As Introduced

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H. B. No. 456

Representative Raussen

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

A B I L L

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

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to provide that these provisions of this act terminate on October 16, 2009, when section 5112.08 of the Revised Code is repealed on that date.

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

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

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

established pursuant to this section by the board. Any or all of the health care plans that contain best practices specified by the board may be self-insured. As used in this section, a "public school district" means a city, local, exempted village, or joint vocational school district, and includes the educational service centers associated with those districts but not charter schools.

(2) The board shall determine what strategies are used by the existing medical plans to manage health care costs and shall study the potential benefits of state or regional consortiums of public schools offering multiple health care plans. As used in this section:

(a) A "health care plan" includes group policies, contracts, and agreements that provide hospital, surgical, or medical expense coverage, including self-insured plans. A "health care plan" does not include an individual plan offered to the employees of a public school district, or a plan that provides coverage only for specific disease or accidents, or a hospital indemnity, medicare supplement, or other plan that provides only supplemental benefits, paid for by the employees of a public school district.

(b) A "health plan sponsor" means a public school district, a consortium of public school districts, or a council of governments.

(B) The school employees health care board is hereby created. The school employees health care board shall consist of the following twelve members and shall include individuals with experience with public school district benefit programs, health care industry providers, and health care plan beneficiaries:

(1) Four members appointed by the governor, one of whom shall be representative of nonadministrative public school district employees;

(2) Four members appointed by the president of the senate, one of whom shall be representative of nonadministrative public school district employees;

(3) Four members appointed by the speaker of the house of representatives, one of whom shall be representative of nonadministrative public school district employees.

A member of the school employees health care board shall not be employed by, represent, or in any way be affiliated with a private entity that is providing services to the board, an individual school district, employers, or employees in the state of Ohio.

(C)(1) Members of the school employees health care board shall serve four-year terms, but may be reappointed, except as otherwise specified in division (B) of this section.

A member shall continue to serve subsequent to the expiration of the member's term until a successor is appointed. Any vacancy occurring during a member's term shall be filled in the same manner as the original appointment, except that the person appointed to fill the vacancy shall be appointed to the remainder of the unexpired term.

(2) Members shall receive compensation fixed pursuant to division (J) of section 124.15 of the Revised Code and shall be reimbursed from the school employees health care fund for actual and necessary expenses incurred in the performance of their official duties as members of the board.

(3) Members may be removed by their appointing authority for misfeasance, malfeasance, incompetence, dereliction of duty, or other just cause.

(D)(1) At the first meeting of the board after the first day of January of each calendar year, the board shall elect a chairperson and may elect members to other positions on the board

as the board considers necessary or appropriate. The board shall meet at least nine times each calendar year and shall also meet at the call of the chairperson or four or more board members. The chairperson shall provide reasonable advance notice of the time and place of board meetings to all members.

(2) A majority of the board constitutes a quorum for the transaction of business at a board meeting. A majority vote of the members present is necessary for official action.

(E) The school employees health care board shall conduct its business at open meetings; however, the records of the board are not public records for purposes of section 149.43 of the Revised Code.

(F) The school employees health care fund is hereby created in the state treasury. The board shall use all funds in the school employees health care fund solely to carry out the provisions of this section and related administrative costs.

(G) The school employees health care board shall do all of the following:

(1) Include disease management and consumer education programs~~,~~ which programs shall include, but are not limited to, wellness programs and other measures designed to encourage the wise use of medical plan coverage. These programs are not services or treatments for purposes of section 3901.71 of the Revised Code.

(2) Adopt and release a set of standards that shall be considered the best practices to which public school districts shall adhere in the selection and implementation of health care plans.

~~(2)~~(3) Include in the standards adopted under division (G)(2) of this section a requirement that the provision of pharmacy benefit management services and the payment and reimbursement for

prescription drugs must be in accordance with contracts negotiated and entered into by the office of pharmaceutical purchasing coordination under Chapter 185. of the Revised Code, or in accordance with the lower pricing as may otherwise be established by the school district pursuant to section 185.06 of the Revised Code;

(4) Require that the plans the health plan sponsors administer make readily available to the public all cost and design elements of the plan;

~~(3)~~(5) Work with health plan sponsors through educational outlets and consultation;

~~(4)~~(6) Maintain a commitment to transparency and public access of its meetings and activity pursuant to division (E) of this section;

~~(5)~~(7) Promote cooperation among all organizations affected by this section in identifying the elements for the successful implementation of this section;

~~(6)~~(8) Promote cost containment measures aligned with patient, plan, and provider management strategies in developing and managing health care plans;

~~(7)~~(9) Prepare and disseminate to the public an annual report on the status of health plan sponsors' effectiveness in making progress to reduce the rate of increase in insurance premiums and employee out of pocket expenses, as well as progress in improving the health status of school district employees and their families.

(H) The sections in Chapter 3923. of the Revised Code regulating public employee benefit plans are not applicable to the health care plans designed pursuant to this section.

(I) The board may contract with one or more independent consultants to analyze costs related to employee health care

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

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

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

(K) The board may adopt rules for the enforcement of health plan sponsors' compliance with the best practices standards adopted by the board pursuant to this section.

(L) Any districts providing health care plan coverage for the employees of public school districts shall provide nonidentifiable aggregate claims data for the coverage to the school employees health care board, without charge, within sixty days after receiving a written request from the board. The claims data shall include data relating to employee group benefit sets, demographics, and claims experience.

(M)(1) The school employees health care board may contract with other state agencies for services as the board deems necessary for the implementation and operation of this section, based on demonstrated experience and expertise in administration, management, data handling, actuarial studies, quality assurance, or for other needed services. The school employees health care board may contract with the department of administrative services for central services until such time the board deems itself able to obtain such services from its own staff or from other sources. The board shall reimburse the department of administrative

services for the reasonable cost of those services.

(2) The board shall hire staff as necessary to provide administrative support to the board and the public school employee health care plan program established by this section.

(N) Not more than ninety days before coverage begins for public school district employees under health care plans containing best practices prescribed by the school employees health care board, a public school district's board of education shall provide detailed information about the health care plans to the employees.

(O) Nothing in this section shall be construed as prohibiting public school districts from consulting with and compensating insurance agents and brokers for professional services.

(P)~~(1)~~ Pursuant to Chapter 117. of the Revised Code, the auditor of state shall conduct all necessary and required audits of the board. The auditor of state, upon request, also shall furnish to the board copies of audits of public school districts or consortia performed by the auditor of state.

Sec. 185.01. As used in this chapter:

"Participant" means the director of job and family services, each managed care organization that contracts with the department of job and family services under section 5111.17 of the Revised Code, the administrator of workers' compensation, each state retirement system, and the board of education of each school district in this state.

"Prescription drug" means a drug that may not be dispensed without a prescription from a licensed health professional authorized to prescribe drugs.

"School district" means a city, local, exempted village, or

joint vocational school district.

"State retirement system" means the public employees retirement system, Ohio police and fire pension fund, state teachers retirement system, school employees retirement system, or the state highway patrol retirement system.

Sec. 185.02. There is hereby created the office of pharmaceutical purchasing coordination in the department of administrative services. The office shall be under the supervision of a manager, who shall be appointed by the director of administrative services.

The director, in consultation with the manager, shall hire or assign employees. The director shall furnish equipment and supplies, as necessary, for the fulfillment of the office's purpose stated in section 185.03 of the Revised Code and the office's duties described in section 185.04 of the Revised Code.

Administrative costs associated with the operation of the office shall be paid from amounts appropriated to the department for such purposes.

Sec. 185.03. The purpose of the office of pharmaceutical purchasing coordination is to maximize the purchasing power of, and value of pharmacy benefit management programs to, the participants, collectively, so that the reimbursement rates paid for all of the following, except as provided in section 185.07 of the Revised Code, are minimized:

(A) Claims for prescription drugs made under the medicaid program established under Chapter 5111. of the Revised Code;

(B) Prescription drugs provided to claimants pursuant to compensable claims filed under Chapters 4121., 4123., 4127., or 4131. of the Revised Code;

(C) Claims for prescription drugs made under a contract or policy established under section 145.58, 742.45, 3307.39, 3309.69, or 5505.28 of the Revised Code or pursuant to a plan established under section 145.81, 3307.81, or 3309.81 of the Revised Code;

(D) Claims for prescription drugs made under insurance or coverage procured or paid for by school districts.

Sec. 185.04. (A) In furtherance of the purpose of the office of pharmaceutical purchasing coordination stated in section 185.03 of the Revised Code, the office shall do both of the following:

(1) Conduct a review of the pharmacy benefit management programs, if any, the participants maintained on or immediately prior to the effective date of this section. The review shall consider, at a minimum, the cost and value of formularies, application of rebates, medication therapy and chronic disease management programs, and electronic prescribing.

(2) Except as provided in section 185.07 of the Revised Code, negotiate and enter into one or more contracts on behalf of each participant with a person under which the person provides pharmacy benefits management services on behalf of the participant for the claims described in section 185.03 of the Revised Code. The provision of pharmacy benefit management services shall include, at a minimum, both of the following:

(a) The negotiation of prices charged for prescription drugs;

(b) Unless a significant negative cost impact can be demonstrated, the maintenance of one or more multiple or regional pharmacy benefit management programs.

(B) Not later than one year after the effective date of this section, the office shall submit a report to the governor and general assembly that summarizes the results of the review

conducted pursuant to division (A) of this section. The report shall contain standards, developed in consultation with the participants, for appropriate pharmacy benefit management activities to be included in contracts negotiated by the office.

Sec. 185.05. Before entering into a contract described in section 185.04 of the Revised Code, the office shall issue a request for proposals from the persons seeking to be considered. The office shall develop a process to be used in issuing the request for proposals, receiving responses to the request, and evaluating the responses on a competitive basis. In accordance with that process, the office shall select the person to be awarded the contract.

The office shall continuously work with each participant and the person selected to provide the pharmacy benefits management services to ensure that the terms of each contract are being fulfilled.

Sec. 185.06. Each participant shall cooperate with the office of pharmaceutical purchasing coordination to provide the office with any information the office needs to fulfill its purpose stated in section 185.05 of the Revised Code and to enter into one or more contracts under section 185.04 of the Revised Code. Information requested by the office shall be provided as soon as practicable after the request is made.

Sec. 185.07. (A) The office of pharmaceutical purchasing coordination shall not enter into a contract with the person selected under section 185.05 of the Revised Code on behalf of a participant if the participant provides written evidence, as determined sufficient by the director of administrative services in the director's sole discretion and by the date established by the director, that the participant is able to secure lower

reimbursement rates for claims it pays that are described in section 185.03 of the Revised Code without being included in a contract negotiated by the office.

(B) If the director of job and family services chooses to submit written evidence to the director of administrative services under division (A) of this section, this evidence may include any or all of the following:

(1) Subject to division (C) of this section, the value of rebates paid by drug manufacturers to the department of job and family services in accordance with a rebate agreement required by 42 U.S.C. 1396r-8;

(2) The value of supplemental rebates, if any, paid by drug manufacturers to the department of job and family services in accordance with the supplemental drug program the department is permitted to establish under section 5111.081 of the Revised Code;

(3) The savings achieved by the department's establishment of the maximum allowable cost program required by section 5111.082 of the Revised Code.

(C) If the director of job and family services chooses to submit the information described in division (B)(1) of this section, the information shall be submitted in a manner that does not disclose the identity of a specific manufacturer or wholesaler as prohibited under 42 U.S.C. 1396r-8(b)(3)(D).

Sec. 185.08. The director of health shall provide information to the office of pharmaceutical purchasing coordination, on the office's request, regarding prescription drugs or other scientific matters.

Sec. 185.09. The director of job and family services shall determine whether a waiver of federal medicaid requirements is necessary to fulfill the requirements in this chapter. If the

director determines a waiver is necessary, the director of job and family services shall notify the office of pharmaceutical purchasing coordination of this fact and apply to the United States secretary of health and human services for the waiver.

Sec. 185.10. The director of administrative services shall adopt rules in accordance with Chapter 119. of the Revised Code, as necessary, to implement this chapter.

Sec. 1731.03. (A) A small employer health care alliance may do any of the following:

(1) Negotiate and enter into agreements with one or more insurers for the insurers to offer and provide one or more health benefit plans to small employers for their employees and retirees, and the dependents and members of the families of such employees and retirees, which coverage may be made available to enrolled small employers without regard to industrial, rating, or other classifications among the enrolled small employers under an alliance program, except as otherwise provided under the alliance program, and for the alliance to perform, or contract with others for the performance of, functions under or with respect to the alliance program;

(2) Contract with another alliance for the inclusion of the small employer members of one in the alliance program of the other;

(3) Provide or cause to be provided to small employers information concerning the availability, coverage, benefits, premiums, and other information regarding an alliance program and promote the alliance program;

(4) Provide, or contract with others to provide, enrollment, record keeping, information, premium billing, collection and transmittal, and other services under an alliance program;

(5) Receive reports and information from the insurer and negotiate and enter into agreements with respect to inspection and audit of the books and records of the insurer;

(6) Provide services to and on behalf of an alliance program sponsored by another alliance, including entering into an agreement described in division (B) of section 1731.01 of the Revised Code on behalf of the other alliance;

(7) If it is a nonprofit corporation created under Chapter 1702. of the Revised Code, exercise all powers and authority of such corporations under the laws of the state, or, if otherwise constituted, exercise such powers and authority as apply to it under the applicable laws, and its articles, regulations, constitution, bylaws, or other relevant governing instruments.

(B) A small employer health care alliance is not and shall not be regarded for any purpose of law as an insurer, an offeror or seller of any insurance, a partner of or joint venturer with any insurer, an agent of, or solicitor for an agent of, or representative of, an insurer or an offeror or seller of any insurance, an adjuster of claims, or a third-party administrator, and will not be liable under or by reason of any insurance coverage or other health benefit plan provided or not provided by any insurer or by reason of any conditions or restrictions on eligibility or benefits under an alliance program or any insurance or other health benefit plan provided under an alliance program or by reason of the application of those conditions or restrictions.

(C) The promotion of an alliance program by an alliance or by an insurer is not and shall not be regarded for any purpose of law as the offer, solicitation, or sale of insurance.

(D)(1) No alliance shall adopt, impose, or enforce medical underwriting rules or underwriting rules requiring a small employer to have more than a minimum number of employees for the

purpose of determining whether an alliance member is eligible to purchase a policy, contract, or plan of health insurance or health benefits from any insurer in connection with the alliance health care program.

(2) No alliance shall reject any applicant for membership in the alliance based on the health status of the applicant's employees or their dependents or because the small employer does not have more than a minimum number of employees.

(3) A violation of division (D)(1) or (2) of this section is deemed to be an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

(4) Nothing in division (D)(1) or (2) of this section shall be construed as inhibiting or preventing an alliance from adopting, imposing, and enforcing rules, conditions, limitations, or restrictions that are based on factors other than the health status of employees or their dependents or the size of the small employer for the purpose of determining whether a small employer is eligible to become a member of the alliance. Division (D)(1) of this section does not apply to an insurer that sells health coverage to an alliance member under an alliance health care program.

(E) Except as otherwise specified in section 1731.09 of the Revised Code, health benefit plans offered and sold to alliance members that are small employers as defined in section 3924.01 of the Revised Code are subject to sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code.

(F) Any person who represents an alliance in bargaining or negotiating a health benefit plan with an insurer shall disclose to the governing board of the alliance any direct or indirect financial relationship the person has or had during the past two

years with the insurer.

Sec. 1731.05. If a qualified alliance, or an alliance that, based upon evidence of interest satisfactory to the superintendent of insurance, will be a qualified alliance within a reasonable time, submits a request for a proposal on a health benefit plan to at least three insurers and does not receive at least one reasonably responsive proposal within ninety days from the date the last such request is submitted, the superintendent, at the request of such alliance, may require that insurers offer proposals to such alliance for health benefit plans for the small employers within such alliance. Such proposals shall include such coverage and benefits for such premiums, as shall take into account the functions provided by the alliance and the economies of scale, and have other terms and provisions as are approved by the superintendent, consistent with the purposes and standards set forth in section 1731.02 of the Revised Code. In making the determination as to which insurers shall be asked to submit proposals under this section, the superintendent shall apply the following standards ~~set forth in division (G)(4)(a) of section 3924.11 of the Revised Code~~:

(A) Demonstration by the carrier of a substantial and established market presence;

(B) Demonstrated experience in the individual market and history of rating and underwriting individual plans;

(C) Commitment to comply with the requirements of section 3923.58 of the Revised Code;

(D) Financial ability to assume and manage the risk of enrolling open enrollment individuals. Any insurer that does not submit a proposal when required to do so by the superintendent hereunder, shall be deemed to be in violation of section 3901.20 of the Revised Code and shall be subject to all of the provisions

of section 3901.22 of the Revised Code, including division (D)(1) of section 3901.22 of the Revised Code as if it provided that the superintendent may suspend or revoke an insurer's license to engage in the business of insurance.

Nothing in this section shall be construed as requiring an insurer to enter into an agreement with an alliance under contractual terms that are not acceptable to the insurer or to authorize the superintendent to require an insurer to enter into an agreement with an alliance under contractual terms that are not acceptable to the insurer.

This section applies beginning eighteen months after its effective date.

Sec. 1731.09. (A) Nothing contained in this chapter is intended to or shall inhibit or prevent the application of the provisions of Chapter 3924. of the Revised Code to any health benefit plan or insurer to which they would otherwise apply in the absence of this chapter, except as otherwise specified in divisions (B) and (C) of this section or unless such application conflicts with the provisions of section 1731.05 of the Revised Code.

(B) An insurer may establish one or more separate classes of business solely comprised of one or more alliances. All of the following shall apply to health plans covering small employers in each class of business established pursuant to this division:

(1) The premium rate limitations set forth in section 3924.04 of the Revised Code apply to each class of business separate and apart from the insurer's other business;

(2) For purposes of applying sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code to a class of business, the base premium rate and midpoint rate shall be determined with respect to

each class of business separate and apart from the insurer's other business.

(3) The midpoint rate for a class of business shall not exceed the midpoint rate for any other class of business or the insurer's non-alliance business by more than fifteen per cent.

(4) The insurer annually shall file with the superintendent of insurance an actuarial certification consistent with section 3924.06 of the Revised Code for each class of business demonstrating that the underwriting and rating methods of the insurer do all of the following:

(a) Comply with accepted actuarial practices;

(b) Are uniformly applied to health benefit plans covering small employers within the class of business;

(c) Comply with the applicable provisions of this section and sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code.

(5) An insurer shall apply sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code to the insurer's non-alliance business and coverage sold through alliances not established as a separate class of business.

(6) An insurer shall file with the superintendent a notification identifying any alliance or alliances to be treated as a separate class of business at least sixty days prior to the date the rates for that class of business take effect.

(7) Any application for a certificate of authority filed pursuant to section 1731.021 of the Revised Code shall include a disclosure as to whether the alliance will be underwritten or rated as part of a separate class of business.

(C) As used in this section:

(1) "Class of business" means a group of small employers, as defined in section 3924.01 of the Revised Code, that are enrolled

employers in one or more alliances.

(2) "Actuarial certification," "base premium rate," and "midpoint rate" have the same meanings as in section 3924.01 of the Revised Code.

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

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

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

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

(C) Notwithstanding section 3901.71 of the Revised Code, if the limiting age for dependent children specified in the policy, contract, or agreement pursuant to division (A) of this section is less than twenty-nine years and both of the following are true of the applicant, the health insuring corporation shall notify the primary policy, contract, or agreement holder thirty days prior to

the dependent's attainment of the limiting age and offer to provide coverage to the child as a dependent until age twenty-nine:

(1) The child is a resident of Ohio or a full-time student at an accredited public or private institution of higher education.

(2) Neither the child nor any spouse of the child is employed by an employer that offers any health benefit plan under which the child is eligible for coverage.

(D) No policy, contract, or agreement for health care services authorized by this chapter that is issued, delivered, or renewed in this state that provides for the coverage of any dependent child shall terminate that coverage based solely upon the fact that the child is married.

(E) Nothing in this section shall require an insurer to cover a dependent child's spouse or children as dependents on the policy, contract, or agreement of the parent or legal guardian of the dependent.

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

(G) As used in this section, "health benefit plan" means any of the following when the contract, policy, or plan provides payment or reimbursement for the costs of health care services other than for specific diseases or accidents only:

(1) An individual or group policy of sickness and accident insurance;

(2) An individual or group contract of a health insuring corporation;

(3) A public employee benefit plan;

(4) A multiple employer welfare arrangement as defined in section 1739.01 of the Revised Code;

(5) A health benefit plan as regulated under the "Employee Retirement Income Security Act of 1974" 29 U.S.C. 1001, et seq.

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

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

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

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

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

(1) Waive the requirement for open enrollment;

(2) Impose a limit on the number of applicants and their

dependents that must be enrolled;

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

(a) Preserve its financial stability;

(b) Prevent excessive adverse selection;

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

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

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

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

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

(b) Is eligible for continuation coverage under state or

federal law;

(c) Is eligible for medicare, and the health insuring corporation does not have an agreement on appropriate payment mechanisms with the governmental agency administering the medicare program.

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

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

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

(1) The proposed public notice of open enrollment;

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

(3) The contractual periodic prepayment and premium rate approved pursuant to section 1751.12 of the Revised Code that will

be applicable during open enrollment;

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

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

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

(H)(1) An open enrollment period shall not satisfy the requirements of this section unless the health insuring corporation provides adequate public notice in accordance with divisions (H)(2) and (3) of this section. No public notice shall be used until the form of the public notice has been filed by the health insuring corporation with the superintendent. If the superintendent does not disapprove the public notice within sixty days after it is filed, it shall be deemed approved, unless the superintendent sooner gives approval for the public notice. If the superintendent determines within this sixty-day period that the public notice fails to meet the requirements of this section, the superintendent shall so notify the health insuring corporation and it shall be unlawful for the health insuring corporation to use the public notice. Such disapproval shall be effected by a written order, which shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

(2) A public notice pursuant to division (H)(1) of this section shall be published in at least one newspaper of general circulation in each county in the health insuring corporation's service area, at least once in each of the two weeks immediately preceding the month in which the open enrollment is to occur and

in each week of that month, or until the enrollment limitation is reached, whichever occurs first. The notice published during the last week of open enrollment shall appear not less than five days before the end of the open enrollment period. It shall be at least two newspaper columns wide or two and one-half inches wide, whichever is larger. The first two lines of the text shall be published in not less than twelve-point, boldface type. The remainder of the text of the notice shall be published in not less than eight-point type. The entire public notice shall be surrounded by a continuous black line not less than one-eighth of an inch wide.

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

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

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

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

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

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

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

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

(4) Within thirty days after the end of an open enrollment period, the health insuring corporation shall submit to the

superintendent proof of publication for the public notices, and shall report the total number of applicants and their dependents enrolled during the open enrollment period.

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

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

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

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

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

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

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

(1) Termination of the conversion option or contract is based upon nonpayment of premium after reasonable notice in writing has been given by the health insuring corporation to the subscriber.

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

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

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

(c) Any policy of insurance or health care plan providing coverage at least comparable to the benefits under division

(A)(2)(a) of this section.

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

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

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

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

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

(C) The option for conversion shall be available:

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

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

(3) Upon the divorce, dissolution, or annulment of the marriage of the subscriber, to the divorced spouse, or, in the event of annulment, to the former spouse of the subscriber.

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

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

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

Sec. 1753.281. (A) Notwithstanding section 3901.71 of the Revised Code, a health insuring corporation policy, contract, or agreement providing coverage for 9-1-1 emergency services shall provide in the policy, contract, or agreement that all payments for 9-1-1 emergency services be paid directly to a nonparticipating 9-1-1 emergency services provider or to the provider's assigned agent for billing purposes, when such a provider is used.

(B) As used in this section:

(1) "9-1-1 emergency services" includes, but is not limited to, the following services:

(a) Transportation provided by an ambulance or other vehicle providing medical service that responds to a call placed to the 9-1-1 system and transfers a person to a hospital emergency department;

(b) All services performed by an emergency room physician that are not covered under the direct payment to hospitals under section 3901.386 of the Revised Code.

(2) "9-1-1 system" has the same meaning as in section 4931.40 of the Revised Code.

Sec. 3313.814. ~~Each~~ (A)(1) In accordance with rules adopted by the state board of education under division (B) of this section, each board of education shall adopt and enforce standards ~~governing~~ that do both of the following:

(a) Govern the types of, and prices for, food and beverages that may be sold on the premises of its schools, ~~and specifying~~ including food and beverages sold by food service programs operated under section 3313.81 of the Revised Code or in vending machines;

(b) Specify the time and place each type of food and beverage may be sold. ~~In~~

(2) In adopting the standards specified in division (A)(1) of this section, the board shall consider each ~~food's~~ food and beverage's nutritional value. ~~No food may be sold on any school premises except in accordance with the standards adopted by the board of education.~~

(B) The state board of education shall ~~formulate and~~ adopt ~~guidelines, which boards of education may follow in enforcing and~~

~~implementing this section~~ rules in accordance with Chapter 119. of the Revised Code governing the types of, and prices for, food and beverages sold on any school premises, including food and beverages sold by food service programs operated under section 3313.81 of the Revised Code and in vending machines.

(C) In no circumstance shall a school do either of the following:

(1) Beginning one year after the effective date of this amendment, sell a food or beverage containing, or prepared using, a food or substance containing artificial trans fat.

(2) Sell a type of food or beverage, or charge a price for food or beverages, that is inconsistent with the rules adopted by the state board of education under division (B) of this section.

For purposes of this division, a food or substance contains artificial trans fat if the food or substance's ingredients include vegetable shortening, margarine, or any kind of partially hydrogenated vegetable oil, unless the food manufacturer's documentation or label required on the food or substance under 21 C.F.R. 101.9 lists the trans fat content as less than one-half of one gram per serving or the label contains the statement "Not a significant source of trans fat."

Sec. 3314.181. (A)(1) In accordance with rules adopted under division (B) of this section, each governing board of a community school shall adopt and enforce standards that do both of the following:

(a) Govern the types of, and prices for, food and beverages that may be sold on the premises of its school, including food and beverages sold by the school's food service program or in vending machines;

(b) Specify the time and place each type of food and beverage

may be sold.

(2) In adopting the standards specified in division (A)(1) of this section, the governing board shall consider each food and beverage's nutritional value.

(B) The state board of education shall adopt rules in accordance with Chapter 119. of the Revised Code governing the types of, and prices for, food and beverages sold on a community school's premises, including food and beverages sold by a school's food service program and in vending machines.

(C) In no circumstance shall a community school do either of the following:

(1) Beginning one year after the effective date of this amendment, sell a food or beverage containing, or prepared using, a food or substance containing artificial trans fat.

(2) Sell a type of food or beverage, or charge a price for food or beverages, that is inconsistent with the rules adopted by the state board of education under division (B) of this section.

For purposes of this division, a food or substance contains artificial trans fat if the food or substance's ingredients include vegetable shortening, margarine, or any kind of partially hydrogenated vegetable oil, unless the food manufacturer's documentation or label required on the food or substance under 21 C.F.R. 101.9 lists the trans fat content as less than one-half of one gram per serving or the label includes the statement "Not a significant source of trans fat."

Sec. 3702.302. (A) As used in sections 3702.302 to 3702.305 of the Revised Code, "ambulatory surgical facility" has the same meaning as in section 3702.30 of the Revised Code.

(B) Annually, on or before the first day of May, each ambulatory surgical facility shall submit to the director of

health the following information pertaining to services provided to patients served by the facility, regardless of who pays the charges incurred for the services:

(1) The type of services provided by the ambulatory surgical facility;

(2) The number of patients for whom the ambulatory surgical facility provided each of the types of services;

(3) The mean and median of total ambulatory surgical facility charges for each type of service.

(C) The name or social security number of a patient or physician shall not be included in the information submitted to the director of health under this section.

(D)(1) The director of health may audit the information submitted under this section.

(2) The director shall permit an ambulatory surgical facility to verify the accuracy of all information submitted under this section and provide corrections in a timely manner.

(E) The information submitted under this section shall not be used to establish or alter any professional standard of care. The information is not admissible as evidence in any civil, criminal, or administrative proceeding.

(F) This section does not require the submission of information for which the ambulatory surgical facility treated fewer than ten patients during the year.

Sec. 3702.303. Every ambulatory surgical facility shall make the information it submits under section 3702.302 of the Revised Code available for inspection by any member of the public at any reasonable time. On request, the ambulatory surgical facility shall make copies available for a reasonable fee, and the ambulatory surgical facility shall advise the requesting person

that the information is available from the director of health, as provided in section 3702.304 of the Revised Code.

Sec. 3702.304. (A) The duties of the director of health under this section apply only to the extent that appropriations are made by the general assembly to make performance of the duties possible.

(B) Not later than ninety days after an ambulatory surgical facility submits information to the director of health under section 3702.302 of the Revised Code, the director shall make the information submitted available to the public on an internet web site. The director shall do all of the following in making the information available on a web site:

(1) Make the web site available to the public without charge;

(2) Provide for the web site to be organized in a manner that enables the public to use it easily;

(3) Exclude any information that compromises patient privacy;

(4) Include links to web sites pertaining to ambulatory surgical facilities for the purpose of allowing the public to obtain additional information about ambulatory surgical facilities;

(5) Allow other internet web sites to link to the web site for purposes of increasing the site's availability and encouraging ongoing improvement;

(6) Update the web site as needed to include new information and correct errors.

(C) Subject to division (A) of this section, the director shall enter into a contract with a person under which the director's duties under this section are performed by the person pursuant to the contract. The contract may be entered into with

any person selected by the director. For the purposes of this section, any person under contract shall meet the requirements listed in division (B)(1) to (6) of this section.

(D) The director of health may accept gifts, grants, donations, and awards for the purposes of paying the fees or other costs incurred when a contract is entered into under this division.

(E) An ambulatory surgical facility that submits information under section 3702.302 of the Revised Code is not liable for misuse or improper release of the information by any of the following:

(1) The department of health;

(2) A person with whom the director of health contracts under this section;

(3) A person whose misuse or improper release of the information is not done on behalf of the ambulatory surgical facility.

(F) Not later than ninety days after an ambulatory surgical facility submits information to the director of health under section 3702.302 of the Revised Code, the director shall make the submitted information available for sale to any interested person or government entity. When the director sells the information, the fee charged shall not exceed a reasonable amount.

Sec. 3702.305. The director of health shall adopt rules, in accordance with Chapter 119. of the Revised Code, governing ambulatory surgical facilities in their submission of information to the director under section 3702.302 of the Revised Code.

Sec. 3727.51. (A) As used in this section:

(1) "Cost of charity care" means direct and indirect costs

incurred by a tax-exempt hospital to provide free or discounted care to individuals unable to afford to pay the cost of services, less any reimbursement received therefor, based on current federal medicare reimbursement rates. "Cost of charity care" does not include bad debt, contractual allowances, or discounts for prompt payment.

(2) "Hospital facilities" has the same meaning as in section 140.01 of the Revised Code.

(3) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided during the hospital's annual accounting period to patients who, for such days, were medicaid recipients, and the denominator of which is the total number of the hospital's inpatient days in that same period. In determining a hospital's medicaid inpatient utilization rate, both of the following shall be included:

(a) Medicaid recipients who participate in the care management system established under section 5111.16 of the Revised Code;

(b) Medicaid recipients who participate in the fee-for-service system.

(4) "Tax-exempt hospital" means a hospital the facilities of which are exempted from ad valorem property taxation in whole or in part.

(5) "Tax savings" means the amount of taxes that would be charged and payable against a tax-exempt hospital's hospital facilities in this state that are exempted from ad valorem property taxes if those facilities were subject to taxation, plus the amount of sales and use taxes that would be due from the hospital under Chapters 5739. and 5741. of the Revised Code if the hospital's otherwise taxable transactions were not exempt from

such taxes.

(B) Each tax-exempt hospital that has a medicaid inpatient utilization rate of less than thirty-five per cent for its annual accounting period ending in calender year 2009 or any calendar year thereafter shall report the following on its web site throughout the twelve-month period that begins on the first day of February following the end of the calendar year:

(1) The cost of charity care incurred in that annual accounting period;

(2) The hospital's tax savings for the calendar year in which that annual accounting period ends.

(C) A tax-exempt hospital that has a medicaid inpatient utilization rate of thirty-five per cent or more for its annual accounting period ending in calendar year 2009 or any calendar year thereafter shall report its medicaid inpatient utilization rate to the auditor of state as required by rules adopted under division (D) of this section.

(D) The auditor of state shall adopt rules in accordance with Chapter 119. of the Revised Code governing the oversight and implementation of this section. The rules shall set forth all of the following:

(1) All forms, notifications, and applications required to be provided by tax-exempt hospitals.

(2) The process the auditor of state shall use to determine compliance with this section.

(3) The process for notifying the public of their rights under this section.

(4) Any other provisions that the auditor of state considers necessary to carry out the purposes of this section.

The auditor of state shall notify the tax commissioner and

the attorney general should a tax-exempt hospital fail to comply with this section.

Sec. 3901.386. (A) No third-party payer shall refuse to accept and honor a validly executed assignment of benefits with a physician, physician group, physician partnership, or physician professional corporation by a beneficiary for medically necessary physician services provided on an emergency basis regardless of whether the third party payer and the physician, physician group, physician partnership, or physician professional corporation have entered into a contract regarding the provision and reimbursement of covered services.

(B)(1) Notwithstanding section 1751.13 or division (I)(2) of section 3923.04 of the Revised Code, a reimbursement contract entered into or renewed on or after June 29, 1988, between a third-party payer and a hospital shall provide that reimbursement for any service provided by a hospital pursuant to a reimbursement contract and covered under a benefits contract shall be made directly to the hospital.

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

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

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

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

not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(B) A provision as follows: Misstatement of age. If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(C) A provision as follows:

(1) Other insurance in this insurer. If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... in excess of ..... dollars, the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to ~~his~~ the insured's estate.

The insurer shall insert the type of coverage or coverages in the first blank space in the provision in division (C)(1) of this section and the maximum limit of indemnity or indemnities in the second blank space in the provision in division (C)(1) of this section.

(2) In lieu of the foregoing provision in division (C)(1) of this section, a provision as follows: Other insurance in this insurer. Insurance effective at any time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, ~~his~~ the insured's beneficiary or ~~his~~ the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(D) A provision as follows: Insurance with other insurers. If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on

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

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

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

organizations or by union welfare plans or employer or employee benefit organizations.

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

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

(E) A provision as follows: Insurance with other insurers. If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which the insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

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

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

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

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

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

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

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

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

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

provided by a governmental agency or otherwise, or benefits provided by union welfare plans or by employer or employee benefit organizations.

(G) A provision as follows: Unpaid premium. Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(H) A provision as follows: Conformity with state statutes. Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(I) A provision as follows: Illegal occupation. The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

~~(J) A provision as follows: Intoxicants and narcotics. The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.~~

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

~~(1) In the case of an individual who is not a federally eligible individual,~~ any of the individual policies of hospital, surgical, or medical expense insurance then being issued by the

insurer with benefit limits not to exceed those in effect under the group policy~~;~~

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

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

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

(1) The effective date of the converted policy;

(2) The date of application therefor; and shall be applicable to the class of risk to which each person covered belongs and to the form and amount of the policy at the person's then attained age. ~~However, premiums charged federally eligible individuals may not exceed an amount that is two times the midpoint of the standard rate charged any other individual of a group to which the insurer is currently accepting new business and for which similar~~

~~copayments and deductibles are applied.~~

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

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

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

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

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

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

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

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

(D) The option for conversion shall be available:

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

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

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

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

(E) If coverage is continued under a group policy on an employee following retirement prior to the time the employee is, or is eligible to be, covered by Title XVIII of the Social Security Act, the employee may elect, in lieu of the continuance of group insurance, to have the same conversion rights as would apply had the employee's insurance terminated at retirement by reason of termination of employment.

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

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

(H) If an employee or member becomes entitled to obtain a converted policy pursuant to this section, and if the employee or member has not received notice of the conversion privilege at least fifteen days prior to the expiration of the thirty-one-day conversion period provided in division (B) of this section, then the employee or member has an additional period within which to exercise the privilege. This additional period shall expire fifteen days after the employee or member receives notice, but in

no event shall the period extend beyond sixty days after the expiration of the thirty-one-day conversion period.

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

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

(I) The converted policy may provide that any hospital, surgical, or medical expense benefits otherwise payable with respect to any person may be reduced by the amount of any such benefits payable under the group policy for the same loss after termination of coverage.

(J) The converted policy may contain:

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

(2) Any provision permitted in this section;

(3) Any other provision not prohibited by law.

Any provision required or permitted in this section may be

made a part of any converted policy by means of an endorsement or rider.

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

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

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

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

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

Sec. 3923.24. (A) Every certificate furnished by an insurer in connection with, or pursuant to any provision of, any group sickness and accident insurance policy delivered, issued for delivery, renewed, or used in this state on or after January 1, 1972, and every policy of sickness and accident insurance delivered, issued for delivery, renewed, or used in this state on or after January 1, 1972, which provides that coverage of ~~an unmarried~~ a dependent child will terminate upon attainment of the limiting age for dependent children specified in the contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child if

the child is and continues to be both:

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

~~(B)~~(2) Primarily dependent upon the policyholder or certificate holder for support and maintenance.

(B) Proof of such incapacity and dependence shall be furnished by the policyholder or by the certificate holder to the insurer within thirty-one days of the child's attainment of the limiting age. Upon request, but not more frequently than annually after the two-year period following the child's attainment of the limiting age, the insurer may require proof satisfactory to it of the continuance of such incapacity and dependency.

(C) Nothing in this section shall require an insurer to cover a dependent child who is mentally retarded or physically handicapped if the contract is underwritten on evidence of insurability based on health factors set forth in the application, or if such dependent child does not satisfy the conditions of the contract as to any requirement for evidence of insurability or other provision of the contract, satisfaction of which is required for coverage thereunder to take effect. In any such case, the terms of the contract shall apply with regard to the coverage or exclusion of the dependent from such coverage. Nothing in this section shall apply to accidental death or dismemberment benefits provided by any such policy of sickness and accident insurance.

(D) Notwithstanding section 3901.71 of the Revised Code, if the limiting age for dependent children specified in the certificate or policy pursuant to division (A) of this section is less than twenty-nine years and both of the following are true of the applicant, the sickness and accident insurer shall notify the primary policy, contract, or agreement holder thirty days prior to the dependent's attainment of the limiting age and offer to

provide coverage to the child as a dependent until age twenty-nine:

(1) The child is a resident of Ohio or a full-time student at an accredited public or private institution of higher education.

(2) Neither the child nor any spouse of the child is employed by an employer that offers any health benefit plan under which the child is eligible for coverage.

(E) No sickness and accident insurance policy delivered, issued for delivery, renewed, or used in this state that provides for the coverage of any dependent child shall terminate that coverage based solely upon the fact that the child is married.

(F) Nothing in this section shall require an insurer to cover a dependent child's spouse or children as dependents on the policy, contract, or agreement of the parent or legal guardian of the dependent.

(G) As used in this section, "health benefit plan" means any of the following when the contract, policy, or plan provides payment or reimbursement for the costs of health care services other than for specific diseases or accidents only:

(1) An individual or group policy of sickness and accident insurance;

(2) An individual or group contract of a health insuring corporation;

(3) A public employee benefit plan;

(4) A multiple employer welfare arrangement as defined in section 1739.01 of the Revised Code;

(5) A health benefit plan as regulated under the "Employee Retirement Income Security Act of 1974" 29 U.S.C. 1001, et seq.

Sec. 3923.241. (A) Notwithstanding section 3901.71 of the

Revised Code, any public employee benefit plan that provides that coverage of an unmarried dependent child will terminate upon attainment of the limiting age for dependent children specified in the plan shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if the child is and continues to be both of the following:

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

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

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

(C) Notwithstanding section 3901.71 of the Revised Code, if the limiting age for dependent children specified in the plan pursuant to division (A) of this section is less than twenty-nine years and both of the following are true of the applicant, the public employee benefit plan shall notify the plan member thirty days prior to the dependent's attainment of the limiting age and offer to provide coverage to the child as a dependent until age twenty-nine:

(1) The child is a resident of Ohio or a full-time student at an accredited public or private institution of higher education.

(2) Neither the child nor any spouse of the child is employed by an employer that offers any health benefit plan under which the child is eligible for coverage.

(D) No public employee benefit plan that provides for the

coverage of any dependent child shall terminate that coverage based solely upon the fact that the child is married.

(E) Nothing in this section shall require an insurer to cover a dependent child's spouse or children as dependents on the policy, contract, or agreement of the parent or legal guardian of the dependent.

(F) As used in this section, "health benefit plan" means any of the following when the contract, policy, or plan provides payment or reimbursement for the costs of health care services other than for specific diseases or accidents only:

(1) An individual or group policy of sickness and accident insurance;

(2) An individual or group contract of a health insuring corporation;

(3) A public employee benefit plan;

(4) A multiple employer welfare arrangement as defined in section 1739.01 of the Revised Code;

(5) A health benefit plan as regulated under the "Employee Retirement Income Security Act of 1974" 29 U.S.C. 1001, et seq.

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

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

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

(3) "Pre-existing conditions provision" means a policy

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

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

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

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

(C) ~~An insurer shall offer to any individual accepted under~~

~~this section the Ohio health care basic and standard plans established by the board of directors of the Ohio health reinsurance program under division (A) of section 3924.10 of the Revised Code or health benefit plans that are substantially similar to the Ohio health care basic and standard plans in benefit plan design and scope of covered services.~~

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

~~For purposes of this division, the superintendent of insurance shall determine whether a health benefit plan is substantially similar to the Ohio health care basic and standard plans in benefit plan design and scope of covered services.~~

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

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

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

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

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

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

~~(I)~~(H) The requirements of this section do not apply to any insurer that is currently in a state of supervision, insolvency, or liquidation. If an insurer demonstrates to the satisfaction of the superintendent that the requirements of this section would place the insurer in a state of supervision, insolvency, or

liquidation, the superintendent may waive or modify the requirements of division (B) or ~~(G)~~(F) of this section. The actions of the superintendent under this division shall be effective for a period of not more than one year. At the expiration of such time, a new showing of need for a waiver or modification by the insurer shall be made before a new waiver or modification is issued or imposed.

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

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

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

contract. The superintendent may adopt, in accordance with Chapter 119. of the Revised Code, such rules as are necessary to enforce this division.

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

Sec. 3923.581. (A) As used in this section:

(1) "Carrier," "health benefit plan," "MEWA," and "pre-existing conditions provision" have the same meanings as in section 3924.01 of the Revised Code.

(2) "Federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

(3) "Health status-related factor" means any of the following:

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability.

(4) "Midpoint rate" means, for individuals with similar case

characteristics and plan designs and as determined by the applicable carrier for a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(5) "Network plan" means a health benefit plan of a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

(B) Beginning in January of each year, carriers in the business of issuing health benefit plans to individuals or nonemployer groups shall accept federally eligible individuals for open enrollment coverage, as provided in this section, in the order in which they apply for coverage and subject to the limitation set forth in division ~~(J)~~(I) of this section.

(C) No carrier shall do either of the following:

(1) Decline to offer such coverage to, or deny enrollment of, such individuals;

(2) Apply any pre-existing conditions provision to such coverage.

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

~~(E)~~ Premiums charged to individuals under this section may not exceed an amount that is two times the midpoint rate charged any other individual to which the carrier is currently accepting

new business, and for which similar copayments and deductibles are applied.

~~(F)~~(E) If a carrier offers a health benefit plan in the individual market through a network plan, the carrier may do both of the following:

(1) Limit the federally eligible individuals that may apply for such coverage to those who live, work, or reside in the service area of the network plan;

(2) Within the service area of the network plan, deny the coverage to federally eligible individuals if the carrier has demonstrated both of the following to the superintendent:

(a) The carrier will not have the capacity to deliver services adequately ~~t~~ to any additional individuals because of the carrier's obligations to existing group contract holders and individuals.

(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.

~~(G)~~(F) A carrier that, pursuant to division ~~(F)~~(E)(2) of this section, denies coverage to an individual in the service area of a 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.

~~(H)~~(G) A carrier may refuse to issue health benefit plans to federally eligible individuals if the carrier has demonstrated both of the following to the superintendent:

(1) The carrier does not have the financial reserves necessary to underwrite additional coverage.

(2) The carrier is applying division ~~(H)~~(G) of this section uniformly to all federally eligible individuals in this state

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

~~(I)~~(H) A carrier that, pursuant to division ~~(H)~~(G) of this section, refuses to issue health benefit plans to federally eligible individuals, shall not offer health benefit plans in the individual market in this state for at least one hundred eighty days after the date the coverage is denied or until the carrier has demonstrated to the superintendent that the carrier has sufficient financial reserves to underwrite additional coverage, whichever is later.

~~(J)~~(I)(1) Except as provided in division ~~(J)~~(I)(2) of this section, a carrier shall not be required to accept annually under this section federally eligible individuals who, in the aggregate, would cause the carrier to have a total number of new insureds that is more than one-half per cent of its total number of insured individuals and nonemployer groups in this state per year, calculated as of the immediately preceding thirty-first day of December and excluding the carrier's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division ~~(M)~~(K) of section 3923.58 of the Revised Code.

(2) An officer of the carrier shall certify to the department of insurance when it has met the enrollment limit set forth in division ~~(J)~~(I)(1) of this section. Upon providing such certification, the carrier shall be relieved of its open enrollment requirement under this section for the remainder of the calendar year unless, prior to the end of the calendar year, all the carriers subject to this section have individually met the enrollment limit set forth in division ~~(J)~~(I)(1) of this section. In that event, carriers shall again accept applicants for open enrollment coverage pursuant to this section, subject to the

enrollment limit set forth in division ~~(J)~~(I)(1) of this section.

~~(K)~~(J) The superintendent may provide for the application of this section on a service-area-specific basis.

~~(L)~~(K) The requirements of this section do not apply to any health benefit plan described in division ~~(M)~~(K) of section 3923.58 of the Revised Code.

Sec. 3923.641. (A) As used in this section:

(1) "Chronic care" means health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions.

(2) "Chronic conditions" include but are not limited to diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.

(3) "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for the physician and patient relationship, and a plan of care emphasizing prevention of complications, utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

(B) Notwithstanding section 3901.71 of the Revised Code, every public employee benefit plan established or modified in this state shall include coverage for chronic care management.

Sec. 3923.651. (A) Notwithstanding section 3901.71 of the Revised Code, every individual or group policy of sickness and accident insurance that provides coverage for 9-1-1 emergency services shall provide that reimbursement under that policy for 9-1-1 emergency services be paid directly to the provider of 9-1-1 emergency services or to the provider's assigned agent for billing purposes.

(B) As used in this section:

(1) "9-1-1 emergency services" includes, but is not limited to, the following services:

(a) Transportation provided by an ambulance or other vehicle providing medical service that responds to a call placed to the 9-1-1 system and transfers a person to a hospital emergency department;

(b) All services performed by an emergency room physician that are not covered under the direct payment to hospitals under section 3901.386 of the Revised Code.

(2) "9-1-1 system" has the same meaning as in section 4931.40 of the Revised Code.

Sec. 3923.80. (A) Notwithstanding section 3901.71 of the Revised Code, no health benefit plan shall contain a provision that limits or excludes an insured's coverage under the plan for a loss the insured sustains that is the result of the insured's use of alcohol or other drugs or both and the loss is otherwise covered under the plan.

(B) As used in this section:

(1) "Carrier" means any sickness and accident insurance company or health insuring corporation authorized to issue health benefit plans in this state, a public employee benefit plan, or a

multiple employer welfare arrangement, as defined in the "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C. 1002, except for any arrangement which is fully insured as defined in that act at 29 U.S.C. 1144 (b)(6)(d).

(2) "Health benefit plan" means any hospital or medical expense policy or certificate or any health plan provided by a carrier, that is delivered, issued for delivery, renewed, or used in this state on or after the date occurring six months after the effective date of this act. "Health benefit plan" does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care; coverage under a one-time, limited duration policy of not longer than six months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(3) "Insured" means a person covered by a health benefit plan issued by a carrier.

Sec. 3923.85. As used in sections 3923.85 to 3923.92 of the Revised Code:

(A) "Insurer" means sickness and accident insurer or health insuring corporation.

(B) "Health benefit plan" means any of the following when the contract, policy, or plan provides payment or reimbursement for the costs of health care services other than for specific diseases or accidents only:

(1) An individual or group policy of sickness and accident

insurance;

(2) An individual or group contract of a health insuring corporation;

(3) A public employee benefit plan;

(4) A multiple employer welfare arrangement as defined in section 1739.01 of the Revised Code.

(C) "Chronic care" and "chronic conditions" have the same meanings as in section 3923.641 of the Revised Code.

Sec. 3923.86. (A) There is hereby created the I-Ohio reinsurance program.

(B) The superintendent shall adopt rules to administer the program including rules to do all of the following:

(1) Establish three categories of individuals that represent a high insurance risk based upon the level of severity of the individuals' health status factors including pre-existing conditions, diseases, chronic conditions, and any other factors the superintendent determines to be relevant:

(a) Individuals that represent a low-high insurance risk;

(b) Individuals that represent a medium-high insurance risk;

(c) Individuals that represent a high-high insurance risk.

(2) Establish a basic, standard policy that includes coverage for chronic care and that, when offered by an insurer to an eligible individual, shall be eligible to be reinsured under the I-Ohio reinsurance program;

(3) Establish the average market premium price on the basis of the arithmetic mean of all insurers' premium rates for policies that are substantially similar to the basic, standard policy adopted by the superintendent or any other equitable basis determined by the superintendent.

(C) The superintendent may enter into contracts with public or private entities to obtain estimates concerning the number of individuals eligible for coverage under the program and the costs of administering and implementing the program.

Sec. 3923.87. The basic, standard policy established by the superintendent of insurance pursuant to section 3923.86 of the Revised Code may cover dependents if either of the following is true:

(A) The dependent is the individual who represents the low-high, medium-high, or high-high insurance risk to be reinsured by the I-Ohio reinsurance program.

(B) The dependent cannot be covered by an employer sponsored health benefit plan, and the insured earns the primary household income.

Sec. 3923.88. (A) Notwithstanding section 3901.71 of the Revised Code, all insurers shall offer basic, standard policies pursuant to sections 3923.85 to 3923.92 of the Revised Code.

(B) Notwithstanding section 3923.90 of the Revised Code, the I-Ohio reinsurance program shall reinsure basic, standard policies offered by insurers if the insurer offers those policies to individuals who have an annual income of less than ninety thousand dollars, are not employed by an employer that offers health insurance coverage, and meet at least one of the following criteria:

(1) The individual has not been covered by a health benefit plan in the six months preceding the individual's application for the policy.

(2) The individual has been declined coverage under a health benefit plan.

(3) The premiums for the individual's most recent health benefit plan exceeded one hundred twenty-five per cent of the average market premium price as determined by the superintendent of insurance.

Sec. 3923.89. (A) The I-Ohio reinsurance program shall not provide reinsurance for any individual reinsured under the program until the individual's insurer has made fifteen thousand dollars in benefit payments for services provided to that individual during a calendar year.

(B) After the fifteen-thousand-dollar deductible, the I-Ohio reinsurance program shall reinsure basic, standard plans offered by health insurance corporations and sickness and accident insurers pursuant to sections 3923.85 to 3923.92 of the Revised Code at eighty-five per cent of claims paid on behalf of an individual up to fifty thousand dollars of total claims paid on behalf of the individual.

Sec. 3923.90. (A)(1) The superintendent of insurance shall estimate the average annual cost of reinsuring each individual under the I-Ohio reinsurance program based upon available data and appropriate actuarial assumptions and determine total eligible enrollment in the program.

(2) The superintendent shall suspend the enrollment of new policies and notify all insurers in writing of such suspension if the superintendent determines that the total enrollment reported by all insurers exceeds the total eligible enrollment.

(B) The superintendent shall suspend the enrollment of new policies issued to individuals who reside in a particular county of this state and shall notify all insurers of such suspension if the superintendent determines that more than ten per cent of the policies reinsured by the program cover individuals who reside in

that county.

(C)(1) In the first two years of the operation of the I-Ohio reinsurance program, the program shall reinsure basic, standard policies offered by insurers to individuals who represent a low-high insurance risk only.

(2) In the third and forth years of the operation of the I-Ohio reinsurance program, the program shall reinsure basic, standard policies offered by insurers to individuals who represent a low-high insurance risk and medium-high risk.

(3) If the superintendent determines that the program has sufficient funding, after the fourth year of the operation of the I-Ohio reinsurance program, the program may reinsure basic, standard policies offered by insurers to individuals who represent a high-high risk in addition to those offered to individuals who represent low-high insurance risk and medium-high risk.

Sec. 3923.91. The superintendent of insurance shall use the fund created in section 5725.24 of the Revised Code to reinsure health insurance policies provided by health insuring corporations and sickness and accident insurers pursuant to sections 3923.85 to 3923.92 of the Revised Code.

Sec. 3923.92. (A) There is hereby created the I-Ohio reinsurance advisory board, consisting of seven members as follows:

(1) Three members appointed by the governor, two of whom shall have backgrounds in the health insurance industry and one of whom shall represent the department of insurance;

(2) Two members appointed by the speaker of the house of representatives, one of whom shall represent small businesses and one of whom shall be a consumer advocate with a background in health care issues;

(3) Two members appointed by the president of the senate, one of whom shall be an insurance underwriter and one of whom shall be a physician.

(B) Terms of office of each member of the board shall be three years. Vacancies shall be filled in the manner prescribed for the original appointment. A member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed shall hold office for the remainder of that term.

(C) The governor shall designate one of the members the governor appoints to the board to serve as chairperson of the board.

(D) The board shall meet at least four times annually. The chairperson shall call special meetings as needed or upon the request of four members.

(E) Members of the board shall serve without compensation, but may be reimbursed for reasonable and necessary expenses incurred in the discharge of their duties.

(F) The department of insurance shall provide the board with staff assistance as requested by the board.

(G) The board shall study all of the following and shall make reports to the governor and the general assembly in January and July of every year regarding the board's findings and the general activities of the board:

(1) The status and implementation of the I-Ohio reinsurance program;

(2) The impact of individuals that represent a high insurance risk on the small group market;

(3) Possible methods for implementing the I-Ohio reinsurance program in the small group market.

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

(A) "Actuarial certification" means a written statement prepared by a member of the American academy of actuaries, or by any other person acceptable to the superintendent of insurance, that states that, based upon the person's examination, a carrier offering health benefit plans to small employers is in compliance with sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code. "Actuarial certification" shall include a review of the appropriate records of, and the actuarial assumptions and methods used by, the carrier relative to establishing premium rates for the health benefit plans.

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

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

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

health insuring corporation for purposes of sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code.

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

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

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

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

equivalent self-insurance.

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

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

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

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

For purposes of this division, "enrollment date" means, with respect to an individual covered under a group health benefit plan, the date of enrollment of the individual in the plan or, if

earlier, the first day of the waiting period for such enrollment.

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

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

(2) For purposes of division ~~(N)~~(M)(1) of this section, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected the employer will employ on business days in the current calendar year. Any reference in division ~~(N)~~(M) of this section to an "employer" includes any predecessor of the employer. Except as otherwise specifically provided, provisions of sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code that apply to a small employer that has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this division.

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

Sec. 3924.02. (A) An individual or group health benefit plan is subject to sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code if it provides health care benefits covering at least two but no more than fifty employees of a small employer, and if it meets either of the following conditions:

(1) Any portion of the premium or benefits is paid by a small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium.

(2) The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for purposes of section 106 or 162 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

(B) Notwithstanding division (A) of this section, divisions (D), (E)(2), (F), and (G) of section 3924.03 of the Revised Code and section 3924.04 of the Revised Code do not apply to health benefit policies that are not sold to owners of small businesses as an employment benefit plan. Such policies shall clearly state that they are not being sold as an employment benefit plan and that the owner of the business is not responsible, either directly or indirectly, for paying the premium or benefits.

(C) Every health benefit plan offered or delivered by a carrier, other than a health insuring corporation, to a small employer is subject to sections 3923.23, 3923.231, 3923.232, 3923.233, and 3923.234 of the Revised Code and any other provision of the Revised Code that requires the reimbursement, utilization, or consideration of a specific category of a licensed or certified health care practitioner.

(D) Except as expressly provided in sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code, no health benefit plan offered to a small employer is subject to any of the following:

(1) Any law that would inhibit any carrier from contracting with providers or groups of providers with respect to health care services or benefits;

(2) Any law that would impose any restriction on the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan;

(3) Any law that would require any carrier to either include a specific provider or class of provider when contracting for health care services or benefits, or to exclude any class of provider that is generally authorized by statute to provide such care.

Sec. 3924.06. (A) Compliance with the underwriting and rating requirements contained in sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code shall be demonstrated through actuarial certification. Carriers offering health benefit plans to small employers shall file annually with the superintendent of insurance an actuarial certification stating that the underwriting and rating methods of the carrier do all of the following:

(1) Comply with accepted actuarial practices;

(2) Are uniformly applied to health benefit plans covering small employers;

(3) Comply with the applicable provisions of sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code.

(B) If a carrier has established a separate class of business for one or more small employer health care alliances in accordance with section 1731.09 of the Revised Code, this section shall apply in accordance with section 1731.09 of the Revised Code.

Sec. 3924.73. (A) As used in this section:

(1) "Health care insurer" means any person legally engaged in the business of providing sickness and accident insurance contracts in this state, a health insuring corporation organized under Chapter 1751. of the Revised Code, or any legal entity that is self-insured and provides health care benefits to its employees or members.

(2) "Small employer" has the same meaning as in section 3924.01 of the Revised Code.

(B)(1) Subject to division (B)(2) of this section, nothing in sections 3924.61 to 3924.74 of the Revised Code shall be construed to limit the rights, privileges, or protections of employees or small employers under sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code.

(2) If any account holder enrolls or applies to enroll in a policy or contract offered by a health care insurer providing sickness and accident coverage that is more comprehensive than, and has a deductible amount that is less than, the coverage and deductible amount of the policy under which the account holder currently is enrolled, the health care insurer to which the account holder applies may subject the account holder to the same medical review, waiting periods, and underwriting requirements to which the health care insurer generally subjects other enrollees or applicants, unless the account holder enrolls or applies to enroll during a designated period of open enrollment.

Sec. 4121.44. (A) The administrator of workers' compensation shall oversee the implementation of the Ohio workers' compensation qualified health plan system as established under section 4121.442 of the Revised Code.

(B) The administrator shall direct the implementation of the health partnership program administered by the bureau as set forth in section 4121.441 of the Revised Code. To implement the health

partnership program, the bureau:

(1) Shall certify one or more external vendors, which shall be known as "managed care organizations," to provide medical management and cost containment services in the health partnership program for a period of two years beginning on the date of certification, consistent with the standards established under this section;

(2) May recertify external vendors for additional periods of two years; and

(3) May integrate the certified vendors with bureau staff and existing bureau services for purposes of operation and training to allow the bureau to assume operation of the health partnership program at the conclusion of the certification periods set forth in division (B)(1) or (2) of this section.

(C) Any vendor selected shall demonstrate all of the following:

(1) Arrangements and reimbursement agreements with a substantial number of the medical, professional, and pharmacy providers currently being utilized by claimants.

(2) Ability to accept a common format of medical bill data in an electronic fashion from any provider who wishes to submit medical bill data in that form.

(3) A computer system able to handle the volume of medical bills and willingness to customize that system to the bureau's needs and to be operated by the vendor's staff, bureau staff, or some combination of both staffs.

(4) A prescription drug system where pharmacies on a statewide basis have access to the eligibility and pricing~~, at a discounted rate,~~ of all prescription drugs as established in a contract for pharmacy benefit management services and the payment

for reimbursement for prescription drugs negotiated and entered into by the office of pharmaceutical purchasing coordination under Chapter 185. of the Revised Code or as may otherwise be established by the administrator pursuant to sections 185.06 and 4121.441 of the Revised Code.

As used in this division, "prescription drug" has the same meaning as in section 185.01 of the Revised Code.

(5) A tracking system to record all telephone calls from claimants and providers regarding the status of submitted medical bills so as to be able to track each inquiry.

(6) Data processing capacity to absorb all of the bureau's medical bill processing or at least that part of the processing which the bureau arranges to delegate.

(7) Capacity to store, retrieve, array, simulate, and model in a relational mode all of the detailed medical bill data so that analysis can be performed in a variety of ways and so that the bureau and its governing authority can make informed decisions.

(8) Wide variety of software programs which translate medical terminology into standard codes, and which reveal if a provider is manipulating the procedures codes, commonly called "unbundling."

(9) Necessary professional staff to conduct, at a minimum, authorizations for treatment, medical necessity, utilization review, concurrent review, post-utilization review, and have the attendant computer system which supports such activity and measures the outcomes and the savings.

(10) Management experience and flexibility to be able to react quickly to the needs of the bureau in the case of required change in federal or state requirements.

(D)(1) Information contained in a vendor's application for certification in the health partnership program, and other

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

(2) Notwithstanding the restrictions imposed by division (D)(1) of this section, the governor, members of select or standing committees of the senate or house of representatives, the auditor of state, the attorney general, or their designees, pursuant to the authority granted in this chapter and Chapter 4123. of the Revised Code, may examine any vendor application or other information furnished to the bureau by the vendor. None of those individuals shall divulge any information secured in the exercise of that authority in respect to a vendor's application for certification or in respect to the business or other trade processes of any vendor to any person.

(E) On and after January 1, 2001, a vendor shall not be any insurance company holding a certificate of authority issued pursuant to Title XXXIX of the Revised Code or any health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code.

(F) The administrator may limit freedom of choice of health care provider or supplier by requiring, beginning with the period set forth in division (B)(1) or (2) of this section, that claimants shall pay an appropriate out-of-plan copayment for selecting a medical provider not within the health partnership program as provided for in this section.

(G) The administrator, six months prior to the expiration of the bureau's certification or recertification of the vendor or vendors as set forth in division (B)(1) or (2) of this section, may certify and provide evidence to the governor, the speaker of the house of representatives, and the president of the senate that the existing bureau staff is able to match or exceed the performance and outcomes of the external vendor or vendors and that the bureau should be permitted to internally administer the health partnership program upon the expiration of the certification or recertification as set forth in division (B)(1) or (2) of this section.

(H) The administrator shall establish and operate a bureau of workers' compensation health care data program. The administrator shall develop reporting requirements from all employees, employers and medical providers, medical vendors, and plans that participate in the workers' compensation system. The administrator shall do all of the following:

(1) Utilize the collected data to measure and perform comparison analyses of costs, quality, appropriateness of medical care, and effectiveness of medical care delivered by all components of the workers' compensation system.

(2) Compile data to support activities of the selected vendor or vendors and to measure the outcomes and savings of the health partnership program.

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

speaker of the house of representatives, and the president of the senate on the first day of each January and July, the measures of outcomes and savings of the health partnership program. The administrator shall protect the confidentiality of all proprietary pricing data.

(I) Any rehabilitation facility the bureau operates is eligible for inclusion in the Ohio workers' compensation qualified health plan system or the health partnership program under the same terms as other providers within health care plans or the program.

(J) In areas outside the state or within the state where no qualified health plan or an inadequate number of providers within the health partnership program exist, the administrator shall permit employees to use a nonplan or nonprogram health care provider and shall pay the provider for the services or supplies provided 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 on a fee schedule the administrator adopts.

(K) No health care provider, whether certified or not, shall charge, assess, or otherwise attempt to collect from an employee, employer, a managed care organization, or the bureau any amount for covered services or supplies that is in excess of the allowed amount paid by a managed care organization, the bureau, or a qualified health plan.

(L) The administrator shall permit any employer or group of employers who agree to abide by the rules adopted under this 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

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

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

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

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

(2) Prohibitions against discrimination against any category of health care providers;

(3) Procedures for reporting injuries to employers and the bureau by providers;

(4) Appropriate financial incentives to reduce service cost and insure proper system utilization without sacrificing the quality of service;

(5) Adequate methods of peer review, utilization review, quality assurance, and dispute resolution to prevent, and provide sanctions for, inappropriate, excessive or not medically necessary treatment;

(6) A timely and accurate method of collection of necessary information regarding medical and health care service and supply costs, quality, and utilization to enable the administrator to determine the effectiveness of the program;

(7) Provisions for necessary emergency medical treatment for an injury or occupational disease provided by a health care provider who is not part of the program;

(8) Discounted pricing for all in-patient and out-patient medical services~~,~~ and all professional services~~, and all pharmaceutical services~~;

(9) Discount pricing for the payment of or reimbursement for prescription drugs and the provision of pharmacy benefit management services that are in accordance with contracts negotiated and entered into by the office of pharmaceutical purchasing coordination under Chapter 185. of the Revised Code, or in accordance with lower pricing as allowed under section 185.06 of the Revised Code;

(10) Provisions for provider referrals, pre-admission and post-admission approvals, second surgical opinions, and other cost

management techniques;

~~(10)~~(11) Antifraud mechanisms;

~~(11)~~(12) Standards and criteria for the bureau to utilize in certifying or recertifying a health care provider or a vendor for participation in the health partnership program;

~~(12)~~(13) Standards and criteria for the bureau to utilize in penalizing or decertifying a health care provider or a vendor from participation in the health partnership program.

(B) The administrator shall implement the health partnership program according to the rules the administrator adopts under this section for the provision and payment of medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code.

Sec. 4123.29. (A) The administrator of workers' compensation, subject to the approval of the bureau of workers' compensation board of directors, shall do all of the following:

(1) Classify occupations or industries with respect to their degree of hazard and determine the risks of the different classes according to the categories the national council on compensation insurance establishes that are applicable to employers in this state;

(2) Fix the rates of premium of the risks of the classes based upon the total payroll in each of the classes of occupation or industry sufficiently large to provide a fund for the compensation provided for in this chapter and to maintain a state insurance fund from year to year. The administrator shall set the rates at a level that assures the solvency of the fund. Where the payroll cannot be obtained or, in the opinion of the

administrator, is not an adequate measure for determining the premium to be paid for the degree of hazard, the administrator may determine the rates of premium upon such other basis, consistent with insurance principles, as is equitable in view of the degree of hazard, and whenever in this chapter reference is made to payroll or expenditure of wages with reference to fixing premiums, the reference shall be construed to have been made also to such other basis for fixing the rates of premium as the administrator may determine under this section.

The administrator in setting or revising rates shall furnish to employers an adequate explanation of the basis for the rates set.

(3) Develop and make available to employers who are paying premiums to the state insurance fund alternative premium plans. Alternative premium plans shall include retrospective rating plans. The administrator may make available plans under which an advanced deposit may be applied against a specified deductible amount per claim.

(4)(a) Offer to insure the obligations of employers under this chapter under a plan that groups, for rating purposes, employers, and pools the risk of the employers within the group provided that the employers meet all of the following conditions:

(i) All of the employers within the group are members of an organization that has been in existence for at least two years prior to the date of application for group coverage;

(ii) The organization was formed for purposes other than that of obtaining group workers' compensation under this division;

(iii) The employers' business in the organization is substantially similar such that the risks which are grouped are substantially homogeneous;

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

members or the aggregate workers' compensation premiums of the members, as determined by the administrator, are expected to exceed one hundred fifty thousand dollars during the coverage period;

(v) The formation and operation of the group program in the organization will substantially improve accident prevention and claims handling for the employers in the group;

(vi) Each employer seeking to enroll in a group for workers' compensation coverage has an industrial insurance account in good standing with the bureau of workers' compensation such that at the time the agreement is processed no outstanding premiums, penalties, or assessments are due from any of the employers.

(b) If an organization sponsors more than one employer group to participate in group plans established under this section, that organization may submit a single application that supplies all of the information necessary for each group of employers that the organization wishes to sponsor.

(c) In providing employer group plans under division (A)(4) of this section, the administrator shall consider an employer group as a single employing entity for purposes of retrospective rating. No employer may be a member of more than one group for the purpose of obtaining workers' compensation coverage under this division.

(d) At the time the administrator revises premium rates pursuant to this section and section 4123.34 of the Revised Code, if the premium rate of an employer who participates in a group plan established under this section changes from the rate established for the previous year, the administrator, in addition to sending the invoice with the rate revision to that employer, shall send a copy of that invoice to the third-party administrator that administers the group plan for that employer's group.

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

(f) In no event shall division (A)(4) of this section be construed as granting to an employer status as a self-insuring employer.

(g) The administrator shall develop classifications of occupations or industries that are sufficiently distinct so as not to group employers in classifications that unfairly represent the risks of employment with the employer.

(5) Generally promote employer participation in the state insurance fund through the regular dissemination of information to all classes of employers describing the advantages and benefits of opting to make premium payments to the fund. To that end, the administrator shall regularly make employers aware of the various workers' compensation premium packages developed and offered pursuant to this section.

(6) Make available to every employer who is paying premiums to the state insurance fund a program whereby the employer or the employer's agent pays to the claimant or on behalf of the claimant the first fifteen thousand dollars of a compensable workers' compensation medical-only claim filed by that claimant that is related to the same injury or occupational disease. No formal application is required; however, an employer must elect to

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

(7) Offer a discount on an employer's premium to an employer

who participates in the Ohio health advantage program pursuant to section 4123.292 of the Revised Code.

(B) The administrator, with the advice and consent of the board, by rule, may do both of the following:

(1) Grant an employer who makes the employer's semiannual premium payment at least one month prior to the last day on which the payment may be made without penalty, a discount as the administrator fixes from time to time;

(2) Levy a minimum annual administrative charge upon risks where semiannual premium reports develop a charge less than the administrator considers adequate to offset administrative costs of processing.

Sec. 4123.292. (A) As used in this section, "qualifying health plan" means either of the following:

(1) A policy of group sickness and accident insurance that is offered by any person authorized under Title XXXIX of the Revised Code to engage in the business of insurance in this state, that provides coverage other than for specific diseases or accidents only, for hospital indemnity only, for supplemental medicare benefits only, or for any other supplemental benefits only, and that is delivered, issued for delivery, or renewed in this state;

(2) A policy, contract, or agreement that is offered by any health insuring corporation authorized under Chapter 1751. of the Revised Code to do business in this state and that covers basic health care services as defined in section 1751.01 of the Revised Code.

(B)(1) There is hereby created the Ohio health advantage program. Under the program, if an employer satisfies the applicable criteria described in division (C) or (D) of this section, an employer may receive the following discounts on the

employer's premium:

(a) Up to a five per cent discount on the employer's premium calculated in accordance with division (C) of this section if the employer establishes and maintains a health and wellness program for the employer's employees in accordance with that division, not to exceed the cost incurred by the employer for establishing and maintaining the program during the previous reporting period;

(b) A fifteen per cent discount on the employer's premium if the employer offers a qualifying health plan in accordance with division (D) of this section, not to exceed the cost incurred by the employer for providing the plan during the previous reporting period;

(c) Up to a twenty per cent discount if the employer establishes and maintains a health and wellness program for the employer's employees in accordance with division (C) of this section and offers a qualifying health plan in accordance with division (D) of this section, not to exceed the total cost incurred by the employer for establishing and maintaining the program and for providing the plan during the previous reporting period.

(2) An employer shall receive a discount provided under the program in addition to any other premium discount offered by the administrator of workers' compensation that the employer receives. An employer shall specify in the employer's application to participate in the program the cost incurred by the employer in establishing and maintaining the health and wellness program under division (C) of this section during the six months prior to the date the employer submits the employer's application, the cost incurred by the employer for providing a qualifying health plan under division (D) of this section, or both, as applicable. An employer who participates in the program shall include in the payroll report the employer must submit to the administrator in

accordance with section 4123.32 of the Revised Code and rules adopted by the administrator pursuant to that section the estimated cost of maintaining the health and wellness program, the estimated cost of providing a qualifying health plan, or both, as applicable, during that reporting period. The administrator shall apply any discount the employer receives pursuant to this section to the employer's premium each time the administrator calculates the employer's premium during the time period that the employer participates in the Ohio health advantage program.

(3) For purposes of division (B) of this section, "reporting period" means both of the following:

(a) For an employer who is applying to participate in the program, the time period beginning six months prior to the date the employer submits the employer's application and ending on the date the employer submits the application;

(b) For an employer who is participating in the program, the time period between payroll reports the employer submits to the administrator in accordance with section 4123.32 of the Revised Code and rules adopted by the administrator pursuant to that section.

(C)(1) The administrator and the director of health, with the advice and consent of the bureau of workers' compensation board of directors, jointly shall adopt rules in accordance with Chapter 119. of the Revised Code to establish a premium discount program for an employer who offers a health or wellness program described in division (C)(2) of this section to the employer's employees. The administrator and director shall include in the rules the administrator and director adopt pursuant to this division requirements an employer must satisfy to participate in the health and wellness premium discount program under the Ohio health advantage program, which shall include a requirement that an employer establish and maintain a program described in division

(C)(2) of this section. The administrator and director shall require in the rules they jointly adopt that an employer who participates in the premium discount program described in this division shall create and maintain documentation or other records to demonstrate that the employer is providing a program described in division (C)(2) of this section and shall specify in those rules the information that the employer must include in the documentation or records. The administrator and the director, one year after the program is created pursuant to this section, jointly may expand or limit the scope of the program.

(2) The administrator shall allow an employer who establishes and maintains at least one of the following programs for the employer's employees and satisfies all other requirements established by the administrator and director to participate in the health and wellness premium discount program under the Ohio health advantage program:

(a) A program that has received accreditation from the commission on accreditation of allied health education programs;

(b) A program that is administered by an individual who holds a certificate under Chapter 4731. of the Revised Code or who is licensed under Chapter 4759. of the Revised Code and that focuses on wellness, nutrition, smoking cessation, or diabetes management, or a similar program;

(c) A nutritional program that focuses on obesity, weight loss, diabetes management, and cholesterol reduction and that has received accreditation from the American dietetic association;

(d) A physical fitness program that is administered by an individual who has received credentials from the American college of sports medicine or who is certified by the national exercise trainers association or the aerobics and fitness association of America.

(3) The administrator shall use the following factors to determine what per cent, up to five, to discount the premium of an employer who participates in the health and wellness premium discount program under the Ohio health advantage program:

(a) Whether onsite programs described in division (C)(2) of this section are offered by an employer at the employer's place of business;

(b) The number of programs described in division (C)(2) of this section an employer offers to the employer's employees;

(c) The degree to which an employer facilitates employee access to fitness equipment and dietary options;

(d) Any other factors the administrator determines are relevant to the Ohio health advantage program.

An employer who participates in the health and wellness premium discount program under the Ohio health advantage program shall receive a discount on the employer's premium only after the employer has participated in the program for six consecutive months. An employer who participates in the health and wellness premium discount program shall allow employees of the bureau of workers' compensation, upon their request, to access the documentation or records that the employer creates and maintains to comply with rules the administrator and director jointly adopt pursuant to division (C)(1) of this section. Employees of the bureau may perform an audit of that documentation or those records to verify that the employer is providing a program described in division (C)(2) of this section to the employer's employees. The administrator shall prorate the discount for the first year the employer participates in this premium discount program, but after the first year the employer must participate in the program for a full year to receive a discount on the employer's premium for that year.

(D) The administrator, with the advice and consent of the board, shall adopt rules in accordance with Chapter 119. of the Revised Code to establish a premium discount program to encourage employers to provide a qualifying health plan to the employees that the employer employs on a full-time basis. The administrator shall allow an employer to participate in the qualifying health plan premium discount program under the Ohio health advantage program if the employer satisfies all of the following criteria:

(1) The employer, for a period of six consecutive months immediately preceding the date the employer applies to participate in the program, did not offer the employer's employees a qualifying health plan.

(2) The employer employs not less than two and not more than fifty employees within this state.

(3) The average annual compensation the employer pays the employer's employees is below forty-five thousand dollars.

(4) The employer's principal place of business is in this state.

(5) The employer has operated the employer's business in this state for at least six months prior to applying to participate in the program.

(6) The employer offers the employer's employees a qualifying health plan.

For purposes of determining the average annual compensation an employer pays the employer's employees, the administrator shall use the compensation paid that the employer reported on the most recent annual report of employee tax withheld that the employer filed in accordance with section 5747.07 of the Revised Code prior to applying to participate in the program and dividing that amount by the number of employees the employer employed during the period covered by that annual report.

An employer may participate in the qualifying health plan premium discount program under the Ohio health advantage program for a period of not more than three years beginning on the date the administrator approves the employer to participate in the program.

Sec. 4715.22. (A) ~~As~~ This section applies only when a licensed dental hygienist is not providing services under a collaboration agreement entered into under section 4715.222 of the Revised Code.

As used in this section, "health care facility" means either of the following:

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

(2) A "home" as defined in section 3721.01 of the Revised Code.

(B) A licensed dental hygienist shall practice under the supervision, order, control, and full responsibility of a dentist licensed under this chapter. A dental hygienist may practice in a dental office, public or private school, health care facility, dispensary, or public institution. Except as provided in division (C) or (D) of this section, a dental hygienist may not provide dental hygiene services to a patient when the supervising dentist is not physically present at the location where the dental hygienist is practicing.

(C) A dental hygienist may provide, for not more than fifteen consecutive business days, dental hygiene services to a patient when the supervising dentist is not physically present at the location at which the services are provided if all of the following requirements are met:

(1) The dental hygienist has at least two years and a minimum

of three thousand hours of experience in the practice of dental hygiene.

(2) The dental hygienist has successfully completed a course approved by the state dental board in the identification and prevention of potential medical emergencies.

(3) The dental hygienist complies with written protocols for emergencies the supervising dentist establishes.

(4) The dental hygienist does not perform, while the supervising dentist is absent from the location, procedures while the patient is anesthetized, definitive root planing, definitive subgingival curettage, or other procedures identified in rules the state dental board adopts.

(5) The supervising dentist has evaluated the dental hygienist's skills.

(6) The supervising dentist examined the patient not more than seven months prior to the date the dental hygienist provides the dental hygiene services to the patient.

(7) The dental hygienist complies with written protocols or written standing orders that the supervising dentist establishes.

(8) The supervising dentist completed and evaluated a medical and dental history of the patient not more than one year prior to the date the dental hygienist provides dental hygiene services to the patient and, except when the dental hygiene services are provided in a health care facility, the supervising dentist determines that the patient is in a medically stable condition.

(9) If the dental hygiene services are provided in a health care facility, a doctor of medicine and surgery or osteopathic medicine and surgery who holds a current certificate issued under Chapter 4731. of the Revised Code or a registered nurse licensed under Chapter 4723. of the Revised Code is present in the health

care facility when the services are provided.

(10) In advance of the appointment for dental hygiene services, the patient is notified that the supervising dentist will be absent from the location and that the dental hygienist cannot diagnose the patient's dental health care status.

(11) The dental hygienist is employed by, or under contract with, one of the following:

(a) The supervising dentist;

(b) A dentist licensed under this chapter who is one of the following:

(i) The employer of the supervising dentist;

(ii) A shareholder in a professional association formed under Chapter 1785. of the Revised Code of which the supervising dentist is a shareholder;

(iii) A member or manager of a limited liability company formed under Chapter 1705. of the Revised Code of which the supervising dentist is a member or manager;

(iv) A shareholder in a corporation formed under division (B) of section 1701.03 of the Revised Code of which the supervising dentist is a shareholder;

(v) A partner or employee of a partnership or a limited liability partnership formed under Chapter 1775. of the Revised Code of which the supervising dentist is a partner or employee.

(c) A government entity that employs the dental hygienist to provide dental hygiene services in a public school or in connection with other programs the government entity administers.

(D) A dental hygienist may provide dental hygiene services to a patient when the supervising dentist is not physically present at the location at which the services are provided if the services are provided as part of a dental hygiene program that is approved

by the state dental board and all of the following requirements are met:

(1) The program is operated through a school district board of education or the governing board of an educational service center; the board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code; a national, state, district, or local dental association; or any other public or private entity recognized by the state dental board.

(2) The supervising dentist is employed by or a volunteer for, and the patients are referred by, the entity through which the program is operated.

(3) The services are performed after examination and diagnosis by the dentist and in accordance with the dentist's written treatment plan.

(E) No person shall do either of the following:

(1) Practice dental hygiene in a manner that is separate or otherwise independent from the dental practice of a supervising dentist;

(2) Establish or maintain an office or practice that is primarily devoted to the provision of dental hygiene services.

(F) The state dental board shall adopt rules under division (C) of section 4715.03 of the Revised Code identifying procedures a dental hygienist may not perform when practicing in the absence of the supervising dentist pursuant to division (C) or (D) of this section.

Sec. 4715.221. As used in this section and sections 4715.222 to 4715.2210 of the Revised Code:

(A) "Collaboration agreement" means an agreement entered into by a dentist and a dental hygienist under section 4715.222 of the

Revised Code.

(B) "Dentist" means an individual licensed under this chapter to practice dentistry who is employed by, or under contract with, a public health facility.

(C) "Dental hygienist" means an individual licensed under this chapter to practice as a dental hygienist.

(D) "Institution of higher education" means a state institution of higher education as defined in section 3345.011 of the Revised Code, a private nonprofit college or university located in this state that possesses a certificate of authorization issued by the Ohio board of regents pursuant to Chapter 1713. of the Revised Code, or a school located in this state that possesses a certificate of registration and one or more program authorizations issued by the state board of career colleges and schools under Chapter 3332. of the Revised Code.

(E) "Patient" means an individual who receives dental hygiene services at a public health facility, a student enrolled in the facility at which the services are provided, or a resident of a facility at which the services are provided.

(F) "Public health facility" means any of the following:

(1) A "public school" or "nonpublic school" as defined in section 3701.93 of the Revised Code;

(2) A "health care facility" as defined in section 4715.22 of the Revised Code;

(3) A clinic or shelter financed with public or private funds;

(4) A comprehensive child development program that receives funds distributed under the "Head Start Act," 95 Stat. 499 (1981), 42 U.S.C. 9831, as amended, and is licensed as a child day-care center;

(5) A corporation, association, group, institution, society, or other organization that is exempt from federal taxation under section 501(c)(3) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 501(c)(3), as amended;

(6) A special needs program;

(7) A residential facility licensed under section 5123.19 of the Revised Code;

(8) A "hospice care program" as defined in section 3712.01 of the Revised Code.

(9) An institution of higher education.

(10) Any other health care facility operated by a governmental entity.

(11) A mobile dental unit located at any location listed in divisions (F)(1) to (10) of this section.

(G) "Special needs program" means a program operated by any of the following:

(1) A school district board of education or the governing board of an educational service center;

(2) The board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code;

(3) A national, state, district, or local dental association.

Sec. 4715.222. (A) A dental hygienist who has provided the evidence required by section 4715.223 of the Revised Code may enter into a collaboration agreement with a dentist under which the dentist authorizes all of the following:

(1) The dental hygienist to provide the services described in section 4715.224 of the Revised Code to patients at any public health facility without the dentist being physically present at

the facility where the services are provided;

(2) The dental hygienist to provide the services described in section 4715.224 of the Revised Code to patients without prior examination of the patients by the dentist or diagnosis or treatment plans approved by the dentist, unless otherwise specified in the collaboration agreement;

(3) The dental hygienist to work with dental assistants certified by the dental assisting national board or the Ohio commission on dental assistant certification who may perform only the duties they are authorized to provide without the direct supervision of a dentist.

(B) A collaboration agreement must meet the requirements of section 4715.225 of the Revised Code.

Sec. 4715.223. Prior to entering into a collaboration agreement, a dental hygienist shall do both of the following:

(A) Submit written evidence of all of the following to the dentist who is to be the collaborating dentist under the agreement:

(1) The dental hygienist has at least two years and a minimum of three thousand hours of experience in the practice of dental hygiene.

(2) The dental hygienist has successfully completed a course approved by the state dental board in the identification and prevention of potential medical emergencies and infection control.

(3) The dental hygienist holds current certification to perform basic life-support procedures as required under section 4715.251 of the Revised Code.

(4) The dental hygienist holds professional liability insurance.

(B) Permit the dentist who is to be the collaborating dentist under the agreement to personally observe the dental hygienist provide to patients the services described in section 4715.224 of the Revised Code.

Sec. 4715.224. A dental hygienist may provide the following services to a patient under a collaboration agreement:

(A) Oral health promotion and disease prevention education, including information gathering, screening, and assessment;

(B) Removal of calcareous deposits or accretions from the crowns and roots of teeth;

(C) Sulcular placement of prescribed materials;

(D) Polishing of the clinical crowns of teeth, including restorations;

(E) Standard diagnostic and radiological procedures for the purpose of contributing to the provision of dental services;

(F) Fluoride applications;

(G) Placement of sealants;

(H) Any other basic remediable intraoral dental task or procedure designated by the state dental board in rules adopted under section 4715.2210 of the Revised Code.

Sec. 4715.225. A collaboration agreement shall be in writing and do all of the following at a minimum:

(A) Contain the following terms:

(1) A procedure the dental hygienist must follow in securing the dentist's review of the patient's record and medical history if the dental hygienist believes the patient's condition is medically compromised;

(2) A procedure the dental hygienist must follow if the

dental hygienist believes the patient's condition presents an emergency dental condition;

(3) Practice protocols for the dental hygienist to follow in providing services to patients who are different ages and who require different procedures, including recommended intervals for the performance of dental hygiene services and a period of time in which an examination by a dentist should occur;

(4) Specific protocols for the placement of pit and fissure sealants and requirements for follow-up care to assure the efficacy of the sealants after application;

(5) A procedure for creating and maintaining dental records for patients that are treated by the dental hygienist. The procedure must specify where the records are to be located.

(6) Services specified under section 4715.224 of the Revised Code, if any, for which the dentist requires either or both of the following:

(a) The patient be examined by the dentist prior to the dental hygienist providing the services;

(b) The dentist to approve a patient-specific diagnosis or treatment plan.

(7) The number of patient visits for dental hygiene services, if any, that the dentist requires the dental hygienist to provide, on an annual basis, to patients in special needs programs for a charge determined according to the sliding fee scale established by the state dental board in rules adopted under section 4715.2210 of the Revised Code.

(8) A statement that the dentist and dental hygienist agree that the dental hygienist's provision of services under a collaboration agreement is neither of the following:

(a) The practice of dental hygiene in a manner that is

separate or otherwise independent from the dental practice of a collaborating dentist;

(b) The establishment or maintenance of an office or practice that is primarily devoted to the provision of dental hygiene services.

(B) Contain a blank copy of a consent to treatment form that the dental hygienist can use for purposes of complying with the requirement of section 4715.227 of the Revised Code;

(C) Be signed and dated by both the dentist and dental hygienist.

Sec. 4715.226. (A) A copy of a collaboration agreement must be maintained by the dentist and the dental hygienist who are parties to the agreement. The dental hygienist shall ensure that each public health facility where the dental hygienist provides services under a collaboration agreement has a copy of the agreement that the dental hygienist works under at that facility.

(B) Except as provided under division (C) of this section, prior approval of a collaboration agreement by the state dental board is not required before a dental hygienist provides services under an agreement, but the dentist or dental hygienist who is a party to the agreement must provide the board with a copy of the agreement on the board's request.

(C) A dentist shall not at any one time be a party to more than three collaboration agreements unless the state dental board determines that the dentist meets the criteria, established by the board in rules adopted under section 4715.2210 of the Revised Code, to be a party to more than three agreements.

Sec. 4715.227. Before performing any services on a patient under a collaboration agreement, a dental hygienist must provide the patient or patient's representative with a consent to

treatment form and secure the signature or mark of the patient or representative on it. The signature or mark may be provided through reasonable accommodation, including the use of assistive technology or augmentative devices.

The form must include a statement advising the patient that the dental hygiene services provided are not a substitute for a dental examination by a dentist, that a dentist will not be present during the provision of dental hygiene services, and that the dental hygienist cannot diagnose the patient's dental health care status.

Sec. 4715.228. Following the provision of services to a patient under a collaboration agreement, the dental hygienist shall refer the patient to the dentist who is the collaborating dentist under the agreement the dental hygienist is working under at the public health facility where the patient was treated. The dental hygienist shall give the patient or patient's representative a completed referral form that lists the name, office address, and office telephone of the collaborating dentist and the date the dental hygienist provided the services to the patient. The dental hygienist shall provide a copy of each completed referral form and the patient's record to the collaborating dentist.

Sec. 4715.229. A collaboration agreement entered into under section 4715.222 of the Revised Code may be terminated by the dentist or dental hygienist who entered into the agreement. A dentist or dental hygienist who terminates a collaboration agreement shall provide written notice to the opposite party. The dental hygienist shall not provide services under the agreement once notice of the termination has been given or sent to the dentist.

Sec. 4715.2210. The state dental board shall adopt rules to do all of the following:

(A) For purposes of division (H) of section 4715.224 of the Revised Code, designate the basic remediable intraoral dental tasks or procedures, in addition to the services listed in divisions (A) to (G) of section 4715.224 of the Revised Code, that a dental hygienist may provide under a collaboration agreement.

(B) For purposes of division (A)(7) of section 4715.225 of the Revised Code, establish a sliding fee scale that determines the fee a patient in a special needs program is charged for dental hygiene services provided by a dental hygienist under a collaboration agreement.

(C) For purposes of division (C) of section 4715.226 of the Revised Code, establish the criteria the board must use in determining whether a dentist can be a party to more than three collaboration agreements at one time.

Sec. 4715.23. Except when a dental hygienist is providing services under a collaboration agreement entered into under section 4715.222 of the Revised Code, all of the following apply with respect to the practice of a dental hygienist:

(A) The practice of a dental hygienist shall consist of those prophylactic, preventive, and other procedures that licensed dentists are authorized by this chapter and rules of the dental board to assign only to licensed dental hygienists or to qualified personnel under section 4715.39 of the Revised Code.

(B) Licensed dentists may assign to dental hygienists intraoral tasks that do not require the professional competence or skill of the licensed dentist and that are authorized by board rule. Such performance of intraoral tasks by dental hygienists shall be under supervision and full responsibility of the licensed

dentist, and at no time shall more than three dental hygienists be practicing clinical hygiene under the supervision of the same dentist. The foregoing shall not be construed as authorizing the assignment of diagnosis, treatment planning and prescription (including prescriptions for drugs and medicaments or authorizations for restorative, prosthodontic, or orthodontic appliances); or, except when done in conjunction with the removal of calcarious deposits, dental cement, or accretions on the crowns and roots of teeth, surgical procedures on hard and soft tissues within the oral cavity or any other intraoral procedure that contributes to or results in an irremediable alteration of the oral anatomy; or the making of final impressions from which casts are made to construct any dental restoration.

(C) The state dental board shall issue rules defining the procedures that may be performed by licensed dental hygienists engaged in school health activities or employed by public agencies.

Sec. 4715.39. (A) The state dental board may define the duties that may be performed by dental assistants and other individuals designated by the board as qualified personnel. If defined, the duties shall be defined in rules adopted in accordance with Chapter 119. of the Revised Code. The rules may include training and practice standards for dental assistants and other qualified personnel. The standards may include examination and issuance of a certificate. If the board issues a certificate, the recipient shall display the certificate in a conspicuous location in any office in which the recipient is employed to perform the duties authorized by the certificate.

(B) A dental assistant may polish the clinical crowns of teeth if all of the following requirements are met:

(1) The dental assistant's polishing activities are limited

to the use of a rubber cup attached to a slow-speed rotary dental hand piece to remove soft deposits that build up over time on the crowns of teeth.

(2) The polishing is performed only after a dentist has evaluated the patient and any calculus detected on the teeth to be polished has been removed by a dentist or dental hygienist.

(3) The dentist supervising the assistant supervises not more than two dental assistants engaging in polishing activities at any given time.

(4) The dental assistant is certified by the dental assisting national board or the Ohio commission on dental assistant certification.

(5) The dental assistant receives a certificate from the board authorizing the assistant to engage in the polishing activities. The board shall issue the certificate if the individual has successfully completed training in the polishing of clinical crowns through a program accredited by the American dental association commission on dental accreditation or equivalent training approved by the board. The training shall include courses in basic dental anatomy and infection control, followed by a course in coronal polishing that includes didactic, preclinical, and clinical training; any other training required by the board; and a skills assessment that includes successful completion of standardized testing. The board shall adopt rules pursuant to division (A) of this section establishing standards for approval of this training.

(C) A dental assistant may apply pit and fissure sealants if all of the following requirements are met:

(1) A dentist evaluates the patient and designates the teeth and surfaces that will benefit from the application of sealant on the day the application is to be performed.

(2) The dental assistant is certified by the dental assisting national board or the Ohio commission on dental assistant certification.

(3) The dental assistant has successfully completed a course in the application of sealants consisting of at least two hours of didactic instruction and six hours of clinical instruction through a program provided by an institution accredited by the American dental association commission on dental accreditation or a program provided by a sponsor of continuing education approved by the board.

(4) The dentist supervising the assistant has observed the assistant successfully apply at least six sealants.

(5) The dentist supervising the assistant checks and approves the application of all sealants placed by the assistant before the patient leaves the location where the sealant application procedure is performed.

(D) Subject to this section and the applicable rules of the board, licensed dentists may assign to dental assistants and other qualified personnel dental procedures that do not require the professional competence or skill of the licensed dentist, a dental hygienist, or an expanded function dental auxiliary as this section or the board by rule authorizes dental assistants and other qualified personnel to perform. The performance of dental procedures by dental assistants and other qualified personnel shall be under direct supervision and full responsibility of the licensed dentist.

(E) Nothing in this section shall be construed by rule of the state dental board or otherwise to do the following:

(1) Authorize dental assistants or other qualified personnel to engage in the practice of dental hygiene as defined by sections 4715.22 and 4715.23 of the Revised Code, to enter into a

collaboration agreement under section 4715.222 of the Revised Code, or to perform the duties of a dental hygienist, including the removal of calcarious deposits, dental cement, or accretions on the crowns and roots of teeth other than as authorized pursuant to this section;

(2) Authorize dental assistants or other qualified personnel to engage in the practice of an expanded function dental auxiliary as specified in section 4715.64 of the Revised Code or to perform the duties of an expanded function dental auxiliary other than as authorized pursuant to this section.

(3) Authorize the assignment of any of the following:

(a) Diagnosis;

(b) Treatment planning and prescription, including prescription for drugs and medicaments or authorization for restorative, prosthodontic, or orthodontic appliances;

(c) Surgical procedures on hard or soft tissue of the oral cavity, or any other intraoral procedure that contributes to or results in an irremediable alteration of the oral anatomy;

(d) The making of final impressions from which casts are made to construct any dental restoration.

(F) No dentist shall assign any dental assistant or other individual acting in the capacity of qualified personnel to perform any dental procedure that the assistant or other individual is not authorized by this section or by board rule to perform. No dental assistant or other individual acting in the capacity of qualified personnel shall perform any dental procedure other than in accordance with this section and any applicable board rule or any dental procedure that the assistant or other individual is not authorized by this section or by board rule to perform.

Sec. 4715.64. (A) The practice of an expanded function dental auxiliary shall consist of the following:

(1) The procedures involved in the placement of restorative materials limited to amalgam restorative materials and ~~non-metallic~~ nonmetallic restorative materials, including direct-bonded restorative materials;

(2) The procedures involved in the placement of sealants;

(3) Any additional procedures authorized by the state dental board in rules adopted under section 4715.66 of the Revised Code.

(B) An expanded function dental auxiliary shall practice under the direct supervision, order, control, and full responsibility of a dentist licensed under this chapter. At no time shall more than two expanded function dental auxiliaries be practicing as expanded function dental auxiliaries under the direct supervision of the same dentist. An expanded function dental auxiliary shall not practice as an expanded function dental auxiliary when the supervising dentist is not physically present at the location where the expanded function dental auxiliary is practicing.

(C) Nothing in this section shall be construed by rule of the board or otherwise to authorize an expanded function dental auxiliary to engage in the practice of dental hygiene as defined by sections 4715.22 and 4715.23 of the Revised Code or to enter into a collaboration agreement under section 4715.222 of the Revised Code.

Sec. 5101.90. There is hereby created the health insurance credit program in the department of job and family services. The department shall administer the program in accordance with sections 5101.91 to 5101.95 of the Revised Code.

Sec. 5101.91. As used in sections 5101.91 to 5101.95 of the Revised Code:

"Basic health care services" has the same meaning as in section 1751.01 of the Revised Code.

"Federal poverty guidelines" means the poverty guidelines as revised annually by the United States department of health and human services in accordance with section 673(2) of the "Omnibus Budget Reconciliation Act of 1981," 95 Stat. 511, 42 U.S.C. 9902, as amended, for a family size equal to the size of the family of the individual whose income is being determined.

"Health insurer" means a health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code or a sickness and accident insurer authorized under Title XXXIX of the Revised Code to do the business of sickness and accident coverage in this state. "Health insurer" does not include an entity that offers only plans with an annual deductible of not less than one thousand one hundred dollars for individual coverage and two thousand two hundred dollars for coverage of an individual and the individual's spouse.

Sec. 5101.92. To be eligible for the health insurance credit program, an applicant must meet all of the following requirements:

(A) Have been a resident of this state for at least six months prior to the date of application for the credit program and be at least eighteen years of age;

(B) Be ineligible for the medicaid program established under Chapter 5111. of the Revised Code, the medicare program established by Title XVIII of the "Social Security Act," 49 Stat. 620, 42 U.S.C. 301, as amended, and the disability medical assistance program established under section 5115.10 of the Revised Code;

(C) Have income in accordance with the following:

(1) For applications approved from July 1, 2009, through July 1, 2011, for a husband and wife, combined income above ninety per cent and not exceeding one hundred per cent of the federal poverty guidelines;

(2) For applications approved from July 1, 2009, through July 1, 2011, for an individual, income above sixty-five per cent and not exceeding one hundred per cent of the federal poverty guidelines;

(3) For applications approved after July 1, 2011, for a husband and wife, combined income above ninety per cent and not exceeding one hundred twenty-five per cent of the federal poverty guidelines;

(4) For applications approved after July 1, 2011, for an individual, income above sixty-five per cent and not exceeding one hundred twenty-five per cent of the federal poverty guidelines.

(D) In the six months prior to the date of application, not have been provided health insurance coverage by the applicant's employer or the employer of a family member of the applicant;

(E) Meet any other requirement established by the department of job and family services in rules adopted under section 5101.95 of the Revised Code.

An individual may apply or reapply on behalf of the individual and the individual's spouse. The guardian or custodian of an individual may apply or reapply on behalf of the individual. Application and annual reapplication for the program shall be in accordance with rules adopted by the department of job and family services under section 5101.95 of the Revised Code. The application shall require the applicant to indicate the health insurer to whom the credit is to be paid.

Sec. 5101.93. On receipt of applications or reapplications for the health insurance credit program, the department of job and family services shall make eligibility determinations in accordance with rules adopted under section 5101.95 of the Revised Code. Each determination that an applicant is eligible is valid for one year beginning on a date determined in accordance with the eligibility determination procedures. The beginning date shall not precede the date on which the applicant's eligibility is determined. An eligibility determination under this section is final and may not be appealed under Chapter 119. or any section of the Revised Code.

Sec. 5101.94. The department of job and family services shall pay a credit from the health insurance credit fund created under section 5725.24 of the Revised code to the health insurer indicated on behalf of each credit program recipient. The credit amount shall be four thousand dollars annually for a husband and wife and twenty-five hundred dollars annually for an individual. The credit shall go towards paying the premium on a health insurance plan that provides, at minimum, basic health care services.

Any amount of money that exceeds the amount necessary to pay the recipient's annual premium shall be credited to an individual account created on behalf of the recipient or the recipient and spouse, to be administered by the health insurer. The individual account may be used to pay any copayment or deductible amounts the credit program recipient or spouse may accrue. Any funds unused at the end of the year shall be refunded by the health insurer to the department.

Sec. 5101.95. In accordance with Chapter 119. of the Revised Code, the department of job and family services shall adopt rules

establishing all of the following:

(A) Application procedures for the health insurance credit program;

(B) Any eligibility requirements in addition to those specified in section 5101.92 of the Revised Code;

(C) Eligibility determination procedures;

(D) The number of credits available to individuals, and to husbands and wives who apply jointly, from the money allocated for the health insurance credit program in the health insurance credit fund created under section 5725.24 of the Revised Code;

(E) Any other requirements or procedures the department considers necessary to implement the health insurance credit program.

Sec. 5111.162. (A) As used in this section:

(1) "Emergency services" has the same meaning as in section 1932(b)(2) of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396u-2(b)(2), as amended.

(2) "Medicaid managed care organization" means a managed care organization that has entered into a contract with the department of job and family services pursuant to section 5111.17 of the Revised Code.

(B) ~~Except as provided in division (C) of this section, when~~ When a participant in the care management system established under section 5111.16 of the Revised Code is enrolled in a medicaid managed care organization and the organization refers the participant to receive services, other than emergency services provided on or after January 1, 2007, at a hospital that participates in the medicaid program but is not under contract with the organization, the hospital shall provide the service for

which the referral was made and shall accept from the organization, as payment in full, ninety-five per cent of the amount derived from the reimbursement rate used by the department to reimburse other hospitals of the same type for providing the same service to a medicaid recipient who is not enrolled in a medicaid managed care organization.

(C) ~~A hospital is not subject to division (B) of this section if all of the following are the case:~~

~~(1) The hospital is located in a county in which participants in the care management system are required before January 1, 2006, to be enrolled in a medicaid managed care organization that is a health insuring corporation;~~

~~(2) The hospital has entered into a contract before January 1, 2006, with at least one health insuring corporation serving the participants specified in division (C)(1) of this section;~~

~~(3) The hospital remains under contract with at least one health insuring corporation serving participants in the care management system who are required to be enrolled in a health insuring corporation.~~

~~(D)~~ The director of job and family services shall adopt rules specifying the circumstances under which a medicaid managed care organization is permitted to refer a participant in the care management system to a hospital that is not under contract with the organization. The director may adopt any other rules necessary to implement this section. All rules adopted under this section shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 5112.08. (A) As used in this section:

(1) "Medicaid managed care contract" means a contract between a hospital and a medicaid managed care organization under which

the hospital is to provide services covered by the contract to medicaid recipients enrolled in the medicaid managed care organization and be paid by the medicaid managed care organization for the services in accordance with the terms of the contract.

(2) "Medicaid managed care organization" means a managed care organization that is under contract with the department of job and family services under section 5111.17 of the Revised Code to provide, or arrange for the provision of, health care services to medicaid recipients who are required or permitted to obtain health care services through managed care organizations as part of the care management system established under section 5111.16 of the Revised Code.

(3) "Medicaid managed care region" means a group of counties that the department of job and family services treats as a specific region of the state for the purpose of the care management system established under section 5111.16 of the Revised Code.

(B) The director of job and family services shall adopt rules under section 5112.03 of the Revised Code establishing a methodology to pay hospitals that is sufficient to expend all money in the indigent care pool. Under the rules:

~~(A)~~(1) The department of job and family services may classify similar hospitals into groups and allocate funds for distribution within each group.

~~(B)~~(2) The department shall establish a method of allocating funds to hospitals, taking into consideration the relative amount of indigent care provided by each hospital or group of hospitals. The amount to be allocated shall be based on any combination of the following indicators of indigent care that the director considers appropriate:

~~(1)~~(a) Total costs, volume, or proportion of services to

recipients of the medical assistance program, including recipients enrolled in health insuring corporations;

~~(2)~~(b) Total costs, volume, or proportion of services to low-income patients in addition to recipients of the medical assistance program, which may include recipients of Title V of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and recipients of financial or medical assistance provided under Chapter 5115. of the Revised Code;

~~(3)~~(c) The amount of uncompensated care provided by the hospital or group of hospitals;

~~(4)~~(d) Other factors that the director considers to be appropriate indicators of indigent care.

~~(C)~~(3) The department shall distribute funds to each hospital or group of hospitals in a manner that first may provide for an additional distribution to individual hospitals that provide a high proportion of indigent care in relation to the total care provided by the hospital or in relation to other hospitals. The department shall establish a formula to distribute the remainder of the funds. The formula shall be consistent with section 1923 of the "Social Security Act," 42 U.S.C.A. 1396r-4, as amended, and shall be based on any combination of the indicators of indigent care listed in division (B)(2) of this section that the director considers appropriate.

~~(D)~~(4) A disproportionate share hospital may receive, for a program year, more funds from the indigent care pool than exceeds the minimum necessary to satisfy 42 U.S.C. 1396r-4 only if the hospital has, for that program year, a valid medicaid managed care contract with each medicaid managed care organization that provides, or arranges for the provision of, health care services to medicaid recipients who reside in the medicaid managed care region in which the hospital is located.

(5) A hospital that is not a disproportionate share hospital may not receive any funds from the indigent care pool for a program year unless the hospital has, for that program year, a valid medicaid managed care contract with each medicaid managed care organization that provides, or arranges for the provision of, health care services to medicaid recipients who reside in the medicaid managed care region in which the hospital is located.

(6) The department shall distribute funds to each hospital in installments not later than ten working days after the deadline established in rules for each hospital to pay an installment on its assessment under section 5112.06 of the Revised Code. In the case of a governmental hospital that makes intergovernmental transfers, the department shall pay an installment under this section not later than ten working days after the earlier of that deadline or the deadline established in rules for the governmental hospital to pay an installment on its intergovernmental transfer. If the amount in the hospital care assurance program fund created under section 5112.18 of the Revised Code and the portion of the health care - federal fund created under section 5111.943 of the Revised Code that is credited to that fund pursuant to division (B) of section 5112.18 of the Revised Code are insufficient to make the total distributions for which hospitals are eligible to receive in any period, the department shall reduce the amount of each distribution by the percentage by which the amount and portion are insufficient. The department shall distribute to hospitals any amounts not distributed in the period in which they are due as soon as moneys are available in the funds.

Sec. 5120.052. (A) As used in this section, "clinic" means a federally qualified health center as that entity is defined under the "Social Security Act," 120 Stat. 4, 42 U.S.C. 1395x, as amended.

(B) The department of rehabilitation and correction shall enter into an agreement with one or more clinics to have the clinics provide health care services, including prescription drug services, to inmates of state correctional institutions.

(C) Division (B) of this section does not apply to an institution if no clinic operates in the county in which the institution is located.

Sec. 5139.031. (A) As used in this section, "clinic" means a federally qualified health center as that entity is defined under the "Social Security Act," 120 Stat. 4, 42 U.S.C. 1395x, as amended.

(B) The department of youth services shall enter into an agreement with one or more clinics to have the clinics provide health care services, including prescription drug services, to delinquent children residing in training or rehabilitation institutions or facilities.

(C) Division (B) of this section does not apply to an institution or facility if no clinic operates in the county in which the institution or facility is located.

Sec. 5725.24. (A) As used in this section, "qualifying dealer" means a dealer in intangibles that is a qualifying dealer in intangibles as defined in section 5733.45 of the Revised Code or a member of a qualifying controlled group, as defined in section 5733.04 of the Revised Code, of which an insurance company also is a member on the first day of January of the year in and for which the tax imposed by section 5707.03 of the Revised Code is required to be paid by the dealer.

(B) The taxes levied by section 5725.18 of the Revised Code and collected pursuant to this chapter shall be paid into the ~~state treasury to the credit of the general revenue fund~~ health

insurance credit fund, which is hereby created in the state treasury. Money in the fund shall be used exclusively to support the programs established in sections 3923.86 and 5101.90 of the Revised Code. Fifty per cent of the funds shall be allocated to the health insurance credit program established in section 5101.90 of the Revised Code, and forty per cent of the funds shall be allocated to the I-Ohio reinsurance program established in section 3923.86 of the Revised Code.

(C) The taxes levied by section 5707.03 of the Revised Code on the value of shares in and capital employed by dealers in intangibles other than those that are qualifying dealers shall be for the use of the general revenue fund of the state and the local government funds of the several counties in which the taxes originate as provided in this division.

During each month for which there is money in the state treasury for disbursement under this division, the tax commissioner shall provide for payment to the county treasurer of each county of five-eighths of the amount of the taxes collected on account of shares in and capital employed by dealers in intangibles other than those that are qualifying dealers, representing capital employed in the county. The balance of the money received and credited on account of taxes assessed on shares in and capital employed by such dealers in intangibles shall be credited to the general revenue fund.

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

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

have their offices.

Money received into the treasury of a county pursuant to this section shall be credited to the undivided local government fund of the county and shall be distributed by the budget commission as provided by law.

(D) All of the taxes levied under section 5707.03 of the Revised Code on the value of the shares in and capital employed by dealers in intangibles that are qualifying dealers shall be paid into the state treasury to the credit of the general revenue fund.

Sec. 5729.03. (A) If the superintendent of insurance finds the annual statement required by section 5729.02 of the Revised Code to be correct, the superintendent shall compute the following amount, as applicable, of the balance of such gross amount, after deducting such return premiums and considerations received for reinsurance, and charge such amount to such company as a tax upon the business done by it in this state for the period covered by such annual statement:

(1) If the company is a health insuring corporation, one per cent of the balance of premium rate payments received, exclusive of payments received under the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or pursuant to the medical assistance program established under Chapter 5111. of the Revised Code, as reflected in its annual report;

(2) If the company is not a health insuring corporation, one and four-tenths per cent of the balance of premiums received, exclusive of premiums received under the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or pursuant to the medical assistance program established under Chapter 5111. of the Revised Code, as reflected in its annual statement, and, if the

company operates a health insuring corporation as a line of business, one per cent of the balance of premium rate payments received from that line of business, exclusive of payments received under the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or pursuant to the medical assistance program established under Chapter 5111. of the Revised Code, as reflected in its annual statement.

(B) Any insurance policies that were not issued in violation of Title XXXIX of the Revised Code and that were issued prior to April 15, 1967, by a life insurance company organized and operated without profit to any private shareholder or individual, exclusively for the purpose of aiding educational or scientific institutions organized and operated without profit to any private shareholder or individual, are not subject to the tax imposed by this section. All taxes collected pursuant to this section shall be credited to the ~~general revenue fund~~ health insurance credit fund created by section 5725.24 of the Revised Code.

(C) In no case shall the tax imposed under this section be less than two hundred fifty dollars.

Sec. 5747.01. Except as otherwise expressly provided or clearly appearing from the context, any term used in this chapter that is not otherwise defined in this section has the same meaning as when used in a comparable context in the laws of the United States relating to federal income taxes or if not used in a comparable context in those laws, has the same meaning as in section 5733.40 of the Revised Code. Any reference in this chapter to the Internal Revenue Code includes other laws of the United States relating to federal income taxes.

As used in this chapter:

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

means federal adjusted gross income, as defined and used in the Internal Revenue Code, adjusted as provided in this section:

(1) Add interest or dividends on obligations or securities of any state or of any political subdivision or authority of any state, other than this state and its subdivisions and authorities.

(2) Add interest or dividends on obligations of any authority, commission, instrumentality, territory, or possession of the United States to the extent that the interest or dividends are exempt from federal income taxes but not from state income taxes.

(3) Deduct interest or dividends on obligations of the United States and its territories and possessions or of any authority, commission, or instrumentality of the United States to the extent that the interest or dividends are included in federal adjusted gross income but exempt from state income taxes under the laws of the United States.

(4) Deduct disability and survivor's benefits to the extent included in federal adjusted gross income.

(5) Deduct benefits under Title II of the Social Security Act and tier 1 railroad retirement benefits to the extent included in federal adjusted gross income under section 86 of the Internal Revenue Code.

(6) In the case of a taxpayer who is a beneficiary of a trust that makes an accumulation distribution as defined in section 665 of the Internal Revenue Code, add, for the beneficiary's taxable years beginning before 2002, the portion, if any, of such distribution that does not exceed the undistributed net income of the trust for the three taxable years preceding the taxable year in which the distribution is made to the extent that the portion was not included in the trust's taxable income for any of the trust's taxable years beginning in 2002 or thereafter.

"Undistributed net income of a trust" means the taxable income of the trust increased by (a)(i) the additions to adjusted gross income required under division (A) of this section and (ii) the personal exemptions allowed to the trust pursuant to section 642(b) of the Internal Revenue Code, and decreased by (b)(i) the deductions to adjusted gross income required under division (A) of this section, (ii) the amount of federal income taxes attributable to such income, and (iii) the amount of taxable income that has been included in the adjusted gross income of a beneficiary by reason of a prior accumulation distribution. Any undistributed net income included in the adjusted gross income of a beneficiary shall reduce the undistributed net income of the trust commencing with the earliest years of the accumulation period.

(7) Deduct the amount of wages and salaries, if any, not otherwise allowable as a deduction but that would have been allowable as a deduction in computing federal adjusted gross income for the taxable year, had the targeted jobs credit allowed and determined under sections 38, 51, and 52 of the Internal Revenue Code not been in effect.

(8) Deduct any interest or interest equivalent on public obligations and purchase obligations to the extent that the interest or interest equivalent is included in federal adjusted gross income.

(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.

(10) Deduct or add amounts, as provided under section 5747.70 of the Revised Code, related to contributions to variable college savings program accounts made or tuition units purchased pursuant to Chapter 3334. of the Revised Code.

~~(11)(a) Deduct, to the extent not otherwise allowable as a deduction or exclusion in computing federal or Ohio adjusted gross income for the taxable year, the amount the taxpayer paid during the taxable year for medical care insurance and qualified long-term care insurance for the taxpayer, the taxpayer's spouse, and dependents. No deduction for medical care insurance under division (A)(11) of this section shall be allowed either to any taxpayer who is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the taxpayer's spouse, or to any taxpayer who is entitled to, or on application would be entitled to, benefits under part A of Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended. For the purposes of division (A)(11)(a) of this section, "subsidized health plan" means a health plan for which the employer pays any portion of the plan's cost. The deduction allowed under division (A)(11)(a) of this section shall be the net of any related premium refunds, related premium reimbursements, or related insurance premium dividends received during the taxable year.~~

~~(b)~~ Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income during the taxable year, the amount the taxpayer paid during the taxable year, not compensated for by any insurance or otherwise, for medical care of the taxpayer, the taxpayer's spouse, and dependents, to the extent the expenses exceed seven and one-half per cent of the taxpayer's federal adjusted gross income.

~~(c)~~(b) For purposes of division (A)(11) of this section~~,~~ ~~"medical~~:

(i) ~~"~~Medical care" has the meaning given in section 213 of the Internal Revenue Code, subject to the special rules, limitations, and exclusions set forth therein~~, and "qualified long-term care" has the same meaning given in section 7702B(c) of~~

~~the Internal Revenue Code~~.

(ii) "Dependent" has the same meaning as in division (O) of this section except that it also includes a child who meets all of the following conditions:

(I) As of the close of the calendar year in which the taxpayer's taxable year begins, the child has attained twenty-four years of age but has not attained thirty years of age.

(II) The child is a resident of Ohio or a full-time student at an accredited public or private institution of higher education.

(III) The child is not employed by an employer that offers the child any health benefit plan.

(12)(a) Deduct any amount included in federal adjusted gross income solely because the amount represents a reimbursement or refund of expenses that in any year the taxpayer had deducted as an itemized deduction pursuant to section 63 of the Internal Revenue Code and applicable United States department of the treasury regulations. The deduction otherwise allowed under division (A)(12)(a) of this section shall be reduced to the extent the reimbursement is attributable to an amount the taxpayer deducted under this section in any taxable year.

(b) Add any amount not otherwise included in Ohio adjusted gross income for any taxable year to the extent that the amount is attributable to the recovery during the taxable year of any amount deducted or excluded in computing federal or Ohio adjusted gross income in any taxable year.

(13) Deduct any portion of the deduction described in section 1341(a)(2) of the Internal Revenue Code, for repaying previously reported income received under a claim of right, that meets both of the following requirements:

(a) It is allowable for repayment of an item that was included in the taxpayer's adjusted gross income for a prior taxable year and did not qualify for a credit under division (A) or (B) of section 5747.05 of the Revised Code for that year;

(b) It does not otherwise reduce the taxpayer's adjusted gross income for the current or any other taxable year.

(14) Deduct an amount equal to the deposits made to, and net investment earnings of, a medical savings account during the taxable year, in accordance with section 3924.66 of the Revised Code. The deduction allowed by division (A)(14) of this section does not apply to medical savings account deposits and earnings otherwise deducted or excluded for the current or any other taxable year from the taxpayer's federal adjusted gross income.

(15)(a) Add an amount equal to the funds withdrawn from a medical savings account during the taxable year, and the net investment earnings on those funds, when the funds withdrawn were used for any purpose other than to reimburse an account holder for, or to pay, eligible medical expenses, in accordance with section 3924.66 of the Revised Code;

(b) Add the amounts distributed from a medical savings account under division (A)(2) of section 3924.68 of the Revised Code during the taxable year.

(16) Add any amount claimed as a credit under section 5747.059 of the Revised Code to the extent that such amount satisfies either of the following:

(a) The amount was deducted or excluded from the computation of the taxpayer's federal adjusted gross income as required to be reported for the taxpayer's taxable year under the Internal Revenue Code;

(b) The amount resulted in a reduction of the taxpayer's federal adjusted gross income as required to be reported for any

of the taxpayer's taxable years under the Internal Revenue Code.

(17) Deduct the amount contributed by the taxpayer to an individual development account program established by a county department of job and family services pursuant to sections 329.11 to 329.14 of the Revised Code for the purpose of matching funds deposited by program participants. On request of the tax commissioner, the taxpayer shall provide any information that, in the tax commissioner's opinion, is necessary to establish the amount deducted under division (A)(17) of this section.

(18) Beginning in taxable year 2001 but not for any taxable year beginning after December 31, 2005, if the taxpayer is married and files a joint return and the combined federal adjusted gross income of the taxpayer and the taxpayer's spouse for the taxable year does not exceed one hundred thousand dollars, or if the taxpayer is single and has a federal adjusted gross income for the taxable year not exceeding fifty thousand dollars, deduct amounts paid during the taxable year for qualified tuition and fees paid to an eligible institution for the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer, who is a resident of this state and is enrolled in or attending a program that culminates in a degree or diploma at an eligible institution. The deduction may be claimed only to the extent that qualified tuition and fees are not otherwise deducted or excluded for any taxable year from federal or Ohio adjusted gross income. The deduction may not be claimed for educational expenses for which the taxpayer claims a credit under section 5747.27 of the Revised Code.

(19) Add any reimbursement received during the taxable year of any amount the taxpayer deducted under division (A)(18) of this section in any previous taxable year to the extent the amount is not otherwise included in Ohio adjusted gross income.

(20)(a)(i) Add five-sixths of the amount of depreciation expense allowed by subsection (k) of section 168 of the Internal

Revenue Code, including the taxpayer's proportionate or distributive share of the amount of depreciation expense allowed by that subsection to a pass-through entity in which the taxpayer has a direct or indirect ownership interest.

(ii) Add five-sixths of the amount of qualifying section 179 depreciation expense, including a person's proportionate or distributive share of the amount of qualifying section 179 depreciation expense allowed to any pass-through entity in which the person has a direct or indirect ownership. For the purposes of this division, "qualifying section 179 depreciation expense" means the difference between (I) the amount of depreciation expense directly or indirectly allowed to the taxpayer under section 179 of the Internal Revenue Code, and (II) the amount of depreciation expense directly or indirectly allowed to the taxpayer under section 179 of the Internal Revenue Code as that section existed on December 31, 2002.

The tax commissioner, under procedures established by the commissioner, may waive the add-backs related to a pass-through entity if the taxpayer owns, directly or indirectly, less than five per cent of the pass-through entity.

(b) Nothing in division (A)(20) of this section shall be construed to adjust or modify the adjusted basis of any asset.

(c) To the extent the add-back required under division (A)(20)(a) of this section is attributable to property generating nonbusiness income or loss allocated under section 5747.20 of the Revised Code, the add-back shall be situsedto the same location as the nonbusiness income or loss generated by the property for the purpose of determining the credit under division (A) of section 5747.05 of the Revised Code. Otherwise, the add-back shall be apportioned, subject to one or more of the four alternative methods of apportionment enumerated in section 5747.21 of the Revised Code.

(d) For the purposes of division (A) of this section, net operating loss carryback and carryforward shall not include five-sixths of the allowance of any net operating loss deduction carryback or carryforward to the taxable year to the extent such loss resulted from depreciation allowed by section 168(k) of the Internal Revenue Code and by the qualifying section 179 depreciation expense amount.

(21)(a) If the taxpayer was required to add an amount under division (A)(20)(a) of this section for a taxable year, deduct one-fifth of the amount so added for each of the five succeeding taxable years.

(b) If the amount deducted under division (A)(21)(a) of this section is attributable to an add-back allocated under division (A)(20)(c) of this section, the amount deducted shall be situsedto the same location. Otherwise, the add-back shall be apportioned using the apportionment factors for the taxable year in which the deduction is taken, subject to one or more of the four alternative methods of apportionment enumerated in section 5747.21 of the Revised Code.

(c) No deduction is available under division (A)(21)(a) of this section with regard to any depreciation allowed by section 168(k) of the Internal Revenue Code and by the qualifying section 179 depreciation expense amount to the extent that such depreciation resulted in or increased a federal net operating loss carryback or carryforward to a taxable year to which division (A)(20)(d) of this section does not apply.

(22) Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income for the taxable year, the amount the taxpayer received during the taxable year as reimbursement for life insurance premiums under section 5919.31 of the Revised Code.

(23) Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income for the taxable year, the amount the taxpayer received during the taxable year as a death benefit paid by the adjutant general under section 5919.33 of the Revised Code.

(24) Deduct, to the extent included in federal adjusted gross income and not otherwise allowable as a deduction or exclusion in computing federal or Ohio adjusted gross income for the taxable year, military pay and allowances received by the taxpayer during the taxable year for active duty service in the United States army, air force, navy, marine corps, or coast guard or reserve components thereof or the national guard. The deduction may not be claimed for military pay and allowances received by the taxpayer while the taxpayer is stationed in this state.

(25) Deduct, to the extent not otherwise allowable as a deduction or exclusion in computing federal or Ohio adjusted gross income for the taxable year and not otherwise compensated for by any other source, the amount of qualified organ donation expenses incurred by the taxpayer during the taxable year, not to exceed ten thousand dollars. A taxpayer may deduct qualified organ donation expenses only once for all taxable years beginning with taxable years beginning in 2007.

For the purposes of division (A)(25) of this section:

(a) "Human organ" means all or any portion of a human liver, pancreas, kidney, intestine, or lung, and any portion of human bone marrow.

(b) "Qualified organ donation expenses" means travel expenses, lodging expenses, and wages and salary forgone by a taxpayer in connection with the taxpayer's donation, while living, of one or more of the taxpayer's human organs to another human being.

(26) Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income for the taxable year, amounts received by the taxpayer as retired military personnel pay for service in the United States army, navy, air force, coast guard, or marine corps or reserve components thereof, or the national guard. If the taxpayer receives income on account of retirement paid under the federal civil service retirement system or federal employees retirement system, or under any successor retirement program enacted by the congress of the United States that is established and maintained for retired employees of the United States government, and such retirement income is based, in whole or in part, on credit for the taxpayer's military service, the deduction allowed under this division shall include only that portion of such retirement income that is attributable to the taxpayer's military service, to the extent that portion of such retirement income is otherwise included in federal adjusted gross income and is not otherwise deducted under this section. Any amount deducted under division (A)(26) of this section is not included in the taxpayer's adjusted gross income for the purposes of section 5747.055 of the Revised Code. No amount may be deducted under division (A)(26) of this section on the basis of which a credit was claimed under section 5747.055 of the Revised Code.

(27) Deduct, to the extent not otherwise deducted or excluded in computing federal or Ohio adjusted gross income for the taxable year, income that would have been excluded from federal adjusted gross income under section 106 of the Internal Revenue Code but for the fact that the taxpayer's child met the conditions set forth in divisions (A)(11)(b)(iii)(I) to (A)(11)(b)(iii)(III) of this section.

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

course of a trade or business and includes income, gain, or loss from real property, tangible property, and intangible property if the acquisition, rental, management, and disposition of the property constitute integral parts of the regular course of a trade or business operation. "Business income" includes income, including gain or loss, from a partial or complete liquidation of a business, including, but not limited to, gain or loss from the sale or other disposition of goodwill.

(C) "Nonbusiness income" means all income other than business income and may include, but is not limited to, compensation, rents and royalties from real or tangible personal property, capital gains, interest, dividends and distributions, patent or copyright royalties, or lottery winnings, prizes, and awards.

(D) "Compensation" means any form of remuneration paid to an employee for personal services.

(E) "Fiduciary" means a guardian, trustee, executor, administrator, receiver, conservator, or any other person acting in any fiduciary capacity for any individual, trust, or estate.

(F) "Fiscal year" means an accounting period of twelve months ending on the last day of any month other than December.

(G) "Individual" means any natural person.

(H) "Internal Revenue Code" means the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

(I) "Resident" means any of the following, provided that division (I)(3) of this section applies only to taxable years of a trust beginning in 2002 or thereafter:

(1) An individual who is domiciled in this state, subject to section 5747.24 of the Revised Code;

(2) The estate of a decedent who at the time of death was domiciled in this state. The domicile tests of section 5747.24 of

the Revised Code are not controlling for purposes of division (I)(2) of this section.

(3) A trust that, in whole or part, resides in this state. If only part of a trust resides in this state, the trust is a resident only with respect to that part.

For the purposes of division (I)(3) of this section:

(a) A trust resides in this state for the trust's current taxable year to the extent, as described in division (I)(3)(d) of this section, that the trust consists directly or indirectly, in whole or in part, of assets, net of any related liabilities, that were transferred, or caused to be transferred, directly or indirectly, to the trust by any of the following:

(i) A person, a court, or a governmental entity or instrumentality on account of the death of a decedent, but only if the trust is described in division (I)(3)(e)(i) or (ii) of this section;

(ii) A person who was domiciled in this state for the purposes of this chapter when the person directly or indirectly transferred assets to an irrevocable trust, but only if at least one of the trust's qualifying beneficiaries is domiciled in this state for the purposes of this chapter during all or some portion of the trust's current taxable year;

(iii) A person who was domiciled in this state for the purposes of this chapter when the trust document or instrument or part of the trust document or instrument became irrevocable, but only if at least one of the trust's qualifying beneficiaries is a resident domiciled in this state for the purposes of this chapter during all or some portion of the trust's current taxable year. If a trust document or instrument became irrevocable upon the death of a person who at the time of death was domiciled in this state for purposes of this chapter, that person is a person described in

division (I)(3)(a)(iii) of this section.

(b) A trust is irrevocable to the extent that the transferor is not considered to be the owner of the net assets of the trust under sections 671 to 678 of the Internal Revenue Code.

(c) With respect to a trust other than a charitable lead trust, "qualifying beneficiary" has the same meaning as "potential current beneficiary" as defined in section 1361(e)(2) of the Internal Revenue Code, and with respect to a charitable lead trust "qualifying beneficiary" is any current, future, or contingent beneficiary, but with respect to any trust "qualifying beneficiary" excludes a person or a governmental entity or instrumentality to any of which a contribution would qualify for the charitable deduction under section 170 of the Internal Revenue Code.

(d) For the purposes of division (I)(3)(a) of this section, the extent to which a trust consists directly or indirectly, in whole or in part, of assets, net of any related liabilities, that were transferred directly or indirectly, in whole or part, to the trust by any of the sources enumerated in that division shall be ascertained by multiplying the fair market value of the trust's assets, net of related liabilities, by the qualifying ratio, which shall be computed as follows:

(i) The first time the trust receives assets, the numerator of the qualifying ratio is the fair market value of those assets at that time, net of any related liabilities, from sources enumerated in division (I)(3)(a) of this section. The denominator of the qualifying ratio is the fair market value of all the trust's assets at that time, net of any related liabilities.

(ii) Each subsequent time the trust receives assets, a revised qualifying ratio shall be computed. The numerator of the revised qualifying ratio is the sum of (1) the fair market value

of the trust's assets immediately prior to the subsequent transfer, net of any related liabilities, multiplied by the qualifying ratio last computed without regard to the subsequent transfer, and (2) the fair market value of the subsequently transferred assets at the time transferred, net of any related liabilities, from sources enumerated in division (I)(3)(a) of this section. The denominator of the revised qualifying ratio is the fair market value of all the trust's assets immediately after the subsequent transfer, net of any related liabilities.

(iii) Whether a transfer to the trust is by or from any of the sources enumerated in division (I)(3)(a) of this section shall be ascertained without regard to the domicile of the trust's beneficiaries.

(e) For the purposes of division (I)(3)(a)(i) of this section:

(i) A trust is described in division (I)(3)(e)(i) of this section if the trust is a testamentary trust and the testator of that testamentary trust was domiciled in this state at the time of the testator's death for purposes of the taxes levied under Chapter 5731. of the Revised Code.

(ii) A trust is described in division (I)(3)(e)(ii) of this section if the transfer is a qualifying transfer described in any of divisions (I)(3)(f)(i) to (vi) of this section, the trust is an irrevocable inter vivos trust, and at least one of the trust's qualifying beneficiaries is domiciled in this state for purposes of this chapter during all or some portion of the trust's current taxable year.

(f) For the purposes of division (I)(3)(e)(ii) of this section, a "qualifying transfer" is a transfer of assets, net of any related liabilities, directly or indirectly to a trust, if the transfer is described in any of the following:

(i) The transfer is made to a trust, created by the decedent before the decedent's death and while the decedent was domiciled in this state for the purposes of this chapter, and, prior to the death of the decedent, the trust became irrevocable while the decedent was domiciled in this state for the purposes of this chapter.

(ii) The transfer is made to a trust to which the decedent, prior to the decedent's death, had directly or indirectly transferred assets, net of any related liabilities, while the decedent was domiciled in this state for the purposes of this chapter, and prior to the death of the decedent the trust became irrevocable while the decedent was domiciled in this state for the purposes of this chapter.

(iii) The transfer is made on account of a contractual relationship existing directly or indirectly between the transferor and either the decedent or the estate of the decedent at any time prior to the date of the decedent's death, and the decedent was domiciled in this state at the time of death for purposes of the taxes levied under Chapter 5731. of the Revised Code.

(iv) The transfer is made to a trust on account of a contractual relationship existing directly or indirectly between the transferor and another person who at the time of the decedent's death was domiciled in this state for purposes of this chapter.

(v) The transfer is made to a trust on account of the will of a testator.

(vi) The transfer is made to a trust created by or caused to be created by a court, and the trust was directly or indirectly created in connection with or as a result of the death of an individual who, for purposes of the taxes levied under Chapter

5731. of the Revised Code, was domiciled in this state at the time of the individual's death.

(g) The tax commissioner may adopt rules to ascertain the part of a trust residing in this state.

(J) "Nonresident" means an individual or estate that is not a resident. An individual who is a resident for only part of a taxable year is a nonresident for the remainder of that taxable year.

(K) "Pass-through entity" has the same meaning as in section 5733.04 of the Revised Code.

(L) "Return" means the notifications and reports required to be filed pursuant to this chapter for the purpose of reporting the tax due and includes declarations of estimated tax when so required.

(M) "Taxable year" means the calendar year or the taxpayer's fiscal year ending during the calendar year, or fractional part thereof, upon which the adjusted gross income is calculated pursuant to this chapter.

(N) "Taxpayer" means any person subject to the tax imposed by section 5747.02 of the Revised Code or any pass-through entity that makes the election under division (D) of section 5747.08 of the Revised Code.

(O) "Dependents" means dependents as defined in the Internal Revenue Code and as claimed in the taxpayer's federal income tax return for the taxable year or which the taxpayer would have been permitted to claim had the taxpayer filed a federal income tax return.

(P) "Principal county of employment" means, in the case of a nonresident, the county within the state in which a taxpayer performs services for an employer or, if those services are

performed in more than one county, the county in which the major portion of the services are performed.

(Q) As used in sections 5747.50 to 5747.55 of the Revised Code:

(1) "Subdivision" means any county, municipal corporation, park district, or township.

(2) "Essential local government purposes" includes all functions that any subdivision is required by general law to exercise, including like functions that are exercised under a charter adopted pursuant to the Ohio Constitution.

(R) "Overpayment" means any amount already paid that exceeds the figure determined to be the correct amount of the tax.

(S) "Taxable income" or "Ohio taxable income" applies only to estates and trusts, and means federal taxable income, as defined and used in the Internal Revenue Code, adjusted as follows:

(1) Add interest or dividends, net of ordinary, necessary, and reasonable expenses not deducted in computing federal taxable income, on obligations or securities of any state or of any political subdivision or authority of any state, other than this state and its subdivisions and authorities, but only to the extent that such net amount is not otherwise includible in Ohio taxable income and is described in either division (S)(1)(a) or (b) of this section:

(a) The net amount is not attributable to the S portion of an electing small business trust and has not been distributed to beneficiaries for the taxable year;

(b) The net amount is attributable to the S portion of an electing small business trust for the taxable year.

(2) Add interest or dividends, net of ordinary, necessary, and reasonable expenses not deducted in computing federal taxable

income, on obligations of any authority, commission, instrumentality, territory, or possession of the United States to the extent that the interest or dividends are exempt from federal income taxes but not from state income taxes, but only to the extent that such net amount is not otherwise includible in Ohio taxable income and is described in either division (S)(1)(a) or (b) of this section;

(3) Add the amount of personal exemption allowed to the estate pursuant to section 642(b) of the Internal Revenue Code;

(4) Deduct interest or dividends, net of related expenses deducted in computing federal taxable income, on obligations of the United States and its territories and possessions or of any authority, commission, or instrumentality of the United States to the extent that the interest or dividends are exempt from state taxes under the laws of the United States, but only to the extent that such amount is included in federal taxable income and is described in either division (S)(1)(a) or (b) of this section;

(5) Deduct the amount of wages and salaries, if any, not otherwise allowable as a deduction but that would have been allowable as a deduction in computing federal taxable income for the taxable year, had the targeted jobs credit allowed under sections 38, 51, and 52 of the Internal Revenue Code not been in effect, but only to the extent such amount relates either to income included in federal taxable income for the taxable year or to income of the S portion of an electing small business trust for the taxable year;

(6) Deduct any interest or interest equivalent, net of related expenses deducted in computing federal taxable income, on public obligations and purchase obligations, but only to the extent that such net amount relates either to income included in federal taxable income for the taxable year or to income of the S portion of an electing small business trust for the taxable year;

(7) Add any loss or deduct any gain resulting from sale, exchange, or other disposition of public obligations to the extent that such loss has been deducted or such gain has been included in computing either federal taxable income or income of the S portion of an electing small business trust for the taxable year;

(8) Except in the case of the final return of an estate, add any amount deducted by the taxpayer on both its Ohio estate tax return pursuant to section 5731.14 of the Revised Code, and on its federal income tax return in determining federal taxable income;

(9)(a) Deduct any amount included in federal taxable income solely because the amount represents a reimbursement or refund of expenses that in a previous year the decedent had deducted as an itemized deduction pursuant to section 63 of the Internal Revenue Code and applicable treasury regulations. The deduction otherwise allowed under division (S)(9)(a) of this section shall be reduced to the extent the reimbursement is attributable to an amount the taxpayer or decedent deducted under this section in any taxable year.

(b) Add any amount not otherwise included in Ohio taxable income for any taxable year to the extent that the amount is attributable to the recovery during the taxable year of any amount deducted or excluded in computing federal or Ohio taxable income in any taxable year, but only to the extent such amount has not been distributed to beneficiaries for the taxable year.

(10) Deduct any portion of the deduction described in section 1341(a)(2) of the Internal Revenue Code, for repaying previously reported income received under a claim of right, that meets both of the following requirements:

(a) It is allowable for repayment of an item that was included in the taxpayer's taxable income or the decedent's adjusted gross income for a prior taxable year and did not qualify

for a credit under division (A) or (B) of section 5747.05 of the Revised Code for that year.

(b) It does not otherwise reduce the taxpayer's taxable income or the decedent's adjusted gross income for the current or any other taxable year.

(11) Add any amount claimed as a credit under section 5747.059 of the Revised Code to the extent that the amount satisfies either of the following:

(a) The amount was deducted or excluded from the computation of the taxpayer's federal taxable income as required to be reported for the taxpayer's taxable year under the Internal Revenue Code;

(b) The amount resulted in a reduction in the taxpayer's federal taxable income as required to be reported for any of the taxpayer's taxable years under the Internal Revenue Code.

(12) Deduct any amount, net of related expenses deducted in computing federal taxable income, that a trust is required to report as farm income on its federal income tax return, but only if the assets of the trust include at least ten acres of land satisfying the definition of "land devoted exclusively to agricultural use" under section 5713.30 of the Revised Code, regardless of whether the land is valued for tax purposes as such land under sections 5713.30 to 5713.38 of the Revised Code. If the trust is a pass-through entity investor, section 5747.231 of the Revised Code applies in ascertaining if the trust is eligible to claim the deduction provided by division (S)(12) of this section in connection with the pass-through entity's farm income.

Except for farm income attributable to the S portion of an electing small business trust, the deduction provided by division (S)(12) of this section is allowed only to the extent that the trust has not distributed such farm income. Division (S)(12) of

this section applies only to taxable years of a trust beginning in 2002 or thereafter.

(13) Add the net amount of income described in section 641(c) of the Internal Revenue Code to the extent that amount is not included in federal taxable income.

(14) Add or deduct the amount the taxpayer would be required to add or deduct under division (A)(20) or (21) of this section if the taxpayer's Ohio taxable income were computed in the same manner as an individual's Ohio adjusted gross income is computed under this section. In the case of a trust, division (S)(14) of this section applies only to any of the trust's taxable years beginning in 2002 or thereafter.

(T) "School district income" and "school district income tax" have the same meanings as in section 5748.01 of the Revised Code.

(U) As used in divisions (A)(8), (A)(9), (S)(6), and (S)(7) of this section, "public obligations," "purchase obligations," and "interest or interest equivalent" have the same meanings as in section 5709.76 of the Revised Code.

(V) "Limited liability company" means any limited liability company formed under Chapter 1705. of the Revised Code or under the laws of any other state.

(W) "Pass-through entity investor" means any person who, during any portion of a taxable year of a pass-through entity, is a partner, member, shareholder, or equity investor in that pass-through entity.

(X) "Banking day" has the same meaning as in section 1304.01 of the Revised Code.

(Y) "Month" means a calendar month.

(Z) "Quarter" means the first three months, the second three months, the third three months, or the last three months of the

taxpayer's taxable year.

(AA)(1) "Eligible institution" means a state university or state institution of higher education as defined in section 3345.011 of the Revised Code, or a private, nonprofit college, university, or other post-secondary institution located in this state that possesses a certificate of authorization issued by the Ohio board of regents pursuant to Chapter 1713. of the Revised Code or a certificate of registration issued by the state board of career colleges and schools under Chapter 3332. of the Revised Code.

(2) "Qualified tuition and fees" means tuition and fees imposed by an eligible institution as a condition of enrollment or attendance, not exceeding two thousand five hundred dollars in each of the individual's first two years of post-secondary education. If the individual is a part-time student, "qualified tuition and fees" includes tuition and fees paid for the academic equivalent of the first two years of post-secondary education during a maximum of five taxable years, not exceeding a total of five thousand dollars. "Qualified tuition and fees" does not include:

(a) Expenses for any course or activity involving sports, games, or hobbies unless the course or activity is part of the individual's degree or diploma program;

(b) The cost of books, room and board, student activity fees, athletic fees, insurance expenses, or other expenses unrelated to the individual's academic course of instruction;

(c) Tuition, fees, or other expenses paid or reimbursed through an employer, scholarship, grant in aid, or other educational benefit program.

(BB)(1) "Modified business income" means the business income included in a trust's Ohio taxable income after such taxable

income is first reduced by the qualifying trust amount, if any.

(2) "Qualifying trust amount" of a trust means capital gains and losses from the sale, exchange, or other disposition of equity or ownership interests in, or debt obligations of, a qualifying investee to the extent included in the trust's Ohio taxable income, but only if the following requirements are satisfied:

(a) The book value of the qualifying investee's physical assets in this state and everywhere, as of the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the date on which the trust recognizes the gain or loss, is available to the trust.

(b) The requirements of section 5747.011 of the Revised Code are satisfied for the trust's taxable year in which the trust recognizes the gain or loss.

Any gain or loss that is not a qualifying trust amount is modified business income, qualifying investment income, or modified nonbusiness income, as the case may be.

(3) "Modified nonbusiness income" means a trust's Ohio taxable income other than modified business income, other than the qualifying trust amount, and other than qualifying investment income, as defined in section 5747.012 of the Revised Code, to the extent such qualifying investment income is not otherwise part of modified business income.

(4) "Modified Ohio taxable income" applies only to trusts, and means the sum of the amounts described in divisions (BB)(4)(a) to (c) of this section:

(a) The fraction, calculated under section 5747.013, and applying section 5747.231 of the Revised Code, multiplied by the sum of the following amounts:

(i) The trust's modified business income;

(ii) The trust's qualifying investment income, as defined in section 5747.012 of the Revised Code, but only to the extent the qualifying investment income does not otherwise constitute modified business income and does not otherwise constitute a qualifying trust amount.

(b) The qualifying trust amount multiplied by a fraction, the numerator of which is the sum of the book value of the qualifying investee's physical assets in this state on the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the day on which the trust recognizes the qualifying trust amount, and the denominator of which is the sum of the book value of the qualifying investee's total physical assets everywhere on the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the day on which the trust recognizes the qualifying trust amount. If, for a taxable year, the trust recognizes a qualifying trust amount with respect to more than one qualifying investee, the amount described in division (BB)(4)(b) of this section shall equal the sum of the products so computed for each such qualifying investee.

(c)(i) With respect to a trust or portion of a trust that is a resident as ascertained in accordance with division (I)(3)(d) of this section, its modified nonbusiness income.

(ii) With respect to a trust or portion of a trust that is not a resident as ascertained in accordance with division (I)(3)(d) of this section, the amount of its modified nonbusiness income satisfying the descriptions in divisions (B)(2) to (5) of section 5747.20 of the Revised Code, except as otherwise provided in division (BB)(4)(c)(ii) of this section. With respect to a trust or portion of a trust that is not a resident as ascertained 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

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

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

(5)(a) Except as set forth in division (BB)(5)(b) of this section, "qualifying investee" means a person in which a trust has an equity or ownership interest, or a person or unit of government the debt obligations of either of which are owned by a trust. For the purposes of division (BB)(2)(a) of this section and for the purpose of computing the fraction described in division (BB)(4)(b) of this section, all of the following apply:

(i) If the qualifying investee is a member of a qualifying controlled group on the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the date on which the trust recognizes the gain or loss, then "qualifying investee" includes all persons in the qualifying controlled group on such last day.

(ii) If the qualifying investee, or if the qualifying investee and any members of the qualifying controlled group of which the qualifying investee is a member on the last day of the qualifying investee's fiscal or calendar year ending immediately prior to the date on which the trust recognizes the gain or loss, separately or cumulatively own, directly or indirectly, on the

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

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

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

to the upper level pass-through entity, then solely for purposes of ascertaining if a gain or loss constitutes a qualifying trust amount, the upper level pass-through entity shall be deemed as owning no equity of the lower level pass-through entity for each day during the upper level pass-through entity's calendar or fiscal year in which or with which ends the lower level pass-through entity's calendar or fiscal year. Nothing in division (BB)(5)(a)(iii) of this section shall be construed to provide for any deduction or exclusion in computing any trust's Ohio taxable income.

(b) With respect to a trust that is not a resident for the taxable year and with respect to a part of a trust that is not a resident for the taxable year, "qualifying investee" for that taxable year does not include a C corporation if both of the following apply:

(i) During the taxable year the trust or part of the trust recognizes a gain or loss from the sale, exchange, or other disposition of equity or ownership interests in, or debt obligations of, the C corporation.

(ii) Such gain or loss constitutes nonbusiness income.

(6) "Available" means information is such that a person is able to learn of the information by the due date plus extensions, if any, for filing the return for the taxable year in which the trust recognizes the gain or loss.

(CC) "Qualifying controlled group" has the same meaning as in section 5733.04 of the Revised Code.

(DD) "Related member" has the same meaning as in section 5733.042 of the Revised Code.

(EE)(1) For the purposes of division (EE) of this section:

(a) "Qualifying person" means any person other than a

qualifying corporation.

(b) "Qualifying corporation" means any person classified for federal income tax purposes as an association taxable as a corporation, except either of the following:

(i) A corporation that has made an election under subchapter S, chapter one, subtitle A, of the Internal Revenue Code for its taxable year ending within, or on the last day of, the investor's taxable year;

(ii) A subsidiary that is wholly owned by any corporation that has made an election under subchapter S, chapter one, subtitle A of the Internal Revenue Code for its taxable year ending within, or on the last day of, the investor's taxable year.

(2) For the purposes of this chapter, unless expressly stated otherwise, no qualifying person indirectly owns any asset directly or indirectly owned by any qualifying corporation.

(FF) For purposes of this chapter and Chapter 5751. of the Revised Code:

(1) "Trust" does not include a qualified pre-income tax trust.

(2) A "qualified pre-income tax trust" is any pre-income tax trust that makes a qualifying pre-income tax trust election as described in division (FF)(3) of this section.

(3) A "qualifying pre-income tax trust election" is an election by a pre-income tax trust to subject to the tax imposed by section 5751.02 of the Revised Code the pre-income tax trust and all pass-through entities of which the trust owns or controls, directly, indirectly, or constructively through related interests, five per cent or more of the ownership or equity interests. The trustee shall notify the tax commissioner in writing of the election on or before April 15, 2006. The election, if timely

made, shall be effective on and after January 1, 2006, and shall apply for all tax periods and tax years until revoked by the trustee of the trust.

(4) A "pre-income tax trust" is a trust that satisfies all of the following requirements:

(a) The document or instrument creating the trust was executed by the grantor before January 1, 1972;

(b) The trust became irrevocable upon the creation of the trust; and

(c) The grantor was domiciled in this state at the time the trust was created.

Sec. 5747.08. An annual return with respect to the tax imposed by section 5747.02 of the Revised Code and each tax imposed under Chapter 5748. of the Revised Code shall be made by every taxpayer for any taxable year for which the taxpayer is liable for the tax imposed by that section or under that chapter, unless the total credits allowed under divisions (E), (F), and (G) of section 5747.05 of the Revised Code for the year are equal to or exceed the tax imposed by section 5747.02 of the Revised Code, in which case no return shall be required unless the taxpayer is liable for a tax imposed pursuant to Chapter 5748. of the Revised Code.

(A) If an individual is deceased, any return or notice required of that individual under this chapter shall be made and filed by that decedent's executor, administrator, or other person charged with the property of that decedent.

(B) If an individual is unable to make a return or notice required by this chapter, the return or notice required of that individual shall be made and filed by the individual's duly authorized agent, guardian, conservator, fiduciary, or other

person charged with the care of the person or property of that individual.

(C) Returns or notices required of an estate or a trust shall be made and filed by the fiduciary of the estate or trust.

(D)(1)(a) Except as otherwise provided in division (D)(1)(b) of this section, any pass-through entity may file a single return on behalf of one or more of the entity's investors other than an investor that is a person subject to the tax imposed under section 5733.06 of the Revised Code. The single return shall set forth the name, address, and social security number or other identifying number of each of those pass-through entity investors and shall indicate the distributive share of each of those pass-through entity investor's income taxable in this state in accordance with sections 5747.20 to 5747.231 of the Revised Code. Such pass-through entity investors for whom the pass-through entity elects to file a single return are not entitled to the exemption or credit provided for by sections 5747.02 and 5747.022 of the Revised Code; shall calculate the tax before business credits at the highest rate of tax set forth in section 5747.02 of the Revised Code for the taxable year for which the return is filed; and are entitled to only their distributive share of the business credits as defined in division (D)(2) of this section. A single check drawn by the pass-through entity shall accompany the return in full payment of the tax due, as shown on the single return, for such investors, other than investors who are persons subject to the tax imposed under section 5733.06 of the Revised Code.

(b)(i) A pass-through entity shall not include in such a single return any investor that is a trust to the extent that any direct or indirect current, future, or contingent beneficiary of the trust is a person subject to the tax imposed under section 5733.06 of the Revised Code.

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

return any investor that is itself a pass-through entity to the extent that any direct or indirect investor in the second pass-through entity is a person subject to the tax imposed under section 5733.06 of the Revised Code.

(c) Nothing in division (D) of this section precludes the tax commissioner from requiring such investors to file the return and make the payment of taxes and related interest, penalty, and interest penalty required by this section or section 5747.02, 5747.09, or 5747.15 of the Revised Code. Nothing in division (D) of this section shall be construed to provide to such an investor or pass-through entity any additional deduction or credit, other than the credit provided by division (J) of this section, solely on account of the entity's filing a return in accordance with this section. Such a pass-through entity also shall make the filing and payment of estimated taxes on behalf of the pass-through entity investors other than an investor that is a person subject to the tax imposed under section 5733.06 of the Revised Code.

(2) For the purposes of this section, "business credits" means the credits listed in section 5747.98 of the Revised Code excluding the following credits:

(a) The retirement credit under division (B) of section 5747.055 of the Revised Code;

(b) The senior citizen credit under division (C) of section 5747.05 of the Revised Code;

(c) The lump sum distribution credit under division (D) of section 5747.05 of the Revised Code;

(d) The dependent care credit under section 5747.054 of the Revised Code;

(e) The lump sum retirement income credit under division (C) of section 5747.055 of the Revised Code;

(f) The lump sum retirement income credit under division (D) of section 5747.055 of the Revised Code;

(g) The lump sum retirement income credit under division (E) of section 5747.055 of the Revised Code;

(h) The credit for displaced workers who pay for job training under section 5747.27 of the Revised Code;

(i) The twenty-dollar personal exemption credit under section 5747.022 of the Revised Code;

(j) The joint filing credit under division (G) of section 5747.05 of the Revised Code;

(k) The nonresident credit under division (A) of section 5747.05 of the Revised Code;

(l) The credit for a resident's out-of-state income under division (B) of section 5747.05 of the Revised Code;

(m) The low-income credit under section 5747.056 of the Revised Code;

(n) The credit for payment of medical care insurance and qualified long-term care insurance contract premiums under section 5747.81 of the Revised Code.

(3) The election provided for under division (D) of this section applies only to the taxable year for which the election is made by the pass-through entity. Unless the tax commissioner provides otherwise, this election, once made, is binding and irrevocable for the taxable year for which the election is made. Nothing in this division shall be construed to provide for any deduction or credit that would not be allowable if a nonresident pass-through entity investor were to file an annual return.

(4) If a pass-through entity makes the election provided for under division (D) of this section, the pass-through entity shall be liable for any additional taxes, interest, interest penalty, or

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

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

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

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

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

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

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

first.

If the tax commissioner considers it necessary in order to ensure the payment of the tax imposed by section 5747.02 of the Revised Code or any tax imposed under Chapter 5748. of the Revised Code, the tax commissioner may require returns and payments to be made otherwise than as provided in this section.

To the extent that any provision in this division conflicts with any provision in section 5747.026 of the Revised Code, the provision in that section prevails.

(H) If any report, claim, statement, or other document required to be filed, or any payment required to be made, within a prescribed period or on or before a prescribed date under this chapter is delivered after that period or that date by United States mail to the agency, officer, or office with which the report, claim, statement, or other document is required to be filed, or to which the payment is required to be made, the date of the postmark stamped on the cover in which the report, claim, statement, or other document, or payment is mailed shall be deemed to be the date of delivery or the date of payment.

If a payment is required to be made by electronic funds transfer pursuant to section 5747.072 of the Revised Code, the payment is considered to be made when the payment is received by the treasurer of state or credited to an account designated by the treasurer of state for the receipt of tax payments.

"The date of the postmark" means, in the event there is more than one date on the cover, the earliest date imprinted on the cover by the United States postal service.

(I) The amounts withheld by the employer pursuant to section 5747.06 of the Revised Code shall be allowed to the recipient of the compensation as credits against payment of the appropriate taxes imposed on the recipient by section 5747.02 and under

Chapter 5748. of the Revised Code.

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

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

Sec. 5747.81. (A) For purposes of this section:

(1) "Medical care" has the meaning given in section 213 of the Internal Revenue Code, subject to the special rules, limitations, and exclusions set forth therein.

(2) "Qualified long-term care contract" has the same meaning given in section 7702B of the Internal Revenue Code.

(3) "Subsidized health plan" means a health plan for which an employer pays any portion of the plan's cost.

(4) "Dependent" has the same meaning as in division (A)(11) of section 5747.01 of the Revised Code.

(B) A nonrefundable credit is allowed against the tax imposed by section 5747.02 of the Revised Code equal to the amount paid by the taxpayer during the taxpayer's taxable year for medical care insurance or a qualified long-term care insurance contract for the taxpayer, the taxpayer's spouse, or dependents. The credit shall not exceed one thousand dollars.

No credit shall be allowed under this section to any taxpayer who is eligible to participate in any subsidized health plan maintained by any employer of the taxpayer or of the taxpayer's spouse, or to any taxpayer who is entitled to, or on application would be entitled to, benefits under part A of Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C. 301, as amended.

The taxpayer shall claim the credit in the order required under section 5747.98 of the Revised Code. To the extent the credit exceeds the taxpayer's tax liability for the taxable year after allowance for any other credits that precede the credit under that section in that order, the credit may be carried forward to succeeding taxable years until fully utilized, but the amount of any excess credit allowed in any such year shall be

deducted from the balance carried forward to the succeeding year.

Sec. 5747.98. (A) To provide a uniform procedure for calculating the amount of tax due under section 5747.02 of the Revised Code, a taxpayer shall claim any credits to which the taxpayer is entitled in the following order:

(1) The retirement income credit under division (B) of section 5747.055 of the Revised Code;

(2) The senior citizen credit under division (C) of section 5747.05 of the Revised Code;

(3) The lump sum distribution credit under division (D) of section 5747.05 of the Revised Code;

(4) The dependent care credit under section 5747.054 of the Revised Code;

(5) The lump sum retirement income credit under division (C) of section 5747.055 of the Revised Code;

(6) The lump sum retirement income credit under division (D) of section 5747.055 of the Revised Code;

(7) The lump sum retirement income credit under division (E) of section 5747.055 of the Revised Code;

(8) The low-income credit under section 5747.056 of the Revised Code;

(9) The credit for displaced workers who pay for job training under section 5747.27 of the Revised Code;

(10) The campaign contribution credit under section 5747.29 of the Revised Code;

(11) The twenty-dollar personal exemption credit under section 5747.022 of the Revised Code;

(12) The joint filing credit under division (G) of section

5747.05 of the Revised Code;

(13) The nonresident credit under division (A) of section 5747.05 of the Revised Code;

(14) The credit for a resident's out-of-state income under division (B) of section 5747.05 of the Revised Code;

(15) The credit for employers that enter into agreements with child day-care centers under section 5747.34 of the Revised Code;

(16) The credit for employers that reimburse employee child care expenses under section 5747.36 of the Revised Code;

(17) The credit for adoption of a minor child under section 5747.37 of the Revised Code;

(18) The credit for purchases of lights and reflectors under section 5747.38 of the Revised Code;

(19) The job retention credit under division (B) of section 5747.058 of the Revised Code;

(20) The credit for selling alternative fuel under section 5747.77 of the Revised Code;

(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;

(22) The job training credit under section 5747.39 of the Revised Code;

(23) The enterprise zone credit under section 5709.66 of the Revised Code;

(24) The credit for the eligible costs associated with a voluntary action under section 5747.32 of the Revised Code;

(25) The credit for employers that establish on-site child day-care centers under section 5747.35 of the Revised Code;

(26) The ethanol plant investment credit under section

5747.75 of the Revised Code;

(27) The credit for purchases of qualifying grape production property under section 5747.28 of the Revised Code;

(28) The export sales credit under section 5747.057 of the Revised Code;

(29) The credit for research and development and technology transfer investors under section 5747.33 of the Revised Code;

(30) The enterprise zone credits under section 5709.65 of the Revised Code;

(31) The research and development credit under section 5747.331 of the Revised Code;

(32) The credit for payment of medical care insurance and qualified long-term care insurance premiums under section 5747.81 of the Revised Code;

(33) The refundable credit for rehabilitating a historic building under section 5747.76 of the Revised Code;

~~(33)~~(34) The refundable jobs creation credit under division (A) of section 5747.058 of the Revised Code;

~~(34)~~(35) The refundable credit for taxes paid by a qualifying entity granted under section 5747.059 of the Revised Code;

~~(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;

~~(36)~~(37) The refundable credit for tax withheld under division (B)(1) of section 5747.062 of the Revised Code;

~~(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.

(B) For any nonrefundable credit, ~~except the credits~~

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

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

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

Not later than July 1, 2013, the Department shall expand the pilot program to six additional counties, three that are primarily urban and three that are primarily rural.

Not later than July 1, 2015, the Department shall expand the pilot program to cover all counties in the state.

The Department shall submit a monthly report to the Health Information Technology Advisory Board regarding the progress of the pilot program.

(B) The Department shall apply to the United States Secretary of Health and Human Services for federal matching funds through the Medicaid program or any other applicable federal program. The Department shall take all steps necessary to ensure the highest federal participation.

(C)(1) There is hereby created the Health Information Technology Advisory Board. The Board shall consist of the following:

(a) The State Chief Information Officer, who shall serve as chairperson;

(b) The Director of the Ohio Department of Health;

(c) One representative from the Ohio Department of Administrative Services;

(d) One representative from the Ohio Hospital Association;

(e) One representative from the Ohio State Medical Association;

(f) An individual who works for a company that provides information technology services;

(g) One representative from a regional health information organization;

(h) One representative from a quality improvement

organization affiliated with the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services;

(i) One representative from an Ohio-based medical college or university;

(j) One professional representing the fields of behavioral health, pharmaceuticals, nursing, and long-term care;

(k) One representative from a consumer-oriented association;

(l) One representative of a non-partisan policy group or organization;

(m) An attorney who is an expert on the topic of health information;

(n) A health care policy and security expert.

(2) The chairperson shall appoint all other members of the Board.

The Board shall meet at least six times per year.

The Ohio Department of Administrative Services shall provide meeting space for the Board.

Board members shall be reimbursed for actual expenses incurred in the performance of official duties. Board members shall serve three-year terms and may be reappointed. Vacancies shall be filled in the manner provided for original appointment. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed shall hold office for the remainder of that term. A member shall continue in office subsequent to the expiration of the member's term or until a period of sixty days has elapsed, whichever occurs first. Five members of the Board constitute a quorum. The Ohio Department of Administrative Services shall provide staff support to the Board.

(3) The Board shall do all of the following:

(a) Create an operational plan on how to implement the recommendations in the Ohio Health Information Security and Privacy Collaboration Implementation Plan and the Ohio Health Informational Technology Strategic Roadmap. The plan shall include possible creation of a state-level, public and private organization to coordinate ongoing efforts to implement a strategy for the adoption and use of electronic health records and exchange of health information;

(b) Identify obstacles to adoption of health information technology by providers and exchange of health information among providers and with consumers;

(c) Advise the Governor and the General Assembly on issues related to the development and implementation of an Ohio health information technology infrastructure and to the privacy and security of health information;

(d) Oversee ongoing work of the Ohio Health Information Security and Privacy Collaboration Implementation Plan;

(e) Oversee implementation of state funded health information technology and health information exchange pilot projects;

(f) Coordinate allocation of state funds to subsidize the adoption of health information technology by providers or the exchange of health information among providers;

(g) Coordinate with the entities focused on creating the broadband infrastructure needed throughout Ohio to allow for health information exchange;

(h) Oversee development of communications efforts with consumers and providers to promote health information technology;

(i) Receive grants, gifts, donations, and other contributions of private, federal, or other public moneys to fund health

information technology and health information exchange efforts in Ohio;

(j) Oversee coordination of relationships with federal initiatives and agencies or with neighboring state efforts on health information technology and health information exchange.

Section 4. (A) There is hereby created the Health Insurance Credit Program Advisory Board. The Board shall consist of the following:

(1) Two representatives from the Ohio Department of Job and Family Services, appointed by the Governor;

(2) One individual who is a consumer advocate on health care issues, appointed by the Governor;

(3) One representative from the health insurance industry, appointed by the Speaker of the House of Representatives;

(4) One representative of a Medicaid managed care company, appointed by the President of the Senate;

(5) One member of the Ohio General Assembly from the majority party, appointed by the Speaker of the House of Representatives;

(6) One member of the Ohio General Assembly from the minority party, appointed by the President of the Senate.

The Governor shall select the chairperson of the Board from among the Governor's appointees. The Board shall meet at least four times per year. Board members shall be reimbursed for actual expenses incurred in the performance of official duties. Board members shall serve three year terms. Vacancies shall be filled in the manner provided for original appointment. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed shall hold office for the remainder of that term. Four members of the Board constitute a quorum. The Ohio Department of Job and Family

Services shall provide staff support to the Board.

(B) The Board shall submit an annual report to the Governor and the General Assembly regarding the costs to the state associated with the program. Three years after its first meeting, the Board shall cease to exist.

Section 5. If necessary, the Department of Job and Family Services shall apply to the United States Secretary of Health and Human Services for a waiver of federal Medicaid requirements to apply Medicaid funds towards the health insurance credit program created by section 5101.90 of the Revised Code. If the Department determines that Medicaid funds may be used for the credit program, or receives a waiver to use funds for the program, the Department is authorized to use those funds in addition to the funds authorized under section 5101.93 of the Revised Code.

Section 6. It is the intent of the General Assembly to support the "Four Cornerstones" principles of health care reform adopted by the United States Secretary of Health and Human Services in accordance with Executive Order Number 13410 issued by the President of the United States on August 22, 2006. The Four Cornerstones are:

(A) Promoting interoperable health information technology;

(B) Measuring and publishing quality health information;

(C) Measuring and publishing quality health price information;

(D) Promoting quality and efficiency of health care.

Section 7. (A) As used in this section, "state institution of higher education" has the same meaning as in section 3345.011 of the Revised Code.

(B) Each state institution of higher education that operates a prelicensure nursing education program approved by the board of nursing under section 4723.06 of the Revised Code shall do all of the following:

(1) Pay an individual who begins teaching nursing classes at that institution in the first state fiscal year that begins on or after the effective date of this section a starting salary that is at least ten thousand dollars higher than whichever of the following applies:

(a) The average starting salary paid to an instructor who began teaching nursing classes at the institution during calendar year 2007;

(b) The average starting salary that, based on past practices, would have been paid had any instructor begun teaching nursing classes at the institution during calendar year 2007.

(2) Pay an individual who begins teaching nursing classes at the institution in the second, third, fourth, and fifth state fiscal years that begin on or after the effective date of this section a starting salary that is at least five thousand dollars higher than the starting salary paid under division (B)(1) of this section;

(3) Pay an individual who taught nursing at the institution in the calendar year immediately prior to the effective date of this section a salary in the first five state fiscal years that begin on or after the effective date of this section a salary that is at least five thousand dollars more than the salary the individual earned in the calendar year immediately prior to the effective date of this section.

(C) A state institution of higher education that operates a prelicensure nursing education program approved by the board of nursing under section 4723.06 of the Revised Code shall not do

either of the following:

(1) Reduce, from the number of nursing classes offered during calendar year 2007, the number of nursing classes offered in each of the first five calendar years that begin on or after the effective date of this section;

(2) Reduce, from the number of nursing instructors employed or contracted with during calendar year 2007, the number of nursing instructors employed or contracted with in each of the first five calendar years that begin on or after the effective date of this section.

Section 8. The amendment or enactment of sections 5725.24, 5729.03, 5747.01, 5747.08, 5747.81, and 5747.98 of the Revised Code applies to taxable years beginning on or after January 1, 2008.

Section 9. A contract between a participant and person for pharmacy benefit management services of the type described in section 185.04 of the Revised Code that is in existence on the effective date of this act shall expire in accordance with the terms of the contract and shall not be renewed or extended.

Section 10. Section 9.901 of the Revised Code, as amended by this act, shall apply to collective bargaining agreements governed by Chapter 4117. of the Revised Code and entered into or modified on or after the effective date of this act.

Section 11. Sections 3923.85 to 3923.91 of this act shall take effect July 1, 2009.

Section 12. The amendment of section 5112.08 of the Revised Code is not intended to supersede the earlier repeal, with delayed effective date, of that section.