that are enrolled

employers in one or more alliances.	572
(2) "Actuarial certification," "base premium rate," and	573
"midpoint rate" have the same meanings as in section 3924.01 of	574
the Revised Code.	575
Sec. 1751.14. (A) Any policy, contract, or agreement for	576
health care services authorized by this chapter that is issued,	577
delivered, or renewed in this state and that provides that	578
coverage of $\frac{1}{2}$ and $\frac{1}{2}$ dependent child will terminate upon	579
attainment of the limiting age for dependent children specified in	580
the policy, contract, or agreement, shall also provide in	581
substance that attainment of the limiting age shall not operate to	582
terminate the coverage of the child if the child is and continues	583
to be both:	584
(1) Incapable of self-sustaining employment by reason of	585
mental retardation or physical handicap;	586
(2) Primarily dependent upon the subscriber for support and	587
maintenance.	588
(B) Proof of incapacity and dependence for purposes of	589
division (A) of this section shall be furnished to the health	590
insuring corporation within thirty-one days of the child's	591
attainment of the limiting age. Upon request, but not more	592
frequently than annually, the health insuring corporation may	593
require proof satisfactory to it of the continuance of such	594
incapacity and dependency.	595
(C) Notwithstanding section 3901.71 of the Revised Code, if	596
the limiting age for dependent children specified in the policy,	597
contract, or agreement pursuant to division (A) of this section is	598
less than twenty-nine years and both of the following are true of	599
the applicant, the health insuring corporation shall notify the	600
primary policy, contract, or agreement holder thirty days prior to	601

the dependent's attainment of the limiting age and offer to	602
provide coverage to the child as a dependent until age	603
<pre>twenty-nine:</pre>	604
(1) The child is a resident of Ohio or a full-time student at	605
an accredited public or private institution of higher education.	606
(2) Neither the child nor any spouse of the child is employed	607
by an employer that offers any health benefit plan under which the	608
child is eligible for coverage.	609
(D) No policy, contract, or agreement for health care	610
services authorized by this chapter that is issued, delivered, or	611
renewed in this state that provides for the coverage of any	612
dependent child shall terminate that coverage based solely upon	613
the fact that the child is married.	614
(E) Nothing in this section shall require an insurer to cover	615
a dependent child's spouse or children as dependents on the	616
policy, contract, or agreement of the parent or legal guardian of	617
the dependent.	618
(F) This section does not apply to any health insuring	619
corporation policy, contract, or agreement offering only	620
supplemental health care services or specialty health care	621
services.	622
(G) As used in this section, "health benefit plan" means any	623
of the following when the contract, policy, or plan provides	624
payment or reimbursement for the costs of health care services	625
other than for specific diseases or accidents only:	626
(1) An individual or group policy of sickness and accident	627
<u>insurance;</u>	628
(2) An individual or group contract of a health insuring	629
corporation;	630
(3) A public employee benefit plan;	631

(4) A multiple employer welfare arrangement as defined in	632
section 1739.01 of the Revised Code;	633
(5) A health benefit plan as regulated under the "Employee	634
Retirement Income Security Act of 1974" 29 U.S.C. 1001, et seq.	635
Sec. 1751.15. (A) After a health insuring corporation has	636
furnished, directly or indirectly, basic health care services for	637
a period of twenty-four months, and if it currently meets the	638
financial requirements set forth in section 1751.28 of the Revised	639
Code and had net income as reported to the superintendent of	640
insurance for at least one of the preceding four calendar	641
quarters, it shall hold an annual open enrollment period of not	642
less than thirty days during its month of licensure for	643
individuals who are not federally eligible individuals at the time	644
they apply for enrollment.	645
(B) During the open enrollment period described in division	646
(A) of this section, the health insuring corporation shall accept	647
applicants and their dependents in the order in which they apply	648
for enrollment and in accordance with any of the following:	649
(1) Up to its capacity, as determined by the health insuring	650
corporation subject to review by the superintendent;	651
(2) If less than its capacity, one per cent of the health	652
insuring corporation's total number of subscribers residing in	653
this state as of the immediately preceding thirty-first day of	654
December.	655
(C) Where a health insuring corporation demonstrates to the	656
satisfaction of the superintendent that such open enrollment would	657
jeopardize its economic viability, the superintendent may do any	658
of the following:	659
(1) Waive the requirement for open enrollment;	660
(2) Impose a limit on the number of applicants and their	661

(b) Is eliqible for continuation coverage under state or

H. B. No. 456
As Introduced

<pre>federal law;</pre>	692
(c) Is eligible for medicare, and the health insuring	693
corporation does not have an agreement on appropriate payment	694
mechanisms with the governmental agency administering the medicare	695
program.	696
(E) A health insuring corporation shall not be required	697
either to enroll applicants or their dependents who are confined	698
to a health care facility because of chronic illness, permanent	699
injury, or other infirmity that would cause economic impairment to	700
the health insuring corporation if such applicants or their	701
dependents were enrolled or to make the effective date of benefits	702
for applicants or their dependents enrolled under this section	703
earlier than ninety days after the date of enrollment.	704
(F) A health insuring corporation shall not be required to	705
cover the fees or costs, or both, for any basic health care	706
service related to a transplant of a body organ if the transplant	707
occurs within one year after the effective date of an enrollee's	708
coverage under this section. This limitation on coverage does not	709
apply to a newly born child who meets the requirements for	710
coverage under section 1751.61 of the Revised Code.	711
(G) Each health insuring corporation required to hold an open	712
enrollment pursuant to division (A) of this section shall file	713
with the superintendent, not later than sixty days prior to the	714
commencement of the proposed open enrollment period, the following	715
documents:	716
(1) The proposed public notice of open enrollment;	717
(2) The evidence of coverage approved pursuant to section	718
1751.11 of the Revised Code that will be used during open	719
enrollment;	720
(3) The contractual periodic prepayment and premium rate	721
approved pursuant to section 1751.12 of the Revised Code that will	722

be applicable during open enrollment;	723
(4) Any solicitation document approved pursuant to section	724
1751.31 of the Revised Code to be sent to applicants, including	725
the application form that will be used during open enrollment;	726
(5) A list of the proposed dates of publication of the public	727
notice, and the names of the newspapers in which the notice will	728
appear;	729
(6) Any request for a restriction, limit, or waiver with	730
respect to the open enrollment period, along with any supporting	731
documentation.	732
(H)(1) An open enrollment period shall not satisfy the	733
requirements of this section unless the health insuring	734
corporation provides adequate public notice in accordance with	735
divisions $(H)(2)$ and (3) of this section. No public notice shall	736
be used until the form of the public notice has been filed by the	737
health insuring corporation with the superintendent. If the	738
superintendent does not disapprove the public notice within sixty	739
days after it is filed, it shall be deemed approved, unless the	740
superintendent sooner gives approval for the public notice. If the	741
superintendent determines within this sixty-day period that the	742
public notice fails to meet the requirements of this section, the	743
superintendent shall so notify the health insuring corporation and	744
it shall be unlawful for the health insuring corporation to use	745
the public notice. Such disapproval shall be effected by a written	746
order, which shall state the grounds for disapproval and shall be	747
issued in accordance with Chapter 119. of the Revised Code.	748
(2) A public notice pursuant to division (H)(1) of this	749
section shall be published in at least one newspaper of general	750
circulation in each county in the health insuring corporation's	751
service area, at least once in each of the two weeks immediately	752
preceding the month in which the open enrollment is to occur and	753

H. B. No. 456
As Introduced

in each week of that month, or until the enrollment limitation is	754
reached, whichever occurs first. The notice published during the	755
last week of open enrollment shall appear not less than five days	756
before the end of the open enrollment period. It shall be at least	757
two newspaper columns wide or two and one-half inches wide,	758
whichever is larger. The first two lines of the text shall be	759
published in not less than twelve-point, boldface type. The	760
remainder of the text of the notice shall be published in not less	761
than eight-point type. The entire public notice shall be	762
surrounded by a continuous black line not less than one-eighth of	763
an inch wide.	764
(3) The following information shall be included in the public	765
notice provided under division (H)(2) of this section:	766
(a) The dates that open enrollment will be held and the date	767
coverage obtained under the open enrollment will become effective;	768
(b) Notice that an applicant or the applicant's dependents	769
will not be denied coverage during open enrollment because of a	770
preexisting health condition, but that some limitations and	771
restrictions may apply;	772
(c) The address where a person may obtain an application;	773
(d) The telephone number that a person may call to request an	774
application or to ask questions;	775
(e) The date the first payment will be due;	776
(f) The actual rates or range of rates that will be	777
applicable for applicants;	778
(g) Any limitation granted by the superintendent on the	779
number of applications that will be accepted by the health	780
insuring corporation.	781
(4) Within thirty days after the end of an open enrollment	782

period, the health insuring corporation shall submit to the

superintendent proof of publication for the public notices, and	784
shall report the total number of applicants and their dependents	785
enrolled during the open enrollment period.	786
(I)(1) No health insuring corporation may employ any scheme,	787
plan, or device that restricts the ability of any person to enroll	788
during open enrollment.	789
(2) No health insuring corporation may require enrollment to	790
be made in person. Every health insuring corporation shall permit	791
application for coverage by mail. A representative of the health	792
insuring corporation may visit an applicant who has submitted an	793
application by mail, in order to explain the operations of the	794
health insuring corporation and to answer any questions the	795
applicant may have. Every health insuring corporation shall make	796
open enrollment applications and solicitation documents readily	797
available to any potential applicant who requests such material.	798
(J) An application postmarked on the last day of an open	799
enrollment period shall qualify as a valid application, regardless	800
of the date on which it is received by the health insuring	801
corporation.	802
(K) This section does not apply to any health insuring	803
corporation that offers only supplemental health care services or	804
specialty health care services, or to any health insuring	805
corporation that offers plans only through Title XVIII or Title	806
XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.	807
301, as amended, and that has no other commercial enrollment, or	808
to any health insuring corporation that offers plans only through	809
other federal health care programs regulated by federal regulatory	810
bodies and that has no other commercial enrollment, or to any	811
health insuring corporation that offers plans only through	812
contracts covering officers or employees of the state that have	813

been entered into by the department of administrative services and

that has no other commercial enrollment.

814

(L) Each health insuring corporation shall accept federally	816
eligible individuals for open enrollment coverage as provided in	817
section 3923.581 of the Revised Code. A health insuring	818
corporation may reinsure coverage of any federally eligible	819
individual acquired under that section with the open enrollment	820
reinsurance program in accordance with division (G) of section	821
3924.11 of the Revised Code. Fixed periodic prepayment rates	822
charged for coverage reinsured by the program shall be established	823
in accordance with section 3924.12 of the Revised Code.	824
(M) As used in this section, "federally eligible individual"	825
means an eligible individual as defined in 45 C.F.R. 148.103.	826
Sec. 1751.16. (A) Except as provided in division (F) of this	827
section, every group contract issued by a health insuring	828
corporation shall provide an option for conversion to an	829
individual contract issued on a direct-payment basis to any	830
subscriber covered by the group contract who terminates employment	831
or membership in the group, unless:	832
(1) Termination of the conversion option or contract is based	833
upon nonpayment of premium after reasonable notice in writing has	834
been given by the health insuring corporation to the subscriber.	835
(2) The subscriber is, or is eligible to be, covered for	836
benefits at least comparable to the group contract under any of	837
the following:	838
(a) Title XVIII of the "Social Security Act," 49 Stat. 620	839
(1935), 42 U.S.C.A. 301, as amended;	840
(b) Any act of congress or law under this or any other state	841
of the United States providing coverage at least comparable to the	842
benefits under division (A)(2)(a) of this section;	843
(c) Any policy of insurance or health care plan providing	844
coverage at least comparable to the benefits under division	845

(A)(2)(a) of this section.	846
(B)(1) The direct-payment contract offered by the health	847
insuring corporation pursuant to division (A) of this section	848
shall provide the following:	849
(a) In the case of an individual who is not a federally	850
eligible individual, benefits comparable to benefits in any of the	851
individual contracts then being issued to individual subscribers	852
by the health insuring corporation÷	853
(b) In the case of a federally eligible individual, a basic	854
and standard plan established by the board of directors of the	855
Ohio health reinsurance program or plans substantially similar to	856
the basic and standard plan in benefit design and scope of covered	857
services. For purposes of division (B)(1)(b) of this section, the	858
superintendent of insurance shall determine whether a plan is	859
substantially similar to the basic or standard plan in benefit	860
design and scope of covered services. The contractual periodic	861
prepayments charged for such plans may not exceed an amount that	862
is two times the midpoint of the standard rate charged any other	863
individual of a group to which the organization is currently	864
accepting new business and for which similar copayments and	865
deductibles are applied.	866
(2) The direct payment contract offered pursuant to division	867
(A) of this section may include a coordination of benefits	868
provision as approved by the superintendent.	869
(3) For purposes of division (B) of this section "federally	870
eligible individual" means an eligible individual as defined in 45	871
C.F.R. 148.103.	872
(C) The option for conversion shall be available:	873
(1) Upon the death of the subscriber, to the surviving spouse	874
with respect to such of the spouse and dependents as are then	875
covered by the group contract;	876

(2) To a child solely with respect to the child upon the	877
child's attaining the limiting age of coverage under the group	878
contract while covered as a dependent under the contract;	879
(3) Upon the divorce, dissolution, or annulment of the	880
marriage of the subscriber, to the divorced spouse, or, in the	881
event of annulment, to the former spouse of the subscriber.	882
(D) No health insuring corporation shall use age as the basis	883
for refusing to renew a converted contract.	884
(E) Written notice of the conversion option provided by this	885
section shall be given to the subscriber by the health insuring	886
corporation by mail. The notice shall be sent to the subscriber's	887
address in the records of the employer upon receipt of notice from	888
the employer of the event giving rise to the conversion option. If	889
the subscriber has not received notice of the conversion privilege	890
at least fifteen days prior to the expiration of the thirty-day	891
conversion period, then the subscriber shall have an additional	892
period within which to exercise the privilege. This additional	893
period shall expire fifteen days after the subscriber receives	894
notice, but in no event shall the period extend beyond sixty days	895
after the expiration of the thirty-day conversion period.	896
(F) This section does not apply to any group contract	897
offering only supplemental health care services or specialty	898
health care services.	899
Sec. 1753.281. (A) Notwithstanding section 3901.71 of the	900
Revised Code, a health insuring corporation policy, contract, or	901
agreement providing coverage for 9-1-1 emergency services shall	902
provide in the policy, contract, or agreement that all payments	903
for 9-1-1 emergency services be paid directly to a	904
nonparticipating 9-1-1 emergency services provider or to the	905
provider's assigned agent for billing purposes, when such a	906
provider is used.	907

(B) As used in this section:	908
(1) "9-1-1 emergency services" includes, but is not limited	909
to, the following services:	910
(a) Transportation provided by an ambulance or other vehicle	911
providing medical service that responds to a call placed to the	912
9-1-1 system and transfers a person to a hospital emergency	913
<pre>department;</pre>	914
(b) All services performed by an emergency room physician	915
that are not covered under the direct payment to hospitals under	916
section 3901.386 of the Revised Code.	917
(2) "9-1-1 system" has the same meaning as in section 4931.40	918
of the Revised Code.	919
Sec. 3313.814. Each (A)(1) In accordance with rules adopted	920
by the state board of education under division (B) of this	921
section, each board of education shall adopt and enforce standards	922
governing that do both of the following:	923
(a) Govern the types of, and prices for, food and beverages	924
that may be sold on the premises of its schools, and specifying	925
including food and beverages sold by food service programs	926
operated under section 3313.81 of the Revised Code or in vending	927
machines;	928
(b) Specify the time and place each type of food and beverage	929
may be sold. In	930
(2) In adopting the standards specified in division (A)(1) of	931
this section, the board shall consider each food's food and	932
<u>beverage's</u> nutritional value. No food may be sold on any school	933
premises except in accordance with the standards adopted by the	934
board of education.	935
(B) The state board of education shall formulate and adopt	936
guidelines, which boards of education may follow in enforcing and	937

implementing this section rules in accordance with Chapter 119. of	938
the Revised Code governing the types of, and prices for, food and	939
beverages sold on any school premises, including food and	940
beverages sold by food service programs operated under section	941
3313.81 of the Revised Code and in vending machines.	942
(C) In no circumstance shall a school do either of the	943
<pre>following:</pre>	944
(1) Beginning one year after the effective date of this	945
amendment, sell a food or beverage containing, or prepared using,	946
a food or substance containing artificial trans fat.	947
(2) Sell a type of food or beverage, or charge a price for	948
food or beverages, that is inconsistent with the rules adopted by	949
the state board of education under division (B) of this section.	950
For purposes of this division, a food or substance contains	951
artificial trans fat if the food or substance's ingredients	952
include vegetable shortening, margarine, or any kind of partially	953
hydrogenated vegetable oil, unless the food manufacturer's	954
documentation or label required on the food or substance under 21	955
C.F.R. 101.9 lists the trans fat content as less than one-half of	956
one gram per serving or the label contains the statement "Not a	957
significant source of trans fat."	958
Sec. 3314.181. (A)(1) In accordance with rules adopted under	959
division (B) of this section, each governing board of a community	960
school shall adopt and enforce standards that do both of the	961
following:	962
(a) Govern the types of, and prices for, food and beverages	963
that may be sold on the premises of its school, including food and	964
beverages sold by the school's food service program or in vending	965
machines;	966
(b) Specify the time and place each type of food and beverage	967

may be sold.	968
(2) In adopting the standards specified in division (A)(1) of	969
this section, the governing board shall consider each food and	970
beverage's nutritional value.	971
(B) The state board of education shall adopt rules in	972
accordance with Chapter 119. of the Revised Code governing the	973
types of, and prices for, food and beverages sold on a community	974
school's premises, including food and beverages sold by a school's	975
food service program and in vending machines.	976
(C) In no circumstance shall a community school do either of	977
the following:	978
(1) Beginning one year after the effective date of this	979
amendment, sell a food or beverage containing, or prepared using,	980
a food or substance containing artificial trans fat.	981
(2) Sell a type of food or beverage, or charge a price for	982
food or beverages, that is inconsistent with the rules adopted by	983
the state board of education under division (B) of this section.	984
For purposes of this division, a food or substance contains	985
artificial trans fat if the food or substance's ingredients	986
include vegetable shortening, margarine, or any kind of partially	987
hydrogenated vegetable oil, unless the food manufacturer's	988
documentation or label required on the food or substance under 21	989
C.F.R. 101.9 lists the trans fat content as less than one-half of	990
one gram per serving or the label includes the statement "Not a	991
significant source of trans fat."	992
Sec. 3702.302. (A) As used in sections 3702.302 to 3702.305	993
of the Revised Code, "ambulatory surgical facility" has the same	994
meaning as in section 3702.30 of the Revised Code.	995
(B) Annually, on or before the first day of May, each	996
ambulatory surgical facility shall submit to the director of	997
ambutacory surgical ractificy shart submit to the director of	フン /

health the following information pertaining to services provided	998
to patients served by the facility, regardless of who pays the	999
charges incurred for the services:	1000
(1) The type of services provided by the ambulatory surgical	1001
<pre>facility;</pre>	1002
(2) The number of patients for whom the ambulatory surgical	1003
facility provided each of the types of services;	1004
(3) The mean and median of total ambulatory surgical facility	1005
charges for each type of service.	1006
(C) The name or social security number of a patient or	1007
physician shall not be included in the information submitted to	1008
the director of health under this section.	1009
(D)(1) The director of health may audit the information	1010
submitted under this section.	1011
(2) The director shall permit an ambulatory surgical facility	1012
to verify the accuracy of all information submitted under this	1013
section and provide corrections in a timely manner.	1014
(E) The information submitted under this section shall not be	1015
used to establish or alter any professional standard of care. The	1016
information is not admissible as evidence in any civil, criminal,	1017
or administrative proceeding.	1018
(F) This section does not require the submission of	1019
information for which the ambulatory surgical facility treated	1020
fewer than ten patients during the year.	1021
Sec. 3702.303. Every ambulatory surgical facility shall make	1022
the information it submits under section 3702.302 of the Revised	1023
Code available for inspection by any member of the public at any	1023
reasonable time. On request, the ambulatory surgical facility	1025
shall make copies available for a reasonable fee, and the	1025
ambulatory surgical facility shall advise the requesting person	1026
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that the information is available from the director of health, as	1028
provided in section 3702.304 of the Revised Code.	1029
Sec. 3702.304. (A) The duties of the director of health under	1030
this section apply only to the extent that appropriations are made	1031
by the general assembly to make performance of the duties	1032
possible.	1033
(B) Not later than ninety days after an ambulatory surgical	1034
facility submits information to the director of health under	1035
section 3702.302 of the Revised Code, the director shall make the	1036
information submitted available to the public on an internet web	1037
site. The director shall do all of the following in making the	1038
information available on a web site:	1039
(1) Make the web site available to the public without charge;	1040
(2) Provide for the web site to be organized in a manner that	1041
enables the public to use it easily;	1042
(3) Exclude any information that compromises patient privacy;	1043
(4) Include links to web sites pertaining to ambulatory	1044
surgical facilities for the purpose of allowing the public to	1045
obtain additional information about ambulatory surgical	1046
<u>facilities;</u>	1047
(5) Allow other internet web sites to link to the web site	1048
for purposes of increasing the site's availability and encouraging	1049
<pre>ongoing improvement;</pre>	1050
(6) Update the web site as needed to include new information	1051
and correct errors.	1052
(C) Subject to division (A) of this section, the director	1053
shall enter into a contract with a person under which the	1054
director's duties under this section are performed by the person	1055
nurguant to the contract. The contract may be entered into with	1056

any person selected by the director. For the purposes of this	1057
section, any person under contract shall meet the requirements	1058
listed in division (B)(1) to (6) of this section.	1059
(D) The director of health may accept gifts, grants,	1060
donations, and awards for the purposes of paying the fees or other	1061
costs incurred when a contract is entered into under this	1062
division.	1063
(E) An ambulatory surgical facility that submits information	1064
under section 3702.302 of the Revised Code is not liable for	1065
misuse or improper release of the information by any of the	1066
<pre>following:</pre>	1067
(1) The department of health;	1068
(2) A person with whom the director of health contracts under	1069
this section;	1070
(3) A person whose misuse or improper release of the	1071
information is not done on behalf of the ambulatory surgical	1072
facility.	1073
(F) Not later than ninety days after an ambulatory surgical	1074
facility submits information to the director of health under	1075
section 3702.302 of the Revised Code, the director shall make the	1076
submitted information available for sale to any interested person	1077
or government entity. When the director sells the information, the	1078
fee charged shall not exceed a reasonable amount.	1079
Sec. 3702.305. The director of health shall adopt rules, in	1080
accordance with Chapter 119. of the Revised Code, governing	1081
ambulatory surgical facilities in their submission of information	1082
to the director under section 3702.302 of the Revised Code.	1083
STATE SEED COLOR STORES OF CITE REVISER CORC.	1003
Sec. 3727.51. (A) As used in this section:	1084
(1) "Cost of charity care" means direct and indirect costs	1085

incurred by a tax-exempt hospital to provide free or discounted	1086
care to individuals unable to afford to pay the cost of services,	1087
less any reimbursement received therefor, based on current federal	1088
medicare reimbursement rates. "Cost of charity care" does not	1089
include bad debt, contractual allowances, or discounts for prompt	1090
payment.	1091
(2) "Hospital facilities" has the same meaning as in section	1092
140.01 of the Revised Code.	1093
(3) "Medicaid inpatient utilization rate" means a fraction,	1094
the numerator of which is the number of a hospital's inpatient	1095
days provided during the hospital's annual accounting period to	1096
patients who, for such days, were medicaid recipients, and the	1097
denominator of which is the total number of the hospital's	1098
inpatient days in that same period. In determining a hospital's	1099
medicaid inpatient utilization rate, both of the following shall	1100
be included:	1101
(a) Medicaid recipients who participate in the care	1102
management system established under section 5111.16 of the Revised	1103
<u>Code;</u>	1104
(b) Medicaid recipients who participate in the	1105
fee-for-service system.	1106
(4) "Tax-exempt hospital" means a hospital the facilities of	1107
which are exempted from ad valorem property taxation in whole or	1108
in part.	1109
(5) "Tax savings" means the amount of taxes that would be	1110
charged and payable against a tax-exempt hospital's hospital	1111
facilities in this state that are exempted from ad valorem	1112
property taxes if those facilities were subject to taxation, plus	1113
the amount of sales and use taxes that would be due from the	1114
hospital under Chapters 5739. and 5741. of the Revised Code if the	1115
hospital's otherwise taxable transactions were not exempt from	1116

<pre>such taxes.</pre>	1117
(B) Each tax-exempt hospital that has a medicaid inpatient	1118
utilization rate of less than thirty-five per cent for its annual	1119
accounting period ending in calender year 2009 or any calendar	1120
year thereafter shall report the following on its web site	1121
throughout the twelve-month period that begins on the first day of	1122
February following the end of the calendar year:	1123
(1) The cost of charity care incurred in that annual	1124
accounting period;	1125
(2) The hospital's tax savings for the calendar year in which	1126
that annual accounting period ends.	1127
(C) A tax-exempt hospital that has a medicaid inpatient	1128
utilization rate of thirty-five per cent or more for its annual	1129
accounting period ending in calendar year 2009 or any calendar	1130
year thereafter shall report its medicaid inpatient utilization	1131
rate to the auditor of state as required by rules adopted under	1132
division (D) of this section.	1133
(D) The auditor of state shall adopt rules in accordance with	1134
Chapter 119. of the Revised Code governing the oversight and	1135
implementation of this section. The rules shall set forth all of	1136
<pre>the following:</pre>	1137
(1) All forms, notifications, and applications required to be	1138
provided by tax-exempt hospitals.	1139
(2) The process the auditor of state shall use to determine	1140
compliance with this section.	1141
(3) The process for notifying the public of their rights	1142
under this section.	1143
(4) Any other provisions that the auditor of state considers	1144
necessary to carry out the purposes of this section.	1145
The auditor of state shall notify the tax commissioner and	1146

the attorney general should a tax-exempt hospital fail to comply	1147
with this section.	1148
Sec. 3901.386. (A) No third-party payer shall refuse to	1149
accept and honor a validly executed assignment of benefits with a	1150
physician, physician group, physician partnership, or physician	1151
professional corporation by a beneficiary for medically necessary	1152
physician services provided on an emergency basis regardless of	1153
whether the third party payer and the physician, physician group,	1154
physician partnership, or physician professional corporation have	1155
entered into a contract regarding the provision and reimbursement	1156
of covered services.	1157
(B)(1) Notwithstanding section 1751.13 or division (I)(2) of	1158
section 3923.04 of the Revised Code, a reimbursement contract	1159
entered into or renewed on or after June 29, 1988, between a	1160
third-party payer and a hospital shall provide that reimbursement	1161
for any service provided by a hospital pursuant to a reimbursement	1162
contract and covered under a benefits contract shall be made	1163
directly to the hospital.	1164
$\frac{(B)}{(2)}$ If the third-party payer and the hospital have not	1165
entered into a contract regarding the provision and reimbursement	1166
of covered services, the third-party payer shall accept and honor	1167
a completed and validly executed assignment of benefits with a	1168
hospital by a beneficiary, except when the third-party payer has	1169
notified the hospital in writing of the conditions under which the	1170
third-party payer will not accept and honor an assignment of	1171
benefits. Such notice shall be made annually.	1172
$\frac{(C)(3)}{(3)}$ A third-party payer may not refuse to accept and honor	1173
a validly executed assignment of benefits with a hospital pursuant	1174
to division (B) (2) of this section for medically necessary	1175
hospital services provided on an emergency basis.	1176

Sec. 3923.05. Except as provided in section 3923.07 of the 1177 Revised Code, no policy of sickness and accident insurance 1178 delivered, issued for delivery, or used in this state shall 1179 contain provisions respecting the matters set forth in this 1180 section unless such provisions are in the words in which the same 1181 appear in this section. Any such provisions in any such policy 1182 1183 shall be preceded by the appropriate caption appearing in this section or, at the option of the insurer, by such appropriate 1184 individual or group captions or subcaptions as the superintendent 1185 of insurance may approve. 1186

(A) A provision as follows: Change of occupation. If the 1187 insured be injured or contract sickness after having changed his 1188 the insured's occupation to one classified by the insurer as more 1189 hazardous than that stated in this policy or while doing for 1190 compensation anything pertaining to an occupation so classified, 1191 the insurer will pay only such portion of the indemnities provided 1192 in this policy as the premium paid would have purchased at the 1193 rates and within the limits fixed by the insurer for such more 1194 hazardous occupation. If the insured changes his the insured's 1195 occupation to one classified by the insurer as less hazardous than 1196 that stated in this policy, the insurer, upon receipt of proof of 1197 such change of occupation, will reduce the premium rate 1198 accordingly, and will return the excess pro rata unearned premium 1199 from the date of change of occupation or from the policy 1200 anniversary date immediately preceding receipt of such proof, 1201 whichever is the more recent. In applying this provision, the 1202 classification for occupational risk and the premium rates shall 1203 be such as have been last filed by the insurer prior to the 1204 occurrence of the loss for which the insurer is liable or prior to 1205 the date of proof of change in occupation with the state official 1206 having supervision of insurance in the state where the insured 1207 resided at the time this policy was issued; but if such filing was 1208

not required, then the classification of occupational risk and the	1209
premium rates shall be those last made effective by the insurer in	1210
such state prior to the occurrence of the loss or prior to the	1211
date of proof of change in occupation.	1212
(B) A provision as follows: Misstatement of age. If the age	1213
of the insured has been misstated, all amounts payable under this	1214
policy shall be such as the premium paid would have purchased at	1215
the correct age.	1216
(C) A provision as follows:	1217
(1) Other insurance in this insurer. If an accident or	1218
sickness or accident and sickness policy or policies previously	1219
issued by the insurer to the insured be in force concurrently	1220
herewith, making the aggregate indemnity for in	1221
excess of dollars, the excess insurance shall be void	1222
and all premiums paid for such excess shall be returned to the	1223
insured or to his the insured's estate.	1224
The insurer shall insert the type of coverage or coverages in	1225
the first blank space in the provision in division (C)(1) of this	1226
section and the maximum limit of indemnity or indemnities in the	1227
second blank space in the provision in division (C)(1) of this	1228
section.	1229
(2) In lieu of the foregoing provision in division (C)(1) of	1230
this section, a provision as follows: Other insurance in this	1231
insurer. Insurance effective at any time on the insured under a	1232
like policy or policies in this insurer is limited to the one such	1233
policy elected by the insured, his the insured's beneficiary or	1234
his the insured's estate, as the case may be, and the insurer will	1235
return all premiums paid for all other such policies.	1236
(D) A provision as follows: Insurance with other insurers. If	1237

there be other valid coverage, not with this insurer, providing

benefits for the same loss on a provision of service basis or on

1238

an expense incurred basis and of which this insurer has not been	1240
given written notice prior to the occurrence or commencement of	1241
loss, the only liability under any expense incurred coverage of	1242
this policy shall be for such proportion of the loss as the amount	1243
which would otherwise have been payable hereunder plus the total	1244
of the like amounts under all such other valid coverages for the	1245
same loss of which this insurer had notice bears to the total like	1246
amounts under all valid coverages for such loss, and for the	1247
return of such portion of the premiums paid as shall exceed the	1248
pro-rata portion for the amount so determined. For the purpose of	1249
applying this provision when other coverage is on a provision of	1250
service basis, the "like amount" of such other coverage shall be	1251
taken as the amount which the services rendered would have cost in	1252
the absence of such coverage.	1253

If the provision in division (D) of this section is included 1254 in a policy of sickness and accident insurance which also contains 1255 the provision in division (E) of this section, the insurer shall 1256 add to the caption of the provision in division (D) of this 1257 section the following: Expense incurred benefits. 1258

The insurer may at its option include in the provision in 1259 division (D) of this section a definition of "other valid 1260 coverage" approved as to form by the superintendent. Such 1261 definition shall be limited in subject matter to coverage provided 1262 by organizations subject to regulation by insurance law or by 1263 insurance authorities of this or any other state of the United 1264 States or any province of the Dominion of Canada, and by hospital 1265 or medical service organizations, and to any other coverage the 1266 inclusion of which may be approved by the superintendent. In the 1267 absence of such definition in the provision in division (D) of 1268 this section, "other valid coverage" as used in such provision 1269 shall not include group insurance, automobile medical payments 1270 insurance, or coverage provided by hospital or medical service 1271

organizations or by union welfare plans or employer or employee	1272
benefit organizations.	1273
For the purpose of applying the provision in division (D) of	1274
this section with respect to any insured, any amount of benefit	1275
provided for such insured pursuant to any compulsory benefit	1276
statute, including any workers' compensation or employer's	1277
liability statute, whether provided by governmental agency or	1278
otherwise, shall in all cases be deemed to be "other valid	1279
coverage" of which the insurer has had notice.	1280
In applying the provision in division (D) of this section no	1281
third party liability coverage shall be included as "other valid	1282
coverage."	1283
(E) A provision as follows: Insurance with other insurers. If	1284
there be other valid coverage, not with this insurer, providing	1285
benefits for the same loss on other than an expense incurred basis	1286
and of which the insurer has not been given written notice prior	1287
to the occurrence or commencement of loss, the only liability for	1288
such benefits under this policy shall be for such proportion of	1289
the indemnities otherwise provided hereunder for such loss as the	1290
like indemnities of which the insurer had notice (including the	1291
indemnities under this policy) bear to the total amount of all	1292
like indemnities for such loss, and for the return of such portion	1293
of the premium paid as shall exceed the pro-rata portion for the	1294
indemnities thus determined.	1295
If the provision in division (E) of this section is included	1296
in a policy of sickness and accident insurance which also contains	1297
the provision in division (D) of this section, the insurer shall	1298
add to the caption of the provision in division (E) of this	1299
section the following: Other benefits.	1300

The insurer may at its option include in the provision in 1301 division (E) of this section a definition of "other valid 1302

coverage" approved as to form by the superintendent. Such	1303
definition shall be limited in subject matter to coverage provided	1304
by organizations subject to regulation by insurance law or by	1305
insurance authorities of this or any other state of the United	1306
States or any province of the Dominion of Canada, and to any other	1307
coverage the inclusion of which may be approved by the	1308
superintendent. In the absence of such definition in the provision	1309
in division (E) of this section, "other valid coverage" as used in	1310
such provision shall not include group insurance, or benefits	1311
provided by union welfare plans or by employer or employee benefit	1312
organizations.	1313

For the purpose of applying the provision in division (E) of this section with respect to any insured, any amount of benefit 1315 provided for such insured pursuant to any compulsory benefit 1316 statute, including any workers' compensation or employer's 1317 liability statute, whether provided by a governmental agency or 1318 otherwise, shall in all cases be deemed to be "other valid 1319 coverage" of which the insurer has had notice. 1320

In applying the provision in division (E) of this section no 1321 third party liability coverage shall be included as "other valid 1322 coverage."

(F) A provision as follows: Relation of earnings to 1324 insurance. If the total monthly amount of loss of time benefits 1325 promised for the same loss under all valid loss of time coverage 1326 upon the insured, whether payable on a weekly or monthly basis, 1327 shall exceed the monthly earnings of the insured at the time 1328 disability commenced or his the insured's average monthly earnings 1329 for the period of two years immediately preceding a disability for 1330 which claim is made, whichever is the greater, the insurer will be 1331 liable only for such proportionate amount of such benefits under 1332 this policy as the amount of such monthly earnings or such average 1333 monthly earnings of the insured bears to the total amount of 1334

monthly benefits for the same loss under all such coverage upon	1335
the insured at the time such disability commences and for the	1336
return of such part of the premiums paid during such two years as	1337
shall exceed the pro-rata amount of the premiums for the	1338
benefits actually paid hereunder; this shall not operate to reduce	1339
the total monthly amount of benefits payable under all such	1340
coverage upon the insured below the sum of two hundred dollars or	1341
the sum of the monthly benefits specified in such coverages,	1342
whichever is the lesser, nor shall this operate to reduce benefits	1343
other than those payable for loss of time.	1344

The provision in division (F) of this section may be placed 1345 only in a policy of sickness and accident insurance which the 1346 insured has a right to continue in force subject to its terms by 1347 the timely payment of premiums until at least age fifty or in a 1348 policy of sickness and accident insurance issued after the insured 1349 has attained age forty-four and which the insured has the right to 1350 continue in force subject to its terms by the timely payment of 1351 premiums for at least five years from its date of issue. 1352

The insurer may at its option include in the provision in 1353 division (F) of this section a definition of "valid loss of time 1354 coverage" approved as to form by the superintendent. Such 1355 definition shall be limited in subject matter to coverage provided 1356 by governmental agencies or by organizations subject to regulation 1357 by insurance law or by insurance authorities of this or any other 1358 state of the United States or any province of the Dominion of 1359 Canada or to any other coverage the inclusion of which may be 1360 approved by the superintendent or any combination of such 1361 coverages. In the absence of such definition in the provision in 1362 division (F) of this section "valid loss of time coverage" as used 1363 in such provision shall not include any coverage provided for such 1364 insured pursuant to any compulsory benefit statute, including any 1365 workers' compensation or employer's liability statute, whether 1366

provided by a governmental agency or otherwise, or benefits	1367
provided by union welfare plans or by employer or employee benefit	1368
organizations.	1369
(G) A provision as follows: Unpaid premium. Upon the payment	1370
of a claim under this policy, any premium then due and unpaid or	1371
covered by any note or written order may be deducted therefrom.	1372
(H) A provision as follows: Conformity with state statutes.	1373
Any provision of this policy which, on its effective date, is in	1374
conflict with the statutes of the state in which the insured	1375
resides on such date is hereby amended to conform to the minimum	1376
requirements of such statutes.	1377
(I) A provision as follows: Illegal occupation. The insurer	1378
shall not be liable for any loss to which a contributing cause was	1379
the insured's commission of or attempt to commit a felony or to	1380
which a contributing cause was the insured's being engaged in an	1381
illegal occupation.	1382
(J) A provision as follows: Intoxicants and narcotics. The	1383
insurer shall not be liable for any loss sustained or contracted	1384
in consequence of the insured's being intoxicated or under the	1385
influence of any narcotic unless administered on the advice of a	1386
physician.	1387
Sec. 3923.122. (A) Every policy of group sickness and	1388
accident insurance providing hospital, surgical, or medical	1389
expense coverage for other than specific diseases or accidents	1390
only, and delivered, issued for delivery, or renewed in this state	1391
on or after January 1, 1976, shall include a provision giving each	1392
insured the option to convert to the following:	1393
(1) In the case of an individual who is not a federally	1394
eligible individual, any of the individual policies of hospital,	1395
surgical, or medical expense insurance then being issued by the	1396

insurer with benefit limits not to exceed those in effect under	1397
the group policy÷	1398
(2) In the case of a federally eligible individual, a basic	1399
or standard plan established by the board of directors of the Ohio	1400
health reinsurance program or plans substantially similar to the	1401
basic and standard plan in benefit design and scope of covered	1402
services. For purposes of division (A)(2) of this section, the	1403
superintendent of insurance shall determine whether a plan is	1404
substantially similar to the basic or standard plan in benefit	1405
design and scope of covered services.	1406
(B) An option for conversion to an individual policy shall be	1407
available without evidence of insurability to every insured,	1408
including any person eligible under division (D) of this section,	1409
who terminates employment or membership in the group holding the	1410
policy after having been continuously insured thereunder for at	1411
least one year.	1412
Upon receipt of the insured's written application and upon	1413
payment of at least the first quarterly premium not later than	1414
thirty-one days after the termination of coverage under the group	1415
policy, the insurer shall issue a converted policy on a form then	1416
available for conversion. The premium shall be in accordance with	1417
the insurer's table of premium rates in effect on the later of the	1418
following dates:	1419
(1) The effective date of the converted policy;	1420
(2) The date of application therefor; and shall be applicable	1421
to the class of risk to which each person covered belongs and to	1422
the form and amount of the policy at the person's then attained	1423
age. However, premiums charged federally eligible individuals may	1424
not exceed an amount that is two times the midpoint of the	1425
standard rate charged any other individual of a group to which the	1426

insurer is currently accepting new business and for which similar

(3) Upon the divorce, dissolution, or annulment of the	1458
marriage of the employee or member, to the divorced spouse, or	1459
former spouse in the event of annulment, of such employee or	1460
member, or upon the legal separation of the spouse from such	1461
employee or member, to the spouse.	1462
Persons possessing the option for conversion pursuant to this	1463
division shall be considered members for the purposes of division	1464
(H) of this section.	1465
(E) If coverage is continued under a group policy on an	1466
employee following retirement prior to the time the employee is,	1467
or is eligible to be, covered by Title XVIII of the Social	1468
Security Act, the employee may elect, in lieu of the continuance	1469
of group insurance, to have the same conversion rights as would	1470
apply had the employee's insurance terminated at retirement by	1471
reason of termination of employment.	1472
(F) If the insurer and the group policyholder agree upon one	1473
or more additional plans of benefits to be available for converted	1474
policies, the applicant for the converted policy may elect such a	1475
plan in lieu of a converted policy.	1476
(G) The converted policy may contain provisions for avoiding	1477
duplication of benefits provided pursuant to divisions $(C)(1)$,	1478
(2), (3), and (4) of this section or provided under any other	1479
insured or noninsured plan or program.	1480
(H) If an employee or member becomes entitled to obtain a	1481
converted policy pursuant to this section, and if the employee or	1482
member has not received notice of the conversion privilege at	1483
least fifteen days prior to the expiration of the thirty-one-day	1484
conversion period provided in division (B) of this section, then	1485
the employee or member has an additional period within which to	1486
exercise the privilege. This additional period shall expire	1487

fifteen days after the employee or member receives notice, but in 1488

no event shall the period extend beyond sixty days after the	1489
expiration of the thirty-one-day conversion period.	1490
Written notice presented to the employee or member, or mailed	1491
by the policyholder to the last known address of the employee or	1492
member as indicated on its records, constitutes notice for the	1493
purpose of this division. In the case of a person who is eligible	1494
for a converted policy under division $(D)(2)$ or $(D)(3)$ of this	1495
section, a policyholder shall not be responsible for presenting or	1496
mailing such notice, unless such policyholder has actual knowledge	1497
of the person's eligibility for a converted policy.	1498
If an additional period is allowed by an employee or member	1499
for the exercise of a conversion privilege, and if written	1500
application for the converted policy, accompanied by at least the	1501
first quarterly premium, is made after the expiration of the	1502
thirty-one-day conversion period, but within the additional period	1503
allowed an employee or member in accordance with this division,	1504
the effective date of the converted policy shall be the date of	1505
application.	1506
(I) The converted policy may provide that any hospital,	1507
surgical, or medical expense benefits otherwise payable with	1508
respect to any person may be reduced by the amount of any such	1509
benefits payable under the group policy for the same loss after	1510
termination of coverage.	1511
(J) The converted policy may contain:	1512
(1) Any exclusion, reduction, or limitation contained in the	1513
group policy or customarily used in individual policies issued by	1514
the insurer;	1515
(2) Any provision permitted in this section;	1516
(3) Any other provision not prohibited by law.	1517
Any provision required or permitted in this section may be	1518

made a part of any converted policy by means of an endorsement or	1519
rider.	1520
(K) The time limit specified in a converted policy for	1521
certain defenses with respect to any person who was covered by a	1522
group policy shall commence on the effective date of such person's	1523
coverage under the group policy.	1524
(L) No insurer shall use deterioration of health as the basis	1525
for refusing to renew a converted policy.	1526
(M) No insurer shall use age as the basis for refusing to	1527
renew a converted policy.	1528
(N) A converted policy made available pursuant to this	1529
section shall, if delivery of the policy is to be made in this	1530
state, comply with this section. If delivery of a converted policy	1531
is to be made in another state, it may be on a form offered by the	1532
insurer in the jurisdiction where the delivery is to be made and	1533
which provides benefits substantially in compliance with those	1534
required in a policy delivered in this state.	1535
(0) As used in this section, "federally eligible individual"	1536
means an eligible individual as defined in 45 C.F.R. 148.103.	1537
Sec. 3923.24. (A) Every certificate furnished by an insurer	1538
in connection with, or pursuant to any provision of, any group	1539
sickness and accident insurance policy delivered, issued for	1540
delivery, renewed, or used in this state on or after January 1,	1541
1972, and every policy of sickness and accident insurance	1542
delivered, issued for delivery, renewed, or used in this state on	1543
or after January 1, 1972, which provides that coverage of an	1544
unmarried <u>a</u> dependent child will terminate upon attainment of the	1545
limiting age for dependent children specified in the contract	1546
shall also provide in substance that attainment of such limiting	1547
age shall not operate to terminate the coverage of such child if	1548

the child is and continues to be both:	1549
$\frac{(A)(1)}{(A)}$ Incapable of self-sustaining employment by reason of	1550
mental retardation or physical handicap;	1551
$\frac{(B)}{(2)}$ Primarily dependent upon the policyholder or	1552
certificate holder for support and maintenance.	1553
(B) Proof of such incapacity and dependence shall be	1554
furnished by the policyholder or by the certificate holder to the	1555
insurer within thirty-one days of the child's attainment of the	1556
limiting age. Upon request, but not more frequently than annually	1557
after the two-year period following the child's attainment of the	1558
limiting age, the insurer may require proof satisfactory to it of	1559
the continuance of such incapacity and dependency.	1560
(C) Nothing in this section shall require an insurer to cover	1561
a dependent child who is mentally retarded or physically	1562
handicapped if the contract is underwritten on evidence of	1563
insurability based on health factors set forth in the application,	1564
or if such dependent child does not satisfy the conditions of the	1565
contract as to any requirement for evidence of insurability or	1566
other provision of the contract, satisfaction of which is required	1567
for coverage thereunder to take effect. In any such case, the	1568
terms of the contract shall apply with regard to the coverage or	1569
exclusion of the dependent from such coverage. Nothing in this	1570
section shall apply to accidental death or dismemberment benefits	1571
provided by any such policy of sickness and accident insurance.	1572
(D) Notwithstanding section 3901.71 of the Revised Code, if	1573
the limiting age for dependent children specified in the	1574
certificate or policy pursuant to division (A) of this section is	1575
less than twenty-nine years and both of the following are true of	1576
the applicant, the sickness and accident insurer shall notify the	1577
primary policy, contract, or agreement holder thirty days prior to	1578
the dependent's attainment of the limiting age and offer to	1579

provide coverage to the child as a dependent until age	1580
twenty-nine:	1581
CWCITCY TITLE.	
(1) The child is a resident of Ohio or a full-time student at	1582
an accredited public or private institution of higher education.	1583
(2) Neither the child nor any spouse of the child is employed	1584
by an employer that offers any health benefit plan under which the	1585
child is eligible for coverage.	1586
(E) No sickness and accident insurance policy delivered,	1587
issued for delivery, renewed, or used in this state that provides	1588
for the coverage of any dependent child shall terminate that	1589
coverage based solely upon the fact that the child is married.	1590
(F) Nothing in this section shall require an insurer to cover	1591
a dependent child's spouse or children as dependents on the	1592
policy, contract, or agreement of the parent or legal guardian of	1593
the dependent.	1594
(G) As used in this section, "health benefit plan" means any	1595
of the following when the contract, policy, or plan provides	1596
payment or reimbursement for the costs of health care services	1597
other than for specific diseases or accidents only:	1598
(1) An individual or group policy of sickness and accident	1599
<u>insurance;</u>	1600
(2) An individual or group contract of a health insuring	1601
corporation;	1602
(3) A public employee benefit plan;	1603
(4) A multiple employer welfare arrangement as defined in	1604
section 1739.01 of the Revised Code;	1605
(5) A health benefit plan as regulated under the "Employee	1606
Retirement Income Security Act of 1974" 29 U.S.C. 1001, et seq.	1607
Sec. 3923.241. (A) Notwithstanding section 3901.71 of the	1608

Revised Code, any public employee benefit plan that provides that	1609
coverage of an unmarried dependent child will terminate upon	1610
attainment of the limiting age for dependent children specified in	1611
the plan shall also provide in substance that attainment of the	1612
limiting age shall not operate to terminate the coverage of the	1613
child if the child is and continues to be both of the following:	1614
(1) Incapable of self-sustaining employment by reason of	1615
mental retardation or physical handicap;	1616
(2) Primarily dependent upon the plan member for support and	1617
maintenance.	1618
(B) Proof of incapacity and dependence for purposes of	1619
division (A) of this section shall be furnished to the public	1620
employee benefit plan within thirty-one days of the child's	1621
attainment of the limiting age. Upon request, but not more	1622
frequently than annually, the public employee benefit plan may	1623
require proof satisfactory to it of the continuance of such	1624
incapacity and dependency.	1625
(C) Notwithstanding section 3901.71 of the Revised Code, if	1626
the limiting age for dependent children specified in the plan	1627
pursuant to division (A) of this section is less than twenty-nine	1628
years and both of the following are true of the applicant, the	1629
public employee benefit plan shall notify the plan member thirty	1630
days prior to the dependent's attainment of the limiting age and	1631
offer to provide coverage to the child as a dependent until age	1632
<pre>twenty-nine:</pre>	1633
(1) The child is a resident of Ohio or a full-time student at	1634
an accredited public or private institution of higher education.	1635
(2) Neither the child nor any spouse of the child is employed	1636
by an employer that offers any health benefit plan under which the	1637
child is eligible for coverage.	1638
(D) No public employee benefit plan that provides for the	1630

coverage of any dependent child shall terminate that coverage	1640
based solely upon the fact that the child is married.	1641
(E) Nothing in this section shall require an insurer to cover	1642
a dependent child's spouse or children as dependents on the	1643
policy, contract, or agreement of the parent or legal guardian of	1644
the dependent.	1645
(F) As used in this section, "health benefit plan" means any	1646
of the following when the contract, policy, or plan provides	1647
payment or reimbursement for the costs of health care services	1648
other than for specific diseases or accidents only:	1649
(1) An individual or group policy of sickness and accident	1650
<u>insurance;</u>	1651
(2) An individual or group contract of a health insuring	1652
corporation;	1653
(3) A public employee benefit plan;	1654
(4) A multiple employer welfare arrangement as defined in	1655
section 1739.01 of the Revised Code;	1656
(5) A health benefit plan as regulated under the "Employee	1657
Retirement Income Security Act of 1974" 29 U.S.C. 1001, et seq.	1658
Sec. 3923.58. (A) As used in sections <u>section</u> 3923.58 and	1659
3923.59 of the Revised Code:	1660
(1) "Health benefit plan" and "MEWA" have the same meanings	1661
as in section 3924.01 of the Revised Code.	1662
(2) "Insurer" means any sickness and accident insurance	1663
company authorized to do business in this state, or MEWA	1664
authorized to issue insured health benefit plans in this state.	1665
"Insurer" does not include any health insuring corporation that is	1666
owned or operated by an insurer.	1667
(3) "Pre-existing conditions provision" means a policy	1668

provision that excludes or limits coverage for charges or expenses 1669 incurred during a specified period following the insured's 1670 effective date of coverage as to a condition which, during a 1671 specified period immediately preceding the effective date of 1672 coverage, had manifested itself in such a manner as would cause an 1673 ordinarily prudent person to seek medical advice, diagnosis, care, 1674 or treatment or for which medical advice, diagnosis, care, or 1675 treatment was recommended or received, or a pregnancy existing on 1676 the effective date of coverage. 1677

Page 56

- (B) Beginning in January of each year, insurers in the 1678 business of issuing individual policies of sickness and accident 1679 insurance as contemplated by section 3923.021 of the Revised Code, 1680 except individual policies issued pursuant to section 3923.122 of 1681 the Revised Code, shall accept applicants for open enrollment 1682 coverage, as set forth in this division, in the order in which 1683 they apply for coverage and subject to the limitation set forth in 1684 division (G) of this section. Insurers shall accept for coverage 1685 pursuant to this section individuals to whom both of the following 1686 conditions apply: 1687
- (1) The individual is not applying for coverage as an 1688 employee of an employer, as a member of an association, or as a 1689 member of any other group.
- (2) The individual is not covered, and is not eligible for 1691 coverage, under any other private or public health benefits 1692 arrangement, including the medicare program established under 1693 Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 1694 U.S.C.A. 301, as amended, or any other act of congress or law of 1695 this or any other state of the United States that provides 1696 benefits comparable to the benefits provided under this section, 1697 any medicare supplement policy, or any continuation of coverage 1698 policy under state or federal law. 1699
 - (C) An insurer shall offer to any individual accepted under

this section the Ohio health care basic and standard plans	1701
established by the board of directors of the Ohio health	1702
reinsurance program under division (A) of section 3924.10 of the	1703
Revised Code or health benefit plans that are substantially	1704
similar to the Ohio health care basic and standard plans in	1705
benefit plan design and scope of covered services.	1706
An insurer may offer other health benefit plans in addition	1707
to, but not in lieu of, the plans required to be offered under	1708
this division. A basic health benefit plan shall provide, at a	1709
minimum, the coverage provided by the Ohio health care basic plan	1710
or any health benefit plan that is substantially similar to the	1711
Ohio health care basic plan in benefit plan design and scope of	1712
covered services. A standard health benefit plan shall provide, at	1713
a minimum, the coverage provided by the Ohio health care standard	1714
plan or any health benefit plan that is substantially similar to	1715
the Ohio health care standard plan in benefit plan design and	1716
scope of covered services.	1717
For purposes of this division, the superintendent of	1718
insurance shall determine whether a health benefit plan is	1719
substantially similar to the Ohio health care basic and standard	1720
plans in benefit plan design and scope of covered services.	1721
(D) Health benefit plans issued under this section may	1722
establish pre-existing conditions provisions that exclude or limit	1723
coverage for a period of up to twelve months following the	1724
individual's effective date of coverage and that may relate only	1725
to conditions during the six months immediately preceding the	1726
effective date of coverage.	1727
$\frac{(E)(D)}{(D)}$ Premiums charged to individuals under this section may	1728
not exceed an amount that is two and one-half times the highest	1729
rate charged any other individual to which the insurer is	1730
currently accepting new business, and for which similar copayments	1731

1732

and deductibles are applied.

$\frac{(F)(E)}{(E)}$ In offering health benefit plans under this section,	1733
an insurer may require the purchase of health benefit plans that	1734
condition the reimbursement of health services upon the use of a	1735
specific network of providers.	1736
$\frac{(G)}{(F)}(1)$ In no event shall an insurer be required to accept	1737
annually under this section individuals who, in the aggregate,	1738
would cause the insurer to have a total number of new insureds	1739
that is more than one-half per cent of its total number of insured	1740
individuals in this state per year, as contemplated by section	1741
3923.021 of the Revised Code, calculated as of the immediately	1742
preceding thirty-first day of December and excluding the insurer's	1743
medicare supplement policies and conversion or continuation of	1744
coverage policies under state or federal law and any policies	1745
described in division $\frac{(L)(K)}{(K)}$ of this section.	1746
(2) An officer of the insurer shall certify to the department	1747
of insurance when it has met the enrollment limit set forth in	1748
division $\frac{(G)}{(F)}(1)$ of this section. Upon providing such	1749
certification, the insurer shall be relieved of its open	1750
enrollment requirement under this section for the remainder of the	1751
calendar year.	1752
$\frac{\mathrm{(H)}(\mathrm{G})}{\mathrm{(G)}}$ An insurer shall not be required to accept under this	1753
section applicants who, at the time of enrollment, are confined to	1754
a health care facility because of chronic illness, permanent	1755
injury, or other infirmity that would cause economic impairment to	1756
the insurer if the applicants were accepted, or to make the	1757
effective date of benefits for individuals accepted under this	1758
section earlier than ninety days after the date of acceptance.	1759
$\frac{(\mathrm{H})}{(\mathrm{H})}$ The requirements of this section do not apply to any	1760
insurer that is currently in a state of supervision, insolvency,	1761
or liquidation. If an insurer demonstrates to the satisfaction of	1762
the superintendent that the requirements of this section would	1763

place the insurer in a state of supervision, insolvency, or

liquidation, the superintendent may waive or modify the	1765
requirements of division (B) or $\frac{(G)}{(F)}$ of this section. The	1766
actions of the superintendent under this division shall be	1767
effective for a period of not more than one year. At the	1768
expiration of such time, a new showing of need for a waiver or	1769
modification by the insurer shall be made before a new waiver or	1770
modification is issued or imposed.	1771

(J)(I) No hospital, health care facility, or health care 1772 practitioner, and no person who employs any health care 1773 practitioner, shall balance bill any individual or dependent of an 1774 individual for any health care supplies or services provided to 1775 the individual or dependent who is insured under a policy issued 1776 under this section. The hospital, health care facility, or health 1777 care practitioner, or any person that employs the health care 1778 practitioner, shall accept payments made to it by the insurer 1779 under the terms of the policy or contract insuring or covering 1780 such individual as payment in full for such health care supplies 1781 or services. 1782

As used in this division, "hospital" has the same meaning as 1783 in section 3727.01 of the Revised Code; "health care practitioner" 1784 has the same meaning as in section 4769.01 of the Revised Code; 1785 and "balance bill" means charging or collecting an amount in 1786 excess of the amount reimbursable or payable under the policy or 1787 health care service contract issued to an individual under this 1788 section for such health care supply or service. "Balance bill" 1789 does not include charging for or collecting copayments or 1790 deductibles required by the policy or contract. 1791

(K)(J) An insurer shall pay an agent a commission in the 1792 amount of five per cent of the premium charged for initial 1793 placement or for otherwise securing the issuance of a policy or 1794 contract issued to an individual under this section, and four per 1795 cent of the premium charged for the renewal of such a policy or 1796

H. B. No. 456
As Introduced

contract. The superintendent may adopt, in accordance with Chapter	1797
119. of the Revised Code, such rules as are necessary to enforce	1798
this division.	1799
$\frac{(L)(K)}{(K)}$ This section does not apply to any policy that	1800
provides coverage for specific diseases or accidents only, or to	1801
any hospital indemnity, medicare supplement, long-term care,	1802
disability income, one-time-limited-duration policy of no longer	1803
than six months, or other policy that offers only supplemental	1804
benefits.	1805
Sec. 3923.581. (A) As used in this section:	1806
(1) "Carrier," "health benefit plan," "MEWA," and	1807
"pre-existing conditions provision" have the same meanings as in	1808
section 3924.01 of the Revised Code.	1809
(2) "Federally eligible individual" means an eligible	1810
individual as defined in 45 C.F.R. 148.103.	1811
(3) "Health status-related factor" means any of the	1812
following:	1813
(a) Health status;	1814
(b) Medical condition, including both physical and mental	1815
illnesses;	1816
(c) Claims experience;	1817
(d) Receipt of health care;	1818
(e) Medical history;	1819
(f) Genetic information;	1820
(g) Evidence of insurability, including conditions arising	1821
out of acts of domestic violence;	1822
(h) Disability.	1823
(4) "Midpoint rate" means, for individuals with similar case	1824

characteristics and plan designs and as determined by the	1825
applicable carrier for a rating period, the arithmetic average of	1826
the applicable base premium rate and the corresponding highest	1827
premium rate.	1828
(5) "Network plan" means a health benefit plan of a carrier	1829
under which the financing and delivery of medical care, including	1830
items and services paid for as medical care, are provided, in	1831
whole or in part, through a defined set of providers under	1832
contract with the carrier.	1833
(B) Beginning in January of each year, carriers in the	1834
business of issuing health benefit plans to individuals or	1835
nonemployer groups shall accept federally eligible individuals for	1836
open enrollment coverage, as provided in this section, in the	1837
order in which they apply for coverage and subject to the	1838
limitation set forth in division $\frac{(J)}{(I)}$ of this section.	1839
(C) No carrier shall do either of the following:	1840
(1) Decline to offer such coverage to, or deny enrollment of,	1841
such individuals;	1842
(2) Apply any pre-existing conditions provision to such	1843
coverage.	1844
(D) A carrier shall offer to federally eligible individuals	1845
the basic and standard plan established by the board of directors	1846
of the Ohio health reinsurance program or plans substantially	1847
similar to the basic and standard plan in benefit design and scope	1848
of covered services. For purposes of this division, the	1849
superintendent of insurance shall determine whether a plan is	1850
substantially similar to the basic or standard plan in benefit	1851
design and scope of covered services.	1852
$\frac{(E)}{E}$ Premiums charged to individuals under this section may	1853
not exceed an amount that is two times the midpoint rate charged	1854

any other individual to which the carrier is currently accepting

new business, and for which similar copayments and deductibles are applied.	1856 1857
$\frac{(F)(E)}{(E)}$ If a carrier offers a health benefit plan in the individual market through a network plan, the carrier may do both	1858 1859
of the following: (1) Limit the federally eligible individuals that may apply for such coverage to those who live, work, or reside in the	1860 1861 1862
service area of the network plan; (2) Within the service area of the network plan, deny the	1863 1864
coverage to federally eligible individuals if the carrier has demonstrated both of the following to the superintendent:	1865 1866
(a) The carrier will not have the capacity to deliver services adequately \pm to any additional individuals because of the	1867 1868
carrier's obligations to existing group contract holders and individuals.	1869 1870
(b) The carrier is applying division $(F)(E)(2)$ of this section uniformly to all federally eligible individuals without regard to any health status-related factor of those individuals.	1871 1872 1873
$\frac{(G)}{(F)}$ A carrier that, pursuant to division $\frac{(F)}{(E)}(2)$ of this section, denies coverage to an individual in the service area of a	1874 1875
network plan, shall not offer coverage in the individual market within that service area for at least one hundred eighty days after the date the coverage is denied.	1876 1877 1878
$\frac{(H)(G)}{(G)}$ A carrier may refuse to issue health benefit plans to federally eligible individuals if the carrier has demonstrated	1879 1880
both of the following to the superintendent: (1) The carrier does not have the financial reserves	1881 1882
necessary to underwrite additional coverage.	1883
(2) The carrier is applying division $\frac{H}{G}$ of this section uniformly to all federally eligible individuals in this state	1884 1885

consistent with the applicable laws and rules of this state and	1886
without regard to any health status-related factor relating to	1887
those individuals.	1888

 $\frac{(1)(H)}{(H)}$ A carrier that, pursuant to division $\frac{(H)(G)}{(H)}$ of this 1889 section, refuses to issue health benefit plans to federally 1890 eligible individuals, shall not offer health benefit plans in the 1891 individual market in this state for at least one hundred eighty 1892 days after the date the coverage is denied or until the carrier 1893 has demonstrated to the superintendent that the carrier has 1894 sufficient financial reserves to underwrite additional coverage, 1895 whichever is later. 1896

 $\frac{(J)(I)}{(I)}$ Except as provided in division $\frac{(J)(I)}{(I)}$ of this 1897 section, a carrier shall not be required to accept annually under 1898 this section federally eligible individuals who, in the aggregate, 1899 would cause the carrier to have a total number of new insureds 1900 that is more than one-half per cent of its total number of insured 1901 individuals and nonemployer groups in this state per year, 1902 calculated as of the immediately preceding thirty-first day of 1903 December and excluding the carrier's medicare supplement policies 1904 and conversion or continuation of coverage policies under state or 1905 federal law and any policies described in division $\frac{(M)(K)}{(K)}$ of 1906 section 3923.58 of the Revised Code. 1907

(2) An officer of the carrier shall certify to the department 1908 of insurance when it has met the enrollment limit set forth in 1909 division $\frac{(J)}{(I)}(1)$ of this section. Upon providing such 1910 certification, the carrier shall be relieved of its open 1911 enrollment requirement under this section for the remainder of the 1912 calendar year unless, prior to the end of the calendar year, all 1913 the carriers subject to this section have individually met the 1914 enrollment limit set forth in division $\frac{J}{(I)}(1)$ of this section. 1915 In that event, carriers shall again accept applicants for open 1916 enrollment coverage pursuant to this section, subject to the 1917

enrollment limit set forth in division $\frac{(J)(I)}{(I)}(1)$ of this section.	1918
$\frac{(K)}{(J)}$ The superintendent may provide for the application of	1919
this section on a service-area-specific basis.	1920
$\frac{(L)}{(K)}$ The requirements of this section do not apply to any	1921
health benefit plan described in division $\frac{(M)(K)}{(K)}$ of section	1922
3923.58 of the Revised Code.	1923
Sec. 3923.641. (A) As used in this section:	1924
(1) "Chronic care" means health services provided by a health	1925
care professional for an established clinical condition that is	1926
expected to last a year or more and that requires ongoing clinical	1927
management attempting to restore the individual to highest	1928
function, minimize the negative effects of the condition, and	1929
prevent complications related to chronic conditions.	1930
(2) "Chronic conditions" include but are not limited to	1931
diabetes, hypertension, cardiovascular disease, cancer, asthma,	1932
pulmonary disease, substance abuse, mental illness, spinal cord	1933
injury, and hyperlipidemia.	1934
(3) "Chronic care management" means a system of coordinated	1935
health care interventions and communications for individuals with	1936
chronic conditions, including significant patient self-care	1937
efforts, systemic supports for the physician and patient	1938
relationship, and a plan of care emphasizing prevention of	1939
complications, utilizing evidence-based practice guidelines,	1940
patient empowerment strategies, and evaluation of clinical,	1941
humanistic, and economic outcomes on an ongoing basis with the	1942
goal of improving overall health.	1943
(B) Notwithstanding section 3901.71 of the Revised Code,	1944
every public employee benefit plan established or modified in this	1945
state shall include coverage for chronic care management.	1946

Sec. 3923.651. (A) Notwithstanding section 3901.71 of the	1947
Revised Code, every individual or group policy of sickness and	1948
accident insurance that provides coverage for 9-1-1 emergency	1949
services shall provide that reimbursement under that policy for	1950
9-1-1 emergency services be paid directly to the provider of 9-1-1	1951
emergency services or to the provider's assigned agent for billing	1952
purposes.	1953
(B) As used in this section:	1954
(1) "9-1-1 emergency services" includes, but is not limited	1955
to, the following services:	1956
(a) Transportation provided by an ambulance or other vehicle	1957
providing medical service that responds to a call placed to the	1958
9-1-1 system and transfers a person to a hospital emergency	1959
<u>department;</u>	1960
(b) All services performed by an emergency room physician	1961
that are not covered under the direct payment to hospitals under	1962
section 3901.386 of the Revised Code.	1963
(2) "9-1-1 system" has the same meaning as in section 4931.40	1964
of the Revised Code.	1965
Sec. 3923.80. (A) Notwithstanding section 3901.71 of the	1966
Revised Code, no health benefit plan shall contain a provision	1967
that limits or excludes an insured's coverage under the plan for a	1968
loss the insured sustains that is the result of the insured's use	1969
of alcohol or other drugs or both and the loss is otherwise	1970
covered under the plan.	1971
(B) As used in this section:	1972
(1) "Carrier" means any sickness and accident insurance	1973
company or health insuring corporation authorized to issue health	1974
benefit plans in this state, a public employee benefit plan, or a	1975

multiple employer welfare arrangement, as defined in the "Employee	1976
Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.	1977
1002, except for any arrangement which is fully insured as defined	1978
in that act at 29 U.S.C. 1144 (b)(6)(d).	1979
(2) "Health benefit plan" means any hospital or medical	1980
expense policy or certificate or any health plan provided by a	1981
carrier, that is delivered, issued for delivery, renewed, or used	1982
in this state on or after the date occurring six months after the	1983
effective date of this act. "Health benefit plan" does not include	1984
policies covering only accident, credit, dental, disability	1985
income, long-term care, hospital indemnity, medicare supplement,	1986
specified disease, or vision care; coverage under a one-time,	1987
limited duration policy of not longer than six months; coverage	1988
issued as a supplement to liability insurance; insurance arising	1989
out of a workers' compensation or similar law; automobile	1990
medical-payment insurance; or insurance under which benefits are	1991
payable with or without regard to fault and which is statutorily	1992
required to be contained in any liability insurance policy or	1993
equivalent self-insurance.	1994
(3) "Insured" means a person covered by a health benefit plan	1995
issued by a carrier.	1996
Sec. 3923.85. As used in sections 3923.85 to 3923.92 of the	1997
Revised Code:	1998
(A) "Insurer" means sickness and accident insurer or health	1999
insuring corporation.	2000
(B) "Health benefit plan" means any of the following when the	2001
contract, policy, or plan provides payment or reimbursement for	2002
the costs of health care services other than for specific diseases	2003
or accidents only:	2004
(1) An individual or group policy of sickness and accident	2005

(C) The superintendent may enter into contracts with public	2035
or private entities to obtain estimates concerning the number of	2036
individuals eligible for coverage under the program and the costs	2037
of administering and implementing the program.	2038
Sec. 3923.87. The basic, standard policy established by the	2039
superintendent of insurance pursuant to section 3923.86 of the	2040
Revised Code may cover dependents if either of the following is	2041
<pre>true:</pre>	2042
(A) The dependent is the individual who represents the	2043
low-high, medium-high, or high-high insurance risk to be reinsured	2044
by the I-Ohio reinsurance program.	2045
(B) The dependent cannot be covered by an employer sponsored	2046
health benefit plan, and the insured earns the primary household	2047
income.	2048
Sec. 3923.88. (A) Notwithstanding section 3901.71 of the	2049
Revised Code, all insurers shall offer basic, standard policies	2050
pursuant to sections 3923.85 to 3923.92 of the Revised Code.	2051
(B) Notwithstanding section 3923.90 of the Revised Code, the	2052
I-Ohio reinsurance program shall reinsure basic, standard policies	2053
offered by insurers if the insurer offers those policies to	2054
individuals who have an annual income of less than ninety thousand	2055
dollars, are not employed by an employer that offers health	2056
insurance coverage, and meet at least one of the following	2057
<pre>criteria:</pre>	2058
(1) The individual has not been covered by a health benefit	2059
plan in the six months preceding the individual's application for	2060
the policy.	2061
(2) The individual has been declined coverage under a health	2062
benefit plan.	2063

(3) The premiums for the individual's most recent health	2064
benefit plan exceeded one hundred twenty-five per cent of the	2065
average market premium price as determined by the superintendent	2066
of insurance.	2067
Sec. 3923.89. (A) The I-Ohio reinsurance program shall not	2068
provide reinsurance for any individual reinsured under the program	2069
until the individual's insurer has made fifteen thousand dollars	2070
in benefit payments for services provided to that individual	2071
<u>during a calendar year.</u>	2072
(B) After the fifteen-thousand-dollar deductible, the I-Ohio	2073
reinsurance program shall reinsure basic, standard plans offered	2074
by health insurance corporations and sickness and accident	2075
insurers pursuant to sections 3923.85 to 3923.92 of the Revised	2076
Code at eighty-five per cent of claims paid on behalf of an	2077
individual up to fifty thousand dollars of total claims paid on	2078
behalf of the individual.	2079
Sec. 3923.90. (A)(1) The superintendent of insurance shall	2080
estimate the average annual cost of reinsuring each individual	2081
under the I-Ohio reinsurance program based upon available data and	2082
appropriate actuarial assumptions and determine total eligible	2083
enrollment in the program.	2084
(2) The superintendent shall suspend the enrollment of new	2085
policies and notify all insurers in writing of such suspension if	2086
the superintendent determines that the total enrollment reported	2087
by all insurers exceeds the total eligible enrollment.	2088
(B) The superintendent shall suspend the enrollment of new	2089
policies issued to individuals who reside in a particular county	2090
of this state and shall notify all insurers of such suspension if	2091
the superintendent determines that more than ten per cent of the	2092
policies reinsured by the program cover individuals who reside in	2093

that county.	2094
(C)(1) In the first two years of the operation of the I-Ohio	2095
reinsurance program, the program shall reinsure basic, standard	2096
policies offered by insurers to individuals who represent a	2097
low-high insurance risk only.	2098
(2) In the third and forth years of the operation of the	2099
I-Ohio reinsurance program, the program shall reinsure basic,	2100
standard policies offered by insurers to individuals who represent	2101
a low-high insurance risk and medium-high risk.	2102
(3) If the superintendent determines that the program has	2103
sufficient funding, after the fourth year of the operation of the	2104
I-Ohio reinsurance program, the program may reinsure basic,	2105
standard policies offered by insurers to individuals who represent	2106
a high-high risk in addition to those offered to individuals who	2107
represent low-high insurance risk and medium-high risk.	2108
Sec. 3923.91. The superintendent of insurance shall use the	2109
fund created in section 5725.24 of the Revised Code to reinsure	2110
health insurance policies provided by health insuring corporations	2111
and sickness and accident insurers pursuant to sections 3923.85 to	2112
3923.92 of the Revised Code.	2113
Sec. 3923.92. (A) There is hereby created the I-Ohio	2114
reinsurance advisory board, consisting of seven members as	2115
follows:	2116
(1) Three members appointed by the governor, two of whom	2117
shall have backgrounds in the health insurance industry and one of	2118
whom shall represent the department of insurance;	2119
(2) Two members appointed by the speaker of the house of	2120
representatives, one of whom shall represent small businesses and	2121
one of whom shall be a consumer advocate with a background in	2122
health care issues;	2123

(3) Two members appointed by the president of the senate, one	2124
of whom shall be an insurance underwriter and one of whom shall be	2125
a physician.	2126
(B) Terms of office of each member of the board shall be	2127
three years. Vacancies shall be filled in the manner prescribed	2128
for the original appointment. A member appointed to fill a vacancy	2129
occurring prior to the expiration of the term for which the	2130
member's predecessor was appointed shall hold office for the	2131
remainder of that term.	2132
(C) The governor shall designate one of the members the	2133
governor appoints to the board to serve as chairperson of the	2134
board.	2135
(D) The board shall meet at least four times annually. The	2136
chairperson shall call special meetings as needed or upon the	2137
request of four members.	2138
(E) Members of the board shall serve without compensation,	2139
but may be reimbursed for reasonable and necessary expenses	2140
incurred in the discharge of their duties.	2141
(F) The department of insurance shall provide the board with	2142
staff assistance as requested by the board.	2143
(G) The board shall study all of the following and shall make	2144
reports to the governor and the general assembly in January and	2145
July of every year regarding the board's findings and the general	2146
activities of the board:	2147
(1) The status and implementation of the I-Ohio reinsurance	2148
program;	2149
(2) The impact of individuals that represent a high insurance	2150
risk on the small group market;	2151
(3) Possible methods for implementing the I-Ohio reinsurance	2152
program in the small group market.	2153

Sec. 3924.01. As used in sections 3924.01 to 3924.14 of the	2154
Revised Code:	2155
(A) "Actuarial certification" means a written statement	2156
prepared by a member of the American academy of actuaries, or by	2157
any other person acceptable to the superintendent of insurance,	2158
that states that, based upon the person's examination, a carrier	2159
offering health benefit plans to small employers is in compliance	2160
with sections 3924.01 to 3924.14 3924.06 of the Revised Code.	2161
"Actuarial certification" shall include a review of the	2162
appropriate records of, and the actuarial assumptions and methods	2163
used by, the carrier relative to establishing premium rates for	2164
the health benefit plans.	2165
(B) "Adjusted average market premium price" means the average	2166
market premium price as determined by the board of directors of	2167
the Ohio health reinsurance program either on the basis of the	2168
arithmetic mean of all carriers' premium rates for an OHC plan	2169
sold to groups with similar case characteristics by all carriers	2170
selling OHC plans in the state, or on any other equitable basis	2171
determined by the board.	2172
(C) "Base premium rate" means, as to any health benefit plan	2173
that is issued by a carrier and that covers at least two but no	2174
more than fifty employees of a small employer, the lowest premium	2175
rate for a new or existing business prescribed by the carrier for	2176
the same or similar coverage under a plan or arrangement covering	2177
any small employer with similar case characteristics.	2178
(D)(C) "Carrier" means any sickness and accident insurance	2179
company or health insuring corporation authorized to issue health	2180
benefit plans in this state or a MEWA. A sickness and accident	2181
insurance company that owns or operates a health insuring	2182
corporation, either as a separate corporation or as a line of	2183

business, shall be considered as a separate carrier from that

health insuring corporation for purposes of sections 3924.01 to	2185
3924.14 <u>3924.06</u> of the Revised Code.	2186
$\frac{(E)(D)}{(D)}$ "Case characteristics" means, with respect to a small	2187
employer, the geographic area in which the employees work; the age	2188
and sex of the individual employees and their dependents; the	2189
appropriate industry classification as determined by the carrier;	2190
the number of employees and dependents; and such other objective	2191
criteria as may be established by the carrier. "Case	2192
characteristics" does not include claims experience, health	2193
status, or duration of coverage from the date of issue.	2194
$\frac{(F)(E)}{(E)}$ "Dependent" means the spouse or child of an eligible	2195
employee, subject to applicable terms of the health benefits plan	2196
covering the employee.	2197
$\frac{(G)}{(F)}$ "Eligible employee" means an employee who works a	2198
normal work week of twenty-five or more hours. "Eligible employee"	2199
does not include a temporary or substitute employee, or a seasonal	2200
employee who works only part of the calendar year on the basis of	2201
natural or suitable times or circumstances.	2202
$\frac{(H)}{(G)}$ "Health benefit plan" means any hospital or medical	2203
expense policy or certificate or any health plan provided by a	2204
carrier, that is delivered, issued for delivery, renewed, or used	2205
in this state on or after the date occurring six months after	2206
November 24, 1995. "Health benefit plan" does not include policies	2207
covering only accident, credit, dental, disability income,	2208
long-term care, hospital indemnity, medicare supplement, specified	2209
disease, or vision care; coverage under a	2210
one-time-limited-duration policy of no longer than six months;	2211
coverage issued as a supplement to liability insurance; insurance	2212
arising out of a workers' compensation or similar law; automobile	2213
medical-payment insurance; or insurance under which benefits are	2214
payable with or without regard to fault and which is statutorily	2215
required to be contained in any liability insurance policy or	2216

equivalent self-insurance.	2217
(I)(H) "Late enrollee" means an eligible employee or	2218
dependent who enrolls in a small employer's health benefit plan	2219
other than during the first period in which the employee or	2220
dependent is eligible to enroll under the plan or during a special	2221
enrollment period described in section 2701(f) of the "Health	2222
Insurance Portability and Accountability Act of 1996," Pub. L. No.	2223
104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as amended.	2224
$\frac{(J)(I)}{(I)}$ "MEWA" means any "multiple employer welfare	2225
arrangement" as defined in section 3 of the "Federal Employee	2226
Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A.	2227
1001, as amended, except for any arrangement which is fully	2228
insured as defined in division (b)(6)(D) of section 514 of that	2229
act.	2230
$\frac{(K)}{(J)}$ "Midpoint rate" means, for small employers with	2231
similar case characteristics and plan designs and as determined by	2232
the applicable carrier for a rating period, the arithmetic average	2233
of the applicable base premium rate and the corresponding highest	2234
premium rate.	2235
$\frac{(L)}{(K)}$ "Pre-existing conditions provision" means a policy	2236
provision that excludes or limits coverage for charges or expenses	2237
incurred during a specified period following the insured's	2238
enrollment date as to a condition for which medical advice,	2239
diagnosis, care, or treatment was recommended or received during a	2240
specified period immediately preceding the enrollment date.	2241
Genetic information shall not be treated as such a condition in	2242
the absence of a diagnosis of the condition related to such	2243
information.	2244
For purposes of this division, "enrollment date" means, with	2245
respect to an individual covered under a group health benefit	2246
plan, the date of enrollment of the individual in the plan or, if	2247

earlier, the first day of the waiting period for such enrollment.	2248
$\frac{(M)}{(L)}$ "Service waiting period" means the period of time	2249
after employment begins before an employee is eligible to be	2250
covered for benefits under the terms of any applicable health	2251
benefit plan offered by the small employer.	2252
$\frac{(N)(M)}{(M)}$ (1) "Small employer" means, in connection with a group	2253
health benefit plan and with respect to a calendar year and a plan	2254
year, an employer who employed an average of at least two but no	2255
more than fifty eligible employees on business days during the	2256
preceding calendar year and who employs at least two employees on	2257
the first day of the plan year.	2258
(2) For purposes of division $\frac{(N)(M)}{(M)}(1)$ of this section, all	2259
persons treated as a single employer under subsection (b), (c),	2260
(m), or (o) of section 414 of the "Internal Revenue Code of 1986,"	2261
100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one	2262
employer. In the case of an employer that was not in existence	2263
throughout the preceding calendar year, the determination of	2264
whether the employer is a small or large employer shall be based	2265
on the average number of eligible employees that it is reasonably	2266
expected the employer will employ on business days in the current	2267
calendar year. Any reference in division $\frac{(N)}{(M)}$ of this section to	2268
an "employer" includes any predecessor of the employer. Except as	2269
otherwise specifically provided, provisions of sections 3924.01 to	2270
3924.14 3924.06 of the Revised Code that apply to a small employer	2271
that has a health benefit plan shall continue to apply until the	2272
plan anniversary following the date the employer no longer meets	2273
the requirements of this division.	2274
(0) "OHC plan" means an Ohio health care plan, which is the	2275
basic, standard, or carrier reimbursement plan for small employers	2276
and individuals established by the board in accordance with	2277
section 3924.10 of the Revised Code.	2278

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Sec. 3924.02. (A) An individual or group health benefit plan	2279
is subject to sections 3924.01 to 3924.14 3924.06 of the Revised	2280
Code if it provides health care benefits covering at least two but	2281
no more than fifty employees of a small employer, and if it meets	2282
either of the following conditions:	2283
(1) Any portion of the premium or benefits is paid by a small	2284
employer, or any covered individual is reimbursed, whether through	2285
wage adjustments or otherwise, by a small employer for any portion	2286
of the premium.	2287
(2) The health benefit plan is treated by the employer or any	2288
of the covered individuals as part of a plan or program for	2289
purposes of section 106 or 162 of the "Internal Revenue Code of	2290
1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.	2291
(B) Notwithstanding division (A) of this section, divisions	2292
(D), (E)(2), (F), and (G) of section 3924.03 of the Revised Code	2293
and section 3924.04 of the Revised Code do not apply to health	2294
benefit policies that are not sold to owners of small businesses	2295
as an employment benefit plan. Such policies shall clearly state	2296
that they are not being sold as an employment benefit plan and	2297
that the owner of the business is not responsible, either directly	2298
or indirectly, for paying the premium or benefits.	2299
(C) Every health benefit plan offered or delivered by a	2300
carrier, other than a health insuring corporation, to a small	2301
employer is subject to sections 3923.23, 3923.231, 3923.232,	2302
3923.233, and 3923.234 of the Revised Code and any other provision	2303
of the Revised Code that requires the reimbursement, utilization,	2304
or consideration of a specific category of a licensed or certified	2305
health care practitioner.	2306
(D) Except as expressly provided in sections 3924.01 to	2307

3924.14 3924.06 of the Revised Code, no health benefit plan

offered to a small employer is subject to any of the following:

H. B. No. 456 As Introduced	Page 77
(1) Any law that would inhibit any carrier from contracting	2310
with providers or groups of providers with respect to health care	2311
services or benefits;	2312
(2) Any law that would impose any restriction on the ability	2313
to negotiate with providers regarding the level or method of	2314
reimbursing care or services provided under the health benefit	2315
plan;	2316
(3) Any law that would require any carrier to either include	2317
a specific provider or class of provider when contracting for	2318
health care services or benefits, or to exclude any class of	2319
provider that is generally authorized by statute to provide such	2320
care.	2321
Sec. 3924.06. (A) Compliance with the underwriting and rating	2322
requirements contained in sections 3924.01 to 3924.14 3924.06 of	2323
the Revised Code shall be demonstrated through actuarial	2324
certification. Carriers offering health benefit plans to small	2325
employers shall file annually with the superintendent of insurance	2326
an actuarial certification stating that the underwriting and	2327
rating methods of the carrier do all of the following:	2328
(1) Comply with accepted actuarial practices;	2329
(2) Are uniformly applied to health benefit plans covering	2330
small employers;	2331
(3) Comply with the applicable provisions of sections 3924.01	2332
to 3924.14 <u>3924.06</u> of the Revised Code.	2333
(B) If a carrier has established a separate class of business	2334
for one or more small employer health care alliances in accordance	2335
with section 1731.09 of the Revised Code, this section shall apply	2336
in accordance with section 1731.09 of the Revised Code.	2337
Sec. 3924.73. (A) As used in this section:	2338

(1) "Health care insurer" means any person legally engaged in	2339
the business of providing sickness and accident insurance	2340
contracts in this state, a health insuring corporation organized	2341
under Chapter 1751. of the Revised Code, or any legal entity that	2342
is self-insured and provides health care benefits to its employees	2343
or members.	2344
(2) "Small employer" has the same meaning as in section	2345
3924.01 of the Revised Code.	2346
(B)(1) Subject to division $(B)(2)$ of this section, nothing in	2347
sections 3924.61 to 3924.74 of the Revised Code shall be construed	2348
to limit the rights, privileges, or protections of employees or	2349
small employers under sections 3924.01 to 3924.14 3924.06 of the	2350
Revised Code.	2351
(2) If any account holder enrolls or applies to enroll in a	2352
policy or contract offered by a health care insurer providing	2353
sickness and accident coverage that is more comprehensive than,	2354
and has a deductible amount that is less than, the coverage and	2355
deductible amount of the policy under which the account holder	2356
currently is enrolled, the health care insurer to which the	2357
account holder applies may subject the account holder to the same	2358
medical review, waiting periods, and underwriting requirements to	2359
which the health care insurer generally subjects other enrollees	2360
or applicants, unless the account holder enrolls or applies to	2361
enroll during a designated period of open enrollment.	2362
Sec. 4121.44. (A) The administrator of workers' compensation	2363
shall oversee the implementation of the Ohio workers' compensation	2364
qualified health plan system as established under section 4121.442	2365
of the Revised Code.	2366
(B) The administrator shall direct the implementation of the	2367

health partnership program administered by the bureau as set forth

in section 4121.441 of the Revised Code. To implement the health

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partnership program, the bureau:	2370
(1) Shall certify one or more external vendors, which shall	2371
be known as "managed care organizations," to provide medical	2372
management and cost containment services in the health partnership	2373
program for a period of two years beginning on the date of	2374
certification, consistent with the standards established under	2375
this section;	2376
(2) May recertify external vendors for additional periods of	2377
two years; and	2378
(3) May integrate the certified vendors with bureau staff and	2379
existing bureau services for purposes of operation and training to	2380
allow the bureau to assume operation of the health partnership	2381
program at the conclusion of the certification periods set forth	2382
in division (B)(1) or (2) of this section.	2383
(C) Any vendor selected shall demonstrate all of the	2384
following:	2385
(1) Arrangements and reimbursement agreements with a	2386
substantial number of the medical, professional, and pharmacy	2387
providers currently being utilized by claimants.	2388
(2) Ability to accept a common format of medical bill data in	2389
an electronic fashion from any provider who wishes to submit	2390
medical bill data in that form.	2391
(3) A computer system able to handle the volume of medical	2392
bills and willingness to customize that system to the bureau's	2393
needs and to be operated by the vendor's staff, bureau staff, or	2394
some combination of both staffs.	2395
(4) A prescription drug system where pharmacies on a	2396
statewide basis have access to the eligibility and pricing, at a	2397
discounted rate, of all prescription drugs as established in a	2398
contract for pharmacy benefit management services and the payment	2399

for reimbursement for prescription drugs negotiated and entered	2400
into by the office of pharmaceutical purchasing coordination under	2401
Chapter 185. of the Revised Code or as may otherwise be	2402
established by the administrator pursuant to sections 185.06 and	2403
4121.441 of the Revised Code.	2404
As used in this division, "prescription drug" has the same	2405
meaning as in section 185.01 of the Revised Code.	2406
(5) A tracking system to record all telephone calls from	2407
claimants and providers regarding the status of submitted medical	2408
bills so as to be able to track each inquiry.	2409
(6) Data processing capacity to absorb all of the bureau's	2410
medical bill processing or at least that part of the processing	2411
which the bureau arranges to delegate.	2412
(7) Capacity to store, retrieve, array, simulate, and model	2413
in a relational mode all of the detailed medical bill data so that	2414
analysis can be performed in a variety of ways and so that the	2415
bureau and its governing authority can make informed decisions.	2416
(8) Wide variety of software programs which translate medical	2417
terminology into standard codes, and which reveal if a provider is	2418
manipulating the procedures codes, commonly called "unbundling."	2419
(9) Necessary professional staff to conduct, at a minimum,	2420
authorizations for treatment, medical necessity, utilization	2421
review, concurrent review, post-utilization review, and have the	2422
attendant computer system which supports such activity and	2423
measures the outcomes and the savings.	2424
(10) Management experience and flexibility to be able to	2425
react quickly to the needs of the bureau in the case of required	2426
change in federal or state requirements.	2427
(D)(1) Information contained in a vendor's application for	2428

certification in the health partnership program, and other

information furnished to the bureau by a vendor for purposes of	2430
obtaining certification or to comply with performance and	2431
financial auditing requirements established by the administrator,	2432
is for the exclusive use and information of the bureau in the	2433
discharge of its official duties, and shall not be open to the	2434
public or be used in any court in any proceeding pending therein,	2435
unless the bureau is a party to the action or proceeding, but the	2436
information may be tabulated and published by the bureau in	2437
statistical form for the use and information of other state	2438
departments and the public. No employee of the bureau, except as	2439
otherwise authorized by the administrator, shall divulge any	2440
information secured by the employee while in the employ of the	2441
bureau in respect to a vendor's application for certification or	2442
in respect to the business or other trade processes of any vendor	2443
to any person other than the administrator or to the employee's	2444
superior.	2445

- (2) Notwithstanding the restrictions imposed by division 2446 (D)(1) of this section, the governor, members of select or 2447 standing committees of the senate or house of representatives, the 2448 auditor of state, the attorney general, or their designees, 2449 pursuant to the authority granted in this chapter and Chapter 2450 4123. of the Revised Code, may examine any vendor application or 2451 other information furnished to the bureau by the vendor. None of 2452 those individuals shall divulge any information secured in the 2453 exercise of that authority in respect to a vendor's application 2454 for certification or in respect to the business or other trade 2455 processes of any vendor to any person. 2456
- (E) On and after January 1, 2001, a vendor shall not be any 2457 insurance company holding a certificate of authority issued 2458 pursuant to Title XXXIX of the Revised Code or any health insuring 2459 corporation holding a certificate of authority under Chapter 1751. 2460 of the Revised Code.

(F) The administrator may limit freedom of choice of health	2462
care provider or supplier by requiring, beginning with the period	2463
set forth in division $(B)(1)$ or (2) of this section, that	2464
claimants shall pay an appropriate out-of-plan copayment for	2465
selecting a medical provider not within the health partnership	2466
program as provided for in this section.	2467
(G) The administrator, six months prior to the expiration of	2468
the bureau's certification or recertification of the vendor or	2469
vendors as set forth in division (B)(1) or (2) of this section,	2470
may certify and provide evidence to the governor, the speaker of	2471
the house of representatives, and the president of the senate that	2472
the existing bureau staff is able to match or exceed the	2473
performance and outcomes of the external vendor or vendors and	2474
that the bureau should be permitted to internally administer the	2475
health partnership program upon the expiration of the	2476
certification or recertification as set forth in division (B)(1)	2477
or (2) of this section.	2478
(H) The administrator shall establish and operate a bureau of	2479
workers' compensation health care data program. The administrator	2480
shall develop reporting requirements from all employees, employers	2481
and medical providers, medical vendors, and plans that participate	2482
in the workers' compensation system. The administrator shall do	2483
all of the following:	2484
(1) Utilize the collected data to measure and perform	2485
comparison analyses of costs, quality, appropriateness of medical	2486
care, and effectiveness of medical care delivered by all	2487
components of the workers' compensation system.	2488
(2) Compile data to support activities of the selected vendor	2489
or vendors and to measure the outcomes and savings of the health	2490

(3) Publish and report compiled data to the governor, the

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partnership program.

speaker of the house of representatives, and the president of the	2493
senate on the first day of each January and July, the measures of	2494
outcomes and savings of the health partnership program. The	2495
administrator shall protect the confidentiality of all proprietary	2496
pricing data.	2497
(I) Any rehabilitation facility the bureau operates is	2498
eligible for inclusion in the Ohio workers' compensation qualified	2499
health plan system or the health partnership program under the	2500
same terms as other providers within health care plans or the	2501
program.	2502
(J) In areas outside the state or within the state where no	2503
qualified health plan or an inadequate number of providers within	2504
the health partnership program exist, the administrator shall	2505
permit employees to use a nonplan or nonprogram health care	2506
provider and shall pay the provider for the services or supplies	2507
provided to or on behalf of an employee for an injury or	2508
occupational disease that is compensable under this chapter or	2509
Chapter 4123., 4127., or 4131. of the Revised Code on a fee	2510
schedule the administrator adopts.	2511
(K) No health care provider, whether certified or not, shall	2512
charge, assess, or otherwise attempt to collect from an employee,	2513
employer, a managed care organization, or the bureau any amount	2514
for covered services or supplies that is in excess of the allowed	2515
amount paid by a managed care organization, the bureau, or a	2516
qualified health plan.	2517
(L) The administrator shall permit any employer or group of	2518
employers who agree to abide by the rules adopted under this	2519

section and sections 4121.441 and 4121.442 of the Revised Code to

provide services or supplies to or on behalf of an employee for an

injury or occupational disease that is compensable under this

chapter or Chapter 4123., 4127., or 4131. of the Revised Code

through qualified health plans of the Ohio workers' compensation

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qualified health plan system pursuant to section 4121.442 of the	2525
Revised Code or through the health partnership program pursuant to	2526
section 4121.441 of the Revised Code. No amount paid under the	2527
qualified health plan system pursuant to section 4121.442 of the	2528
Revised Code by an employer who is a state fund employer shall be	2529
charged to the employer's experience or otherwise be used in	2530
merit-rating or determining the risk of that employer for the	2531
purpose of the payment of premiums under this chapter, and if the	2532
employer is a self-insuring employer, the employer shall not	2533
include that amount in the paid compensation the employer reports	2534
under section 4123.35 of the Revised Code.	2535

Sec. 4121.441. (A) The administrator of workers' 2536 compensation, with the advice and consent of the bureau of 2537 workers' compensation board of directors, shall adopt rules under 2538 Chapter 119. of the Revised Code for the health care partnership 2539 program administered by the bureau of workers' compensation to 2540 provide medical, surgical, nursing, drug, hospital, and 2541 rehabilitation services and supplies to an employee for an injury 2542 or occupational disease that is compensable under this chapter or 2543 Chapter 4123., 4127., or 4131. of the Revised Code. 2544

The rules shall include, but are not limited to, the 2545 following:

(1) Procedures for the resolution of medical disputes between 2547 an employer and an employee, an employee and a provider, or an 2548 employer and a provider, prior to an appeal under section 4123.511 2549 of the Revised Code. Rules the administrator adopts pursuant to 2550 division (A)(1) of this section may specify that the resolution 2551 procedures shall not be used to resolve disputes concerning 2552 medical services rendered that have been approved through standard 2553 treatment guidelines, pathways, or presumptive authorization 2554 guidelines. 2555

(2) Prohibitions against discrimination against any category	2556
of health care providers;	2557
(3) Procedures for reporting injuries to employers and the	2558
bureau by providers;	2559
(4) Appropriate financial incentives to reduce service cost	2560
and insure proper system utilization without sacrificing the	2561
quality of service;	2562
(E) Adoquate methods of poer review utilization review	2563
(5) Adequate methods of peer review, utilization review,	
quality assurance, and dispute resolution to prevent, and provide	2564
sanctions for, inappropriate, excessive or not medically necessary	2565
treatment;	2566
(6) A timely and accurate method of collection of necessary	2567
information regarding medical and health care service and supply	2568
costs, quality, and utilization to enable the administrator to	2569
determine the effectiveness of the program;	2570
(7) Provisions for necessary emergency medical treatment for	2571
an injury or occupational disease provided by a health care	2572
provider who is not part of the program;	2573
(8) Discounted pricing for all in-patient and out-patient	2574
medical services, and all professional services, and all	2575
pharmaceutical services;	2576
(9) Discount pricing for the payment of or reimbursement for	2577
prescription drugs and the provision of pharmacy benefit	2578
management services that are in accordance with contracts	2579
negotiated and entered into by the office of pharmaceutical	2580
purchasing coordination under Chapter 185. of the Revised Code, or	2581
in accordance with lower pricing as allowed under section 185.06	2582
of the Revised Code;	2583
(10) Provisions for provider referrals, pre-admission and	2584
post-admission approvals, second surgical opinions, and other cost	2585

management techniques;	2586
(10)(11) Antifraud mechanisms;	2587
$\frac{(11)}{(12)}$ Standards and criteria for the bureau to utilize in	2588
certifying or recertifying a health care provider or a vendor for	2589
participation in the health partnership program;	2590
$\frac{(12)}{(13)}$ Standards and criteria for the bureau to utilize in	2591
penalizing or decertifying a health care provider or a vendor from	2592
participation in the health partnership program.	2593
(B) The administrator shall implement the health partnership	2594
program according to the rules the administrator adopts under this	2595
section for the provision and payment of medical, surgical,	2596
nursing, drug, hospital, and rehabilitation services and supplies	2597
to an employee for an injury or occupational disease that is	2598
compensable under this chapter or Chapter 4123., 4127., or 4131.	2599
of the Revised Code.	2600
Sec. 4123.29. (A) The administrator of workers' compensation,	2601
subject to the approval of the bureau of workers' compensation	2602
board of directors, shall do all of the following:	2603
(1) Classify occupations or industries with respect to their	2604
degree of hazard and determine the risks of the different classes	2605
according to the categories the national council on compensation	2606
insurance establishes that are applicable to employers in this	2607
state;	2608
(2) Fix the rates of premium of the risks of the classes	2609
based upon the total payroll in each of the classes of occupation	2610
or industry sufficiently large to provide a fund for the	2611
compensation provided for in this chapter and to maintain a state	2612
insurance fund from year to year. The administrator shall set the	2613
rates at a level that assures the solvency of the fund. Where the	2614
payroll cannot be obtained or, in the opinion of the	2615

administrator, is not an adequate measure for determining the	2616
premium to be paid for the degree of hazard, the administrator may	2617
determine the rates of premium upon such other basis, consistent	2618
with insurance principles, as is equitable in view of the degree	2619
of hazard, and whenever in this chapter reference is made to	2620
payroll or expenditure of wages with reference to fixing premiums,	2621
the reference shall be construed to have been made also to such	2622
other basis for fixing the rates of premium as the administrator	2623
may determine under this section.	2624
The administrator in setting or revising rates shall furnish	2625
to employers an adequate explanation of the basis for the rates	2626
set.	2627
(3) Develop and make available to employers who are paying	2628
premiums to the state insurance fund alternative premium plans.	2629
Alternative premium plans shall include retrospective rating	2630
plans. The administrator may make available plans under which an	2631
advanced deposit may be applied against a specified deductible	2632
amount per claim.	2633
(4)(a) Offer to insure the obligations of employers under	2634
this chapter under a plan that groups, for rating purposes,	2635
employers, and pools the risk of the employers within the group	2636
provided that the employers meet all of the following conditions:	2637
(i) All of the employers within the group are members of an	2638
organization that has been in existence for at least two years	2639
prior to the date of application for group coverage;	2640
(ii) The organization was formed for purposes other than that	2641
of obtaining group workers' compensation under this division;	2642
(iii) The employers' business in the organization is	2643
substantially similar such that the risks which are grouped are	2644
substantially homogeneous;	2645

(iv) The group of employers consists of at least one hundred

members or the aggregate workers' compensation premiums of the	2647
members, as determined by the administrator, are expected to	2648
exceed one hundred fifty thousand dollars during the coverage	2649
period;	2650
(v) The formation and operation of the group program in the	2651
organization will substantially improve accident prevention and	2652
claims handling for the employers in the group;	2653
(vi) Each employer seeking to enroll in a group for workers'	2654
compensation coverage has an industrial insurance account in good	2655
standing with the bureau of workers' compensation such that at the	2656
time the agreement is processed no outstanding premiums,	2657
penalties, or assessments are due from any of the employers.	2658
(b) If an organization sponsors more than one employer group	2659
to participate in group plans established under this section, that	2660
organization may submit a single application that supplies all of	2661
the information necessary for each group of employers that the	2662
organization wishes to sponsor.	2663
(c) In providing employer group plans under division (A)(4)	2664
of this section, the administrator shall consider an employer	2665
group as a single employing entity for purposes of retrospective	2666
rating. No employer may be a member of more than one group for the	2667
purpose of obtaining workers' compensation coverage under this	2668
division.	2669
(d) At the time the administrator revises premium rates	2670
pursuant to this section and section 4123.34 of the Revised Code,	2671
if the premium rate of an employer who participates in a group	2672
plan established under this section changes from the rate	2673
established for the previous year, the administrator, in addition	2674
to sending the invoice with the rate revision to that employer,	2675
shall send a copy of that invoice to the third-party administrator	2676

that administers the group plan for that employer's group.

(e) In providing employer group plans under division $(A)(4)$	2678
of this section, the administrator shall establish a program	2679
designed to mitigate the impact of a significant claim that would	2680
come into the experience of a private, state fund group-rated	2681
employer for the first time and be a contributing factor in that	2682
employer being excluded from a group-rated plan. The administrator	2683
shall establish eligibility criteria and requirements that such	2684
employers must satisfy in order to participate in this program.	2685
For purposes of this program, the administrator shall establish a	2686
discount on premium rates applicable to employers who qualify for	2687
the program.	2688

- (f) In no event shall division (A)(4) of this section be

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 construed as granting to an employer status as a self-insuring

 2690

 employer.
- (g) The administrator shall develop classifications of 2692 occupations or industries that are sufficiently distinct so as not 2693 to group employers in classifications that unfairly represent the 2694 risks of employment with the employer.
- (5) Generally promote employer participation in the state 2696 insurance fund through the regular dissemination of information to 2697 all classes of employers describing the advantages and benefits of 2698 opting to make premium payments to the fund. To that end, the 2699 administrator shall regularly make employers aware of the various 2700 workers' compensation premium packages developed and offered 2701 pursuant to this section.
- (6) Make available to every employer who is paying premiums 2703 to the state insurance fund a program whereby the employer or the 2704 employer's agent pays to the claimant or on behalf of the claimant 2705 the first fifteen thousand dollars of a compensable workers' 2706 compensation medical-only claim filed by that claimant that is 2707 related to the same injury or occupational disease. No formal 2708 application is required; however, an employer must elect to 2709

participate by telephoning the bureau after July 1, 1995. Once an	2710
employer has elected to participate in the program, the employer	2711
will be responsible for all bills in all medical-only claims with	2712
a date of injury the same or later than the election date, unless	2713
the employer notifies the bureau within fourteen days of receipt	2714
of the notification of a claim being filed that it does not wish	2715
to pay the bills in that claim, or the employer notifies the	2716
bureau that the fifteen thousand dollar maximum has been paid, or	2717
the employer notifies the bureau of the last day of service on	2718
which it will be responsible for the bills in a particular	2719
medical-only claim. If an employer elects to enter the program,	2720
the administrator shall not reimburse the employer for such	2721
amounts paid and shall not charge the first fifteen thousand	2722
dollars of any medical-only claim paid by an employer to the	2723
employer's experience or otherwise use it in merit rating or	2724
determining the risks of any employer for the purpose of payment	2725
of premiums under this chapter. If an employer elects to enter the	2726
program and the employer fails to pay a bill for a medical-only	2727
claim included in the program, the employer shall be liable for	2728
that bill and the employee for whom the employer failed to pay the	2729
bill shall not be liable for that bill. The administrator shall	2730
adopt rules to implement and administer division (A)(6) of this	2731
section. Upon written request from the bureau, the employer shall	2732
provide documentation to the bureau of all medical-only bills that	2733
they are paying directly. Such requests from the bureau may not be	2734
made more frequently than on a semiannual basis. Failure to	2735
provide such documentation to the bureau within thirty days of	2736
receipt of the request may result in the employer's forfeiture of	2737
participation in the program for such injury. The provisions of	2738
this section shall not apply to claims in which an employer with	2739
knowledge of a claimed compensable injury or occupational disease,	2740
has paid wages in lieu of compensation or total disability.	2741

who participates in the Ohio health advantage program pursuant to	2743
section 4123.292 of the Revised Code.	2744
(B) The administrator, with the advice and consent of the	2745
board, by rule, may do both of the following:	2746
(1) Grant an employer who makes the employer's semiannual	2747
premium payment at least one month prior to the last day on which	2748
the payment may be made without penalty, a discount as the	2749
administrator fixes from time to time;	2750
(2) Levy a minimum annual administrative charge upon risks	2751
where semiannual premium reports develop a charge less than the	2752
administrator considers adequate to offset administrative costs of	2753
processing.	2754
Sec. 4123.292. (A) As used in this section, "qualifying	2755
health plan" means either of the following:	2756
(1) A policy of group sickness and accident insurance that is	2757
offered by any person authorized under Title XXXIX of the Revised	2758
Code to engage in the business of insurance in this state, that	2759
provides coverage other than for specific diseases or accidents	2760
only, for hospital indemnity only, for supplemental medicare	2761
benefits only, or for any other supplemental benefits only, and	2762
that is delivered, issued for delivery, or renewed in this state;	2763
(2) A policy, contract, or agreement that is offered by any	2764
health insuring corporation authorized under Chapter 1751. of the	2765
Revised Code to do business in this state and that covers basic	2766
health care services as defined in section 1751.01 of the Revised	2767
Code.	2768
(B)(1) There is hereby created the Ohio health advantage	2769
program. Under the program, if an employer satisfies the	2770
applicable criteria described in division (C) or (D) of this	2771
section, an employer may receive the following discounts on the	2772

employer's premium:	2773
(a) Up to a five per cent discount on the employer's premium	2774
calculated in accordance with division (C) of this section if the	2775
employer establishes and maintains a health and wellness program	2776
for the employer's employees in accordance with that division, not	2777
to exceed the cost incurred by the employer for establishing and	2778
maintaining the program during the previous reporting period;	2779
(b) A fifteen per cent discount on the employer's premium if	2780
the employer offers a qualifying health plan in accordance with	2781
division (D) of this section, not to exceed the cost incurred by	2782
the employer for providing the plan during the previous reporting	2783
period;	2784
(c) Up to a twenty per cent discount if the employer	2785
establishes and maintains a health and wellness program for the	2786
employer's employees in accordance with division (C) of this	2787
section and offers a qualifying health plan in accordance with	2788
division (D) of this section, not to exceed the total cost	2789
incurred by the employer for establishing and maintaining the	2790
program and for providing the plan during the previous reporting	2791
period.	2792
(2) An employer shall receive a discount provided under the	2793
program in addition to any other premium discount offered by the	2794
administrator of workers' compensation that the employer receives.	2795
An employer shall specify in the employer's application to	2796
participate in the program the cost incurred by the employer in	2797
establishing and maintaining the health and wellness program under	2798
division (C) of this section during the six months prior to the	2799
date the employer submits the employer's application, the cost	2800
incurred by the employer for providing a qualifying health plan	2801
under division (D) of this section, or both, as applicable. An	2802
employer who participates in the program shall include in the	2803
payroll report the employer must submit to the administrator in	2804

accordance with section 4123.32 of the Revised Code and rules	2805
adopted by the administrator pursuant to that section the	2806
estimated cost of maintaining the health and wellness program, the	2807
estimated cost of providing a qualifying health plan, or both, as	2808
applicable, during that reporting period. The administrator shall	2809
apply any discount the employer receives pursuant to this section	2810
to the employer's premium each time the administrator calculates	2811
the employer's premium during the time period that the employer	2812
participates in the Ohio health advantage program.	2813
(3) For purposes of division (B) of this section, "reporting	2814
period" means both of the following:	2815
(a) For an employer who is applying to participate in the	2816
program, the time period beginning six months prior to the date	2817
the employer submits the employer's application and ending on the	2818
date the employer submits the application;	2819
(b) For an employer who is participating in the program, the	2820
time period between payroll reports the employer submits to the	2821
administrator in accordance with section 4123.32 of the Revised	2822
Code and rules adopted by the administrator pursuant to that	2823
section.	2824
(C)(1) The administrator and the director of health, with the	2825
advice and consent of the bureau of workers' compensation board of	2826
directors, jointly shall adopt rules in accordance with Chapter	2827
119. of the Revised Code to establish a premium discount program	2828
for an employer who offers a health or wellness program described	2829
in division (C)(2) of this section to the employer's employees.	2830
The administrator and director shall include in the rules the	2831
administrator and director adopt pursuant to this division	2832
requirements an employer must satisfy to participate in the health	2833
and wellness premium discount program under the Ohio health	2834
advantage program, which shall include a requirement that an	2835
employer establish and maintain a program described in division	2836

(C)(2) of this section. The administrator and director shall	2837
require in the rules they jointly adopt that an employer who	2838
participates in the premium discount program described in this	2839
division shall create and maintain documentation or other records	2840
to demonstrate that the employer is providing a program described	2841
in division (C)(2) of this section and shall specify in those	2842
rules the information that the employer must include in the	2843
documentation or records. The administrator and the director, one	2844
year after the program is created pursuant to this section,	2845
jointly may expand or limit the scope of the program.	2846
(2) The administrator shall allow an employer who establishes	2847
and maintains at least one of the following programs for the	2848
employer's employees and satisfies all other requirements	2849
established by the administrator and director to participate in	2850
the health and wellness premium discount program under the Ohio	2851
health advantage program:	2852
(a) A program that has received accreditation from the	2853
commission on accreditation of allied health education programs;	2854
(b) A program that is administered by an individual who holds	2855
a certificate under Chapter 4731. of the Revised Code or who is	2856
licensed under Chapter 4759. of the Revised Code and that focuses	2857
on wellness, nutrition, smoking cessation, or diabetes management,	2858
or a similar program;	2859
(c) A nutritional program that focuses on obesity, weight	2860
loss, diabetes management, and cholesterol reduction and that has	2861
received accreditation from the American dietetic association;	2862
(d) A physical fitness program that is administered by an	2863
individual who has received credentials from the American college	2864
of sports medicine or who is certified by the national exercise	2865
trainers association or the aerobics and fitness association of	2866
America.	2867

(3) The administrator shall use the following factors to	2868
determine what per cent, up to five, to discount the premium of an	2869
employer who participates in the health and wellness premium	2870
discount program under the Ohio health advantage program:	2871
(a) Whether onsite programs described in division (C)(2) of	2872
this section are offered by an employer at the employer's place of	2873
<u>business;</u>	2874
(b) The number of programs described in division (C)(2) of	2875
this section an employer offers to the employer's employees;	2876
(c) The degree to which an employer facilitates employee	2877
access to fitness equipment and dietary options;	2878
(d) Any other factors the administrator determines are	2879
relevant to the Ohio health advantage program.	2880
An employer who participates in the health and wellness	2881
premium discount program under the Ohio health advantage program	2882
shall receive a discount on the employer's premium only after the	2883
employer has participated in the program for six consecutive	2884
months. An employer who participates in the health and wellness	2885
premium discount program shall allow employees of the bureau of	2886
workers' compensation, upon their request, to access the	2887
documentation or records that the employer creates and maintains	2888
to comply with rules the administrator and director jointly adopt	2889
pursuant to division (C)(1) of this section. Employees of the	2890
bureau may perform an audit of that documentation or those records	2891
to verify that the employer is providing a program described in	2892
division (C)(2) of this section to the employer's employees. The	2893
administrator shall prorate the discount for the first year the	2894
employer participates in this premium discount program, but after	2895
the first year the employer must participate in the program for a	2896
full year to receive a discount on the employer's premium for that	2897
year.	2898

(D) The administrator, with the advice and consent of the	2899
board, shall adopt rules in accordance with Chapter 119. of the	2900
Revised Code to establish a premium discount program to encourage	2901
employers to provide a qualifying health plan to the employees	2902
that the employer employs on a full-time basis. The administrator	2903
shall allow an employer to participate in the qualifying health	2904
plan premium discount program under the Ohio health advantage	2905
program if the employer satisfies all of the following criteria:	2906
(1) The employer, for a period of six consecutive months	2907
immediately preceding the date the employer applies to participate	2908
in the program, did not offer the employer's employees a	2909
qualifying health plan.	2910
(2) The employer employs not less than two and not more than	2911
fifty employees within this state.	2912
(3) The average annual compensation the employer pays the	2913
employer's employees is below forty-five thousand dollars.	2914
(4) The employer's principal place of business is in this	2915
state.	2916
(5) The employer has operated the employer's business in this	2917
state for at least six months prior to applying to participate in	2918
the program.	2919
(6) The employer offers the employer's employees a qualifying	2920
health plan.	2921
For purposes of determining the average annual compensation	2922
an employer pays the employer's employees, the administrator shall	2923
use the compensation paid that the employer reported on the most	2924
recent annual report of employee tax withheld that the employer	2925
filed in accordance with section 5747.07 of the Revised Code prior	2926
to applying to participate in the program and dividing that amount	2927
by the number of employees the employer employed during the period	2928
covered by that annual report	2920

An employer may participate in the qualifying health plan	2930
premium discount program under the Ohio health advantage program	2931
for a period of not more than three years beginning on the date	2932
the administrator approves the employer to participate in the	2933
program.	2934
Sec. 4715.22. (A) As This section applies only when a	2935
licensed dental hygienist is not providing services under a	2936
collaboration agreement entered into under section 4715.222 of the	2937
Revised Code.	2938
As used in this section, "health care facility" means either	2939
of the following:	2940
(1) A hospital registered under section 3701.07 of the	2941
Revised Code;	2942
(2) A "home" as defined in section 3721.01 of the Revised	2943
Code.	2944
(B) A licensed dental hygienist shall practice under the	2945
supervision, order, control, and full responsibility of a dentist	2946
licensed under this chapter. A dental hygienist may practice in a	2947
dental office, public or private school, health care facility,	2948
dispensary, or public institution. Except as provided in division	2949
(C) or (D) of this section, a dental hygienist may not provide	2950
dental hygiene services to a patient when the supervising dentist	2951
is not physically present at the location where the dental	2952
hygienist is practicing.	2953
(C) A dental hygienist may provide, for not more than fifteen	2954
consecutive business days, dental hygiene services to a patient	2955
when the supervising dentist is not physically present at the	2956
location at which the services are provided if all of the	2957
following requirements are met:	2958
(1) The dental hygienist has at least two years and a minimum	2959

of three thousand hours of experience in the practice of dental	2960
hygiene.	2961
(2) The dental hygienist has successfully completed a course	2962
approved by the state dental board in the identification and	2963
prevention of potential medical emergencies.	2964
(3) The dental hygienist complies with written protocols for	2965
emergencies the supervising dentist establishes.	2966
(4) The dental hygienist does not perform, while the	2967
supervising dentist is absent from the location, procedures while	2968
the patient is anesthetized, definitive root planing, definitive	2969
subgingival curettage, or other procedures identified in rules the	2970
state dental board adopts.	2971
(5) The supervising dentist has evaluated the dental	2972
hygienist's skills.	2973
(6) The supervising dentist examined the patient not more	2974
than seven months prior to the date the dental hygienist provides	2975
the dental hygiene services to the patient.	2976
(7) The dental hygienist complies with written protocols or	2977
written standing orders that the supervising dentist establishes.	2978
(8) The supervising dentist completed and evaluated a medical	2979
and dental history of the patient not more than one year prior to	2980
the date the dental hygienist provides dental hygiene services to	2981
the patient and, except when the dental hygiene services are	2982
provided in a health care facility, the supervising dentist	2983
determines that the patient is in a medically stable condition.	2984
(9) If the dental hygiene services are provided in a health	2985
care facility, a doctor of medicine and surgery or osteopathic	2986
medicine and surgery who holds a current certificate issued under	2987
Chapter 4731. of the Revised Code or a registered nurse licensed	2988

under Chapter 4723. of the Revised Code is present in the health

care facility when the services are provided.	2990
(10) In advance of the appointment for dental hygiene	2991
services, the patient is notified that the supervising dentist	2992
will be absent from the location and that the dental hygienist	2993
cannot diagnose the patient's dental health care status.	2994
(11) The dental hygienist is employed by, or under contract	2995
with, one of the following:	2996
(a) The supervising dentist;	2997
(b) A dentist licensed under this chapter who is one of the	2998
following:	2999
(i) The employer of the supervising dentist;	3000
(ii) A shareholder in a professional association formed under	3001
Chapter 1785. of the Revised Code of which the supervising dentist	3002
is a shareholder;	3003
(iii) A member or manager of a limited liability company	3004
formed under Chapter 1705. of the Revised Code of which the	3005
supervising dentist is a member or manager;	3006
(iv) A shareholder in a corporation formed under division (B)	3007
of section 1701.03 of the Revised Code of which the supervising	3008
dentist is a shareholder;	3009
(v) A partner or employee of a partnership or a limited	3010
liability partnership formed under Chapter 1775. of the Revised	3011
Code of which the supervising dentist is a partner or employee.	3012
(c) A government entity that employs the dental hygienist to	3013
provide dental hygiene services in a public school or in	3014
connection with other programs the government entity administers.	3015
(D) A dental hygienist may provide dental hygiene services to	3016
a patient when the supervising dentist is not physically present	3017
at the location at which the services are provided if the services	3018
are provided as part of a dental hygiene program that is approved	3019

by a dentist and a dental hygienist under section 4715.222 of the

Revised Code.	3050
(B) "Dentist" means an individual licensed under this chapter	3051
to practice dentistry who is employed by, or under contract with,	3052
a public health facility.	3053
(C) "Dental hygienist" means an individual licensed under	3054
this chapter to practice as a dental hygienist.	3055
(D) "Institution of higher education" means a state	3056
institution of higher education as defined in section 3345.011 of	3057
the Revised Code, a private nonprofit college or university	3058
located in this state that possesses a certificate of	3059
authorization issued by the Ohio board of regents pursuant to	3060
Chapter 1713. of the Revised Code, or a school located in this	3061
state that possesses a certificate of registration and one or more	3062
program authorizations issued by the state board of career	3063
colleges and schools under Chapter 3332. of the Revised Code.	3064
(E) "Patient" means an individual who receives dental hygiene	3065
services at a public health facility, a student enrolled in the	3066
facility at which the services are provided, or a resident of a	3067
facility at which the services are provided.	3068
(F) "Public health facility" means any of the following:	3069
(1) A "public school" or "nonpublic school" as defined in	3070
section 3701.93 of the Revised Code;	3071
(2) A "health care facility" as defined in section 4715.22 of	3072
the Revised Code;	3073
(3) A clinic or shelter financed with public or private	3074
funds;	3075
(4) A comprehensive child development program that receives	3076
funds distributed under the "Head Start Act," 95 Stat. 499 (1981),	3077
42 U.S.C. 9831, as amended, and is licensed as a child day-care	3078
<u>center;</u>	3079

(5) A corporation, association, group, institution, society,	3080
or other organization that is exempt from federal taxation under	3081
section 501(c)(3) of the "Internal Revenue Code of 1986," 100	3082
<pre>Stat. 2085, 26 U.S.C. 501(c)(3), as amended;</pre>	3083
(6) A special needs program;	3084
(7) A residential facility licensed under section 5123.19 of	3085
the Revised Code;	3086
(8) A "hospice care program" as defined in section 3712.01 of	3087
the Revised Code.	3088
(9) An institution of higher education.	3089
(10) Any other health care facility operated by a	3090
governmental entity.	3091
(11) A mobile dental unit located at any location listed in	3092
divisions (F)(1) to (10) of this section.	3093
(G) "Special needs program" means a program operated by any	3094
of the following:	3095
(1) A school district board of education or the governing	3096
board of an educational service center;	3097
(2) The board of health of a city or general health district	3098
or the authority having the duties of a board of health under	3099
section 3709.05 of the Revised Code;	3100
(3) A national, state, district, or local dental association.	3101
Sec. 4715.222. (A) A dental hygienist who has provided the	3102
evidence required by section 4715.223 of the Revised Code may	3103
enter into a collaboration agreement with a dentist under which	3104
the dentist authorizes all of the following:	3105
(1) The dental hygienist to provide the services described in	3106
section 4715.224 of the Revised Code to patients at any public	3107
health facility without the dentist being physically present at	3108

the facility where the services are provided;	3109
(2) The dental hygienist to provide the services described in	3110
section 4715.224 of the Revised Code to patients without prior	3111
examination of the patients by the dentist or diagnosis or	3112
treatment plans approved by the dentist, unless otherwise	3113
specified in the collaboration agreement;	3114
(3) The dental hygienist to work with dental assistants	3115
certified by the dental assisting national board or the Ohio	3116
commission on dental assistant certification who may perform only	3117
the duties they are authorized to provide without the direct	3118
supervision of a dentist.	3119
(B) A collaboration agreement must meet the requirements of	3120
section 4715.225 of the Revised Code.	3121
Sec. 4715.223. Prior to entering into a collaboration	3122
agreement, a dental hygienist shall do both of the following:	3123
(A) Submit written evidence of all of the following to the	3124
dentist who is to be the collaborating dentist under the	3125
agreement:	3126
(1) The dental hygienist has at least two years and a minimum	3127
of three thousand hours of experience in the practice of dental	3128
hygiene.	3129
(2) The dental hygienist has successfully completed a course	3130
approved by the state dental board in the identification and	3131
prevention of potential medical emergencies and infection control.	3132
(3) The dental hygienist holds current certification to	3133
perform basic life-support procedures as required under section	3134
4715.251 of the Revised Code.	3135
(4) The dental hygienist holds professional liability	3136
insurance	3137

(B) Permit the dentist who is to be the collaborating dentist	3138
under the agreement to personally observe the dental hygienist	3139
provide to patients the services described in section 4715.224 of	3140
the Revised Code.	3141
Sec. 4715.224. A dental hygienist may provide the following	3142
services to a patient under a collaboration agreement:	3143
(A) Oral health promotion and disease prevention education,	3144
including information gathering, screening, and assessment;	3145
(B) Removal of calcareous deposits or accretions from the	3146
<pre>crowns and roots of teeth;</pre>	3147
(C) Sulcular placement of prescribed materials;	3148
(D) Polishing of the clinical crowns of teeth, including	3149
<u>restorations;</u>	3150
(E) Standard diagnostic and radiological procedures for the	3151
purpose of contributing to the provision of dental services;	3152
(F) Fluoride applications;	3153
(G) Placement of sealants;	3154
(H) Any other basic remediable intraoral dental task or	3155
procedure designated by the state dental board in rules adopted	3156
under section 4715.2210 of the Revised Code.	3157
Sec. 4715.225. A collaboration agreement shall be in writing	3158
and do all of the following at a minimum:	3159
(A) Contain the following terms:	3160
(1) A procedure the dental hygienist must follow in securing	3161
the dentist's review of the patient's record and medical history	3162
if the dental hygienist believes the patient's condition is	3163
medically compromised;	3164
(2) A procedure the dental hygienist must follow if the	3165

dental hygienist believes the patient's condition presents an	3166
emergency dental condition;	3167
(3) Practice protocols for the dental hygienist to follow in	3168
providing services to patients who are different ages and who	3169
require different procedures, including recommended intervals for	3170
the performance of dental hygiene services and a period of time in	3171
which an examination by a dentist should occur;	3172
(4) Specific protocols for the placement of pit and fissure	3173
sealants and requirements for follow-up care to assure the	3174
efficacy of the sealants after application;	3175
(5) A procedure for creating and maintaining dental records	3176
for patients that are treated by the dental hygienist. The	3177
procedure must specify where the records are to be located.	3178
(6) Services specified under section 4715.224 of the Revised	3179
Code, if any, for which the dentist requires either or both of the	3180
following:	3181
(a) The patient be examined by the dentist prior to the	3182
dental hygienist providing the services;	3183
(b) The dentist to approve a patient-specific diagnosis or	3184
treatment plan.	3185
(7) The number of patient visits for dental hygiene services,	3186
if any, that the dentist requires the dental hygienist to provide,	3187
on an annual basis, to patients in special needs programs for a	3188
charge determined according to the sliding fee scale established	3189
by the state dental board in rules adopted under section 4715.2210	3190
of the Revised Code.	3191
(8) A statement that the dentist and dental hygienist agree	3192
that the dental hygienist's provision of services under a	3193
collaboration agreement is neither of the following:	3194
(a) The practice of dental hygiene in a manner that is	3195

separate or otherwise independent from the dental practice of a	3196
collaborating dentist;	3197
(b) The establishment or maintenance of an office or practice	3198
that is primarily devoted to the provision of dental hygiene	3199
services.	3200
(B) Contain a blank copy of a consent to treatment form that	3201
the dental hygienist can use for purposes of complying with the	3202
requirement of section 4715.227 of the Revised Code;	3203
(C) Be signed and dated by both the dentist and dental	3204
hygienist.	3205
Sec. 4715.226. (A) A copy of a collaboration agreement must	3206
be maintained by the dentist and the dental hygienist who are	3207
parties to the agreement. The dental hygienist shall ensure that	3208
each public health facility where the dental hygienist provides	3209
services under a collaboration agreement has a copy of the	3210
agreement that the dental hygienist works under at that facility.	3211
(B) Except as provided under division (C) of this section,	3212
prior approval of a collaboration agreement by the state dental	3213
board is not required before a dental hygienist provides services	3214
under an agreement, but the dentist or dental hygienist who is a	3215
party to the agreement must provide the board with a copy of the	3216
agreement on the board's request.	3217
(C) A dentist shall not at any one time be a party to more	3218
than three collaboration agreements unless the state dental board	3219
determines that the dentist meets the criteria, established by the	3220
board in rules adopted under section 4715.2210 of the Revised	3221
Code, to be a party to more than three agreements.	3222
Sec. 4715.227. Before performing any services on a patient	3223
under a collaboration agreement, a dental hygienist must provide	3224
the patient or patient's representative with a consent to	3225

treatment form and secure the signature or mark of the patient or	3226
representative on it. The signature or mark may be provided	3227
through reasonable accommodation, including the use of assistive	3228
technology or augmentative devices.	3229
The form must include a statement advising the patient that	3230
the dental hygiene services provided are not a substitute for a	3231
dental examination by a dentist, that a dentist will not be	3232
present during the provision of dental hygiene services, and that	3233
the dental hygienist cannot diagnose the patient's dental health	3234
care status.	3235
Sec. 4715.228. Following the provision of services to a	3236
patient under a collaboration agreement, the dental hygienist	3237
shall refer the patient to the dentist who is the collaborating	3238
dentist under the agreement the dental hygienist is working under	3239
at the public health facility where the patient was treated. The	3240
dental hygienist shall give the patient or patient's	3241
representative a completed referral form that lists the name,	3242
office address, and office telephone of the collaborating dentist	3243
and the date the dental hygienist provided the services to the	3244
patient. The dental hygienist shall provide a copy of each	3245
completed referral form and the patient's record to the	3246
collaborating dentist.	3247
Sec. 4715.229. A collaboration agreement entered into under	3248
section 4715.222 of the Revised Code may be terminated by the	3249
dentist or dental hygienist who entered into the agreement. A	3250
dentist or dental hygienist who terminates a collaboration	3251
agreement shall provide written notice to the opposite party. The	3252
dental hygienist shall not provide services under the agreement	3253
once notice of the termination has been given or sent to the	3254
dentist.	3255

Sec. 4715.2210. The state dental board shall adopt rules to	3256
do all of the following:	3257
(A) For purposes of division (H) of section 4715.224 of the	3258
Revised Code, designate the basic remediable intraoral dental	3259
tasks or procedures, in addition to the services listed in	3260
divisions (A) to (G) of section 4715.224 of the Revised Code, that	3261
a dental hygienist may provide under a collaboration agreement.	3262
(B) For purposes of division (A)(7) of section 4715.225 of	3263
the Revised Code, establish a sliding fee scale that determines	3264
the fee a patient in a special needs program is charged for dental	3265
hygiene services provided by a dental hygienist under a	3266
collaboration agreement.	3267
(C) For purposes of division (C) of section 4715.226 of the	3268
Revised Code, establish the criteria the board must use in	3269
determining whether a dentist can be a party to more than three	3270
collaboration agreements at one time.	3271
Sec. 4715.23. Except when a dental hygienist is providing	3272
services under a collaboration agreement entered into under	3273
section 4715.222 of the Revised Code, all of the following apply	3274
with respect to the practice of a dental hygienist:	3275
(A) The practice of a dental hygienist shall consist of those	3276
prophylactic, preventive, and other procedures that licensed	3277
dentists are authorized by this chapter and rules of the dental	3278
board to assign only to licensed dental hygienists or to qualified	3279
personnel under section 4715.39 of the Revised Code.	3280
(B) Licensed dentists may assign to dental hygienists	3281
intraoral tasks that do not require the professional competence or	3282
skill of the licensed dentist and that are authorized by board	3283
rule. Such performance of intraoral tasks by dental hygienists	3284
shall be under supervision and full responsibility of the licensed	3285

dentist, and at no time shall more than three dental hygienists be	3286
practicing clinical hygiene under the supervision of the same	3287
dentist. The foregoing shall not be construed as authorizing the	3288
assignment of diagnosis, treatment planning and prescription	3289
(including prescriptions for drugs and medicaments or	3290
authorizations for restorative, prosthodontic, or orthodontic	3291
appliances); or, except when done in conjunction with the removal	3292
of calcarious deposits, dental cement, or accretions on the crowns	3293
and roots of teeth, surgical procedures on hard and soft tissues	3294
within the oral cavity or any other intraoral procedure that	3295
contributes to or results in an irremediable alteration of the	3296
oral anatomy; or the making of final impressions from which casts	3297
are made to construct any dental restoration.	3298
(C) The state dental board shall issue rules defining the	3299
procedures that may be performed by licensed dental hygienists	3300
engaged in school health activities or employed by public	3301
agencies.	3302
Sec. 4715.39. (A) The state dental board may define the	3303

- duties that may be performed by dental assistants and other 3304 individuals designated by the board as qualified personnel. If 3305 defined, the duties shall be defined in rules adopted in 3306 accordance with Chapter 119. of the Revised Code. The rules may 3307 include training and practice standards for dental assistants and 3308 other qualified personnel. The standards may include examination 3309 and issuance of a certificate. If the board issues a certificate, 3310 the recipient shall display the certificate in a conspicuous 3311 location in any office in which the recipient is employed to 3312 perform the duties authorized by the certificate. 3313
- (B) A dental assistant may polish the clinical crowns of 3314 teeth if all of the following requirements are met: 3315
 - (1) The dental assistant's polishing activities are limited 3316

to the use of a rubber cup attached to a slow-speed rotary dental	3317
hand piece to remove soft deposits that build up over time on the	3318
crowns of teeth.	3319
(2) The polishing is performed only after a dentist has	3320
evaluated the patient and any calculus detected on the teeth to be	3321
polished has been removed by a dentist or dental hygienist.	3322
(3) The dentist supervising the assistant supervises not more	3323
than two dental assistants engaging in polishing activities at any	3324
given time.	3325
(4) The dental assistant is certified by the dental assisting	3326
national board or the Ohio commission on dental assistant	3327
certification.	3328
(5) The dental assistant receives a certificate from the	3329
board authorizing the assistant to engage in the polishing	3330
activities. The board shall issue the certificate if the	3331
individual has successfully completed training in the polishing of	3332
clinical crowns through a program accredited by the American	3333
dental association commission on dental accreditation or	3334
equivalent training approved by the board. The training shall	3335
include courses in basic dental anatomy and infection control,	3336
followed by a course in coronal polishing that includes didactic,	3337
preclinical, and clinical training; any other training required by	3338
the board; and a skills assessment that includes successful	3339
completion of standardized testing. The board shall adopt rules	3340
pursuant to division (A) of this section establishing standards	3341
for approval of this training.	3342
(C) A dental assistant may apply pit and fissure sealants if	3343
all of the following requirements are met:	3344
(1) A dentist evaluates the patient and designates the teeth	3345
and surfaces that will benefit from the application of sealant on	3346
the day the application is to be performed.	3347

(2) The dental assistant is certified by the dental assisting	3348
national board or the Ohio commission on dental assistant	3349
certification.	3350
(3) The dental assistant has successfully completed a course	3351
in the application of sealants consisting of at least two hours of	3352
didactic instruction and six hours of clinical instruction through	3353
a program provided by an institution accredited by the American	3354
dental association commission on dental accreditation or a program	3355
provided by a sponsor of continuing education approved by the	3356
board.	3357
(4) The dentist supervising the assistant has observed the	3358
assistant successfully apply at least six sealants.	3359
(5) The dentist supervising the assistant checks and approves	3360
the application of all sealants placed by the assistant before the	3361
patient leaves the location where the sealant application	3362
procedure is performed.	3363
(D) Subject to this section and the applicable rules of the	3364
board, licensed dentists may assign to dental assistants and other	3365
qualified personnel dental procedures that do not require the	3366
professional competence or skill of the licensed dentist, a dental	3367
hygienist, or an expanded function dental auxiliary as this	3368
section or the board by rule authorizes dental assistants and	3369
other qualified personnel to perform. The performance of dental	3370
procedures by dental assistants and other qualified personnel	3371
shall be under direct supervision and full responsibility of the	3372
licensed dentist.	3373
(E) Nothing in this section shall be construed by rule of the	3374
state dental board or otherwise to do the following:	3375
(1) Authorize dental assistants or other qualified personnel	3376
to engage in the practice of dental hygiene as defined by sections	3377

4715.22 and 4715.23 of the Revised Code, to enter into a

collaboration agreement under section 4715.222 of the Revised	3379
<u>Code</u> , or to perform the duties of a dental hygienist, including	3380
the removal of calcarious deposits, dental cement, or accretions	3381
on the crowns and roots of teeth other than as authorized pursuant	3382
to this section;	3383
(2) Authorize dental assistants or other qualified personnel	3384
to engage in the practice of an expanded function dental auxiliary	3385
as specified in section 4715.64 of the Revised Code or to perform	3386
the duties of an expanded function dental auxiliary other than as	3387
authorized pursuant to this section.	3388
(3) Authorize the assignment of any of the following:	3389
(a) Diagnosis;	3390
(b) Treatment planning and prescription, including	3391
prescription for drugs and medicaments or authorization for	3392
restorative, prosthodontic, or orthodontic appliances;	3393
(c) Surgical procedures on hard or soft tissue of the oral	3394
cavity, or any other intraoral procedure that contributes to or	3395
results in an irremediable alteration of the oral anatomy;	3396
(d) The making of final impressions from which casts are made	3397
to construct any dental restoration.	3398
(F) No dentist shall assign any dental assistant or other	3399
individual acting in the capacity of qualified personnel to	3400
perform any dental procedure that the assistant or other	3401
individual is not authorized by this section or by board rule to	3402
perform. No dental assistant or other individual acting in the	3403
capacity of qualified personnel shall perform any dental procedure	3404
other than in accordance with this section and any applicable	3405
board rule or any dental procedure that the assistant or other	3406
individual is not authorized by this section or by board rule to	3407
perform.	3408

Sec. 4715.64. (A) The practice of an expanded function dental	3409
auxiliary shall consist of the following:	3410
(1) The procedures involved in the placement of restorative	3411
materials limited to amalgam restorative materials and	3412
non metallic nonmetallic restorative materials, including	3413
direct-bonded restorative materials;	3414
(2) The procedures involved in the placement of sealants;	3415
(3) Any additional procedures authorized by the state dental	3416
board in rules adopted under section 4715.66 of the Revised Code.	3417
(B) An expanded function dental auxiliary shall practice	3418
under the direct supervision, order, control, and full	3419
responsibility of a dentist licensed under this chapter. At no	3420
time shall more than two expanded function dental auxiliaries be	3421
practicing as expanded function dental auxiliaries under the	3422
direct supervision of the same dentist. An expanded function	3423
dental auxiliary shall not practice as an expanded function dental	3424
auxiliary when the supervising dentist is not physically present	3425
at the location where the expanded function dental auxiliary is	3426
practicing.	3427
(C) Nothing in this section shall be construed by rule of the	3428
board or otherwise to authorize an expanded function dental	3429
auxiliary to engage in the practice of dental hygiene as defined	3430
by sections 4715.22 and 4715.23 of the Revised Code or to enter	3431
into a collaboration agreement under section 4715.222 of the	3432
Revised Code.	3433
Sec. 5101.90. There is hereby created the health insurance	3434
credit program in the department of job and family services. The	3435
department shall administer the program in accordance with	3436
sections 5101.91 to 5101.95 of the Revised Code.	3437

Sec. 5101.91. As used in sections 5101.91 to 5101.95 of the	3438
Revised Code:	3439
"Basic health care services" has the same meaning as in	3440
section 1751.01 of the Revised Code.	3441
"Federal poverty guidelines" means the poverty guidelines as	3442
revised annually by the United States department of health and	3443
human services in accordance with section 673(2) of the "Omnibus	3444
Budget Reconciliation Act of 1981," 95 Stat. 511, 42 U.S.C. 9902,	3445
as amended, for a family size equal to the size of the family of	3446
the individual whose income is being determined.	3447
"Health insurer" means a health insuring corporation holding	3448
a certificate of authority under Chapter 1751. of the Revised Code	3449
or a sickness and accident insurer authorized under Title XXXIX of	3450
the Revised Code to do the business of sickness and accident	3451
coverage in this state. "Health insurer" does not include an	3452
entity that offers only plans with an annual deductible of not	3453
less than one thousand one hundred dollars for individual coverage	3454
and two thousand two hundred dollars for coverage of an individual	3455
and the individual's spouse.	3456
Sec. 5101.92. To be eligible for the health insurance credit	3457
program, an applicant must meet all of the following requirements:	3458
(A) Have been a resident of this state for at least six	3459
months prior to the date of application for the credit program and	3460
be at least eighteen years of age;	3461
(B) Be ineligible for the medicaid program established under	3462
Chapter 5111. of the Revised Code, the medicare program	3463
established by Title XVIII of the "Social Security Act," 49 Stat.	3464
620, 42 U.S.C. 301, as amended, and the disability medical	3465
assistance program established under section 5115.10 of the	3466
Revised Code;	3467

(C) Have income in accordance with the following:	3468
(1) For applications approved from July 1, 2009, through July	3469
1, 2011, for a husband and wife, combined income above ninety per	3470
cent and not exceeding one hundred per cent of the federal poverty	3471
<pre>guidelines;</pre>	3472
(2) For applications approved from July 1, 2009, through July	3473
1, 2011, for an individual, income above sixty-five per cent and	3474
not exceeding one hundred per cent of the federal poverty	3475
<pre>guidelines;</pre>	3476
(3) For applications approved after July 1, 2011, for a	3477
husband and wife, combined income above ninety per cent and not	3478
exceeding one hundred twenty-five per cent of the federal poverty	3479
guidelines;	3480
(4) For applications approved after July 1, 2011, for an	3481
individual, income above sixty-five per cent and not exceeding one	3482
hundred twenty-five per cent of the federal poverty guidelines.	3483
(D) In the six months prior to the date of application, not	3484
have been provided health insurance coverage by the applicant's	3485
employer or the employer of a family member of the applicant;	3486
(E) Meet any other requirement established by the department	3487
of job and family services in rules adopted under section 5101.95	3488
of the Revised Code.	3489
An individual may apply or reapply on behalf of the	3490
individual and the individual's spouse. The guardian or custodian	3491
of an individual may apply or reapply on behalf of the individual.	3492
Application and annual reapplication for the program shall be in	3493
accordance with rules adopted by the department of job and family	3494
services under section 5101.95 of the Revised Code. The	3495
application shall require the applicant to indicate the health	3496
insurer to whom the credit is to be paid.	3497

Sec. 5101.93. On receipt of applications or reapplications	3498
for the health insurance credit program, the department of job and	3499
family services shall make eligibility determinations in	3500
accordance with rules adopted under section 5101.95 of the Revised	3501
Code. Each determination that an applicant is eligible is valid	3502
for one year beginning on a date determined in accordance with the	3503
eligibility determination procedures. The beginning date shall not	3504
precede the date on which the applicant's eligibility is	3505
determined. An eligibility determination under this section is	3506
final and may not be appealed under Chapter 119. or any section of	3507
the Revised Code.	3508
	2500
Sec. 5101.94. The department of job and family services shall	3509
pay a credit from the health insurance credit fund created under	3510
section 5725.24 of the Revised code to the health insurer	3511
indicated on behalf of each credit program recipient. The credit	3512
amount shall be four thousand dollars annually for a husband and	3513
wife and twenty-five hundred dollars annually for an individual.	3514
The credit shall go towards paying the premium on a health	3515
insurance plan that provides, at minimum, basic health care	3516
services.	3517
Any amount of money that exceeds the amount necessary to pay	3518
the recipient's annual premium shall be credited to an individual	3519
account created on behalf of the recipient or the recipient and	3520
spouse, to be administered by the health insurer. The individual	3521
account may be used to pay any copayment or deductible amounts the	3522
credit program recipient or spouse may accrue. Any funds unused at	3523
the end of the year shall be refunded by the health insurer to the	3524
department.	3525
Sec. 5101.95. In accordance with Chapter 119. of the Revised	3526
Code, the department of job and family services shall adopt rules	3527

establishing all of the following:	3528
(A) Application procedures for the health insurance credit	3529
program;	3530
(B) Any eligibility requirements in addition to those	3531
specified in section 5101.92 of the Revised Code;	3532
(C) Eligibility determination procedures;	3533
(D) The number of credits available to individuals, and to	3534
husbands and wives who apply jointly, from the money allocated for	3535
the health insurance credit program in the health insurance credit	3536
fund created under section 5725.24 of the Revised Code;	3537
(E) Any other requirements or procedures the department	3538
considers necessary to implement the health insurance credit	3539
program.	3540
Sec. 5111.162. (A) As used in this section:	3541
(1) "Emergency services" has the same meaning as in section	3542
1932(b)(2) of the "Social Security Act," 79 Stat. 286 (1965), 42	3543
U.S.C. 1396u-2(b)(2), as amended.	3544
(2) "Medicaid managed care organization" means a managed care	3545
organization that has entered into a contract with the department	3546
of job and family services pursuant to section 5111.17 of the	3547
Revised Code.	3548
(B) Except as provided in division (C) of this section, when	3549
When a participant in the care management system established under	3550
section 5111.16 of the Revised Code is enrolled in a medicaid	3551
managed care organization and the organization refers the	3552
participant to receive services, other than emergency services	3553
provided on or after January 1, 2007, at a hospital that	3554
participates in the medicaid program but is not under contract	3555
with the organization, the hospital shall provide the service for	3556

which the referral was made and shall accept from the	3557
organization, as payment in full, ninety-five per cent of the	3558
amount derived from the reimbursement rate used by the department	3559
to reimburse other hospitals of the same type for providing the	3560
same service to a medicaid recipient who is not enrolled in a	3561
medicaid managed care organization.	3562
(C) A hospital is not subject to division (B) of this section	3563
if all of the following are the case:	3564
(1) The hospital is located in a county in which participants	3565
in the care management system are required before January 1, 2006,	3566
to be enrolled in a medicaid managed care organization that is a	3567
health-insuring-corporation;	3568
(2) The hospital has entered into a contract before January	3569
1, 2006, with at least one health insuring corporation serving the	3570
participants specified in division (C)(1) of this section;	3571
(3) The hospital remains under contract with at least one	3572
health insuring corporation serving participants in the care	3573
management system who are required to be enrolled in a health	3574
insuring corporation.	3575
(D) The director of job and family services shall adopt rules	3576
specifying the circumstances under which a medicaid managed care	3577
organization is permitted to refer a participant in the care	3578
management system to a hospital that is not under contract with	3579
the organization. The director may adopt any other rules necessary	3580
to implement this section. All rules adopted under this section	3581
shall be adopted in accordance with Chapter 119. of the Revised	3582
Code.	3583
Sec. 5112.08. (A) As used in this section:	3584
(1) "Medicaid managed care contract" means a contract between	3585
a hospital and a medicaid managed care organization under which	3586

the hospital is to provide services covered by the contract to	3587
medicaid recipients enrolled in the medicaid managed care	3588
organization and be paid by the medicaid managed care organization	3589
for the services in accordance with the terms of the contract.	3590
(2) "Medicaid managed care organization" means a managed care	3591
organization that is under contract with the department of job and	3592
family services under section 5111.17 of the Revised Code to	3593
provide, or arrange for the provision of, health care services to	3594
medicaid recipients who are required or permitted to obtain health	3595
care services through managed care organizations as part of the	3596
care management system established under section 5111.16 of the	3597
Revised Code.	3598
(3) "Medicaid managed care region" means a group of counties	3599
that the department of job and family services treats as a	3600
specific region of the state for the purpose of the care	3601
management system established under section 5111.16 of the Revised	3602
Code.	3603
(B) The director of job and family services shall adopt rules	3604
under section 5112.03 of the Revised Code establishing a	3605
methodology to pay hospitals that is sufficient to expend all	3606
money in the indigent care pool. Under the rules:	3607
$\frac{(A)}{(1)}$ The department of job and family services may classify	3608
similar hospitals into groups and allocate funds for distribution	3609
within each group.	3610
$\frac{(B)(2)}{(B)}$ The department shall establish a method of allocating	3611
funds to hospitals, taking into consideration the relative amount	3612
of indigent care provided by each hospital or group of hospitals.	3613
The amount to be allocated shall be based on any combination of	3614
the following indicators of indigent care that the director	3615
considers appropriate:	3616
$\frac{(1)(a)}{(a)}$ Total costs, volume, or proportion of services to	3617

recipients of the medical assistance program, including recipients	3618
enrolled in health insuring corporations;	3619
$\frac{(2)}{(b)}$ Total costs, volume, or proportion of services to	3620
low-income patients in addition to recipients of the medical	3621
assistance program, which may include recipients of Title V of the	3622
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as	3623
amended, and recipients of financial or medical assistance	3624
provided under Chapter 5115. of the Revised Code;	3625
$\frac{(3)(c)}{(c)}$ The amount of uncompensated care provided by the	3626
hospital or group of hospitals;	3627
$\frac{(4)}{(d)}$ Other factors that the director considers to be	3628
appropriate indicators of indigent care.	3629
$\frac{(C)(3)}{(3)}$ The department shall distribute funds to each hospital	3630
or group of hospitals in a manner that first may provide for an	3631
additional distribution to individual hospitals that provide a	3632
high proportion of indigent care in relation to the total care	3633
provided by the hospital or in relation to other hospitals. The	3634
department shall establish a formula to distribute the remainder	3635
of the funds. The formula shall be consistent with section 1923 of	3636
the "Social Security Act," 42 U.S.C.A. 1396r-4, as amended, and	3637
shall be based on any combination of the indicators of indigent	3638
care listed in division (B) (2) of this section that the director	3639
considers appropriate.	3640
(D)(4) A disproportionate share hospital may receive, for a	3641
program year, more funds from the indigent care pool than exceeds	3642
the minimum necessary to satisfy 42 U.S.C. 1396r-4 only if the	3643
hospital has, for that program year, a valid medicaid managed care	3644
contract with each medicaid managed care organization that	3645
provides, or arranges for the provision of, health care services	3646
to medicaid recipients who reside in the medicaid managed care	3647
region in which the hospital is located.	3648

(5) A hospital that is not a disproportionate share hospital	3649
may not receive any funds from the indigent care pool for a	3650
program year unless the hospital has, for that program year, a	3651
valid medicaid managed care contract with each medicaid managed	3652
care organization that provides, or arranges for the provision of,	3653
health care services to medicaid recipients who reside in the	3654
medicaid managed care region in which the hospital is located.	3655
(6) The department shall distribute funds to each hospital in	3656
installments not later than ten working days after the deadline	3657
established in rules for each hospital to pay an installment on	3658
its assessment under section 5112.06 of the Revised Code. In the	3659
case of a governmental hospital that makes intergovernmental	3660
transfers, the department shall pay an installment under this	3661
section not later than ten working days after the earlier of that	3662
deadline or the deadline established in rules for the governmental	3663
hospital to pay an installment on its intergovernmental transfer.	3664
If the amount in the hospital care assurance program fund created	3665
under section 5112.18 of the Revised Code and the portion of the	3666
health care - federal fund created under section 5111.943 of the	3667
Revised Code that is credited to that fund pursuant to division	3668
(B) of section 5112.18 of the Revised Code are insufficient to	3669
make the total distributions for which hospitals are eligible to	3670
receive in any period, the department shall reduce the amount of	3671
each distribution by the percentage by which the amount and	3672
portion are insufficient. The department shall distribute to	3673
hospitals any amounts not distributed in the period in which they	3674
are due as soon as moneys are available in the funds.	3675
Sec. 5120.052. (A) As used in this section, "clinic" means a	3676
federally qualified health center as that entity is defined under	3677
the "Social Security Act," 120 Stat. 4, 42 U.S.C. 1395x, as	3678
amended.	3679

(B) The department of rehabilitation and correction shall	3680
enter into an agreement with one or more clinics to have the	3681
clinics provide health care services, including prescription drug	3682
services, to inmates of state correctional institutions.	3683
(C) Division (B) of this section does not apply to an	3684
institution if no clinic operates in the county in which the	3685
institution is located.	3686
Sec. 5139.031. (A) As used in this section, "clinic" means a	3687
federally qualified health center as that entity is defined under	3688
the "Social Security Act," 120 Stat. 4, 42 U.S.C. 1395x, as	3689
amended.	3690
(B) The department of youth services shall enter into an	3691
agreement with one or more clinics to have the clinics provide	3692
health care services, including prescription drug services, to	3693
delinquent children residing in training or rehabilitation	3694
institutions or facilities.	3695
(C) Division (B) of this section does not apply to an	3696
institution or facility if no clinic operates in the county in	3697
which the institution or facility is located.	3698
Sec. 5725.24. (A) As used in this section, "qualifying	3699
dealer" means a dealer in intangibles that is a qualifying dealer	3700
in intangibles as defined in section 5733.45 of the Revised Code	3701
or a member of a qualifying controlled group, as defined in	3702
section 5733.04 of the Revised Code, of which an insurance company	3703
also is a member on the first day of January of the year in and	3704
for which the tax imposed by section 5707.03 of the Revised Code	3705
is required to be paid by the dealer.	3706
(B) The taxes levied by section 5725.18 of the Revised Code	3707
and collected pursuant to this chapter shall be paid into the	3708
state treasury to the gredit of the general revenue fund health	3700

insurance credit fund, which is hereby created in the state	3710
treasury. Money in the fund shall be used exclusively to support	3711
the programs established in sections 3923.86 and 5101.90 of the	3712
Revised Code. Fifty per cent of the funds shall be allocated to	3713
the health insurance credit program established in section 5101.90	3714
of the Revised Code, and forty per cent of the funds shall be	3715
allocated to the I-Ohio reinsurance program established in section	3716
3923.86 of the Revised Code.	3717
(C) The taxes levied by section 5707.03 of the Revised Code	3718
on the value of shares in and capital employed by dealers in	3719
intangibles other than those that are qualifying dealers shall be	3720
for the use of the general revenue fund of the state and the local	3721

Originate as provided in this division. 3723

During each month for which there is money in the state 3724

3722

3733

government funds of the several counties in which the taxes

credited to the general revenue fund.

treasury for disbursement under this division, the tax 3725 commissioner shall provide for payment to the county treasurer of 3726 each county of five-eighths of the amount of the taxes collected 3727 on account of shares in and capital employed by dealers in 3728 intangibles other than those that are qualifying dealers, 3729 representing capital employed in the county. The balance of the 3730 money received and credited on account of taxes assessed on shares 3731 in and capital employed by such dealers in intangibles shall be 3732

Reductions in the amount of taxes collected on account of 3734 credits allowed under section 5725.151 of the Revised Code shall 3735 be applied to reduce the amount credited to the general revenue 3736 fund and shall not be applied to reduce the amount to be credited 3737 to the undivided local government funds of the counties in which 3738 such taxes originate. 3739

For the purpose of this division, such taxes are deemed to 3740 originate in the counties in which such dealers in intangibles 3741

have their offices.	3742
Money received into the treasury of a county pursuant to this	3743
section shall be credited to the undivided local government fund	3744
of the county and shall be distributed by the budget commission as	3745
provided by law.	3746
(D) All of the taxes levied under section 5707.03 of the	3747
Revised Code on the value of the shares in and capital employed by	3748
dealers in intangibles that are qualifying dealers shall be paid	3749
into the state treasury to the credit of the general revenue fund.	3750
Sec. 5729.03. (A) If the superintendent of insurance finds	3751
the annual statement required by section 5729.02 of the Revised	3752
Code to be correct, the superintendent shall compute the following	3753
amount, as applicable, of the balance of such gross amount, after	3754
deducting such return premiums and considerations received for	3755
reinsurance, and charge such amount to such company as a tax upon	3756
the business done by it in this state for the period covered by	3757
such annual statement:	3758
(1) If the company is a health insuring corporation, one per	3759
cent of the balance of premium rate payments received, exclusive	3760
of payments received under the medicare program established under	3761
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42	3762
U.S.C.A. 301, as amended, or pursuant to the medical assistance	3763
program established under Chapter 5111. of the Revised Code, as	3764
reflected in its annual report;	3765
(2) If the company is not a health insuring corporation, one	3766
and four-tenths per cent of the balance of premiums received,	3767
exclusive of premiums received under the medicare program	3768
established under Title XVIII of the "Social Security Act," 49	3769
Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or pursuant to the	3770
medical assistance program established under Chapter 5111. of the	3771

Revised Code, as reflected in its annual statement, and, if the

company operates a health insuring corporation as a line of	3773
business, one per cent of the balance of premium rate payments	3774
received from that line of business, exclusive of payments	3775
received under the medicare program established under Title XVIII	3776
of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.	3777
301, as amended, or pursuant to the medical assistance program	3778
established under Chapter 5111. of the Revised Code, as reflected	3779
in its annual statement.	3780
(B) Any insurance policies that were not issued in violation	3781
of Title XXXIX of the Revised Code and that were issued prior to	3782
April 15, 1967, by a life insurance company organized and operated	3783
without profit to any private shareholder or individual,	3784
exclusively for the purpose of aiding educational or scientific	3785
institutions organized and operated without profit to any private	3786
shareholder or individual, are not subject to the tax imposed by	3787
this section. All taxes collected pursuant to this section shall	3788
be credited to the general revenue fund <u>health insurance credit</u>	3789
fund created by section 5725.24 of the Revised Code.	3790
(C) In no case shall the tax imposed under this section be	3791
less than two hundred fifty dollars.	3792
Cod F747 01 Evgent og ethemvige evnyegglv provided en	3793
Sec. 5747.01. Except as otherwise expressly provided or	
clearly appearing from the context, any term used in this chapter	3794
that is not otherwise defined in this section has the same meaning	3795
as when used in a comparable context in the laws of the United	3796
States relating to federal income taxes or if not used in a	3797
comparable context in those laws, has the same meaning as in	3798
section 5733.40 of the Revised Code. Any reference in this chapter	3799
to the Internal Revenue Code includes other laws of the United	3800
States relating to federal income taxes.	3801
As used in this chapter:	3802

(A) "Adjusted gross income" or "Ohio adjusted gross income" 3803

means federal adjusted gross income, as defined and used in the	3804
Internal Revenue Code, adjusted as provided in this section:	3805
(1) Add interest or dividends on obligations or securities of	3806
any state or of any political subdivision or authority of any	3807
state, other than this state and its subdivisions and authorities.	3808
(2) Add interest or dividends on obligations of any	3809
authority, commission, instrumentality, territory, or possession	3810
of the United States to the extent that the interest or dividends	3811
are exempt from federal income taxes but not from state income	3812
taxes.	3813
(3) Deduct interest or dividends on obligations of the United	3814
States and its territories and possessions or of any authority,	3815
commission, or instrumentality of the United States to the extent	3816
that the interest or dividends are included in federal adjusted	3817
gross income but exempt from state income taxes under the laws of	3818
the United States.	3819
(4) Deduct disability and survivor's benefits to the extent	3820
included in federal adjusted gross income.	3821
(5) Deduct benefits under Title II of the Social Security Act	3822
and tier 1 railroad retirement benefits to the extent included in	3823
federal adjusted gross income under section 86 of the Internal	3824
Revenue Code.	3825
(6) In the case of a taxpayer who is a beneficiary of a trust	3826
that makes an accumulation distribution as defined in section 665	3827
of the Internal Revenue Code, add, for the beneficiary's taxable	3828
years beginning before 2002, the portion, if any, of such	3829
distribution that does not exceed the undistributed net income of	3830
the trust for the three taxable years preceding the taxable year	3831
in which the distribution is made to the extent that the portion	3832
was not included in the trust's taxable income for any of the	3833

trust's taxable years beginning in 2002 or thereafter.

"Undistributed net income of a trust" means the taxable income of	3835
the trust increased by (a)(i) the additions to adjusted gross	3836
income required under division (A) of this section and (ii) the	3837
personal exemptions allowed to the trust pursuant to section	3838
642(b) of the Internal Revenue Code, and decreased by (b)(i) the	3839
deductions to adjusted gross income required under division (A) of	3840
this section, (ii) the amount of federal income taxes attributable	3841
to such income, and (iii) the amount of taxable income that has	3842
been included in the adjusted gross income of a beneficiary by	3843
reason of a prior accumulation distribution. Any undistributed net	3844
income included in the adjusted gross income of a beneficiary	3845
shall reduce the undistributed net income of the trust commencing	3846
with the earliest years of the accumulation period.	3847
(7) Deduct the amount of wages and salaries, if any, not	3848
otherwise allowable as a deduction but that would have been	3849

- (7) Deduct the amount of wages and salaries, if any, not 3848 otherwise allowable as a deduction but that would have been 3849 allowable as a deduction in computing federal adjusted gross 3850 income for the taxable year, had the targeted jobs credit allowed 3851 and determined under sections 38, 51, and 52 of the Internal 3852 Revenue Code not been in effect. 3853
- (8) Deduct any interest or interest equivalent on public 3854 obligations and purchase obligations to the extent that the 3855 interest or interest equivalent is included in federal adjusted 3856 gross income. 3857
- (9) Add any loss or deduct any gain resulting from the sale,
 exchange, or other disposition of public obligations to the extent
 that the loss has been deducted or the gain has been included in
 computing federal adjusted gross income.
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- (10) Deduct or add amounts, as provided under section 5747.70 3862 of the Revised Code, related to contributions to variable college 3863 savings program accounts made or tuition units purchased pursuant 3864 to Chapter 3334. of the Revised Code. 3865

(11)(a) Deduct, to the extent not otherwise allowable as a	3866
deduction or exclusion in computing federal or Ohio adjusted gross	3867
income for the taxable year, the amount the taxpayer paid during	3868
the taxable year for medical care insurance and qualified	3869
long term care insurance for the taxpayer, the taxpayer's spouse,	3870
and dependents. No deduction for medical care insurance under	3871
division (A)(11) of this section shall be allowed either to any	3872
taxpayer who is eligible to participate in any subsidized health	3873
plan maintained by any employer of the taxpayer or of the	3874
taxpayer's spouse, or to any taxpayer who is entitled to, or on	3875
application would be entitled to, benefits under part A of Title	3876
XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.	3877
301, as amended. For the purposes of division (A)(11)(a) of this	3878
section, "subsidized health plan" means a health plan for which	3879
the employer pays any portion of the plan's cost. The deduction	3880
allowed under division (A)(11)(a) of this section shall be the net	3881
of any related premium refunds, related premium reimbursements, or	3882
related insurance premium dividends received during the taxable	3883
year.	3884
(b) Deduct, to the extent not otherwise deducted or excluded	3885
in computing federal or Ohio adjusted gross income during the	3886
taxable year, the amount the taxpayer paid during the taxable	3887
year, not compensated for by any insurance or otherwise, for	3888
medical care of the taxpayer, the taxpayer's spouse, and	3889
dependents, to the extent the expenses exceed seven and one-half	3890
per cent of the taxpayer's federal adjusted gross income.	3891
$\frac{(c)(b)}{(b)}$ For purposes of division (A)(11) of this section,	3892
"medical:	3893
(i) "Medical care" has the meaning given in section 213 of	3894
the Internal Revenue Code, subject to the special rules,	3895
limitations, and exclusions set forth therein, and "qualified	3896

long-term care" has the same meaning given in section 7702B(c) of

the Internal Revenue Code.	3898
(ii) "Dependent" has the same meaning as in division (0) of	3899
this section except that it also includes a child who meets all of	3900
the following conditions:	3901
(I) As of the close of the calendar year in which the	3902
taxpayer's taxable year begins, the child has attained twenty-four	3903
years of age but has not attained thirty years of age.	3904
(II) The child is a resident of Ohio or a full-time student	3905
at an accredited public or private institution of higher	3906
education.	3907
(III) The child is not employed by an employer that offers	3908
the child any health benefit plan.	3909
(12)(a) Deduct any amount included in federal adjusted gross	3910
income solely because the amount represents a reimbursement or	3911
refund of expenses that in any year the taxpayer had deducted as	3912
an itemized deduction pursuant to section 63 of the Internal	3913
Revenue Code and applicable United States department of the	3914
treasury regulations. The deduction otherwise allowed under	3915
division (A)(12)(a) of this section shall be reduced to the extent	3916
the reimbursement is attributable to an amount the taxpayer	3917
deducted under this section in any taxable year.	3918
(b) Add any amount not otherwise included in Ohio adjusted	3919
gross income for any taxable year to the extent that the amount is	3920
attributable to the recovery during the taxable year of any amount	3921
deducted or excluded in computing federal or Ohio adjusted gross	3922
income in any taxable year.	3923
(13) Deduct any portion of the deduction described in section	3924
1341(a)(2) of the Internal Revenue Code, for repaying previously	3925
reported income received under a claim of right, that meets both	3926
of the following requirements:	3927

(a) It is allowable for repayment of an item that was	3928
included in the taxpayer's adjusted gross income for a prior	3929
taxable year and did not qualify for a credit under division (A)	3930
or (B) of section 5747.05 of the Revised Code for that year;	3931
(b) It does not otherwise reduce the taxpayer's adjusted	3932
gross income for the current or any other taxable year.	3933
(14) Deduct an amount equal to the deposits made to, and net	3934
investment earnings of, a medical savings account during the	3935
taxable year, in accordance with section 3924.66 of the Revised	3936
Code. The deduction allowed by division (A)(14) of this section	3937
does not apply to medical savings account deposits and earnings	3938
otherwise deducted or excluded for the current or any other	3939
taxable year from the taxpayer's federal adjusted gross income.	3940
(15)(a) Add an amount equal to the funds withdrawn from a	3941
medical savings account during the taxable year, and the net	3942
investment earnings on those funds, when the funds withdrawn were	3943
used for any purpose other than to reimburse an account holder	3944
for, or to pay, eligible medical expenses, in accordance with	3945
section 3924.66 of the Revised Code;	3946
(b) Add the amounts distributed from a medical savings	3947
account under division (A)(2) of section 3924.68 of the Revised	3948
Code during the taxable year.	3949
(16) Add any amount claimed as a credit under section	3950
5747.059 of the Revised Code to the extent that such amount	3951
satisfies either of the following:	3952
(a) The amount was deducted or excluded from the computation	3953
of the taxpayer's federal adjusted gross income as required to be	3954
reported for the taxpayer's taxable year under the Internal	3955
Revenue Code;	3956
(b) The amount resulted in a reduction of the taxpayer's	3957

federal adjusted gross income as required to be reported for any

of the taxpayer's taxable years under the Internal Revenue Code. 3959 (17) Deduct the amount contributed by the taxpayer to an 3960 individual development account program established by a county 3961 department of job and family services pursuant to sections 329.11 3962 to 329.14 of the Revised Code for the purpose of matching funds 3963 deposited by program participants. On request of the tax 3964 commissioner, the taxpayer shall provide any information that, in 3965 the tax commissioner's opinion, is necessary to establish the 3966 amount deducted under division (A)(17) of this section. 3967 (18) Beginning in taxable year 2001 but not for any taxable 3968 year beginning after December 31, 2005, if the taxpayer is married 3969 and files a joint return and the combined federal adjusted gross 3970 income of the taxpayer and the taxpayer's spouse for the taxable 3971 year does not exceed one hundred thousand dollars, or if the 3972 taxpayer is single and has a federal adjusted gross income for the 3973 taxable year not exceeding fifty thousand dollars, deduct amounts 3974 paid during the taxable year for qualified tuition and fees paid 3975 to an eligible institution for the taxpayer, the taxpayer's 3976 spouse, or any dependent of the taxpayer, who is a resident of 3977 this state and is enrolled in or attending a program that 3978 culminates in a degree or diploma at an eligible institution. The 3979 deduction may be claimed only to the extent that qualified tuition 3980 and fees are not otherwise deducted or excluded for any taxable 3981 year from federal or Ohio adjusted gross income. The deduction may 3982 not be claimed for educational expenses for which the taxpayer 3983 claims a credit under section 5747.27 of the Revised Code. 3984 (19) Add any reimbursement received during the taxable year 3985 of any amount the taxpayer deducted under division (A)(18) of this 3986 section in any previous taxable year to the extent the amount is 3987 not otherwise included in Ohio adjusted gross income. 3988

(20)(a)(i) Add five-sixths of the amount of depreciation

expense allowed by subsection (k) of section 168 of the Internal

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Revenue Code, including the taxpayer's proportionate or	3991
distributive share of the amount of depreciation expense allowed	3992
by that subsection to a pass-through entity in which the taxpayer	3993
has a direct or indirect ownership interest.	3994
(ii) Add five-sixths of the amount of qualifying section 179	3995
depreciation expense, including a person's proportionate or	3996
distributive share of the amount of qualifying section 179	3997
depreciation expense allowed to any pass-through entity in which	3998
the person has a direct or indirect ownership. For the purposes of	3999
this division, "qualifying section 179 depreciation expense" means	4000
the difference between (I) the amount of depreciation expense	4001
directly or indirectly allowed to the taxpayer under section 179	4002
of the Internal Revenue Code, and (II) the amount of depreciation	4003
expense directly or indirectly allowed to the taxpayer under	4004
section 179 of the Internal Revenue Code as that section existed	4005
on December 31, 2002.	4006
The tax commissioner, under procedures established by the	4007
commissioner, may waive the add-backs related to a pass-through	4008
entity if the taxpayer owns, directly or indirectly, less than	4009
five per cent of the pass-through entity.	4010
(b) Nothing in division (A)(20) of this section shall be	4011
construed to adjust or modify the adjusted basis of any asset.	4012
(c) To the extent the add-back required under division	4013
(A)(20)(a) of this section is attributable to property generating	4014
nonbusiness income or loss allocated under section 5747.20 of the	4015
Revised Code, the add-back shall be sitused to the same location	4016
as the nonbusiness income or loss generated by the property for	4017
the purpose of determining the credit under division (A) of	4018
section 5747.05 of the Revised Code. Otherwise, the add-back shall	4019
be apportioned, subject to one or more of the four alternative	4020
methods of apportionment enumerated in section 5747.21 of the	4021

Revised Code.

(d) For the purposes of division (A) of this section, net	4023
operating loss carryback and carryforward shall not include	4024
five-sixths of the allowance of any net operating loss deduction	4025
carryback or carryforward to the taxable year to the extent such	4026
loss resulted from depreciation allowed by section $168(k)$ of the	4027
Internal Revenue Code and by the qualifying section 179	4028
depreciation expense amount.	4029
(21)(a) If the taxpayer was required to add an amount under	4030
division (A)(20)(a) of this section for a taxable year, deduct	4031
one-fifth of the amount so added for each of the five succeeding	4032
taxable years.	4033
(b) If the amount deducted under division (A)(21)(a) of this	4034
section is attributable to an add-back allocated under division	4035
(A)(20)(c) of this section, the amount deducted shall be sitused	4036
to the same location. Otherwise, the add-back shall be apportioned	4037
using the apportionment factors for the taxable year in which the	4038
deduction is taken, subject to one or more of the four alternative	4039
methods of apportionment enumerated in section 5747.21 of the	4040
Revised Code.	4041
(c) No deduction is available under division (A)(21)(a) of	4042
this section with regard to any depreciation allowed by section	4043
168(k) of the Internal Revenue Code and by the qualifying section	4044
179 depreciation expense amount to the extent that such	4045
depreciation resulted in or increased a federal net operating loss	4046
carryback or carryforward to a taxable year to which division	4047
(A)(20)(d) of this section does not apply.	4048
(22) Deduct, to the extent not otherwise deducted or excluded	4049
in computing federal or Ohio adjusted gross income for the taxable	4050
year, the amount the taxpayer received during the taxable year as	4051
reimbursement for life insurance premiums under section 5919.31 of	4052

the Revised Code.

(23) Deduct, to the extent not otherwise deducted or excluded	4054
in computing federal or Ohio adjusted gross income for the taxable	4055
year, the amount the taxpayer received during the taxable year as	4056
a death benefit paid by the adjutant general under section 5919.33	4057
of the Revised Code.	4058
(24) Deduct, to the extent included in federal adjusted gross	4059
income and not otherwise allowable as a deduction or exclusion in	4060
computing federal or Ohio adjusted gross income for the taxable	4061
year, military pay and allowances received by the taxpayer during	4062
the taxable year for active duty service in the United States	4063
army, air force, navy, marine corps, or coast guard or reserve	4064
components thereof or the national guard. The deduction may not be	4065
claimed for military pay and allowances received by the taxpayer	4066
while the taxpayer is stationed in this state.	4067
(25) Deduct, to the extent not otherwise allowable as a	4068
deduction or exclusion in computing federal or Ohio adjusted gross	4069
income for the taxable year and not otherwise compensated for by	4070
any other source, the amount of qualified organ donation expenses	4071
incurred by the taxpayer during the taxable year, not to exceed	4072
ten thousand dollars. A taxpayer may deduct qualified organ	4073
donation expenses only once for all taxable years beginning with	4074
taxable years beginning in 2007.	4075
For the purposes of division (A)(25) of this section:	4076
(a) "Human organ" means all or any portion of a human liver,	4077
pancreas, kidney, intestine, or lung, and any portion of human	4078
bone marrow.	4079
(b) "Qualified organ donation expenses" means travel	4080
expenses, lodging expenses, and wages and salary forgone by a	4081
taxpayer in connection with the taxpayer's donation, while living,	4082

of one or more of the taxpayer's human organs to another human

being.

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(26) Deduct, to the extent not otherwise deducted or excluded	4085
in computing federal or Ohio adjusted gross income for the taxable	4086
year, amounts received by the taxpayer as retired military	4087
personnel pay for service in the United States army, navy, air	4088
force, coast guard, or marine corps or reserve components thereof,	4089
or the national guard. If the taxpayer receives income on account	4090
of retirement paid under the federal civil service retirement	4091
system or federal employees retirement system, or under any	4092
successor retirement program enacted by the congress of the United	4093
States that is established and maintained for retired employees of	4094
the United States government, and such retirement income is based,	4095
in whole or in part, on credit for the taxpayer's military	4096
service, the deduction allowed under this division shall include	4097
only that portion of such retirement income that is attributable	4098
to the taxpayer's military service, to the extent that portion of	4099
such retirement income is otherwise included in federal adjusted	4100
gross income and is not otherwise deducted under this section. Any	4101
amount deducted under division (A)(26) of this section is not	4102
included in the taxpayer's adjusted gross income for the purposes	4103
of section 5747.055 of the Revised Code. No amount may be deducted	4104
under division (A)(26) of this section on the basis of which a	4105
credit was claimed under section 5747.055 of the Revised Code.	4106
	4107
(27) Deduct, to the extent not otherwise deducted or excluded	4108
in computing federal or Ohio adjusted gross income for the taxable	4109
year, income that would have been excluded from federal adjusted	4110
gross income under section 106 of the Internal Revenue Code but	4111
for the fact that the taxpaver's child met the conditions set	4112

(B) "Business income" means income, including gain or loss, 4115 arising from transactions, activities, and sources in the regular 4116

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forth in divisions (A)(11)(b)(iii)(I) to (A)(11)(b)(iii)(III) of

this section.

course of a trade or business and includes income, gain, or loss	4117
from real property, tangible property, and intangible property if	4118
the acquisition, rental, management, and disposition of the	4119
property constitute integral parts of the regular course of a	4120
trade or business operation. "Business income" includes income,	4121
including gain or loss, from a partial or complete liquidation of	4122
a business, including, but not limited to, gain or loss from the	4123
sale or other disposition of goodwill.	4124
(C) "Nonbusiness income" means all income other than business	4125
income and may include, but is not limited to, compensation, rents	4126
and royalties from real or tangible personal property, capital	4127
gains, interest, dividends and distributions, patent or copyright	4128
royalties, or lottery winnings, prizes, and awards.	4129
(D) "Compensation" means any form of remuneration paid to an	4130
employee for personal services.	4131
(E) "Fiduciary" means a guardian, trustee, executor,	4132
administrator, receiver, conservator, or any other person acting	4133
in any fiduciary capacity for any individual, trust, or estate.	4134
(F) "Fiscal year" means an accounting period of twelve months	4135
ending on the last day of any month other than December.	4136
(G) "Individual" means any natural person.	4137
(H) "Internal Revenue Code" means the "Internal Revenue Code	4138
of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.	4139
(I) "Resident" means any of the following, provided that	4140
division (I)(3) of this section applies only to taxable years of a	4141
trust beginning in 2002 or thereafter:	4142
(1) An individual who is domiciled in this state, subject to	4143
section 5747.24 of the Revised Code;	4144
(2) The estate of a decedent who at the time of death was	4145
domiciled in this state. The domicile tests of section 5747.24 of	4146

the Revised Code are not controlling for purposes of division	4147
(I)(2) of this section.	4148
(3) A trust that, in whole or part, resides in this state. If	4149
only part of a trust resides in this state, the trust is a	4150
resident only with respect to that part.	4151
For the purposes of division (I)(3) of this section:	4152
(a) A trust resides in this state for the trust's current	4153
taxable year to the extent, as described in division (I)(3)(d) of	4154
this section, that the trust consists directly or indirectly, in	4155
whole or in part, of assets, net of any related liabilities, that	4156
were transferred, or caused to be transferred, directly or	4157
indirectly, to the trust by any of the following:	4158
(i) A person, a court, or a governmental entity or	4159
instrumentality on account of the death of a decedent, but only if	4160
the trust is described in division $(I)(3)(e)(i)$ or (ii) of this	4161
section;	4162
(ii) A person who was domiciled in this state for the	4163
purposes of this chapter when the person directly or indirectly	4164
transferred assets to an irrevocable trust, but only if at least	4165
one of the trust's qualifying beneficiaries is domiciled in this	4166
state for the purposes of this chapter during all or some portion	4167
of the trust's current taxable year;	4168
(iii) A person who was domiciled in this state for the	4169
purposes of this chapter when the trust document or instrument or	4170
part of the trust document or instrument became irrevocable, but	4171
only if at least one of the trust's qualifying beneficiaries is a	4172
resident domiciled in this state for the purposes of this chapter	4173
during all or some portion of the trust's current taxable year. If	4174
a trust document or instrument became irrevocable upon the death	4175
of a person who at the time of death was domiciled in this state	4176
for purposes of this chapter, that person is a person described in	4177

division (I)(3)(a)(iii) of this section.	4178
(b) A trust is irrevocable to the extent that the transferor	4179
is not considered to be the owner of the net assets of the trust	4180
under sections 671 to 678 of the Internal Revenue Code.	4181
(c) With respect to a trust other than a charitable lead	4182
trust, "qualifying beneficiary" has the same meaning as "potential	4183
current beneficiary" as defined in section 1361(e)(2) of the	4184
Internal Revenue Code, and with respect to a charitable lead trust	4185
"qualifying beneficiary" is any current, future, or contingent	4186
beneficiary, but with respect to any trust "qualifying	4187
beneficiary" excludes a person or a governmental entity or	4188
instrumentality to any of which a contribution would qualify for	4189
the charitable deduction under section 170 of the Internal Revenue	4190
Code.	4191
(d) For the purposes of division (I)(3)(a) of this section,	4192
the extent to which a trust consists directly or indirectly, in	4193
whole or in part, of assets, net of any related liabilities, that	4194
were transferred directly or indirectly, in whole or part, to the	4195
trust by any of the sources enumerated in that division shall be	4196
ascertained by multiplying the fair market value of the trust's	4197
assets, net of related liabilities, by the qualifying ratio, which	4198
shall be computed as follows:	4199
(i) The first time the trust receives assets, the numerator	4200
of the qualifying ratio is the fair market value of those assets	4201
at that time, net of any related liabilities, from sources	4202
enumerated in division (I)(3)(a) of this section. The denominator	4203
of the qualifying ratio is the fair market value of all the	4204
trust's assets at that time, net of any related liabilities.	4205
(ii) Each subsequent time the trust receives assets, a	4206
revised qualifying ratio shall be computed. The numerator of the	4207

revised qualifying ratio is the sum of (1) the fair market value

of the trust's assets immediately prior to the subsequent	4209
transfer, net of any related liabilities, multiplied by the	4210
qualifying ratio last computed without regard to the subsequent	4211
transfer, and (2) the fair market value of the subsequently	4212
transferred assets at the time transferred, net of any related	4213
liabilities, from sources enumerated in division (I)(3)(a) of this	4214
section. The denominator of the revised qualifying ratio is the	4215
fair market value of all the trust's assets immediately after the	4216
subsequent transfer, net of any related liabilities.	4217
(iii) Whether a transfer to the trust is by or from any of	4218
the sources enumerated in division (I)(3)(a) of this section shall	4219
be ascertained without regard to the domicile of the trust's	4220
beneficiaries.	4221
(e) For the purposes of division (I)(3)(a)(i) of this	4222
section:	4223
(i) A trust is described in division (I)(3)(e)(i) of this	4224
section if the trust is a testamentary trust and the testator of	4225
that testamentary trust was domiciled in this state at the time of	4226
the testator's death for purposes of the taxes levied under	4227
Chapter 5731. of the Revised Code.	4228
(ii) A trust is described in division (I)(3)(e)(ii) of this	4229
section if the transfer is a qualifying transfer described in any	4230
of divisions $(I)(3)(f)(i)$ to (vi) of this section, the trust is an	4231
irrevocable inter vivos trust, and at least one of the trust's	4232
qualifying beneficiaries is domiciled in this state for purposes	4233
of this chapter during all or some portion of the trust's current	4234
taxable year.	4235
(f) For the purposes of division (I)(3)(e)(ii) of this	4236
section, a "qualifying transfer" is a transfer of assets, net of	4237
any related liabilities, directly or indirectly to a trust, if the	4238

transfer is described in any of the following:

(i) The transfer is made to a trust, created by the decedent	4240
before the decedent's death and while the decedent was domiciled	4241
in this state for the purposes of this chapter, and, prior to the	4242
death of the decedent, the trust became irrevocable while the	4243
decedent was domiciled in this state for the purposes of this	4244
chapter.	4245
(ii) The transfer is made to a trust to which the decedent,	4246
prior to the decedent's death, had directly or indirectly	4247
transferred assets, net of any related liabilities, while the	4248
decedent was domiciled in this state for the purposes of this	4249
chapter, and prior to the death of the decedent the trust became	4250
irrevocable while the decedent was domiciled in this state for the	4251
purposes of this chapter.	4252
(iii) The transfer is made on account of a contractual	4253
relationship existing directly or indirectly between the	4254
transferor and either the decedent or the estate of the decedent	4255
at any time prior to the date of the decedent's death, and the	4256
decedent was domiciled in this state at the time of death for	4257
purposes of the taxes levied under Chapter 5731. of the Revised	4258
Code.	4259
(iv) The transfer is made to a trust on account of a	4260
contractual relationship existing directly or indirectly between	4261
the transferor and another person who at the time of the	4262
decedent's death was domiciled in this state for purposes of this	4263
chapter.	4264
(v) The transfer is made to a trust on account of the will of	4265
a testator.	4266
(vi) The transfer is made to a trust created by or caused to	4267
be created by a court, and the trust was directly or indirectly	4268
created in connection with or as a result of the death of an	4269

individual who, for purposes of the taxes levied under Chapter

5731. of the Revised Code, was domiciled in this state at the time	4271
of the individual's death.	4272
(g) The tax commissioner may adopt rules to ascertain the	4273
part of a trust residing in this state.	4274
(J) "Nonresident" means an individual or estate that is not a	4275
resident. An individual who is a resident for only part of a	4276
taxable year is a nonresident for the remainder of that taxable	4277
year.	4278
(K) "Pass-through entity" has the same meaning as in section	4279
5733.04 of the Revised Code.	4280
(L) "Return" means the notifications and reports required to	4281
be filed pursuant to this chapter for the purpose of reporting the	4282
tax due and includes declarations of estimated tax when so	4283
required.	4284
(M) "Taxable year" means the calendar year or the taxpayer's	4285
fiscal year ending during the calendar year, or fractional part	4286
thereof, upon which the adjusted gross income is calculated	4287
pursuant to this chapter.	4288
(N) "Taxpayer" means any person subject to the tax imposed by	4289
section 5747.02 of the Revised Code or any pass-through entity	4290
that makes the election under division (D) of section 5747.08 of	4291
the Revised Code.	4292
(0) "Dependents" means dependents as defined in the Internal	4293
Revenue Code and as claimed in the taxpayer's federal income tax	4294
return for the taxable year or which the taxpayer would have been	4295
permitted to claim had the taxpayer filed a federal income tax	4296
return.	4297
(P) "Principal county of employment" means, in the case of a	4298
nonresident, the county within the state in which a taxpayer	4299
performs services for an employer or, if those services are	4300

performed in more than one county, the county in which the major	4301
portion of the services are performed.	4302
(Q) As used in sections 5747.50 to 5747.55 of the Revised	4303
Code:	4304
(1) "Subdivision" means any county, municipal corporation,	4305
park district, or township.	4306
(2) "Essential local government purposes" includes all	4307
functions that any subdivision is required by general law to	4308
exercise, including like functions that are exercised under a	4309
charter adopted pursuant to the Ohio Constitution.	4310
(R) "Overpayment" means any amount already paid that exceeds	4311
the figure determined to be the correct amount of the tax.	4312
(S) "Taxable income" or "Ohio taxable income" applies only to	4313
estates and trusts, and means federal taxable income, as defined	4314
and used in the Internal Revenue Code, adjusted as follows:	4315
(1) Add interest or dividends, net of ordinary, necessary,	4316
and reasonable expenses not deducted in computing federal taxable	4317
income, on obligations or securities of any state or of any	4318
political subdivision or authority of any state, other than this	4319
state and its subdivisions and authorities, but only to the extent	4320
that such net amount is not otherwise includible in Ohio taxable	4321
income and is described in either division $(S)(1)(a)$ or (b) of	4322
this section:	4323
(a) The net amount is not attributable to the S portion of an	4324
electing small business trust and has not been distributed to	4325
beneficiaries for the taxable year;	4326
(b) The net amount is attributable to the S portion of an	4327
electing small business trust for the taxable year.	4328
(2) Add interest or dividends, net of ordinary, necessary,	4329
and reasonable expenses not deducted in computing federal taxable	4329
and reasonable expenses not acqueted in computing rederal taxable	1000

income, on obligations of any authority, commission,	4331
instrumentality, territory, or possession of the United States to	4332
the extent that the interest or dividends are exempt from federal	4333
income taxes but not from state income taxes, but only to the	4334
extent that such net amount is not otherwise includible in Ohio	4335
taxable income and is described in either division (S)(1)(a) or	4336
(b) of this section;	4337
(3) Add the amount of personal exemption allowed to the	4338
estate pursuant to section 642(b) of the Internal Revenue Code;	4339
(4) Deduct interest or dividends, net of related expenses	4340
deducted in computing federal taxable income, on obligations of	4341
the United States and its territories and possessions or of any	4342
authority, commission, or instrumentality of the United States to	4343
the extent that the interest or dividends are exempt from state	4344
taxes under the laws of the United States, but only to the extent	4345
that such amount is included in federal taxable income and is	4346
described in either division (S)(1)(a) or (b) of this section;	4347
(5) Deduct the amount of wages and salaries, if any, not	4348
otherwise allowable as a deduction but that would have been	4349
allowable as a deduction in computing federal taxable income for	4350
the taxable year, had the targeted jobs credit allowed under	4351
sections 38, 51, and 52 of the Internal Revenue Code not been in	4352
effect, but only to the extent such amount relates either to	4353
income included in federal taxable income for the taxable year or	4354
to income of the S portion of an electing small business trust for	4355
the taxable year;	4356
(6) Deduct any interest or interest equivalent, net of	4357
related expenses deducted in computing federal taxable income, on	4358
public obligations and purchase obligations, but only to the	4359
extent that such net amount relates either to income included in	4360
federal taxable income for the taxable year or to income of the S	4361

portion of an electing small business trust for the taxable year;

(7) Add any loss or deduct any gain resulting from sale,	4363
exchange, or other disposition of public obligations to the extent	4364
that such loss has been deducted or such gain has been included in	4365
computing either federal taxable income or income of the S portion	4366
of an electing small business trust for the taxable year;	4367
(8) Except in the case of the final return of an estate, add	4368
any amount deducted by the taxpayer on both its Ohio estate tax	4369
return pursuant to section 5731.14 of the Revised Code, and on its	4370
federal income tax return in determining federal taxable income;	4371
(9)(a) Deduct any amount included in federal taxable income	4372
solely because the amount represents a reimbursement or refund of	4373
expenses that in a previous year the decedent had deducted as an	4374
itemized deduction pursuant to section 63 of the Internal Revenue	4375
Code and applicable treasury regulations. The deduction otherwise	4376
allowed under division (S)(9)(a) of this section shall be reduced	4377
to the extent the reimbursement is attributable to an amount the	4378
taxpayer or decedent deducted under this section in any taxable	4379
year.	4380
(b) Add any amount not otherwise included in Ohio taxable	4381
income for any taxable year to the extent that the amount is	4382
attributable to the recovery during the taxable year of any amount	4383
deducted or excluded in computing federal or Ohio taxable income	4384
in any taxable year, but only to the extent such amount has not	4385
been distributed to beneficiaries for the taxable year.	4386
(10) Deduct any portion of the deduction described in section	4387
1341(a)(2) of the Internal Revenue Code, for repaying previously	4388
reported income received under a claim of right, that meets both	4389
of the following requirements:	4390
(a) It is allowable for repayment of an item that was	4391
included in the taxpayer's taxable income or the decedent's	4392

adjusted gross income for a prior taxable year and did not qualify 4393

for a credit under division (A) or (B) of section 5747.05 of the	4394
Revised Code for that year.	4395
(b) It does not otherwise reduce the taxpayer's taxable	4396
income or the decedent's adjusted gross income for the current or	4397
any other taxable year.	4398
(11) Add any amount claimed as a credit under section	4399
5747.059 of the Revised Code to the extent that the amount	4400
satisfies either of the following:	4401
(a) The amount was deducted or excluded from the computation	4402
of the taxpayer's federal taxable income as required to be	4403
reported for the taxpayer's taxable year under the Internal	4404
Revenue Code;	4405
(b) The amount resulted in a reduction in the taxpayer's	4406
federal taxable income as required to be reported for any of the	4407
taxpayer's taxable years under the Internal Revenue Code.	4408
(12) Deduct any amount, net of related expenses deducted in	4409
computing federal taxable income, that a trust is required to	4410
report as farm income on its federal income tax return, but only	4411
if the assets of the trust include at least ten acres of land	4412
satisfying the definition of "land devoted exclusively to	4413
agricultural use" under section 5713.30 of the Revised Code,	4414
regardless of whether the land is valued for tax purposes as such	4415
land under sections 5713.30 to 5713.38 of the Revised Code. If the	4416
trust is a pass-through entity investor, section 5747.231 of the	4417
Revised Code applies in ascertaining if the trust is eligible to	4418
claim the deduction provided by division (S)(12) of this section	4419
in connection with the pass-through entity's farm income.	4420
Except for farm income attributable to the S portion of an	4421
electing small business trust, the deduction provided by division	4422
(S)(12) of this section is allowed only to the extent that the	4423
trust has not distributed such farm income. Division (S)(12) of	4424

this section applies only to taxable years of a trust beginning in	4425
2002 or thereafter.	4426
(13) Add the net amount of income described in section 641(c)	4427
of the Internal Revenue Code to the extent that amount is not	4428
included in federal taxable income.	4429
(14) Add or deduct the amount the taxpayer would be required	4430
to add or deduct under division (A)(20) or (21) of this section if	4431
the taxpayer's Ohio taxable income were computed in the same	4432
manner as an individual's Ohio adjusted gross income is computed	4433
under this section. In the case of a trust, division (S)(14) of	4434
this section applies only to any of the trust's taxable years	4435
beginning in 2002 or thereafter.	4436
(T) "School district income" and "school district income tax"	4437
have the same meanings as in section 5748.01 of the Revised Code.	4438
(U) As used in divisions (A)(8), (A)(9), (S)(6), and (S)(7)	4439
of this section, "public obligations," "purchase obligations," and	4440
"interest or interest equivalent" have the same meanings as in	4441
section 5709.76 of the Revised Code.	4442
(V) "Limited liability company" means any limited liability	4443
company formed under Chapter 1705. of the Revised Code or under	4444
the laws of any other state.	4445
(W) "Pass-through entity investor" means any person who,	4446
during any portion of a taxable year of a pass-through entity, is	4447
a partner, member, shareholder, or equity investor in that	4448
pass-through entity.	4449
(X) "Banking day" has the same meaning as in section 1304.01	4450
of the Revised Code.	4451
(Y) "Month" means a calendar month.	4452
(Z) "Quarter" means the first three months, the second three	4453
months, the third three months, or the last three months of the	4454

taxpayer's taxable year.	4455
(AA)(1) "Eligible institution" means a state university or	4456
state institution of higher education as defined in section	4457
3345.011 of the Revised Code, or a private, nonprofit college,	4458
university, or other post-secondary institution located in this	4459
state that possesses a certificate of authorization issued by the	4460
Ohio board of regents pursuant to Chapter 1713. of the Revised	4461
Code or a certificate of registration issued by the state board of	4462
career colleges and schools under Chapter 3332. of the Revised	4463
Code.	4464
(2) "Qualified tuition and fees" means tuition and fees	4465
imposed by an eligible institution as a condition of enrollment or	4466
attendance, not exceeding two thousand five hundred dollars in	4467
each of the individual's first two years of post-secondary	4468
education. If the individual is a part-time student, "qualified	4469
tuition and fees" includes tuition and fees paid for the academic	4470
equivalent of the first two years of post-secondary education	4471
during a maximum of five taxable years, not exceeding a total of	4472
five thousand dollars. "Qualified tuition and fees" does not	4473
include:	4474
(a) Expenses for any course or activity involving sports,	4475
games, or hobbies unless the course or activity is part of the	4476
individual's degree or diploma program;	4477
(b) The cost of books, room and board, student activity fees,	4478
athletic fees, insurance expenses, or other expenses unrelated to	4479
the individual's academic course of instruction;	4480
(c) Tuition, fees, or other expenses paid or reimbursed	4481
through an employer, scholarship, grant in aid, or other	4482
educational benefit program.	4483
(BB)(1) "Modified business income" means the business income	4484
included in a trust's Ohio taxable income after such taxable	4485

income is first reduced by the qualifying trust amount, if any.	4486
(2) "Qualifying trust amount" of a trust means capital gains	4487
and losses from the sale, exchange, or other disposition of equity	4488
or ownership interests in, or debt obligations of, a qualifying	4489
investee to the extent included in the trust's Ohio taxable	4490
income, but only if the following requirements are satisfied:	4491
(a) The book value of the qualifying investee's physical	4492
assets in this state and everywhere, as of the last day of the	4493
qualifying investee's fiscal or calendar year ending immediately	4494
prior to the date on which the trust recognizes the gain or loss,	4495
is available to the trust.	4496
(b) The requirements of section 5747.011 of the Revised Code	4497
are satisfied for the trust's taxable year in which the trust	4498
recognizes the gain or loss.	4499
Any gain or loss that is not a qualifying trust amount is	4500
modified business income, qualifying investment income, or	4501
modified nonbusiness income, as the case may be.	4502
(3) "Modified nonbusiness income" means a trust's Ohio	4503
taxable income other than modified business income, other than the	4504
qualifying trust amount, and other than qualifying investment	4505
income, as defined in section 5747.012 of the Revised Code, to the	4506
extent such qualifying investment income is not otherwise part of	4507
modified business income.	4508
(4) "Modified Ohio taxable income" applies only to trusts,	4509
and means the sum of the amounts described in divisions (BB)(4)(a)	4510
to (c) of this section:	4511
(a) The fraction, calculated under section 5747.013, and	4512
applying section 5747.231 of the Revised Code, multiplied by the	4513
sum of the following amounts:	4514
(i) The trust's modified business income;	4515

(ii) The trust's qualifying investment income, as defined in	4516
section 5747.012 of the Revised Code, but only to the extent the	4517
qualifying investment income does not otherwise constitute	4518
modified business income and does not otherwise constitute a	4519
qualifying trust amount.	4520
(b) The qualifying trust amount multiplied by a fraction, the	4521
numerator of which is the sum of the book value of the qualifying	4522
investee's physical assets in this state on the last day of the	4523
qualifying investee's fiscal or calendar year ending immediately	4524
prior to the day on which the trust recognizes the qualifying	4525
trust amount, and the denominator of which is the sum of the book	4526
value of the qualifying investee's total physical assets	4527
everywhere on the last day of the qualifying investee's fiscal or	4528
calendar year ending immediately prior to the day on which the	4529
trust recognizes the qualifying trust amount. If, for a taxable	4530
year, the trust recognizes a qualifying trust amount with respect	4531
to more than one qualifying investee, the amount described in	4532
division (BB)(4)(b) of this section shall equal the sum of the	4533
products so computed for each such qualifying investee.	4534
(c)(i) With respect to a trust or portion of a trust that is	4535
a resident as ascertained in accordance with division $(I)(3)(d)$ of	4536
this section, its modified nonbusiness income.	4537
(ii) With respect to a trust or portion of a trust that is	4538
not a resident as ascertained in accordance with division	4539
$(\mathrm{I})(\mathrm{3})(\mathrm{d})$ of this section, the amount of its modified nonbusiness	4540
income satisfying the descriptions in divisions (B)(2) to (5) of	4541
section 5747.20 of the Revised Code, except as otherwise provided	4542
in division $(BB)(4)(c)(ii)$ of this section. With respect to a	4543
trust or portion of a trust that is not a resident as ascertained	4544

in accordance with division (I)(3)(d) of this section, the trust's

portion of modified nonbusiness income recognized from the sale,

exchange, or other disposition of a debt interest in or equity

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interest in a section 5747.212 entity, as defined in section	4548
5747.212 of the Revised Code, without regard to division (A) of	4549
that section, shall not be allocated to this state in accordance	4550
with section 5747.20 of the Revised Code but shall be apportioned	4551
to this state in accordance with division (B) of section 5747.212	4552
of the Revised Code without regard to division (A) of that	4553
section.	4554
	4555

If the allocation and apportionment of a trust's income under divisions (BB)(4)(a) and (c) of this section do not fairly 4556 represent the modified Ohio taxable income of the trust in this 4557 state, the alternative methods described in division (C) of 4558 section 5747.21 of the Revised Code may be applied in the manner 4559 and to the same extent provided in that section. 4560

- (5)(a) Except as set forth in division (BB)(5)(b) of this 4561 section, "qualifying investee" means a person in which a trust has 4562 an equity or ownership interest, or a person or unit of government 4563 the debt obligations of either of which are owned by a trust. For 4564 the purposes of division (BB)(2)(a) of this section and for the 4565 purpose of computing the fraction described in division (BB)(4)(b) 4566 of this section, all of the following apply: 4567
- (i) If the qualifying investee is a member of a qualifying 4568 controlled group on the last day of the qualifying investee's 4569 fiscal or calendar year ending immediately prior to the date on 4570 which the trust recognizes the gain or loss, then "qualifying 4571 investee" includes all persons in the qualifying controlled group 4572 on such last day.
- (ii) If the qualifying investee, or if the qualifying 4574 investee and any members of the qualifying controlled group of 4575 which the qualifying investee is a member on the last day of the 4576 qualifying investee's fiscal or calendar year ending immediately 4577 prior to the date on which the trust recognizes the gain or loss, 4578 separately or cumulatively own, directly or indirectly, on the 4579

last day of the qualifying investee's fiscal or calendar year	4580
ending immediately prior to the date on which the trust recognizes	4581
the qualifying trust amount, more than fifty per cent of the	4582
equity of a pass-through entity, then the qualifying investee and	4583
the other members are deemed to own the proportionate share of the	4584
pass-through entity's physical assets which the pass-through	4585
entity directly or indirectly owns on the last day of the	4586
pass-through entity's calendar or fiscal year ending within or	4587
with the last day of the qualifying investee's fiscal or calendar	4588
year ending immediately prior to the date on which the trust	4589
recognizes the qualifying trust amount.	4590

(iii) For the purposes of division (BB)(5)(a)(iii) of this 4591 section, "upper level pass-through entity" means a pass-through entity directly or indirectly owning any equity of another 4593 pass-through entity, and "lower level pass-through entity" means 4594 that other pass-through entity.

An upper level pass-through entity, whether or not it is also 4596 a qualifying investee, is deemed to own, on the last day of the 4597 upper level pass-through entity's calendar or fiscal year, the 4598 proportionate share of the lower level pass-through entity's 4599 physical assets that the lower level pass-through entity directly 4600 or indirectly owns on the last day of the lower level pass-through 4601 entity's calendar or fiscal year ending within or with the last 4602 day of the upper level pass-through entity's fiscal or calendar 4603 year. If the upper level pass-through entity directly and 4604 indirectly owns less than fifty per cent of the equity of the 4605 lower level pass-through entity on each day of the upper level 4606 pass-through entity's calendar or fiscal year in which or with 4607 which ends the calendar or fiscal year of the lower level 4608 pass-through entity and if, based upon clear and convincing 4609 evidence, complete information about the location and cost of the 4610 physical assets of the lower pass-through entity is not available 4611

to the upper level pass-through entity, then solely for purposes	4612
of ascertaining if a gain or loss constitutes a qualifying trust	4613
amount, the upper level pass-through entity shall be deemed as	4614
owning no equity of the lower level pass-through entity for each	4615
day during the upper level pass-through entity's calendar or	4616
fiscal year in which or with which ends the lower level	4617
pass-through entity's calendar or fiscal year. Nothing in division	4618
(BB)(5)(a)(iii) of this section shall be construed to provide for	4619
any deduction or exclusion in computing any trust's Ohio taxable	4620
income.	4621
(b) With respect to a trust that is not a resident for the	4622
taxable year and with respect to a part of a trust that is not a	4623
resident for the taxable year, "qualifying investee" for that	4624
taxable year does not include a C corporation if both of the	4625
following apply:	4626
(i) During the taxable year the trust or part of the trust	4627
recognizes a gain or loss from the sale, exchange, or other	4628
disposition of equity or ownership interests in, or debt	4629
obligations of, the C corporation.	4630
(ii) Such gain or loss constitutes nonbusiness income.	4631
(6) "Available" means information is such that a person is	4632
able to learn of the information by the due date plus extensions,	4633
if any, for filing the return for the taxable year in which the	4634
trust recognizes the gain or loss.	4635
(CC) "Qualifying controlled group" has the same meaning as in	4636
section 5733.04 of the Revised Code.	4637
(DD) "Related member" has the same meaning as in section	4638
5733.042 of the Revised Code.	4639
(EE)(1) For the purposes of division (EE) of this section:	4640
(a) "Qualifying person" means any person other than a	4641

qualifying corporation.	4642
(b) "Qualifying corporation" means any person classified for	4643
federal income tax purposes as an association taxable as a	4644
corporation, except either of the following:	4645
(i) A corporation that has made an election under subchapter	4646
S, chapter one, subtitle A, of the Internal Revenue Code for its	4647
taxable year ending within, or on the last day of, the investor's	4648
taxable year;	4649
(ii) A subsidiary that is wholly owned by any corporation	4650
that has made an election under subchapter S, chapter one,	4651
subtitle A of the Internal Revenue Code for its taxable year	4652
ending within, or on the last day of, the investor's taxable year.	4653
(2) For the purposes of this chapter, unless expressly stated	4654
otherwise, no qualifying person indirectly owns any asset directly	4655
or indirectly owned by any qualifying corporation.	4656
(FF) For purposes of this chapter and Chapter 5751. of the	4657
Revised Code:	4658
(1) "Trust" does not include a qualified pre-income tax	4659
trust.	4660
(2) A "qualified pre-income tax trust" is any pre-income tax	4661
trust that makes a qualifying pre-income tax trust election as	4662
described in division (FF)(3) of this section.	4663
(3) A "qualifying pre-income tax trust election" is an	4664
election by a pre-income tax trust to subject to the tax imposed	4665
by section 5751.02 of the Revised Code the pre-income tax trust	4666
and all pass-through entities of which the trust owns or controls,	4667
directly, indirectly, or constructively through related interests,	4668
five per cent or more of the ownership or equity interests. The	4669
trustee shall notify the tax commissioner in writing of the	4670
election on or before April 15, 2006. The election, if timely	4671

made, shall be effective on and after January 1, 2006, and shall	4672
apply for all tax periods and tax years until revoked by the	4673
trustee of the trust.	4674
(4) A "pre-income tax trust" is a trust that satisfies all of	4675
the following requirements:	4676
(a) The document or instrument creating the trust was	4677
executed by the grantor before January 1, 1972;	4678
(b) The trust became irrevocable upon the creation of the	4679
trust; and	4680
(c) The grantor was domiciled in this state at the time the	4681
trust was created.	4682
Sec. 5747.08. An annual return with respect to the tax	4683
imposed by section 5747.02 of the Revised Code and each tax	4684
imposed under Chapter 5748. of the Revised Code shall be made by	4685
every taxpayer for any taxable year for which the taxpayer is	4686
liable for the tax imposed by that section or under that chapter,	4687
unless the total credits allowed under divisions (E), (F), and (G)	4688
of section 5747.05 of the Revised Code for the year are equal to	4689
or exceed the tax imposed by section 5747.02 of the Revised Code,	4690
in which case no return shall be required unless the taxpayer is	4691
liable for a tax imposed pursuant to Chapter 5748. of the Revised	4692
Code.	4693
(A) If an individual is deceased, any return or notice	4694
required of that individual under this chapter shall be made and	4695
filed by that decedent's executor, administrator, or other person	4696
charged with the property of that decedent.	4697
(B) If an individual is unable to make a return or notice	4698
required by this chapter, the return or notice required of that	4699
individual shall be made and filed by the individual's duly	4700
authorized agent, guardian, conservator, fiduciary, or other	4700
addictive agenc, guaranti, conservator, rraderary, or other	1/01

Page 155

4732

4733

person charged with the care of the person or property of that	4702
individual.	4703
(C) Returns or notices required of an estate or a trust shall	4704
be made and filed by the fiduciary of the estate or trust.	4705
(D)(1)(a) Everant or athornica provided in division (D)(1)(b)	4706
(D)(1)(a) Except as otherwise provided in division (D)(1)(b)	
of this section, any pass-through entity may file a single return	4707
on behalf of one or more of the entity's investors other than an	4708
investor that is a person subject to the tax imposed under section	4709
5733.06 of the Revised Code. The single return shall set forth the	4710
name, address, and social security number or other identifying	4711
number of each of those pass-through entity investors and shall	4712
indicate the distributive share of each of those pass-through	4713
entity investor's income taxable in this state in accordance with	4714
sections 5747.20 to 5747.231 of the Revised Code. Such	4715
pass-through entity investors for whom the pass-through entity	4716
elects to file a single return are not entitled to the exemption	4717
or credit provided for by sections 5747.02 and 5747.022 of the	4718
Revised Code; shall calculate the tax before business credits at	4719
the highest rate of tax set forth in section 5747.02 of the	4720
Revised Code for the taxable year for which the return is filed;	4721
and are entitled to only their distributive share of the business	4722
credits as defined in division (D)(2) of this section. A single	4723
check drawn by the pass-through entity shall accompany the return	4724
in full payment of the tax due, as shown on the single return, for	4725
such investors, other than investors who are persons subject to	4726
the tax imposed under section 5733.06 of the Revised Code.	4727
(b)(i) A pass-through entity shall not include in such a	4728
single return any investor that is a trust to the extent that any	4729
direct or indirect current, future, or contingent beneficiary of	4730
the trust is a person subject to the tax imposed under section	4731

(ii) A pass-through entity shall not include in such a single

5733.06 of the Revised Code.

return any investor that is itself a pass-through entity to the	4734
extent that any direct or indirect investor in the second	4735
pass-through entity is a person subject to the tax imposed under	4736
section 5733.06 of the Revised Code.	4737
(c) Nothing in division (D) of this section precludes the tax	4738
commissioner from requiring such investors to file the return and	4739
make the payment of taxes and related interest, penalty, and	4740
interest penalty required by this section or section 5747.02,	4741
5747.09, or 5747.15 of the Revised Code. Nothing in division (D)	4742
of this section shall be construed to provide to such an investor	4743
or pass-through entity any additional deduction or credit, other	4744
than the credit provided by division (J) of this section, solely	4745
on account of the entity's filing a return in accordance with this	4746
section. Such a pass-through entity also shall make the filing and	4747
payment of estimated taxes on behalf of the pass-through entity	4748
investors other than an investor that is a person subject to the	4749
tax imposed under section 5733.06 of the Revised Code.	4750
(2) For the purposes of this section, "business credits"	4751
means the credits listed in section 5747.98 of the Revised Code	4752
excluding the following credits:	4753
(a) The retirement credit under division (B) of section	4754
5747.055 of the Revised Code;	4755
(b) The senior citizen credit under division (C) of section	4756
5747.05 of the Revised Code;	4757
(c) The lump sum distribution credit under division (D) of	4758
section 5747.05 of the Revised Code;	
section 5/4/.05 of the Revised Code,	4759
(d) The dependent care credit under section 5747.054 of the	4760
Revised Code;	4761
(e) The lump sum retirement income credit under division (C)	4762
of section 5747.055 of the Revised Code;	4763

(f) The lump sum retirement income credit under division (D)	4764
of section 5747.055 of the Revised Code;	4765
(g) The lump sum retirement income credit under division (E)	4766
of section 5747.055 of the Revised Code;	4767
(h) The credit for displaced workers who pay for job training	4768
under section 5747.27 of the Revised Code;	4769
(i) The twenty-dollar personal exemption credit under section	4770
5747.022 of the Revised Code;	4771
(j) The joint filing credit under division (G) of section	4772
5747.05 of the Revised Code;	4773
(k) The nonresident credit under division (A) of section	4774
5747.05 of the Revised Code;	4775
(1) The credit for a resident's out-of-state income under	4776
division (B) of section 5747.05 of the Revised Code;	4777
(m) The low-income credit under section 5747.056 of the	4778
Revised Code;	4779
(n) The credit for payment of medical care insurance and	4780
qualified long-term care insurance contract premiums under section	4781
5747.81 of the Revised Code.	4782
(3) The election provided for under division (D) of this	4783
section applies only to the taxable year for which the election is	4784
made by the pass-through entity. Unless the tax commissioner	4785
provides otherwise, this election, once made, is binding and	4786
irrevocable for the taxable year for which the election is made.	4787
Nothing in this division shall be construed to provide for any	4788
deduction or credit that would not be allowable if a nonresident	4789
pass-through entity investor were to file an annual return.	4790
(4) If a pass-through entity makes the election provided for	4791
under division (D) of this section, the pass-through entity shall	4792
be liable for any additional taxes interest interest penalty or	4793

penalties imposed by this chapter if the tax commissioner finds	4794
that the single return does not reflect the correct tax due by the	4795
pass-through entity investors covered by that return. Nothing in	4796
this division shall be construed to limit or alter the liability,	4797
if any, imposed on pass-through entity investors for unpaid or	4798
underpaid taxes, interest, interest penalty, or penalties as a	4799
result of the pass-through entity's making the election provided	4800
for under division (D) of this section. For the purposes of	4801
division (D) of this section, "correct tax due" means the tax that	4802
would have been paid by the pass-through entity had the single	4803
return been filed in a manner reflecting the tax commissioner's	4804
findings. Nothing in division (D) of this section shall be	4805
construed to make or hold a pass-through entity liable for tax	4806
attributable to a pass-through entity investor's income from a	4807
source other than the pass-through entity electing to file the	4808
single return.	4809

(E) If a husband and wife file a joint federal income tax 4810 return for a taxable year, they shall file a joint return under 4811 this section for that taxable year, and their liabilities are 4812 joint and several, but, if the federal income tax liability of 4813 either spouse is determined on a separate federal income tax 4814 return, they shall file separate returns under this section. 4815

If either spouse is not required to file a federal income tax 4816 return and either or both are required to file a return pursuant 4817 to this chapter, they may elect to file separate or joint returns, 4818 and, pursuant to that election, their liabilities are separate or 4819 joint and several. If a husband and wife file separate returns 4820 pursuant to this chapter, each must claim the taxpayer's own 4821 exemption, but not both, as authorized under section 5747.02 of 4822 the Revised Code on the taxpayer's own return. 4823

(F) Each return or notice required to be filed under this section shall contain the signature of the taxpayer or the

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taxpayer's duly authorized agent and of the person who prepared	4826
the return for the taxpayer, and shall include the taxpayer's	4827
social security number. Each return shall be verified by a	4828
declaration under the penalties of perjury. The tax commissioner	4829
shall prescribe the form that the signature and declaration shall	4830
take.	4831

(G) Each return or notice required to be filed under this 4832 section shall be made and filed as required by section 5747.04 of 4833 the Revised Code, on or before the fifteenth day of April of each 4834 year, on forms that the tax commissioner shall prescribe, together 4835 with remittance made payable to the treasurer of state in the 4836 combined amount of the state and all school district income taxes 4837 shown to be due on the form, unless the combined amount shown to 4838 be due is one dollar or less, in which case that amount need not 4839 be remitted. 4840

Upon good cause shown, the tax commissioner may extend the 4841 period for filing any notice or return required to be filed under 4842 this section and may adopt rules relating to extensions. If the 4843 extension results in an extension of time for the payment of any 4844 state or school district income tax liability with respect to 4845 which the return is filed, the taxpayer shall pay at the time the 4846 tax liability is paid an amount of interest computed at the rate 4847 per annum prescribed by section 5703.47 of the Revised Code on 4848 that liability from the time that payment is due without extension 4849 to the time of actual payment. Except as provided in section 4850 5747.132 of the Revised Code, in addition to all other interest 4851 charges and penalties, all taxes imposed under this chapter or 4852 Chapter 5748. of the Revised Code and remaining unpaid after they 4853 become due, except combined amounts due of one dollar or less, 4854 bear interest at the rate per annum prescribed by section 5703.47 4855 of the Revised Code until paid or until the day an assessment is 4856 issued under section 5747.13 of the Revised Code, whichever occurs 4857

first.	4858
If the tax commissioner considers it necessary in order to	4859
ensure the payment of the tax imposed by section 5747.02 of the	4860
Revised Code or any tax imposed under Chapter 5748. of the Revised	4861
Code, the tax commissioner may require returns and payments to be	4862
made otherwise than as provided in this section.	4863
To the extent that any provision in this division conflicts	4864
with any provision in section 5747.026 of the Revised Code, the	4865
provision in that section prevails.	4866
(H) If any report, claim, statement, or other document	4867
required to be filed, or any payment required to be made, within a	4868
prescribed period or on or before a prescribed date under this	4869
chapter is delivered after that period or that date by United	4870
States mail to the agency, officer, or office with which the	4871
report, claim, statement, or other document is required to be	4872
filed, or to which the payment is required to be made, the date of	4873
the postmark stamped on the cover in which the report, claim,	4874
statement, or other document, or payment is mailed shall be deemed	4875
to be the date of delivery or the date of payment.	4876
If a payment is required to be made by electronic funds	4877
transfer pursuant to section 5747.072 of the Revised Code, the	4878
payment is considered to be made when the payment is received by	4879
the treasurer of state or credited to an account designated by the	4880
treasurer of state for the receipt of tax payments.	4881
"The date of the postmark" means, in the event there is more	4882
than one date on the cover, the earliest date imprinted on the	4883
cover by the United States postal service.	4884
(I) The amounts withheld by the employer pursuant to section	4885
5747.06 of the Revised Code shall be allowed to the recipient of	4886
the compensation as credits against payment of the appropriate	4887

taxes imposed on the recipient by section 5747.02 and under

Chapter 5748. of the Revised Code. 4889

(J) If, in accordance with division (D) of this section, a 4890 pass-through entity elects to file a single return and if any 4891 investor is required to file the return and make the payment of 4892 taxes required by this chapter on account of the investor's other 4893 income that is not included in a single return filed by a 4894 4895 pass-through entity, the investor is entitled to a refundable credit equal to the investor's proportionate share of the tax paid 4896 by the pass-through entity on behalf of the investor. The investor 4897 shall claim the credit for the investor's taxable year in which or 4898 with which ends the taxable year of the pass-through entity. 4899 Nothing in this chapter shall be construed to allow any credit 4900 provided in this chapter to be claimed more than once. For the 4901 purposes of computing any interest, penalty, or interest penalty, 4902 the investor shall be deemed to have paid the refundable credit 4903 provided by this division on the day that the pass-through entity 4904 paid the estimated tax or the tax giving rise to the credit. 4905

(K) The tax commissioner shall ensure that each return 4906 required to be filed under this section includes a box that the 4907 taxpayer may check to authorize a paid tax preparer who prepared 4908 the return to communicate with the department of taxation about 4909 matters pertaining to the return. The return or instructions 4910 accompanying the return shall indicate that by checking the box 4911 the taxpayer authorizes the department of taxation to contact the 4912 preparer concerning questions that arise during the processing of 4913 the return and authorizes the preparer only to provide the 4914 department with information that is missing from the return, to 4915 contact the department for information about the processing of the 4916 return or the status of the taxpayer's refund or payments, and to 4917 respond to notices about mathematical errors, offsets, or return 4918 preparation that the taxpayer has received from the department and 4919 has shown to the preparer. 4920

Sec. 5747.81. (A) For purposes of this section:	4921
(1) "Medical care" has the meaning given in section 213 of	4922
the Internal Revenue Code, subject to the special rules,	4923
limitations, and exclusions set forth therein.	4924
(2) "Qualified long-term care contract" has the same meaning	4925
given in section 7702B of the Internal Revenue Code.	4926
(3) "Subsidized health plan" means a health plan for which an	4927
employer pays any portion of the plan's cost.	4928
(4) "Dependent" has the same meaning as in division (A)(11)	4929
of section 5747.01 of the Revised Code.	4930
(B) A nonrefundable credit is allowed against the tax imposed	4931
by section 5747.02 of the Revised Code equal to the amount paid by	4932
the taxpayer during the taxpayer's taxable year for medical care	4933
insurance or a qualified long-term care insurance contract for the	4934
taxpayer, the taxpayer's spouse, or dependents. The credit shall	4935
not exceed one thousand dollars.	4936
No credit shall be allowed under this section to any taxpayer	4937
who is eligible to participate in any subsidized health plan	4938
maintained by any employer of the taxpayer or of the taxpayer's	4939
spouse, or to any taxpayer who is entitled to, or on application	4940
would be entitled to, benefits under part A of Title XVIII of the	4941
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as	4942
amended.	4943
The taxpayer shall claim the credit in the order required	4944
under section 5747.98 of the Revised Code. To the extent the	4945
credit exceeds the taxpayer's tax liability for the taxable year	4946
after allowance for any other credits that precede the credit	4947
under that section in that order, the credit may be carried	4948
forward to succeeding taxable years until fully utilized, but the	4949
amount of any excess credit allowed in any such year shall be	4950

deducted from the balance carried forward to the succeeding year.	4951
Sec. 5747.98. (A) To provide a uniform procedure for	4952
calculating the amount of tax due under section 5747.02 of the	4953
Revised Code, a taxpayer shall claim any credits to which the	4954
taxpayer is entitled in the following order:	4955
(1) The retirement income credit under division (B) of	4956
section 5747.055 of the Revised Code;	4957
(2) The senior citizen credit under division (C) of section	4958
5747.05 of the Revised Code;	4959
(3) The lump sum distribution credit under division (D) of	4960
section 5747.05 of the Revised Code;	4961
(4) The dependent care credit under section 5747.054 of the	4962
Revised Code;	4963
(5) The lump sum retirement income credit under division (C)	4964
of section 5747.055 of the Revised Code;	4965
(6) The lump sum retirement income credit under division (D)	4966
of section 5747.055 of the Revised Code;	4967
(7) The lump sum retirement income credit under division (E)	4968
of section 5747.055 of the Revised Code;	4969
(8) The low-income credit under section 5747.056 of the	4970
Revised Code;	4971
(9) The credit for displaced workers who pay for job training	4972
under section 5747.27 of the Revised Code;	4973
(10) The campaign contribution credit under section 5747.29	4974
of the Revised Code;	4975
(11) The twenty-dollar personal exemption credit under	4976
section 5747.022 of the Revised Code;	4977
(12) The joint filing credit under division (G) of section	4978

5747.05 of the Revised Code;	4979
(13) The nonresident credit under division (A) of section 5747.05 of the Revised Code;	4980 4981
(14) The credit for a resident's out-of-state income under division (B) of section 5747.05 of the Revised Code;	4982 4983
(15) The credit for employers that enter into agreements with child day-care centers under section 5747.34 of the Revised Code;	4984 4985
(16) The credit for employers that reimburse employee child care expenses under section 5747.36 of the Revised Code;	4986 4987
(17) The credit for adoption of a minor child under section 5747.37 of the Revised Code;	4988 4989
(18) The credit for purchases of lights and reflectors under section 5747.38 of the Revised Code;	4990 4991
(19) The job retention credit under division (B) of section 5747.058 of the Revised Code;	4992 4993
(20) The credit for selling alternative fuel under section 5747.77 of the Revised Code;	4994 4995
(21) The second credit for purchases of new manufacturing machinery and equipment and the credit for using Ohio coal under section 5747.31 of the Revised Code;	4996 4997 4998
(22) The job training credit under section 5747.39 of the Revised Code;	4999 5000
(23) The enterprise zone credit under section 5709.66 of the Revised Code;	5001 5002
(24) The credit for the eligible costs associated with a voluntary action under section 5747.32 of the Revised Code;	5003 5004
(25) The credit for employers that establish on-site child day-care centers under section 5747.35 of the Revised Code;	5005 5006
(26) The ethanol plant investment credit under section	5007

5747.75 of the Revised Code;	5008
(27) The credit for purchases of qualifying grape production property under section 5747.28 of the Revised Code;	5009 5010
(28) The export sales credit under section 5747.057 of the Revised Code;	5011 5012
(29) The credit for research and development and technology transfer investors under section 5747.33 of the Revised Code;	5013 5014
(30) The enterprise zone credits under section 5709.65 of the Revised Code;	5015 5016
(31) The research and development credit under section 5747.331 of the Revised Code;	5017 5018
(32) The credit for payment of medical care insurance and qualified long-term care insurance premiums under section 5747.81 of the Revised Code;	5019 5020 5021
(33) The refundable credit for rehabilitating a historic building under section 5747.76 of the Revised Code;	5022 5023
$\frac{(33)(34)}{(34)}$ The refundable jobs creation credit under division (A) of section 5747.058 of the Revised Code;	5024 5025
$\frac{(34)(35)}{(35)}$ The refundable credit for taxes paid by a qualifying entity granted under section 5747.059 of the Revised Code;	5026 5027
(35)(36) The refundable credits for taxes paid by a qualifying pass-through entity granted under division (J) of section 5747.08 of the Revised Code;	5028 5029 5030
$\frac{(36)(37)}{(37)}$ The refundable credit for tax withheld under division (B)(1) of section 5747.062 of the Revised Code;	5031 5032
(37)(38) The refundable credit under section 5747.80 of the Revised Code for losses on loans made to the Ohio venture capital program under sections 150.01 to 150.10 of the Revised Code.	5033 5034 5035
(B) For any <u>nonrefundable</u> credit, except the credits	5036

enumerated in divisions (A)(32) to (37) of this section and the	5037
credit granted under division (I) of section 5747.08 of the	5038
Revised Code, the amount of the credit for a taxable year shall	5039
not exceed the tax due after allowing for any other credit that	5040
precedes it in the order required under this section. Any excess	5041
amount of a particular credit may be carried forward if authorized	5042
under the section creating that credit. Nothing in this chapter	5043
shall be construed to allow a taxpayer to claim, directly or	5044
indirectly, a credit more than once for a taxable year.	5045
	5046

Section 2. That existing sections 9.901, 1731.03, 1731.05, 5047 1731.09, 1751.14, 1751.15, 1751.16, 3313.814, 3901.386, 3923.05, 5048 3923.122, 3923.24, 3923.58, 3923.581, 3924.01, 3924.02, 3924.06, 5049 3924.73, 4121.44, 4121.441, 4123.29, 4715.22, 4715.23, 4715.39, 5050 4715.64, 5111.162, 5112.08, 5725.24, 5729.03, 5747.01, 5747.08, 5051 and 5747.98 and sections 3923.59, 3924.07, 3924.08, 3924.09, 5052 3924.10, 3924.11, 3924.111, 3924.12, 3924.13, and 3924.14 of the 5053 Revised Code are hereby repealed. 5054

Section 3. (A) Not later than July 1, 2009, the Ohio 5055 Department of Job and Family Services shall establish a pilot 5056 program in Hamilton County to provide all providers contracting 5057 with the Department under the Medicaid program with equipment, 5058 software, and any other items necessary to retain the medical 5059 records of Medicaid recipients in an electronic format. Each 5060 medical record shall be capable of electronically retaining 5061 information regarding a patient's wellness, preventive care, and 5062 medical history. The medical record shall be maintained in a 5063 format that is transferable to all Medicaid providers and to the 5064 Department. Not later than October 1, 2009, Medicaid providers 5065 shall begin using the equipment to maintain Medicaid patient 5066 records. 5067

Not later than July 1, 2013, the Department shall expand the	5068
pilot program to six additional counties, three that are primarily	5069
urban and three that are primarily rural.	5070
Not later than July 1, 2015, the Department shall expand the	5071
pilot program to cover all counties in the state.	5072
The Department shall submit a monthly report to the Health	5073
Information Technology Advisory Board regarding the progress of	5074
the pilot program.	5075
(B) The Department shall apply to the United States Secretary	5076
of Health and Human Services for federal matching funds through	5077
the Medicaid program or any other applicable federal program. The	5078
Department shall take all steps necessary to ensure the highest	5079
federal participation.	5080
(C)(1) There is hereby created the Health Information	5081
Technology Advisory Board. The Board shall consist of the	5082
following:	5083
(a) The State Chief Information Officer, who shall serve as	5084
chairperson;	5085
(b) The Director of the Ohio Department of Health;	5086
(c) One representative from the Ohio Department of	5087
Administrative Services;	5088
(d) One representative from the Ohio Hospital Association;	5089
(e) One representative from the Ohio State Medical	5090
Association;	5091
(f) An individual who works for a company that provides	5092
information technology services;	5093
(g) One representative from a regional health information	5094
organization;	5095
(h) One representative from a quality improvement	5096

organization affiliated with the Centers for Medicare and Medicaid	5097
Services of the United States Department of Health and Human	5098
Services;	5099
(i) One representative from an Ohio-based medical college or	5100
university;	5101
(j) One professional representing the fields of behavioral	5102
health, pharmaceuticals, nursing, and long-term care;	5103
(k) One representative from a consumer-oriented association;	5104
(1) One representative of a non-partisan policy group or	5105
organization;	5106
(m) An attorney who is an expert on the topic of health	5107
information;	5108
(n) A health care policy and security expert.	5109
(2) The chairperson shall appoint all other members of the	5110
Board.	5111
The Board shall meet at least six times per year.	5112
The Ohio Department of Administrative Services shall provide	5113
meeting space for the Board.	5114
Board members shall be reimbursed for actual expenses	5115
incurred in the performance of official duties. Board members	5116
shall serve three-year terms and may be reappointed. Vacancies	5117
shall be filled in the manner provided for original appointment.	5118
Any member appointed to fill a vacancy occurring prior to the	5119
expiration of the term for which the member's predecessor was	5120
appointed shall hold office for the remainder of that term. A	5121
member shall continue in office subsequent to the expiration of	5122
the member's term or until a period of sixty days has elapsed,	5123
whichever occurs first. Five members of the Board constitute a	5124
quorum. The Ohio Department of Administrative Services shall	5125
provide staff support to the Board.	5126

(3) The Board shall do all of the following:	5127
(a) Create an operational plan on how to implement the	5128
recommendations in the Ohio Health Information Security and	5129
Privacy Collaboration Implementation Plan and the Ohio Health	5130
Informational Technology Strategic Roadmap. The plan shall include	5131
possible creation of a state-level, public and private	5132
organization to coordinate ongoing efforts to implement a strategy	5133
for the adoption and use of electronic health records and exchange	5134
of health information;	5135
(b) Identify obstacles to adoption of health information	5136
technology by providers and exchange of health information among	5137
providers and with consumers;	5138
(c) Advise the Governor and the General Assembly on issues	5139
related to the development and implementation of an Ohio health	5140
information technology infrastructure and to the privacy and	5141
security of health information;	5142
(d) Oversee ongoing work of the Ohio Health Information	5143
Security and Privacy Collaboration Implementation Plan;	5144
(e) Oversee implementation of state funded health information	5145
technology and health information exchange pilot projects;	5146
(f) Coordinate allocation of state funds to subsidize the	5147
adoption of health information technology by providers or the	5148
exchange of health information among providers;	5149
(g) Coordinate with the entities focused on creating the	5150
broadband infrastructure needed throughout Ohio to allow for	5151
health information exchange;	5152
(h) Oversee development of communications efforts with	5153
consumers and providers to promote health information technology;	5154
(i) Receive grants, gifts, donations, and other contributions	5155
of private, federal, or other public moneys to fund health	5156

information technology and health information exchange efforts in	5157
Ohio;	5158
(j) Oversee coordination of relationships with federal	5159
initiatives and agencies or with neighboring state efforts on	5160
health information technology and health information exchange.	5161
Section 4. (A) There is hereby created the Health Insurance	5162
Credit Program Advisory Board. The Board shall consist of the	5163
following:	5164
(1) Two representatives from the Ohio Department of Job and	5165
Family Services, appointed by the Governor;	5166
(2) One individual who is a consumer advocate on health care	5167
issues, appointed by the Governor;	5168
(3) One representative from the health insurance industry,	5169
appointed by the Speaker of the House of Representatives;	5170
(4) One representative of a Medicaid managed care company,	5171
appointed by the President of the Senate;	5172
(5) One member of the Ohio General Assembly from the majority	5173
party, appointed by the Speaker of the House of Representatives;	5174
(6) One member of the Ohio General Assembly from the minority	5175
party, appointed by the President of the Senate.	5176
The Governor shall select the chairperson of the Board from	5177
among the Governor's appointees. The Board shall meet at least	5178
four times per year. Board members shall be reimbursed for actual	5179
expenses incurred in the performance of official duties. Board	5180
members shall serve three year terms. Vacancies shall be filled in	5181
the manner provided for original appointment. Any member appointed	5182
to fill a vacancy occurring prior to the expiration of the term	5183
for which the member's predecessor was appointed shall hold office	5184
for the remainder of that term. Four members of the Board	5185
constitute a quorum. The Ohio Department of Job and Family	5186

Services shall provide staff support to the Board.	5187
(B) The Board shall submit an annual report to the Governor	5188
and the General Assembly regarding the costs to the state	5189
associated with the program. Three years after its first meeting,	5190
the Board shall cease to exist.	5191
Section 5. If necessary, the Department of Job and Family	5192
Services shall apply to the United States Secretary of Health and	5193
Human Services for a waiver of federal Medicaid requirements to	5194
apply Medicaid funds towards the health insurance credit program	5195
created by section 5101.90 of the Revised Code. If the Department	5196
determines that Medicaid funds may be used for the credit program,	5197
or receives a waiver to use funds for the program, the Department	5198
is authorized to use those funds in addition to the funds	5199
authorized under section 5101.93 of the Revised Code.	5200
Section 6. It is the intent of the General Assembly to	5201
-	5201
support the "Four Cornerstones" principles of health care reform	5202
adopted by the United States Secretary of Health and Human	
Services in accordance with Executive Order Number 13410 issued by	5204
the President of the United States on August 22, 2006. The Four	5205 5206
Cornerstones are:	5206
(A) Promoting interoperable health information technology;	5207
(B) Measuring and publishing quality health information;	5208
(C) Measuring and publishing quality health price	5209
information;	5210
(D) Promoting quality and efficiency of health care.	5211
Section 7. (A) As used in this section, "state institution of	5212
higher education" has the same meaning as in section 3345.011 of	5213
the Revised Code.	5214

	-01-
(B) Each state institution of higher education that operates	5215
a prelicensure nursing education program approved by the board of	5216
nursing under section 4723.06 of the Revised Code shall do all of	5217
the following:	5218
(1) Pay an individual who begins teaching nursing classes at	5219
that institution in the first state fiscal year that begins on or	5220
after the effective date of this section a starting salary that is	5221
at least ten thousand dollars higher than whichever of the	5222
following applies:	5223
(a) The average starting salary paid to an instructor who	5224
began teaching nursing classes at the institution during calendar	5225
year 2007;	5226
(b) The average starting salary that, based on past	5227
practices, would have been paid had any instructor begun teaching	5228
nursing classes at the institution during calendar year 2007.	5229
(2) Pay an individual who begins teaching nursing classes at	5230
the institution in the second, third, fourth, and fifth state	5231
fiscal years that begin on or after the effective date of this	5232
section a starting salary that is at least five thousand dollars	5233
higher than the starting salary paid under division (B)(1) of this	5234
section;	5235
(3) Pay an individual who taught nursing at the institution	5236
in the calendar year immediately prior to the effective date of	5237
this section a salary in the first five state fiscal years that	5238
begin on or after the effective date of this section a salary that	5239
is at least five thousand dollars more than the salary the	5240
individual earned in the calendar year immediately prior to the	5241
effective date of this section.	5242
(C) A state institution of higher education that operates a	5243
prelicensure nursing education program approved by the board of	5244
nursing under section 4723.06 of the Revised Code shall not do	5245

either of the following:	5246
(1) Reduce, from the number of nursing classes offered during	5247
calendar year 2007, the number of nursing classes offered in each	5248
of the first five calendar years that begin on or after the	5249
effective date of this section;	5250
(2) Reduce, from the number of nursing instructors employed	5251
or contracted with during calendar year 2007, the number of	5252
nursing instructors employed or contracted with in each of the	5253
first five calendar years that begin on or after the effective	5254
date of this section.	5255
Section 8. The amendment or enactment of sections 5725.24,	5256
5729.03, 5747.01, 5747.08, 5747.81, and 5747.98 of the Revised	5257
Code applies to taxable years beginning on or after January 1,	5258
2008.	5259
Section 9. A contract between a participant and person for	5260
pharmacy benefit management services of the type described in	5261
section 185.04 of the Revised Code that is in existence on the	5262
effective date of this act shall expire in accordance with the	5263
terms of the contract and shall not be renewed or extended.	5264
Section 10. Section 9.901 of the Revised Code, as amended by	5265
this act, shall apply to collective bargaining agreements governed	5266
by Chapter 4117. of the Revised Code and entered into or modified	5267
on or after the effective date of this act.	5268
Section 11. Sections 3923.85 to 3923.91 of this act shall	5269
take effect July 1, 2009.	5270
Section 12. The amendment of section 5112.08 of the Revised	5271
Code is not intended to supersede the earlier repeal, with delayed	5272
effective date, of that section.	5273