128HB1-CC4924/HLB

Am. Sub. H.B. 1
As Passed by the Senate
CC-4924
JFS069

_______________ moved to amend as follows:

In line 408, after "5139.43," insert "5153.163,"

Between lines 80086 and 80087, insert:

"**Sec. 5153.163.** (A) As used in this section, "adoptive parent" means, as the context requires, a prospective adoptive parent or an adoptive parent.

(B)(1) Before a child's adoption is finalized, a public children services agency ~~shall~~ may enter into an agreement with the child's adoptive parent under which the agency ~~shall~~, to the extent state funds are available, may make state adoption maintenance subsidy payments as needed on behalf of the child when all of the following apply:

(a) The child is a child with special needs.

(b) The child was placed in the adoptive home by a public children services agency or a private child placing agency and may legally be adopted.

(c) The adoptive parent has the capability of providing the permanent family relationships needed by the child.

(d) The needs of the child are beyond the economic resources

of the adoptive parent. 19

(e) Acceptance of the child as a member of the adoptive parent's family would not be in the child's best interest without payments on the child's behalf under this section. 20 21 22

(f) The gross income of the adoptive parent's family does not exceed one hundred twenty per cent of the median income of a family of the same size, including the child, as most recently determined for this state by the secretary of health and human services under Title XX of the "Social Security Act," 88 Stat. 2337, 42 U.S.C.A. 1397, as amended. 23 24 25 26 27 28

(g) The child is not eligible for adoption assistance payments under Title IV-E of the "Social Security Act," 94 Stat. 501 (1980), 42 U.S.C.A. 671, as amended. 29 30 31

(2) State adoption maintenance subsidy payment agreements must be made by either the public children services agency that has permanent custody of the child or the public children services agency of the county in which the private child placing agency that has permanent custody of the child is located. 32 33 34 35 36

(3) State adoption maintenance subsidy payments shall be made in accordance with the agreement between the public children services agency and the adoptive parent and are subject to an annual redetermination of need. 37 38 39 40

(4) Payments under this division may begin either before or after issuance of the final adoption decree, except that payments made before issuance of the final adoption decree may be made only while the child is living in the adoptive parent's home. Preadoption payments may be made for not more than twelve months, unless the final adoption decree is not issued within that time because of a delay in court proceedings. Payments that begin before issuance of the final adoption decree may continue after 41 42 43 44 45 46 47 48

its issuance.

(C)(1) If, after the child's adoption is finalized, a public children services agency considers a child residing in the county served by the agency to be in need of public care or protective services, the agency may, to the extent state funds are ~~appropriated~~ available for this purpose, enter into an agreement with the child's adoptive parent under which the agency ~~shall~~ may make post adoption special services subsidy payments on behalf of the child as needed when both of the following apply:

(a) The child has a physical or developmental handicap or mental or emotional condition that either:

(i) Existed before the adoption petition was filed; or

(ii) Developed after the adoption petition was filed and can be directly attributed to factors in the child's preadoption background, medical history, or biological family's background or medical history.

(b) The agency determines the expenses necessitated by the child's handicap or condition are beyond the adoptive parent's economic resources.

(2) Services for which a public children services agency may make post adoption special services subsidy payments on behalf of a child under this division shall include medical, surgical, psychiatric, psychological, and counseling services, including residential treatment.

(3) The department of job and family services shall establish clinical standards to evaluate a child's physical or developmental handicap or mental or emotional condition and assess the child's need for services.

(4) The total dollar value of post adoption special services subsidy payments made on a child's behalf shall not exceed ten

thousand dollars in any fiscal year, unless the department determines that extraordinary circumstances exist that necessitate further funding of services for the child. Under such extraordinary circumstances, the value of the payments made on the child's behalf shall not exceed fifteen thousand dollars in any fiscal year. 79 80 81 82 83 84

(5) The adoptive parent or parents of a child who receives post adoption special services subsidy payments shall pay at least five per cent of the total cost of all services provided to the child; except that a public children services agency may waive this requirement if the gross annual income of the child's adoptive family is not more than two hundred per cent of the federal poverty guideline. 85 86 87 88 89 90 91

(6) A public children services agency may use other sources of revenue to make post adoption special services subsidy payments, in addition to any state funds appropriated for that purpose. 92 93 94 95

(D) No payment shall be made under division (B) or (C) of this section on behalf of any person eighteen years of age or older beyond the end of the school year during which the person attains the age of eighteen or on behalf of a mentally or physically handicapped person twenty-one years of age or older. 96 97 98 99 100

(E) The director of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code that are needed to implement this section. The rules shall establish all of the following: 101 102 103 104

(1) The application process for all forms of assistance provided under this section; 105 106

(2) The method to determine the amount of assistance payable under division (B) of this section; 107 108

(3) The definition of "child with special needs" for this 109
section; 110

(4) The process whereby a child's continuing need for 111
services provided under division (B) of this section is annually 112
redetermined; 113

(5) The method of determining the amount, duration, and scope 114
of services provided to a child under division (C) of this 115
section; 116

(6) Any other rule, requirement, or procedure the department 117
considers appropriate for the implementation of this section. 118

(F) The state adoption special services subsidy program 119
ceases to exist on July 1, 2004, except that, subject to the 120
findings of the annual redetermination process established under 121
division (E) of this section and the child's individual need for 122
services, a public children services agency may continue to 123
provide state adoption special services subsidy payments on behalf 124
of a child for whom payments were being made prior to July 1, 125
2004. 126

(G) No public children services agency shall, pursuant to 127
either section 2151.353 or 5103.15 of the Revised Code, place or 128
maintain a child with special needs who is in the permanent 129
custody of an institution or association certified by the 130
department of job and family services under section 5103.03 of the 131
Revised Code in a setting other than with a person seeking to 132
adopt the child, unless the agency has determined and redetermined 133
at intervals of not more than six months the impossibility of 134
adoption by a person ~~listed pursuant to division (B), (C), or (D)~~ 135
~~of section 5103.154 of the Revised Code~~ who wishes to adopt 136
children, and is approved by an agency so empowered under Chapter 137
5103. of the Revised Code, or by a person who wishes to adopt a 138
child with special needs as defined in rules adopted under this 139

section, and who is approved by an agency so empowered under 140
Chapter 5103. of the Revised Code, including the impossibility of 141
entering into a payment agreement with such a person. The agency 142
so maintaining such a child shall report its reasons for doing so 143
to the department of job and family services. 144

The department may take any action permitted under section 145
5101.24 of the Revised Code for an agency's failure to determine, 146
redetermine, and report on a child's status." 147

In line 90911, after "5139.43," insert "5153.163," 148

In line 106547, after "5123.193," insert "5153.163," 149

In line 158 of the title, after "5139.43," insert "5153.163," 150

The motion was __________ agreed to.

SYNOPSIS

**State Adoption Maintenance Subsidy and Post Adoption Special 151
Services Subsidy** 152

R.C. 5153.163 153

Eliminates the requirement that a public children services 154
agency must enter into an agreement with a special needs child's 155
adoptive parent, under certain circumstances, under which the 156
agency must make state adoption maintenance subsidy payments, and 157
instead permits the agency to enter into an agreement if state 158
funds are available; eliminates the requirement that if, after a 159
child's adoption is finalized, a public children services agency 160
considers the child to be in need of public care or protective 161
services, the agency must enter into an agreement with the child's 162
adoptive parent under which the agency must make post adoption 163
special services subsidy payments to the extent state funds are 164

appropriated, and instead permits the agency to enter into an 165
agreement if state funds are available. 166

Am. Sub. H.B. 1
As Passed by the Senate
CC-4926
JFS071

_______________ moved to amend as follows:

In line 408, after "5139.43," insert "5153.163," 1

Between lines 80086 and 80087, insert: 2

"**Sec. 5153.163.** (A) As used in this section, "adoptive 3
parent" means, as the context requires, a prospective adoptive 4
parent or an adoptive parent. 5

(B)(1) Before a child's adoption is finalized, a public 6
children services agency shall enter into an agreement with the 7
child's adoptive parent under which the agency shall make state 8
adoption maintenance subsidy payments as needed on behalf of the 9
child when all of the following apply: 10

(a) The child is a child with special needs. 11

(b) The child was placed in the adoptive home by a public 12
children services agency or a private child placing agency and may 13
legally be adopted. 14

(c) The adoptive parent has the capability of providing the 15
permanent family relationships needed by the child. 16

(d) The needs of the child are beyond the economic resources 17
of the adoptive parent. 18

(e) Acceptance of the child as a member of the adoptive parent's family would not be in the child's best interest without payments on the child's behalf under this section. 19 20 21

(f) The gross income of the adoptive parent's family does not exceed one hundred twenty per cent of the median income of a family of the same size, including the child, as most recently determined for this state by the secretary of health and human services under Title XX of the "Social Security Act," 88 Stat. 2337, 42 U.S.C.A. 1397, as amended. 22 23 24 25 26 27

(g) The child is not eligible for adoption assistance payments under Title IV-E of the "Social Security Act," 94 Stat. 501 (1980), 42 U.S.C.A. 671, as amended. 28 29 30

(2) State adoption maintenance subsidy payment agreements must be made by either the public children services agency that has permanent custody of the child or the public children services agency of the county in which the private child placing agency that has permanent custody of the child is located. 31 32 33 34 35

(3) State adoption maintenance subsidy payments shall be made in accordance with the agreement between the public children services agency and the adoptive parent and are subject to an annual redetermination of need. 36 37 38 39

(4) Payments under this division may begin either before or after issuance of the final adoption decree, except that payments made before issuance of the final adoption decree may be made only while the child is living in the adoptive parent's home. Preadoption payments may be made for not more than twelve months, unless the final adoption decree is not issued within that time because of a delay in court proceedings. Payments that begin before issuance of the final adoption decree may continue after its issuance. 40 41 42 43 44 45 46 47 48

(C)(1) If, after the child's adoption is finalized, a public children services agency considers a child residing in the county served by the agency to be in need of public care or protective services, the agency may, to the extent state funds are appropriated for this purpose, enter into an agreement with the child's adoptive parent under which the agency shall make post adoption special services subsidy payments on behalf of the child as needed when both of the following apply: 49 50 51 52 53 54 55 56

(a) The child has a physical or developmental handicap or mental or emotional condition that either: 57 58

(i) Existed before the adoption petition was filed; or 59

(ii) Developed after the adoption petition was filed and can be directly attributed to factors in the child's preadoption background, medical history, or biological family's background or medical history. 60 61 62 63

(b) The agency determines the expenses necessitated by the child's handicap or condition are beyond the adoptive parent's economic resources. 64 65 66

(2) Services for which a public children services agency may make post adoption special services subsidy payments on behalf of a child under this division shall include medical, surgical, psychiatric, psychological, and counseling services, including residential treatment. 67 68 69 70 71

(3) The department of job and family services shall establish clinical standards to evaluate a child's physical or developmental handicap or mental or emotional condition and assess the child's need for services. 72 73 74 75

(4) The total dollar value of post adoption special services subsidy payments made on a child's behalf shall not exceed ten thousand dollars in any fiscal year, unless the department 76 77 78

determines that extraordinary circumstances exist that necessitate further funding of services for the child. Under such extraordinary circumstances, the value of the payments made on the child's behalf shall not exceed fifteen thousand dollars in any fiscal year. 79 80 81 82 83

(5) The adoptive parent or parents of a child who receives post adoption special services subsidy payments shall pay at least five per cent of the total cost of all services provided to the child; except that a public children services agency may waive this requirement if the gross annual income of the child's adoptive family is not more than two hundred per cent of the federal poverty guideline. 84 85 86 87 88 89 90

(6) A public children services agency may use other sources of revenue to make post adoption special services subsidy payments, in addition to any state funds appropriated for that purpose. 91 92 93 94

(D) No payment shall be made under division (B) or (C) of this section on behalf of any person eighteen years of age or older beyond the end of the school year during which the person attains the age of eighteen or on behalf of a mentally or physically handicapped person twenty-one years of age or older. 95 96 97 98 99

(E) The director of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code that are needed to implement this section. The rules shall establish all of the following: 100 101 102 103

(1) The application process for all forms of assistance provided under this section; 104 105

(2) The method to determine the amount of assistance payable under division (B) of this section; 106 107

(3) The definition of "child with special needs" for this 108

section; 109

(4) The process whereby a child's continuing need for services provided under division (B) of this section is annually redetermined; 110 111 112

(5) The method of determining the amount, duration, and scope of services provided to a child under division (C) of this section; 113 114 115

(6) Any other rule, requirement, or procedure the department considers appropriate for the implementation of this section. 116 117

(F) The state adoption special services subsidy program ceases to exist on July 1, 2004, except that, subject to the findings of the annual redetermination process established under division (E) of this section and the child's individual need for services, a public children services agency may continue to provide state adoption special services subsidy payments on behalf of a child for whom payments were being made prior to July 1, 2004. 118 119 120 121 122 123 124 125

(G) No public children services agency shall, pursuant to either section 2151.353 or 5103.15 of the Revised Code, place or maintain a child with special needs who is in the permanent custody of an institution or association certified by the department of job and family services under section 5103.03 of the Revised Code in a setting other than with a person seeking to adopt the child, unless the agency has determined and redetermined at intervals of not more than six months the impossibility of adoption by a person ~~listed pursuant to division (B), (C), or (D) of section 5103.154 of the Revised Code~~ <u>who wishes to adopt children, and is approved by an agency so empowered under Chapter 5103. of the Revised Code, or by a person who wishes to adopt a child with special needs as defined in rules adopted under this section, and who is approved by an agency so empowered under</u> 126 127 128 129 130 131 132 133 134 135 136 137 138 139

Chapter 5103. of the Revised Code, including the impossibility of entering into a payment agreement with such a person. The agency so maintaining such a child shall report its reasons for doing so to the department of job and family services. 140 141 142 143

The department may take any action permitted under section 5101.24 of the Revised Code for an agency's failure to determine, redetermine, and report on a child's status." 144 145 146

In line 90911, after "5139.43," insert "5153.163," 147

In line 90950, after "5101.072," insert "5103.154," 148

In line 158 of the title, after "5139.43," insert "5153.163," 149

In line 243 of the title, after "5101.072," insert "5103.154," 150 151

The motion was __________ agreed to.

SYNOPSIS

Listing of Children Available for Adoption and Prospective Adoptive Parents 152 153

R.C. 5103.154 and 5153.163 154

Eliminates the required listing of all children who are in the permanent custody of an institution or association certified by ODJFS and the required listing of all persons who wish to adopt children and who are approved by an agency so empowered under Chapter 5103. of the Revised Code; eliminates the requirement that ODJFS compile a report with conclusions regarding the effectiveness of the listing program and submit it to the General Assembly. 155 156 157 158 159 160 161 162

128HB1-CC4927X1/HLB

Am. Sub. H.B. 1
As Passed by the Senate
CC-4927-1

_______________________________ moved to amend as follows:

Between lines 101716 and 101717, insert: 1

"**Section 385.40.** SURVEY OF COMMUNITY SPACE 2

The Executive Director of the Ohio School Facilities 3
Commission shall survey classroom facilities projects financed by 4
the Commission under Chapter 3318. of the Revised Code and compile 5
descriptions of how spaces within those facilities are used for 6
activities, services, and programs shared between schools and 7
other public and private entities in their communities. The 8
Executive Director shall identify and describe such spaces 9
included in current or completed projects and shall recommend best 10
practices for enhancing opportunities for including shared 11
community spaces in future projects. The Executive Director shall 12
submit the survey and recommendations to the Commission not later 13
than December 31, 2009." 14

The motion was __________ agreed to.

SYNOPSIS

Survey of Community Space 15

Section 385.40 16

Requires the Executive Director of the School Facilities 17
Commission to (1) survey state-assisted classroom facilities 18
projects and compile descriptions of how spaces within those 19
facilities are used for activities, services, and programs shared 20
between schools and other public and private entities in their 21
communities and (2) recommend best practices for increasing shared 22
community spaces in future projects. The results of the survey 23
must be submitted to the Commission by December 31, 2009. 24

1 128HB1-CC4928.docx/ar

2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4928
5 EDU-192

6 ______________________ moved to amend as follows:

7 Between lines 106510 and 106511, insert:

8 "The amendments by this act to sections 3319.391 and
9 3327.10 of the Revised Code take effect January 1, 2010."

10 Between lines 106601 and 106602, insert:

11 "**Section 812.___.** (A) The amendments by this act to
12 sections 109.57, 109.572, and 3319.291 of the Revised Code are
13 subject to the referendum. Except as otherwise provided in
14 division (B) of this section, the amendments take effect on the
15 ninety-first day after this act is filed with the Secretary of
16 State.

17 (B) The following amendments take effect January 1, 2010:

18 (1) The amendment creating division (F)(2)(c) of section
19 109.57 of the Revised Code and the amendment to division (F)(4)
20 of that section;

21 (2) The amendment to division (B)(2) of section 109.572 of
22 the Revised Code;

23 (3) All of the amendments to section 3319.291 of the
24 Revised Code except the amendments to divisions (A)(3) and (4)
25 of that section."

26 The motion was ________ agreed to.

27 SYNOPSIS

28 **Criminal Records Checks of School Employees**

29 **Sections 812.10 and 812.___**

30 Delays the effective date of the following provisions of
31 the bill until January 1, 2010:

32 (1) The requirement for criminal records checks of persons
33 applying for issuance of an educator license or for employment
34 with a public or chartered nonpublic school or educational
35 service center to include only an FBI check, if the person (1)
36 has previously had a records check by the Bureau of Criminal
37 Identification and Investigation (BCII) for licensure or
38 employment purposes and (2) the person provides proof of
39 continuous Ohio residency for the previous five-year period; and

40 (2) The prohibition on the State Board of Education
41 requiring a criminal records check for licensure purposes any
42 more often than every five years.

Am. Sub. H.B. 1
As Passed by the Senate
CC-4929-1
EDU-140

_______________ moved to amend as follows:

In line 438, after "3304.182," insert "3306.29, 3306.291, 3306.292," 1 2

Between lines 35657 and 35658, insert: 3

"**Sec. 3306.29.** (A) The Ohio school funding advisory council is hereby established. The council shall consist of the following members: 4 5 6

(1) The governor, or the governor's designee; 7

(2) The superintendent of public instruction, or the superintendent's designee; 8 9

(3) The chancellor of the Ohio board of regents, or the chancellor's designee; 10 11

(4) Two school district teachers, appointed by the governor; 12

(5) Two nonteaching, nonadministrative school district employees, appointed by the governor; 13 14

(6) One school district principal, appointed by the speaker of the house of representatives; 15 16

(7) One school district superintendent, appointed by the president of the senate; 17 18

(8) One school district treasurer, appointed by the speaker of the house of representatives; 19 20

(9) One member of a school district board, appointed by the president of the senate; 21 22

(10) One representative of a college of education, appointed by the speaker of the house of representatives; 23 24

(11) One representative of the business community, appointed by the president of the senate; 25 26

(12) One representative of a philanthropic organization, appointed by the speaker of the house of representatives; 27 28

(13) One representative of the Ohio academy of science, appointed by the president of the senate; 29 30

(14) One representative of the general public, appointed by the president of the senate; 31 32

(15) One representative of educational service centers, appointed by the speaker of the house of representatives; 33 34

(16) One parent of a student attending a school operated by a school district, appointed by the governor; 35 36

(17) One representative of community school sponsors, appointed by the governor; 37 38

(18) One representative of operators of community schools, appointed by the president of the senate; 39 40

(19) One community school fiscal officer, appointed by the speaker of the house of representatives; 41 42

(20) One parent of a student attending a community school, appointed by the president of the senate; 43 44

(21) One representative of early childhood education providers, appointed by the governor; 45 46

(22) One representative of chartered nonpublic schools, appointed by the speaker of the house of representatives; 47 48

(23) Two persons appointed by the president of the senate, one of whom shall be recommended by the minority leader of the senate; 49 50 51

(24) Two persons appointed by the speaker of the house of representatives, one of whom shall be recommended by the minority leader of the house of representatives. 52 53 54

The members shall serve without compensation. 55

(B) The superintendent of public instruction, or the superintendent's designee to the council, shall be the chairperson of the council. 56 57 58

The department of education shall provide staffing assistance to the council. 59 60

(C) Not later than December 1, 2010, and the first day of July of each even-numbered year thereafter, the council shall present to the state board of education, the general assembly, in accordance with section 101.68 of the Revised Code, and the public recommendations for revisions to the educational adequacy components of the school funding model established under this chapter. 61 62 63 64 65 66 67

(1) The recommendations shall be based on current, high quality research, information provided by school districts, and best practices in operational efficiencies. 68 69 70

(2) In preparing its recommendations due December 1, 2010, the council's analyses shall include, but shall not be limited to, the adequacy of the model's financing for special education, gifted education services, career-technical education, arts education, services for limited English proficient students, and early college high schools. This analysis shall consider, for each 71 72 73 74 75 76

area, current educational need, current educational practices, and best practices. In its December 1, 2010, report the council also shall include all of the following: 77 78 79

(a) Recommendations for a student-centered evidence-based model for schools that uses a per pupil level of funding to follow a student to the school that best meets the student's individual learning needs; 80 81 82 83

(b) A study of the extent to which current funding for joint vocational school districts and compact and comprehensive career-technical schools is responsive to state, regional, and local business and industry needs, and recommendations for revisions to career-technical education programming and funding; 84 85 86 87 88

(c) A study of the extent to which the current educational service center system supports school districts in academic achievement, teacher quality, shared educational services, and the purchasing of educational services and commodities, and recommendations for a new regional service delivery system, the educational service system governance structure, and accountability metrics for educational service centers; 89 90 91 92 93 94 95

(d) An examination of the existing structures and systems that support compensation and retirement benefits for teachers, and recommendations for changes to the systems of teacher compensation and retirement benefits to improve the connections between teacher compensation, teaching excellence, and higher levels of student learning; 96 97 98 99 100 101

(e) A consideration of whether community schools and STEM schools should be subject to the expenditure and reporting standards adopted under section 3306.25 of the Revised Code and the accountability requirements of sections 3306.30 to 3306.40 of the Revised Code; 102 103 104 105 106

(f) An analysis of the effects of open enrollment on students and school districts, and recommendations for ensuring that open enrollment policy and financing is equitable for students and school districts. 107 108 109 110

(3) In preparing its recommendations due December 1, 2010, and in subsequent biennia, the council's analyses may address, but need not be limited to, any of the following: 111 112 113

(a) Strategies and incentives to promote school cost-saving measures and efficiencies; 114 115

(b) Options for adding learning time to the learning year, such as moving professional development for educators to summer, adding learning time for children with greater educational needs, accounting for learning time by hours instead of days, and appropriate compensation to school districts and staff for providing additional learning time; 116 117 118 119 120 121

(c) The adequacy of the model's accounting for and financing of operational costs, including district-level administration and administrative and transportation challenges experienced by low-density and low-wealth school districts, and the effect of those costs on student academic achievement; 122 123 124 125 126

(d) The accuracy of the calculation of each component of the funding model, and of the model as a whole, in light of current educational needs, current educational practices, and best practices; 127 128 129 130

(e) Options to encourage school districts and schools already attaining excellent ratings under section 3302.03 of the Revised Code to go beyond state standards and aspire to higher international norms. 131 132 133 134

Sec. 3306.291. (A) A subcommittee of the Ohio school funding 135

advisory council is hereby established to study and make recommendations to foster collaboration between school districts and community schools established under Chapter 3314. of the Revised Code. The subcommittee shall recommend fiscal strategies, including changes to the funding model established under this chapter, that will provide incentives and compensation for Ohio school districts and community schools to enter into collaborative agreements that result in creative and innovative academic programming for students and academic and fiscal efficiency. The subcommittee shall report its findings and recommendations to the council and, in accordance with section 101.68 of the Revised Code, the general assembly not later than September 1, 2010, and periodically thereafter at the direction of the superintendent of public instruction. 136 137 138 139 140 141 142 143 144 145 146 147 148 149

(B) The subcommittee shall consist of the following members of the council: 150 151

(1) The school district superintendent; 152

(2) The school district treasurer; 153

(3) One of the school district teachers, selected by the superintendent of public instruction; 154 155

(4) The member representing a college of education; 156

(5) The member representing sponsors of community schools; 157

(6) The member representing operators of community schools; 158

(7) The community school fiscal officer; 159

(8) The parent of a student attending a community school; 160

(9) The parent of a student attending a school operated by a school district. 161 162

The members of the subcommittee shall serve without 163

compensation. 164

Sec. 3306.292. The Ohio school funding advisory council may 165
establish subcommittees in addition to the subcommittee 166
established under section 3306.291 of the Revised Code. The 167
council shall determine the membership and duties of the 168
additional subcommittees. Up to one-half of the members of each 169
additional subcommittee may be individuals who are not members of 170
the council." 171

Delete lines 94890 through 94997 172

In line 106538, after "3301.95," insert "3306.29, 3306.291, 173
3306.292," 174

In line 198 of the title, after "3304.182," insert "3306.29, 175
3306.291, 3306.292," 176

The motion was __________ agreed to.

SYNOPSIS

Ohio School Funding Advisory Council 177

R.C. 3306.29, 3306.291, and 3306.292; Section 265.30.[illegible]7 178

Removes the bill's provision creating the temporary 179
Student-Centered Evidence-Based Funding Council and replaces it 180
with a provision creating a permanent Ohio School Funding Advisory 181
Council to provide recommendations to State Board of Education, 182
the General Assembly, and the public every two years on the 183
adequacy of the evidence-based school funding model, similar to 184
the Ohio School Funding Research Advisory Council created by the 185
House version. The membership of the council created by the 186
amendment is the same as the temporary council created by the 187

bill, except that the amendment specifies that the Governor, the state Superintendent, and the Chancellor of the Board of Regents may appoint a designee to sit on the council in their stead and that the state Superintendent or designee is the chair of the council, instead of the Governor as under the bill. In its report due December 1, 2010, the council must include all of the following: 188 189 190 191 192 193 194

(1) An analysis of the funding model's adequacy in financing for special education and, as in the House version, gifted education services, career-technical education, arts education, services for limited English proficient students, and early college high schools; 195 196 197 198 199

(2) Recommendations for a student-centered evidence-based model that uses a per pupil level of funding to follow a student to the school that best meets the student's individual learning needs (as in the Senate version); 200 201 202 203

(3) A study of the extent to which current funding for joint vocational school districts and compact and comprehensive career-technical schools is responsive to state, regional, and local business and industry needs and recommendations for revisions to career-technical education programming and funding (as provided separately for a different study committee in the House version); 204 205 206 207 208 209 210

(4) A study of the extent to which the current educational service center system supports school districts and recommendations for a new regional service delivery system, the educational service system governance structure, and accountability metrics for educational service centers (as provided separately for a different study committee in the House version); 211 212 213 214 215 216 217

(5) A study of existing compensation and retirement benefits 218

for teachers, and recommendations for changes to the systems of teacher compensation and retirement benefits to improve the connections between teacher compensation, teaching excellence, and higher levels of student learning (as provided separately for a different study committee in the House version); 219 220 221 222 223

(6) A consideration of whether community schools and STEM schools should be subject to the expenditure and reporting standards and accountability requirements that apply to school districts; and 224 225 226 227

(7) Analysis of the effects of open enrollment on students and school districts, and recommendations for ensuring that open enrollment policy and financing is equitable for students and school districts. 228 229 230 231

In addition, the biennial reports of the council may include all of the items permitted under the House version, plus recommendations for options to encourage "excellent" school districts and schools to go beyond state standards and aspire to higher international norms. 232 233 234 235 236

Establishes a subcommittee of the Council to make recommendations for fostering collaboration between school districts and community schools (same as the House version). 237 238 239

Permits the Council to establish other subcommittees, as in the House version. 240 241

128HB1-CC4931/RYT

Am. Sub. H.B. 1
As Passed by the Senate
CC-4931

______________________ moved to amend as follows:

In line 302, after "124.183," insert "124.22," 1

Between lines 10819 and 10820, insert: 2

"**Sec. 124.22.** Rules establishing educational requirements as 3
a condition of taking a civil service examination shall only be 4
adopted with respect to positions for which educational 5
requirements are expressly imposed by a section of the Revised 6
Code or federal requirements or for which the director determines 7
that the educational requirements are job-related. An applicant 8
for a civil service examination must be a United States citizen or 9
have ~~legally declared the intention of becoming a United States~~ 10
~~citizen~~ a valid permanent resident card." 11

In line 11278, after the second "of" insert "more than"; 12
strike through "or more" 13

In line 11280, after "of" insert "more than"; strike through 14
"or more" 15

In line 11282, after the first "of" insert "more than"; 16
strike through "or more" 17

In line 11284, after the first "of" insert "more than"; 18
strike through "or more" 19

In line 90804, after "124.183," insert "124.22," 20

In line 12 of the title, after "124.183," insert "124.22," 21

The motion was __________ agreed to.

SYNOPSIS

Civil Service Applicants; Disciplinary Actions 22

R.C. 124.22 and 124.34 23

Restores a provision from the House version requiring an 24
applicant for a civil service examination to be a United States 25
citizen or have a valid permanent resident card, rather than be a 26
United States citizen or have legally declared the intention to 27
become a United States citizen as required under current law. 28

Restores a provision from the House version specifying that 29
certain disciplinary actions that, under current law, are linked 30
to 24 or 40 or more hours of work or pay, instead be linked to 31
more than 24 or 40 hours of work or pay. 32

Am. Sub. H.B. 1
As Passed by the Senate
CC-4934-2

_______________ moved to amend as follows:

In line 442, after "3333.91," insert "3353.20," 1

Between lines 46267 and 46268, insert: 2

"**Sec. 3353.20.** (A) The eTech Ohio commission shall develop and implement an interactive distance learning pilot project to provide, beginning with the 2009-2010 school year, access to at least three interactive distance learning courses in each school year free of charge for all high schools operated by school districts. The courses offered shall include two advanced placement courses and one foreign language course. 3 4 5 6 7 8 9

The commission shall do all of the following: 10

(1) Contract for the development and offering of interactive distance learning courses; 11 12

(2) Produce and broadcast the courses offered by the pilot project; 13 14

(3) Provide the funds for schools to purchase video conferencing telecommunications equipment and connectivity devices, if necessary, so that the schools may participate in the pilot project; 15 16 17 18

(4) Assist schools in arranging for the purchase and 19

installation of telecommunications equipment and connectivity devices, if necessary, so that the schools may participate in the pilot project; 20 21 22

(5) Pay, for up to one school year, the cost of upgrading internet service for schools that currently have a connection not faster than 1.544 megabits per second; 23 24 25

(6) Offer training in the use of the telecommunications equipment necessary to participate in the pilot project; 26 27

(7) Administer and oversee the operation of the pilot project. 28 29

(B) The department of education, in consultation with the chancellor of the Ohio board of regents, shall select courses to be offered by the pilot project and shall develop the standards for the curriculum of each course selected. 30 31 32 33

(C) The commission and the department jointly, and in consultation with the chancellor, shall select the teachers to develop and teach the courses offered by the pilot project. 34 35 36

(D) The commission, the department, and the chancellor jointly shall notify schools of and promote participation in the pilot project. 37 38 39

(E) Each high school shall determine the manner in which and facilities at which students may participate in courses consistent with specifications for technology and connectivity required by the commission. 40 41 42 43

(F) The grade for a student enrolled in a course offered through the pilot project shall be assigned by the course teacher and shall be transmitted to the student's high school. 44 45 46

(G) Not later than December 31, 2010, the superintendent of public instruction, the chancellor, and the commission shall 47 48

submit to the governor and the general assembly, in accordance with section 101.68 of the Revised Code, a formative evaluation of the implementation and results of and legislative recommendations for changes in the pilot project." 49 50 51 52

Between lines 95096 and 95097, insert: 53

"**Section** _____. EDUCATION TECHNOLOGY 54

(A) As used in this section, "eligible entity" means an "eligible local entity" for purposes of the "Enhancing Education Through Technology Act of 2001," as defined in 20 U.S.C. 6753. 55 56 57

(B) Notwithstanding anything in section 3353.20 of the Revised Code to the contrary, for fiscal years 2010 and 2011, the interactive distance learning pilot project required by that section shall be developed and administered only as prescribed by this section. 58 59 60 61 62

Of the foregoing appropriation item 200641, Education Technology, the Department of Education, in each fiscal year, shall use the lesser of one-half of the amount of federal funds allocated to the state for the fiscal year as an Education Technology State Grant (CFDA 84.318) or $4,500,000 in collaboration with the eTech Ohio Commission to provide grants on a competitive basis to eligible entities for their participation in the interactive distance learning pilot project. 63 64 65 66 67 68 69 70

An amount equal to the unexpended, unencumbered portion of this set aside at the end of fiscal year 2010 is hereby reappropriated to the Department of Education for fiscal year 2011 to provide grants under this section. 71 72 73 74

(1) The Department and the Commission shall enter into a memorandum of understanding giving the Commission the authority to set the grant criteria and to select the grant recipients and giving the Department all federal monitoring and compliance 75 76 77 78

responsibilities. The memorandum of understanding also shall specify all of the following: 79 80

(a) Administrative functions to be provided by each of the Department and the Commission and the distribution between the Department and the Commission of the costs associated with those functions; 81 82 83 84

(b) The process that the Department shall use to draw down and transfer the funds necessary under this section in accordance with the "Cash Management Improvement Act of 1990," 31 U.S.C. 6501 et seq. to support the Commission in its functions; 85 86 87 88

(c) The amount that may be used for administration of the pilot project is limited to not more than five per cent of the total amount expended under this section. 89 90 91

The memorandum of understanding shall comply with all relevant federal guidelines and regulations. 92 93

(2) The Commission shall issue a request for proposals for awards to be issued before or during the 2009-2010 academic year. 94 95

(3) The Commission shall limit the number of grants so that each grant recipient receives an amount that is sufficient to ensure full participation in the program. The Commission shall endeavor to award grants in a manner that ensures diversity among grant recipients according to geographical regions, economic scale, and school district size. 96 97 98 99 100 101

(4) In awarding grants under this section, the Commission shall give priority to the following: 102 103

(a) School districts for which advanced placement or foreign language course offerings make up less than one per cent of the district's total course offerings; 104 105 106

(b) Schools and school districts that without additional 107

assistance lack the necessary connectivity to offer interactive 108
distance learning courses; 109

(c) Schools and school districts that demonstrate commitment 110
to appropriately supporting distance learning offerings, as 111
determined satisfactory by the Commission, including but not 112
limited to: 113

(i) Enrolling a minimum number of students to participate in 114
the distance learning classes; 115

(ii) Committing the necessary personnel to facilitate and 116
assist students with distance learning classes; 117

(iii) Committing the necessary personnel capable of operating 118
distance learning equipment. 119

(d) Schools and school districts that without additional 120
assistance lack the necessary equipment to offer interactive 121
distance learning courses; 122

(e) School districts that demonstrate that the course 123
offerings will take place during the regular school day. 124

(C) In implementing this section, the Commission shall do all 125
of the following: 126

(1) Solicit all eligible entities to participate in the 127
program; 128

(2) Require twenty-five per cent of any grant award to be 129
used for professional development. This professional development 130
shall include at least one component of training in the classroom. 131
It also shall include any training conducted by the Commission 132
that the Commission deems necessary to participate in the program. 133

(3) Require that eligible entities awarded grants under this 134
section use a percentage of their respective grant awards to 135
contract with a vendor selected by the Commission for the 136

development and offering of interactive distance learning courses; 137

(4) Require each eligible entity submitting a proposal to specify the amount, if any, needed to purchase video conferencing telecommunications equipment and connectivity devices and the cost of upgrading the school. 138 139 140 141

(5) Require each eligible entity submitting a proposal to specify the amount needed to upgrade its Internet service, if the school currently has a connection slower than 1.544 Mbits per second; 142 143 144 145

(6) Assist eligible entities awarded grants in arranging for the purchase and installation of telecommunications equipment and connectivity devices. 146 147 148

(D) In the development of, administration of, oversight of, and award of funds for the program, the Commission shall not be obligated for more than the amount appropriated. 149 150 151

(E) In fiscal years 2010 and 2011, no school that is not an eligible entity shall be entitled to the items specified in divisions (A)(3) to (5) of section 3353.20 of the Revised Code. However, any student, teacher, or other school employee of a public or nonpublic school that is not awarded a grant under this section may participate in the interactive distance learning pilot project, as long as such participation does not impose an additional cost to the state, does not diminish the quality of project outcomes for those entities that are awarded grants, and aligns with federal regulations and guidelines. 152 153 154 155 156 157 158 159 160 161

(F) The Superintendent of Public Instruction, the Chancellor of the Board of Regents, and the Commission shall submit the formative evaluation prescribed by division (G) of section 3353.20 of the Revised Code." 162 163 164 165

In line 106542, after "3345.32," insert "3353.20," 166

In line 202 of the title, after "3333.91," insert "3353.20," 167

The motion was ________ agreed to.

SYNOPSIS

Interactive Distance Learning Pilot Project 168

R.C. 3353.20 and Sections _____, _____, and _____ 169

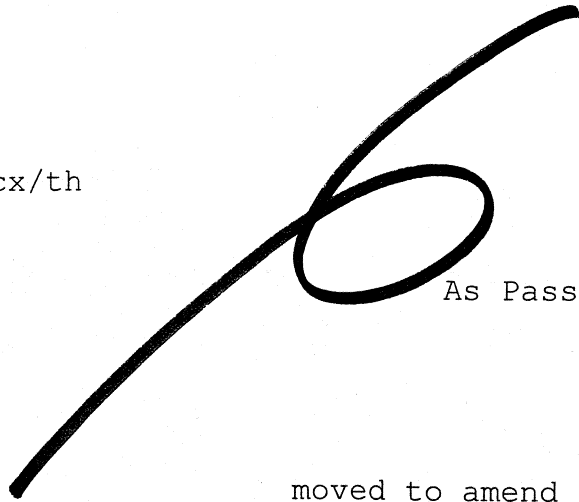
Reinstates with revisions the House provision that requires 170
the eTech Ohio Commission, with assistance from the Department of 171
Education and in consultation with the Chancellor of the Board of 172
Regents, to develop and implement a pilot project to provide at 173
least two Advanced Placement and one foreign language interactive 174
distance learning courses through grants to eligible schools. The 175
amendment does not include a House provision that appropriated 176
state funds to the Commission to administer the pilot project and 177
to provide some services and materials. Rather, the amendment 178
earmarks the lesser of one-half of the amount allocated to the 179
state for federal Enhancing Education Through Technology grants or 180
$4.5 million each fiscal year from FED appropriation item 200641, 181
Education Technology, for the pilot project and requires the 182
Department of Education and the Commission to enter into a 183
memorandum of understanding. This is instead of transferring $4.5 184
million of federal funds. 185

Qualifies entities eligible under the federal Enhancing 186
Education Through Technology Act for the grants, instead of Title 187
I schools as under the House provision. (These entities are (1) 188
school districts that qualify for Title I funds and have one or 189
more schools in "improvement status," under the federal No Child 190
Left Behind Act, (2) school districts that have substantial need 191

for assistance in acquiring and using technology, or (3) entities in a collaborative partnership with a district described in (1) or (2).) 192 193 194

Permits students, teachers, and other school employees of schools not awarded a grant to participate in the pilot project at their own expense. 195 196 197

1 128HB1-CC4936X1.docx/th



2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4936-1

5 _______________________________ moved to amend as follows:

6 Delete lines 49648 through 49676 and insert "If the
7 director of environmental protection determines that
8 implementation of a motor vehicle inspection and maintenance
9 program is necessary for the state to effectively comply with
10 the federal Clean Air Act after June 30, 2009, the director may
11 provide for the implementation of the program in those counties
12 in this state in which such a program is federally mandated.
13 Upon making such a determination, the director of environmental
14 protection may request the director of administrative services
15 to extend the terms of the contract that was entered into under
16 the authority of Section 7 of Am. Sub. H.B. 24 of the 127th
17 general assembly. Upon receiving the request, the director of
18 administrative services shall extend the contract, beginning on
19 July 1, 2009, in accordance with this section. The contract
20 shall be extended for a period of up to six months with the
21 contractor who conducted the motor vehicle inspection and
22 maintenance program under that contract.

23 (2) Prior to the expiration of the contract extension that
24 is authorized by division (A)(1) of this section, the director

25 of environmental protection may request the director of
26 administrative services to enter into a contract with a vendor
27 to operate a motor vehicle inspection and maintenance program in
28 each county in this state in which such a program is federally
29 mandated through June 30, 2011, with an option for the state to
30 renew the contract through June 30, 2012. The contract shall
31 ensure that the motor vehicle inspection and maintenance program
32 achieves at least the same ozone precursor reductions as
33 achieved by the program operated under the authority of the
34 contract that was extended under division (A)(1) of this
35 section. The director of administrative services shall select a
36 vendor through a competitive selection process in compliance
37 with Chapter 125. of the Revised Code."

38 In line 49709, delete everything after "(4)"

39 Delete lines 49710 through 49712

40 In line 49713, delete "(5)"

41 Delete lines 49789 through 49829

42 The motion was ________ agreed to.

43 SYNOPSIS

44 **E-Check**

45 **R.C. 3704.14**

46 Makes the following changes in the provisions of the bill
47 governing the motor vehicle inspection and maintenance program:

48 --The inclusion of language from the House-passed version
49 of the bill that authorizes the Director of Environmental
50 Protection to request the Director of Administrative Services to
51 extend for six months the motor vehicle inspection and
52 maintenance program contract that is scheduled to expire on June
53 30, 2009, and that authorizes the Director of Environmental
54 Protection, prior to the expiration of the six-month contract
55 extension, to request the Director of Administrative Services to
56 enter into a new contract through June 30, 2011, with an option
57 for the state to renew the contract through June 30, 2012;

58 --The removal of language in the Senate-passed version of
59 the bill that requires the Governor to issue executive orders
60 regarding the contract extension and new contract;

61 --The elimination of language in the Senate-passed version
62 of the bill that states the General Assembly's intent concerning
63 the program and that requires the Director of Environmental
64 Protection annually to request the United States Environmental
65 Protection Agency to provide information on alternative
66 approaches to meet federal performance standards and program
67 changes.

1 128HB1-CC4937.docx/mlp

2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4937

5 ______________________________ moved to amend as follows:

6 In line 41087, after the first "the" insert "sum of the";
7 after "district" insert "under divisions (A)(1) and (2) of
8 section 3317.021 of the Revised Code"

9 In line 41088, strike through everything after "years"

10 In line 41089, strike through everything before the period

11 In line 41091, after "of" insert "the sum of"; after
12 "district" insert "under division (A)(1) and as public utility
13 personal property under division (A)(2) of section 3317.021 of
14 the Revised Code"

15 In line 41092, delete "under" and insert an underlined
16 period

17 Delete line 41093

18 In line 41114, delete ",on August 31, 2005,"

19 In line 41115, delete the underlined comma

20 In line 41116, after "Code" insert "for tax year 2005,
21 excluding the taxable value of public utility personal property"

22 In line 41117, delete everything after "value" and insert
23 "for tax year 2005 as certified under that section."

24 Delete line 41118

25 The motion was ________ agreed to.

26 SYNOPSIS

27 **Tangible Personal Property Phase-Out Impacted District**

28 **R.C. 3318.011**

29 Modifies a provision in the Senate-passed bill specifying
30 that if a school district's business tangible personal property
31 valuation (excluding public utility personal property) was equal
32 to or greater than 20% of the district's total taxable value for
33 tax year 2005, the district's 3-year "average taxable value"
34 used for computing wealth percentile rankings of school
35 districts for school facilities assistance excludes the value of
36 the district's business tangible personal property.

Am. Sub. H.B. 1
As Passed by the Senate
CC-4938
JFS072

_______________ moved to amend as follows:

In line 396, after "5101.162," insert "5101.24," 1

Between lines 73468 and 73469, insert: 2

"**Sec. 5101.24.** (A) As used in this section, "responsible county grantee" means whichever county grantee, as defined in section 5101.21 of the Revised Code, the director of job and family services determines is appropriate to take action against under division (C) of this section. 3 4 5 6 7

(B) Regardless of whether a family services duty is performed by a county family services agency, private or government entity pursuant to a contract entered into under section 307.982 of the Revised Code or division (C)(2) of section 5153.16 of the Revised Code, or private or government provider of a family service duty, the department of job and family services may take action under division (C) of this section against the responsible county grantee if the department determines any of the following are the case: 8 9 10 11 12 13 14 15 16

(1) A requirement of a grant agreement entered into under section 5101.21 of the Revised Code that includes a grant for the family services duty, including a requirement for grant agreements 17 18 19

established by rules adopted under that section, is not complied with; 20 21

(2) A county family services agency fails to develop, submit to the department, or comply with a corrective action plan under division (B) of section 5101.221 of the Revised Code, or the department disapproves the agency's corrective action plan developed under division (B) of section 5101.221 of the Revised Code; 22 23 24 25 26 27

(3) A requirement for the family services duty established by the department or any of the following is not complied with: a federal or state law, state plan for receipt of federal financial participation, grant agreement between the department and a federal agency, or executive order issued by the governor; 28 29 30 31 32

(4) The responsible county grantee is solely or partially responsible, as determined by the director of job and family services, for an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty regarding the family services duty. 33 34 35 36 37

(C) The department may take one or more of the following actions against the responsible county grantee when authorized by division (B)(1), (2), (3), or (4) of this section: 38 39 40

(1) Require the responsible county grantee to comply with a corrective action plan pursuant to a time schedule specified by the department. The corrective action plan shall be established or approved by the department and shall not require a county grantee to commit resources to the plan. 41 42 43 44 45

(2) Require the responsible county grantee to comply with a corrective action plan pursuant to a time schedule specified by the department. The corrective action plan shall be established or approved by the department and require a county grantee to commit 46 47 48 49

to the plan existing resources identified by the agency. 50

(3) Require the responsible county grantee to do one of the following: 51 52

(a) Share with the department a final disallowance of federal financial participation or other sanction or penalty; 53 54

(b) Reimburse the department the final amount the department pays to the federal government or another entity that represents the amount the responsible county grantee is responsible for of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or other entity; 55 56 57 58 59 60 61

(c) Pay the federal government or another entity the final amount that represents the amount the responsible county grantee is responsible for of an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or other entity; 62 63 64 65 66 67

(d) Pay the department the final amount that represents the amount the responsible county grantee is responsible for of an adverse audit finding or adverse quality control finding. 68 69 70

(4) Impose an administrative sanction issued by the department against the responsible county grantee. A sanction may be increased if the department has previously taken action against the responsible entity under this division. 71 72 73 74

(5) Perform, or contract with a government or private entity for the entity to perform, the family services duty until the department is satisfied that the responsible county grantee ensures that the duty will be performed satisfactorily. If the department performs or contracts with an entity to perform a 75 76 77 78 79

family services duty under division (C)(5) of this section, the department may do either or both of the following: 80 81

(a) Spend funds in the county treasury appropriated by the board of county commissioners for the duty; 82 83

(b) Withhold funds allocated or reimbursements due to the responsible county grantee for the duty and spend the funds for the duty. 84 85 86

(6) Request that the attorney general bring mandamus proceedings to compel the responsible county grantee to take or cease the action that causes division (B)(1), (2), (3), or (4) of this section to apply. The attorney general shall bring mandamus proceedings in the Franklin county court of appeals at the department's request. 87 88 89 90 91 92

(7) If the department takes action under this division because of division (B)(3) of this section, temporarily withhold funds allocated or reimbursement due to the responsible county grantee until the department determines that the responsible county grantee is in compliance with the requirement. The department shall release the funds when the department determines that compliance has been achieved. 93 94 95 96 97 98 99

(D) If the department proposes to take action against the responsible county grantee under division (C) of this section, the department shall notify the responsible county grantee, director of the appropriate county family services agency, and county auditor. The notice shall be in writing and specify the action the department proposes to take. The department shall send the notice by regular United States mail. 100 101 102 103 104 105 106

Except as provided by division (E) of this section, the responsible county grantee may request an administrative review of a proposed action in accordance with administrative review 107 108 109

procedures the department shall establish. The administrative review procedures shall comply with all of the following: 110 111

(1) A request for an administrative review shall state specifically all of the following: 112 113

(a) The proposed action specified in the notice from the department for which the review is requested; 114 115

(b) The reason why the responsible county grantee believes the proposed action is inappropriate; 116 117

(c) All facts and legal arguments that the responsible county grantee wants the department to consider; 118 119

(d) The name of the person who will serve as the responsible county grantee's representative in the review. 120 121

(2) If the department's notice specifies more than one proposed action and the responsible county grantee does not specify all of the proposed actions in its request pursuant to division (D)(1)(a) of this section, the proposed actions not specified in the request shall not be subject to administrative review and the parts of the notice regarding those proposed actions shall be final and binding on the responsible county grantee. 122 123 124 125 126 127 128 129

(3) In the case of a proposed action under division (C)(1) of this section, the responsible county grantee shall have fifteen calendar days after the department mails the notice to the responsible county grantee to send a written request to the department for an administrative review. If it receives such a request within the required time, the department shall postpone taking action under division (C)(1) of this section for fifteen calendar days following the day it receives the request or extended period of time provided for in division (D)(5) of this section to allow a representative of the department and a 130 131 132 133 134 135 136 137 138 139

representative of the responsible county grantee an informal opportunity to resolve any dispute during that fifteen-day or extended period. 140 141 142

(4) In the case of a proposed action under division (C)(2), (3), (4), (5), or (7) of this section, the responsible county grantee shall have thirty calendar days after the department mails the notice to the responsible county grantee to send a written request to the department for an administrative review. If it receives such a request within the required time, the department shall postpone taking action under division (C)(2), (3), (4), (5), or (7) of this section for thirty calendar days following the day it receives the request or extended period of time provided for in division (D)(5) of this section to allow a representative of the department and a representative of the responsible county grantee an informal opportunity to resolve any dispute during that thirty-day or extended period. 143 144 145 146 147 148 149 150 151 152 153 154 155

(5) If the informal opportunity provided in division (D)(3) or (4) of this section does not result in a written resolution to the dispute within the fifteen- or thirty-day period, the director of job and family services and representative of the responsible county grantee may enter into a written agreement extending the time period for attempting an informal resolution of the dispute under division (D)(3) or (4) of this section. 156 157 158 159 160 161 162

(6) In the case of a proposed action under division (C)(3) of this section, the responsible county grantee may not include in its request disputes over a finding, final disallowance of federal financial participation, or other sanction or penalty issued by the federal government, auditor of state, or entity other than the department. 163 164 165 166 167 168

(7) If the responsible county grantee fails to request an administrative review within the required time, the responsible 169 170

county grantee loses the right to request an administrative review of the proposed actions specified in the notice and the notice becomes final and binding on the responsible county grantee. 171 172 173 174

(8) If the informal opportunity provided in division (D)(3) or (4) of this section does not result in a written resolution to the dispute within the time provided by division (D)(3), (4), or (5) of this section, the director shall appoint an administrative review panel to conduct the administrative review. The review panel shall consist of department employees and one director or other representative of the type of county family services agency that is responsible for the kind of family services duty that is the subject of the dispute and serves a different county than the county served by the responsible county grantee. No individual involved in the department's proposal to take action against the responsible county grantee may serve on the review panel. The review panel shall review the responsible county grantee's request. The review panel may require that the department or responsible county grantee submit additional information and schedule and conduct an informal hearing to obtain testimony or additional evidence. A review of a proposal to take action under division (C)(3) of this section shall be limited solely to the issue of the amount the responsible county grantee shall share with the department, reimburse the department, or pay to the federal government, department, or other entity under division (C)(3) of this section. The review panel is not required to make a stenographic record of its hearing or other proceedings. 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197

(9) After finishing an administrative review, an administrative review panel appointed under division (D)(8) of this section shall submit a written report to the director setting forth its findings of fact, conclusions of law, and recommendations for action. The director may approve, modify, or 198 199 200 201 202

disapprove the recommendations. If the director modifies or disapproves the recommendations, the director shall state the reasons for the modification or disapproval and the actions to be taken against the responsible county grantee. 203 204 205 206

(10) The director's approval, modification, or disapproval under division (D)(9) of this section shall be final and binding on the responsible county grantee and shall not be subject to further departmental review. 207 208 209 210

(E) The responsible county grantee is not entitled to an administrative review under division (D) of this section for any of the following: 211 212 213

(1) An action taken under division (C)(6) of this section; 214

(2) An action taken under section 5101.242 of the Revised Code; 215 216

(3) An action taken under division (C)(3) of this section if the federal government, auditor of state, or entity other than the department has identified the responsible county grantee as being solely or partially responsible for an adverse audit finding, adverse quality control finding, final disallowance of federal financial participation, or other sanction or penalty; 217 218 219 220 221 222

(4) An adjustment to an allocation, cash draw, advance, or reimbursement to a responsible county grantee that the department determines necessary for budgetary reasons; 223 224 225

(5) Withholding of a cash draw or reimbursement due to noncompliance with a reporting requirement established in rules adopted under section 5101.243 of the Revised Code; 226 227 228

(6) An action taken under division (C)(5) of this section if the department determines that an emergency exists. 229 230

(F) This section does not apply to other actions the 231

department takes against the responsible county grantee pursuant to authority granted by another state law unless the other state law requires the department to take the action in accordance with this section. 232 233 234 235

(G) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this section." 236 237 238

In line 90898, after "5101.162," insert "5101.24," 239

In line 142 of the title, after "5101.162," insert "5101.24," 240

The motion was __________ agreed to.

SYNOPSIS

Action Against a County regarding Family Services Duties 241

R.C. 5101.24 242

Provides that a board of county commissioners, county children services board, or child support enforcement agency is not entitled to an administrative review when ODJFS, pursuant to its authority to take various actions against a county regarding a family services duty, performs or contracts with another entity to perform the family services duty if ODJFS determines that an emergency exists. 243 244 245 246 247 248 249

1 128HB1-CC4939.docx/ss

2 Am. Sub. H. B. 1
3 As Passed by the Senate
4 CC-4939
5 DAS094

6 ______________________ moved to amend as follows:

7 Between lines 96087 and 96088, insert:

8 "PAYROLL WITHHOLDING FUND TRANSFER

9 On July 1, 2009, or as soon as possible thereafter, the
10 Director of Budget and Management shall transfer $33,065.48 from
11 the Payroll Withholding Fund (Fund 1240) to the General Revenue
12 Fund. This amount represents the remaining balance in the
13 Manual Emergency Payroll Account. After the transfer is
14 completed, the Manual Emergency Payroll Account shall be
15 closed."

16 The motion was ________ agreed to.

17 SYNOPSIS

18 **Employee Benefits Funds**

19 **Section 271.10**

20 Transfers $33,065.48 from the Payroll Withholding Fund
21 (Fund 1240) to the GRF; closes the Manual Emergency Payroll
22 Account in Fund 1240 upon the completion of the transfer.

1 128HB1-CC4940.docx/ss

2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4940
5 DEV086

6 ______________________ moved to amend as follows:

7 In line 93167, delete "$4,356,424 $4,356,424" and insert
8 "$8,400,000 $3,800,000"

9 In line 93179, add $4,043,576 to fiscal year 2010 and
10 subtract $556,424 from fiscal year 2011

11 In line 93204, add $4,043,576 to fiscal year 2010 and
12 subtract $556,424 from fiscal year 2011

13 In line 93680, delete "$6,100,000" and insert "$8,400,000"

14 In line 93688, delete "$6,100,000" and insert "$3,800,000"

15 The motion was ________ agreed to.

16 SYNOPSIS

17 **Department of Development**

18 **Sections 259.10 and 259.30.70**

19 Increases Fund 4F20 appropriation item 195676, Marketing
20 Initiatives, to $8,400,000 in fiscal year 2010 and decreases the
21 appropriation item to $3,800,000 in fiscal year 2011, and
22 revises the amounts of unclaimed funds to be transferred to Fund
23 4F20 for the appropriation item accordingly.

1 128HB1-CC4943.docx/ss

2 Am. Sub. H. B. 1
3 As Passed by the Senate
4 CC-4943
5 RSC-13

6 ______________________ moved to amend as follows:

7 In line 35604, delete "ten" and insert "thirteen"

8 In line 35607, delete "six" and insert "three"

9 The motion was ________ agreed to.

10 SYNOPSIS

11 **Rehabilitation Services Commission**

12 **R.C. 3304.182**

13 Modifies the bill's provision requiring the Rehabilitation
14 Services Commission to seek funding from, and enter contracts
15 with, private and public entities to receive federal funding at
16 the maximum amount possible by requiring that the contracts:

17 (1) Provide 3 months notice (rather than 6 months) prior
18 to discontinuing a contract;

19 (2) Provide that the amount of the funds under the
20 contract used for the Commission's administrative expenses not
21 exceed 13% (rather than 10%).

1 128HB1-CC4946.docx/ar

2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4946
5 DNR050

6 ______________________________ moved to amend as follows:

7 In line 98902, delete "$301,087 $301,087" and insert
8 "$380,000 $383,000"

9 In line 98904, add $78,913 to fiscal year 2010 and $81,913
10 to fiscal year 2011

11 In line 98905, add $78,913 to fiscal year 2010 and $81,913
12 to fiscal year 2011

13 In line 99629, delete the first "$772,011" and insert
14 "$1,072,011"

15 In line 99631, add $300,000 to fiscal year 2010

16 In line 99652, delete "$6,000,000 $6,000,000" and insert
17 "$7,200,000 $7,200,000"

18 In line 99654, delete "$29,885,528 $29,885,528" and insert
19 "$31,885,528 $31,885,528"

20 In line 99655, delete "$757,113 $757,113" and insert
21 "$1,074,113 $974,113"

22 In line 99656, delete "$2,574,378 $2,574,378" and insert
23 "$2,974,378 $2,974,378"

24 In line 99660, delete "$1,932,491 $1,932,491" and insert
25 "$3,267,587 $3,364,361"
26 In line 99677, add $5,252,096 to fiscal year 2010 and
27 $5,248,870 to fiscal year 2011
28 In line 99708, add $5,552,096 to fiscal year 2010 and
29 $5,248,870 to fiscal year 2011

30 The motion was ________ agreed to.

31 SYNOPSIS

32 **Lake Erie Commission and Department of Natural Resources**
33 **Sections 315.10 and 343.10**

34 Makes changes to various appropriations in the Lake Erie
35 Commission and the Department of Natural Resources.

128HB1-CC4948/BLF

Am. Sub. H.B. 1
As Passed by the Senate
CC-4948
DAS090-01

_______________ moved to amend as follows:

Between lines 91570 and 91571, insert: 1

"**Section 207.20.30.** BROADBAND OHIO 2

Any unencumbered, unexpended amounts of the foregoing appropriation item 100607, IT Services Delivery, that were allocated for implementation of the NextGen Network in fiscal years 2008 and 2009, and are necessary for the continuation of the Connect Ohio contract in fiscal years 2010 and 2011, are hereby reappropriated for the same purpose in fiscal years 2010 and 2011." 3 4 5 6 7 8 9

In line 103703, after "103.80.90," insert "301.10.50," 10

Between lines 103736 and 103736a, insert: 11

"**Sec. 301.10.50.** THIRD FRONTIER PROJECT 12

The foregoing appropriation item C23506, Third Frontier Project, shall be used to acquire, renovate, or construct facilities and purchase equipment for research programs, technology development, product development, and commercialization programs at or involving state-supported and state-assisted institutions of higher education. The funds shall be used to make 13 14 15 16 17 18

grants awarded on a competitive basis, and shall be administered by the Third Frontier Commission. Expenditure of these funds shall comply with Section 2n of Article VIII, Ohio Constitution, and sections 151.01 and 151.04 of the Revised Code for the period beginning July 1, 2008, and ending June 30, 2010.

Of the foregoing appropriation item C23506, Third Frontier Project, a portion of the unexpended, unencumbered portion at the end of fiscal year 2008 that was allocated for the implementation of the NextGen Network, and is necessary for the continuation of the implementation of the Connect Ohio contract, shall be used for the same purpose in fiscal year 2009 and fiscal year 2010.

The Third Frontier Commission shall develop guidelines relative to the application for and selection of projects funded from appropriation item C23506, Third Frontier Project. The commission may develop these guidelines in consultation with other interested parties. The Board of Regents and all state-assisted and state-supported institutions of higher education shall take all actions necessary to implement grants awarded by the Third Frontier Commission.

The foregoing appropriation item C23506, Third Frontier Project, for which an appropriation is made from the Higher Education Improvement Fund (Fund 7034), is determined to consist of capital improvements and capital facilities for state-supported and state-assisted institutions of higher education, and is designated for the capital facilities to which proceeds of obligations in the Higher Education Improvement Fund (Fund 7034) are to be applied."

In line 103792, after "103.80.90," insert "301.10.50,"

In line 252 of the title, after "103.80.90," insert "301.10.50,"

The motion was __________ agreed to.

SYNOPSIS

Sections 207.20.30, 259.30.80, and 610.10, 610.11 49

Earmarks the unexpended, unencumbered amounts of Department 50
of Administrative Services' appropriation item 100607, IT Services 51
Delivery, that were allocated for implementation of the NextGen 52
Network in FY 2008 and FY 2009 for the same purpose in FY 2010 and 53
FY 2011. 54

Earmarks in FY 2009 and FY 2010 a portion of the unexpended, 55
unencumbered amounts of capital appropriation item C23506, Third 56
Frontier Project, which were previously allocated to implement the 57
NextGen Network. 58

1 128HB1-CC4949.docx/ar

2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4949
5 DEV087

6 ______________________________ moved to amend as follows:

7 In line 105251, after "(A)" insert "To facilitate the
8 implementation of the motion picture production tax credit
9 authorized in section 122.85 of the Revised Code, the Director
10 of Development may develop, publish, accept, and review
11 applications for certification of motion pictures as tax credit-
12 eligible productions and may indicate preliminary certification
13 before the effective date of that section. A motion picture for
14 which the director has issued a preliminary certification
15 becomes a motion picture certified as a tax credit-eligible
16 production on the effective date of section 122.85 of the
17 Revised Code.

18 (B)"

19 In line 105257, delete "(B)" and insert "(C)"

20 In line 105265, delete "(A)" and insert "(B)"

21 The motion was ________ agreed to.

22 SYNOPSIS

23 **Motion Picture Production Tax Credit**

24 **Section 701.90**

25 Authorizes the Director of Development to create, publish,
26 accept, and review applications for motion picture tax credit-
27 eligible certification, and may issue preliminary
28 certifications, before the effective date of the operative
29 section of the Revised Code (R.C. 122.85).

1 128HB1-CC4951X1.docx/ar

2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4951-1
5 BOR-22

6 ________________________ moved to amend as follows:

7 In line 100315, after the first comma insert "and"

8 In line 100316, delete "and 235646, State Share of"

9 In line 100317, delete "Instruction - Federal Stimulus -
10 Government Services,"

11 In line 100322, after the first comma insert "and"

12 In line 100323, delete "and 235646, State Share of
13 Instruction - Federal"

14 In line 100324, delete "Stimulus - Government Services,"

15 In line 100455, after the first comma insert "and"

16 In line 100456, delete "and 235646, State Share of
17 Instruction -"

18 In line 100457, delete "Federal Stimulus - Government
19 Services,"

20 In line 100469, after the first comma insert "and"

21 In line 100470, delete "and 235646, State Share of
22 Instruction -"

23 In line 100471, delete "Federal Stimulus - Government
24 Services,"

25 In line 100517, after the first comma insert "and"

26 In line 100518, delete "and 235646, State Share of

27 Instruction -"

28 In line 100519, delete "Federal Stimulus - Government

29 Services,"

30 In line 100528, after the first comma insert "and"

31 In line 100529, delete "and 235646, State Share of

32 Instruction -"

33 In line 100530, delete "Federal Stimulus - Government

34 Services,"

35 In line 100538, after the first comma insert "and"

36 In line 100539, delete "and 235646, State Share of

37 Instruction -"

38 In line 100540, delete "Federal Stimulus - Government

39 Services,"

40 In line 100668, after the second comma insert "and"

41 In line 100669, delete "and 235646, State"

42 Delete line 100670

43 In line 100675, after the first comma insert "and"

44 In line 100676, delete "and 235646, State Share of

45 Instruction -"

46 In line 100677, delete "Federal Stimulus - Government

47 Services,"

48 In line 100698, after the period delete the balance of the
49 line
50 Delete lines 100699 through 100706
51 In line 100707, delete "2010-2011 academic year, each main
52 campus of a" and insert "Each"
53 In line 100708, delete "university" and insert
54 "institution"
55 In line 100710, delete "2009-2010" and insert "preceding"
56 In line 100719, after the period insert "These limitations
57 may also be modified by the Chancellor of the Board of Regents,
58 with the approval of the Controlling Board, to respond to
59 exceptional circumstances as identified by the Chancellor of the
60 Board of Regents."
61 In line 100721, after the second comma insert "and"
62 In line 100722, delete "and 235646, State"
63 Delete line 100723
64 In line 100729, after the second comma insert "and"
65 In line 100730, delete "and 235646, State"
66 Delete line 100731
67 In line 100739, after the second comma insert "and"
68 In line 100740, delete "and"
69 Delete line 100741
70 In line 100742, delete "Services,"
71 In line 100747, after the second comma insert "and"

72 In line 100748, delete "and"

73 Delete line 100749

74 In line 100750, delete "Services,"

75 In line 100755, after the second comma insert "and"

76 In line 100756, delete "and"

77 Delete line 100757

78 In line 100758, delete "Services,"

79 In line 100762, after the second comma insert "and"

80 In line 100763, delete "and"

81 Delete line 100764

82 In line 100765, delete "Services,"

83 Between lines 100773 and 100774, insert:

84 "(E)(1) After making the computations required by Sections
85 371.20.80 and 371.20.90 of this act for fiscal year 2010, the
86 Chancellor of the Board of Regents shall make reductions
87 totaling $87,955,700 to the amounts computed before determining
88 the amounts actually paid to campuses during fiscal year 2010
89 from the foregoing appropriation items 235501, State Share of
90 Instruction, and 235644, State Share of Instruction - Federal
91 Stimulus - Education.

92 (2) Notwithstanding any provision of law to the contrary,
93 in fiscal year 2011, from the combined appropriations of the
94 foregoing appropriation items 235501, State Share of
95 Instruction, and 235644, State Share of Instruction - Federal

96 Stimulus - Education, the Chancellor of the Board of Regents
97 shall first pay to each campus an amount equal to the amount
98 each campus's allocation in fiscal year 2010 was reduced under
99 division (E)(1) of this section.

100 (3) In addition to the payments made under division (E)(2)
101 of this section, after making the computations required by
102 Sections 371.20.80 and 371.20.90 of this act for fiscal year
103 2011, the Chancellor of the Board of Regents shall make
104 reductions totaling $20,000,000 to the amounts computed for
105 state-assisted university branch campuses, community colleges,
106 state community colleges, and technical colleges. The
107 Chancellor shall then make additional reductions totaling
108 $170,000,000 to the amounts computed for all campuses. Such
109 additional reductions shall be made proportionally to the
110 allocations originally computed for the following three sectors:
111 (1) university main campuses, (2) university branch campuses,
112 and (3) community colleges, state community colleges, and
113 technical colleges combined. Within each sector, each campus's
114 allocation shall be reduced proportionally, except that the
115 Chancellor, in consultation with representatives of state-
116 assisted institutions of higher education, may establish a
117 percentage below which no campus's allocation is to fall when
118 compared with the campus's payment in the preceding year and

119 proportionally reduce the allocations of all other campuses to
120 support that percentage."
121 In line 100797, after the second comma insert "and"
122 In line 100798, delete ", and"
123 Delete line 100799
124 In line 100800, delete "Services"
125 In line 100815, after the first comma insert "and"
126 In line 100816, delete "and 235646, State Share of
127 Instruction -"
128 In line 100817, delete "Federal Stimulus - Government
129 Services,"
130 In line 101315, delete "235646, SSI - Federal Stimulus -
131 Government Services,"

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132 The motion was ________ agreed to.

133 SYNOPSIS

134 **Board of Regents**

135 **Sections 371.20.80, 371.20.90, 371.20.95, and 371.60.95**

136 Removes the prohibition of any increase of in-state
137 undergraduate instructional and general fees in FY 2010 at all
138 state-assisted institutions of higher education. Limits the
139 increase of fees at all state-assisted institutions of higher
140 education in FY 2010 and FY 2011 to 3.5% above what was charged
141 in the prior academic year.

6

142 Authorizes the Chancellor, with approval of the Controlling
143 Board, to modify higher education tuition limitations in
144 response to exceptional circumstances.

145 Requires that the Chancellor make reductions of $87,955,700
146 to the State Share of Instruction (SSI) campus payments in FY
147 2010.

148 Requires in FY 2011 that the Chancellor pay to each campus
149 the amount that the campus's allocation was reduced in FY 2010.

150 Requires that the Chancellor make reductions of $20.0
151 million to the SSI allocations of university branch campuses,
152 community colleges, state community colleges, and technical
153 colleges in FY 2011. Requires that the Chancellor make
154 additional reductions of $170.0 million proportionally to the
155 SSI allocations of all campuses except permits the Chancellor to
156 establish a percentage below which no campus's allocation is to
157 fall when compared with the campus's payment in the preceding
158 year.

159 Eliminates all references to GRF appropriation item 235646,
160 State Share of Instruction - Federal Stimulus - Government
161 Services.

1 128HB1-CC4952X3.docx/ss

2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4952-3

5 ______________________ moved to amend as follows:

6 In line 70808, after "certification" insert ",
7 registration,"

8 In line 70809, strike through the last comma

9 In line 70810, strike through "within"; delete "twelve";
10 strike through the balance of the line

11 Strike through line 70811

12 In line 70812, strike through everything before "renew"

13 In line 70814, strike through "payment" and insert "doing
14 either of the following:

15 (1) Filing a renewal application and submitting payment"

16 In line 70815, after "Code" insert "within three months
17 after the expiration of the certificate holder's, registrant's,
18 or licensee's certificate, registration, or license;

19 (2) Obtaining a medical exception under division (C) of
20 this section, filing a renewal application, and submitting
21 payment of all fees for renewal and payment of the late filing
22 fee set forth in section 4763.09 of the Revised Code"

23 In line 70820, reinsert "three-month"; delete "twelve-
24 month"
25 In line 70822, after "date" insert ", or during the time
26 period for which a medical exception applies,"
27 Between lines 70823 and 70824, insert:
28 "(C) The superintendent may grant a medical exception upon
29 application by a person certified, registered, or licensed under
30 this chapter. To receive an exception, the certificate holder,
31 registrant, or licensee shall submit a request to the
32 superintendent with proof satisfactory that a medical exception
33 is warranted. If the superintendent makes a determination that
34 satisfactory proof has not been presented, within fifteen days
35 of the date of the denial of the medical exception the
36 certificate holder, registrant, or licensee may file with the
37 division of real estate a request that the real estate appraiser
38 board review the determination. The board may adopt reasonable
39 rules in accordance with Chapter 119. of the Revised Code to
40 implement this division."
41 In line 70837, strike through "If the" and insert "A"
42 In line 70838, after "registrant" insert "who"
43 In line 70839, strike through ", the"
44 In line 70840, strike through everything before "~~or~~";
45 delete the underlined comma

46 In line 70841, strike through "license"; delete ", or
47 registration"; strike through the balance of the line
48 In line 70842, strike through everything before "~~or~~";
49 delete the underlined comma in both places; strike through
50 "licensee"
51 In line 70843, delete "or registrant"; strike through
52 everything before "~~or~~"; delete the underlined comma
53 In line 70844, strike through "licensee"; delete ", or
54 registrant"; strike through the balance of the line
55 Strike through lines 70845 and 70846
56 In line 70847, strike through "certificate"; delete the
57 first underlined comma; strike through "license"; delete ", or
58 registration"; strike through the balance of the line
59 In line 70848, delete the first underlined comma; strike
60 through "licensee"; delete ", or registrant"; strike through
61 "whose certificate"; delete the third underlined comma; strike
62 through "license"; delete ", or"
63 In line 70849, delete "registration"; strike through the
64 balance of the line
65 In line 70850, strike through "certified"; delete the first
66 underlined comma; strike through "licensed"; delete ", or
67 registered"; strike through the balance of the line

68 In line 70851, strike through "certificate holder"; delete
69 the first underlined comma; strike through "licensee"; delete ",
70 or registrant"; strike through the balance of the line
71 In line 70852, strike through "initial certificate"; delete
72 the first underlined comma; strike through "license"; delete ",
73 or registration"; strike through the balance of the line
74 Strike through line 70853
75 In line 70854, strike through "the issuance of a
76 certificate"; delete the first underlined comma; strike through
77 "license"; delete ", or registration" and insert "is ineligible
78 to obtain a renewal certificate, license, or registration and
79 shall comply with section 4763.05 of the Revised Code in order
80 to regain a certificate, license, or registration, except that
81 the certificate holder, licensee, or registrant may submit proof
82 to the superintendent of meeting these requirements within three
83 months after the date of expiration of the certificate, license,
84 or registration, or by obtaining a medical exception under
85 division (E) of this section, without having to comply with
86 section 4763.05 of the Revised Code. A certificate holder,
87 licensee, or registrant may not engage in any activities
88 permitted by the certificate, license, or registration during
89 the three-month period following the certificate's, license's,

90 or registration's normal expiration date or during the time
91 period for which a medical exception applies"
92 In line 70864, strike through "and a" and insert an
93 underlined comma; after "licensee" insert ", or registrant"
94 In line 70866, strike through "and" and insert an
95 underlined comma; after "licensee" insert ", or registrant"
96 Between lines 70899 and 70900, insert:
97 "(E) The superintendent may grant a medical exception upon
98 application by a person certified, registered, or licensed under
99 this chapter. To receive an exception, the certificate holder,
100 registrant, or licensee shall submit a request to the
101 superintendent with proof satisfactory that a medical exception
102 is warranted. If the superintendent makes a determination that
103 satisfactory proof has not been presented, within fifteen days
104 of the date of the denial of the medical exception, the
105 certificate holder, registrant, or licensee may file with the
106 division of real estate a request that the real estate appraiser
107 board review the determination. The board may adopt reasonable
108 rules in accordance with Chapter 119. of the Revised Code to
109 implement this division."
110 Delete lines 106437 through 106450

111 The motion was ________ agreed to.

112 SYNOPSIS

113 **Real Estate Appraiser License Renewal**

114 **R.C. 4763.06 and 4763.07; Section 803.40**

115 Reduces the 12-month grace period adopted by the Senate for
116 renewal of an expired real estate appraiser certificate,
117 license, or registration before the individual is required to
118 reapply and retake the examination, with the result of retaining
119 the three-month grace period under current law.

120 Creates a medical exception to the requirement that a real
121 estate appraiser who has allowed the appraiser's certificate,
122 license, or registration to expire and has not renewed it during
123 the three-month grace period, or who has failed to meet the
124 continuing education requirements, must reapply and retake the
125 examination.

126 Requires a real estate appraiser seeking a medical
127 exception to submit an application to the Superintendent of Real
128 Estate along with satisfactory proof that the medical exception
129 is warranted.

130 Authorizes a real estate appraiser to submit to the
131 Division of Real Estate a request for review of a denial of a
132 medical exception application within 15 days of the denial.

133 Prohibits an individual from engaging in the practice of
134 real estate appraisal during the grace period for renewal of an
135 expired certificate, license, or registration, or during the
136 time period for which a medical exception applies, until the
137 continuing education requirements have been met and all renewal
138 fees and the late filing fee have been paid.

1 128HB1-CC4961.docx/mlp

2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4961
5 JFS099

6 _______________ moved to amend as follows:

7 Delete lines 98122 through 98221

8 The motion was ________ agreed to.

9 SYNOPSIS

10 **Third Party Liability - Pilot Program**

11 **Section 309.32.60**

12 Removes provisions from the bill that require the ODJFS
13 Director to establish and administer a pilot program for the
14 purpose of identifying third parties that are liable for paying
15 all or a portion of a claim for a medical item or service
16 provided to a Medicaid recipient before the claim is submitted
17 to, or paid by, the Medicaid Program.

128HB1-CC4962.docx/mlp

Am. Sub. H.B. 1
As Passed by the Senate
CC-4962
JES111

_______________________ moved to amend as follows:

In line 450, delete "5111.142,"

Delete lines 75767 through 75775

In line 75875, delete ", including the medicaid recipients"

In line 75876, delete "specified in section 5111.142 of the Revised Code"

In line 213 of the title, delete "5111.142,"

The motion was ________ agreed to.

SYNOPSIS

Review of Medicaid Case Management Services

R.C. 5111.142 and 5111.165

Removes provisions that would have required the Department of Job and Family Services to conduct a review of case management services under the fee-for-service component of the Medicaid program and designate individuals identified as ineligible to participate in the Care Management System as participants in the Alternative Care Management Program.

1 128HB1-CC4963.docx/mlp

2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4963

5 ______________________ moved to amend as follows:

6 In line 450, delete "5111.141,"

7 Delete lines 75740 through 75766

8 In line 213 of the title, delete "5111.141,"

9 The motion was ________ agreed to.

10 SYNOPSIS

11 **Medicaid Disease Management Program**

12 **R.C. 5111.141**

13 Removes provisions that would have required the Department
14 of Job and Family Services to implement a disease management
15 component of the Medicaid program, consisting of a system of
16 coordinated health care interventions and patient communications
17 for certain Medicaid recipients with medical conditions
18 necessitating self-care efforts.

_______________ moved to amend as follows:

In line 373, after "3923.021," insert "3923.022," 1

Between lines 59358 and 59359, insert: 2

"**Sec. 3923.022.** (A) As used in this section: 3

(1)(a) "Administrative expense" means the amount resulting 4
from the following: the amount of premiums ~~received~~ earned by the 5
insurer for sickness and accident insurance business plus the 6
amount of losses recovered from reinsurance coverage minus the sum 7
of the amount of claims for losses paid; the amount of losses 8
incurred but not reported; the amount ~~paid~~ incurred for state 9
fees, federal and state taxes, and reinsurance; and the incurred 10
costs and expenses related, either directly or indirectly, to the 11
payment of commissions, measures to control fraud, and managed 12
care. 13

(b) "Administrative expense" does not include any amounts 14
collected, or administrative expenses incurred, by an insurer for 15
the administration of an employee health benefit plan subject to 16
regulation by the federal "Employee Retirement Income Security Act 17
of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended. "Amounts 18
collected or administrative expenses incurred" means the total 19

amount paid to an administrator for the administration and payment of claims minus the sum of the amount of claims for losses paid and the amount of losses incurred but not reported.

(2) "Insurer" means any insurance company authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state.

(3) "Sickness and accident insurance business" does not include coverage provided by an insurer for specific diseases or accidents only; 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; or coverage provided to individuals who are not residents of this state.

(4) "Individual business" includes both individual sickness and accident insurance and sickness and accident insurance made available by insurers in the individual market to individuals, with or without family members or dependents, through group policies issued to one or more associations or entities.

(B) Notwithstanding section 3941.14 of the Revised Code, ~~the following apply to every insurer:~~

~~(1) For calendar year 1993, each insurer shall have aggregate administrative expenses of no more than forty per cent of the premium income of the insurer, based on the premiums received in that year on the sickness and accident insurance business of the insurer.~~

~~(2) For calendar year 1994, each insurer shall have aggregate administrative expenses of no more than thirty per cent of the premium income of the insurer, based on the premiums received in that year on the sickness and accident insurance business of the insurer.~~

~~(3) For calendar year 1995, each insurer shall have aggregate administrative expenses of no more than twenty five per cent of the premium income of the insurer, based on the premiums received in that year on the sickness and accident insurance business of the insurer.~~

~~(4) For calendar year 1996 and every calendar year thereafter,~~ each insurer shall have aggregate administrative expenses of no more than twenty per cent of the premium income of the insurer, based on the premiums ~~received~~ earned in that year on the sickness and accident insurance business of the insurer.

(C)(1) Each insurer, on the first day of January or within sixty days thereafter, shall annually prepare, under oath, and deposit in the office of the superintendent of insurance a statement of the aggregate administrative expenses of the insurer, based on the premiums ~~received~~ earned in the immediately preceding calendar year on the sickness and accident insurance business of the insurer. The statement shall itemize and separately detail all of the following information with respect to the insurer's sickness and accident insurance business:

(a) The amount of premiums earned by the insurer both before and after any costs related to the insurer's purchase of reinsurance coverage;

(b) The total amount of claims for losses paid by the insurer both before and after any reimbursement from reinsurance coverage;

(c) The amount of any losses incurred by the insurer but not reported by the insurer in the current or prior year;

(d) The amount of costs incurred by the insurer for state fees and federal and state taxes;

(e) The amount of costs incurred by the insurer for reinsurance coverage;

(f) The amount of costs incurred by the insurer that are 80
related to the insurer's payment of commissions; 81

(g) The amount of costs incurred by the insurer that are 82
related to the insurer's fraud prevention measures; 83

(h) The amount of costs incurred by the insurer that are 84
related to managed care; and 85

(i) Any other administrative expenses incurred by the 86
insurer. 87

(2) The statement also shall include all of the information 88
required under division (C)(1) of this section separately detailed 89
for the insurer's individual business, small group business, and 90
large group business. 91

(D) No insurer shall fail to comply with ~~division (B) of~~ this 92
section. 93

(E) If the superintendent determines that an insurer has 94
violated ~~division (D) of~~ this section, the superintendent, 95
pursuant to an adjudication conducted in accordance with Chapter 96
119. of the Revised Code, may order the suspension of the 97
insurer's license to do the business of sickness and accident 98
insurance in this state until the superintendent is satisfied that 99
the insurer is in compliance with ~~division (B) of~~ this section. If 100
the insurer continues to do the business of sickness and accident 101
insurance in this state while under the suspension order, the 102
superintendent shall order the insurer to pay one thousand dollars 103
for each day of the violation. 104

(F) Any money collected by the superintendent under division 105
(E) of this section shall be deposited by ~~him~~ the superintendent 106
into the state treasury to the credit of the department of 107
insurance operating fund. 108

(G) The statement of aggregate expenses filed pursuant to 109

this section separately detailing an insurer's individual, small group, and large group business shall be considered work papers resulting from the conduct of a market analysis of an entity subject to examination by the superintendent under division (C) of section 3901.48 of the Revised Code, except that the superintendent may share aggregated market information that identifies the premiums earned as reported under division (C)(1)(a) of this section, the administrative expenses reported under division (C)(1)(i) of this section, the amount of commissions reported under division (C)(1)(f) of this section, the amount of taxes paid as reported under division (C)(1)(d) of this section, the total of the remaining benefit costs as reported under divisions (C)(1)(b) and (c) of this section, and the amount of fraud and managed care expenses reported under divisions (C)(1)(g) and (h) of this section." 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124

In line 90875, after "3923.021," insert "3923.022," 125

In line 110 of the title, after "3923.021," insert "3923.022," 126 127

The motion was __________ agreed to.

SYNOPSIS

Administrative Expenses Incurred by Sickness and Accident Insurers 128 129

R.C. 3923.022 130

Includes in the definition of administrative expenses, for purposes of the current cap on sickness and accident insurers' administrative expenses, premiums "earned" rather than just "received," plus the amount of losses recovered from reinsurance 131 132 133 134

coverage; the amount "incurred," rather than "paid," for state 135
fees, federal and state taxes, and reinsurance; and, the 136
"incurred" costs related to payment of commissions. 137

Requires insurers to provide specified information concerning 138
the insurer's earnings and administrative expenses related to the 139
insurer's sickness and accident insurance business separately, 140
including the insurer's individual, small group, and large group 141
sickness and accident insurance businesses, as part of the 142
currently required annual statement of the insurer's 143
administrative expenses; specifies that the statement of aggregate 144
expenses separately detailing an insurer's individual, small 145
group, and large group business is considered work papers, meaning 146
that the statement is not public record, but allows the 147
superintendent to share aggregated market information that 148
identifies all of the itemized information except for the amount 149
of costs incurred by an insurer for reinsurance coverage. 150

Allows the Superintendent of Insurance to suspend the license 151
of an insurer if the insurer fails to submit the required annual 152
statement. 153

128HB1-CC4970X1/BLF

Am. Sub. H.B. 1
As Passed by the Senate
CC-4970-1

_______________ moved to amend as follows:

In line 453, after "5112.372," insert "5112.40, 5112.41, 1
5112.42, 5112.43, 5112.44, 5112.45, 5112.46, 5112.47, 5112.48," 2

Between lines 78394 and 78395, insert: 3

"**Sec. 5112.40.** As used in sections 5112.40 to 5112.48 of the 4
Revised Code: 5

(A) "Assessment program year" means the twelve-month period 6
beginning the first day of October of a calendar year and ending 7
the last day of September of the following calendar year. 8

(B) "Cost reporting period" means the period of time used by 9
a hospital in reporting costs for purposes of the medicare 10
program. 11

(C) "Federal fiscal year" means the twelve-month period 12
beginning the first day of October of a calendar year and ending 13
the last day of September of the following calendar year. 14

(D)(1) Except as provided in division (D)(2) of this section, 15
"hospital" means a hospital to which any of the following applies: 16
17

(a) The hospital is registered under section 3701.07 of the 18
Revised Code as a general medical and surgical hospital or a 19

pediatric general hospital and provides inpatient hospital services, as defined in 42 C.F.R. 440.10. 20 21

(b) The hospital is recognized under the medicare program as a cancer hospital and is exempt from the medicare prospective payment system. 22 23 24

(c) The hospital is a psychiatric hospital licensed under section 5119.20 of the Revised Code. 25 26

(2) "Hospital" does not include either of the following: 27

(a) A federal hospital; 28

(b) A hospital that does not charge any of its patients for its services. 29 30

(E) "Hospital care assurance program" means the program established under sections 5112.01 to 5112.21 of the Revised Code. 31 32

(F) "Medicaid" has the same meaning as in section 5111.01 of the Revised Code. 33 34

(G) "Medicare" means the program established under Title XVIII of the Social Security Act. 35 36

(H) "State fiscal year" means the twelve-month period beginning the first day of July of a calendar year and ending the last day of June of the following calendar year. 37 38 39

(I)(1) Except as provided in divisions (I)(2) and (3) of this section, "total facility costs" means the total costs to a hospital for all care provided to all patients, including the direct, indirect, and overhead costs to the hospital of all services, supplies, equipment, and capital related to the care of patients, regardless of whether patients are enrolled in a health insuring corporation. 40 41 42 43 44 45 46

(2) "Total facility costs" excludes all of the following of a hospital's costs as shown on the cost-reporting data used for 47 48

purposes of determining the hospital's assessment under section 5112.41 of the Revised Code: 49 50

(a) Skilled nursing services provided in distinct-part nursing facility units; 51 52

(b) Home health services; 53

(c) Hospice services; 54

(d) Ambulance services; 55

(e) Renting durable medical equipment; 56

(f) Selling durable medical equipment. 57

(3) "Total facility costs" excludes any costs excluded from a hospital's total facility costs pursuant to rules, if any, adopted under division (B) of section 5112.46 of the Revised Code. 58 59 60

Sec. 5112.41. (A) For the purposes specified in section 5112.45 of the Revised Code and subject to section 5112.48 of the Revised Code, there is hereby imposed an assessment on all hospitals each assessment program year. The amount of a hospital's assessment for an assessment program year shall equal, except as provided in division (D) of this section, the percentage specified in division (B) of this section of the hospital's total facility costs for the period of time specified in division (C) of this section. The amount of a hospital's total facility costs shall be derived from cost-reporting data for the hospital submitted to the department of job and family services for purposes of the hospital care assurance program. The cost-reporting data used to determine a hospital's assessment is subject to the same type of adjustments made to the data under the hospital care assurance program. 61 62 63 64 65 66 67 68 69 70 71 72 73 74

75

(B) The percentage specified in this division is the following: 76 77

(1) For the first assessment program year beginning after the effective date of this section, one and fifty-two hundredths per cent; 78 79 80

(2) Subject to division (D) of this section, for the second assessment program year after the effective date of this section and each successive assessment program year, one and sixty-one hundredths per cent. 81 82 83 84

(C) The period of time specified in this division is the hospital's cost reporting period that ends in the state fiscal year that ends in the federal fiscal year that precedes the federal fiscal year that precedes the assessment program year for which the assessment is imposed. 85 86 87 88 89

(D) The department of job and family services shall apply to the United States secretary of health and human services for a waiver under 42 U.S.C. 1396b(w)(3)(E) to establish, for the second assessment program year after the effective date of this section and each successive assessment program year, a tiered assessment on hospitals' total facility costs instead of applying the percentage specified in division (B)(2) of this section. If the United States secretary denies the waiver, the department shall apply the percentage specified in division (B)(2) of this section for the second assessment program year after the effective date of this section and each successive assessment program year. 90 91 92 93 94 95 96 97 98 99 100

(E) The assessment imposed by this section on a hospital is in addition to the assessment imposed by section 5112.06 of the Revised Code. 101 102 103

Sec. 5112.42. (A) Before or during each assessment program year, the department of job and family services shall mail to each hospital by certified mail, return receipt requested, the preliminary determination of the amount that the hospital is 104 105 106 107

assessed under section 5112.41 of the Revised Code for the assessment program year. Except as provided in division (B) of this section, the preliminary determination becomes the final determination for the assessment program year fifteen days after the preliminary determination is mailed to the hospital. 108 109 110 111 112

(B) A hospital may request that the department reconsider the preliminary determination mailed to the hospital under division (A) of this section by submitting to the department a written request for a reconsideration not later than fourteen days after the hospital's preliminary determination is mailed to the hospital. The request must be accompanied by written materials setting forth the basis for the reconsideration. On receipt of the timely request, the department shall reconsider the preliminary determination and may adjust the preliminary determination on the basis of the written materials accompanying the request. The result of the reconsideration is the final determination of the hospital's assessment under section 5112.41 of the Revised Code for the assessment program year. 113 114 115 116 117 118 119 120 121 122 123 124 125

(C) The department shall mail to each hospital a written notice of the final determination of its assessment for the assessment program year. A hospital may appeal the final determination to the court of common pleas of Franklin county. While a judicial appeal is pending, the hospital shall pay, in accordance with section 5112.43 of the Revised Code, any amount of its assessment that is not in dispute. 126 127 128 129 130 131 132

Sec. 5112.43. Unless rules adopted under section 5112.46 of the Revised Code establish a different payment schedule, each hospital shall pay the amount it is assessed under section 5112.41 of the Revised Code in accordance with the following payment schedule: 133 134 135 136 137

(A) Twenty-eight per cent of a hospital's assessment is due on the last business day of October of each assessment program year. 138 139 140

(B) Thirty-one per cent of a hospital's assessment is due on the last business day of February of each assessment program year. 141 142

(C) Forty-one per cent of a hospital's assessment is due on the last business day of May of each assessment program year. 143 144

Sec. 5112.44. The department of job and family services may audit a hospital to ensure that the hospital properly pays the amount it is assessed under section 5112.41 of the Revised Code. The department shall take action to recover from a hospital any amount the audit reveals that the hospital should have paid but did not pay. 145 146 147 148 149 150

Sec. 5112.45. There is hereby created in the state treasury the hospital assessment fund. All installment payments made by hospitals under section 5112.43 of the Revised Code and all recoveries the department of job and family services makes under section 5112.44 of the Revised Code shall be deposited into the fund. All investment earnings of the fund shall be credited to the fund. The department shall use money in the fund to pay for the costs of the medicaid program, including the program's administrative costs. 151 152 153 154 155 156 157 158 159

Sec. 5112.46. (A) The director of job and family services may adopt, amend, and rescind rules in accordance with Chapter 119. of the Revised Code as necessary to implement sections 5112.40 to 5112.48 of the Revised Code. 161 162 163 164

(B) The rules adopted under this section may provide that a hospital's total facility costs for the purpose of the assessment 165 166

under section 5112.41 of the Revised Code exclude any of the following: 167 168

(1) A hospital's costs associated with providing care to recipients of any of the following: 169 170

(a) The medicaid program; 171

(b) The medicare program; 172

(c) The disability financial assistance program established under Chapter 5115. of the Revised Code; 173 174

(d) The disability medical assistance program established under Chapter 5115. of the Revised Code; 175 176

(e) The program for medically handicapped children established under section 3701.023 of the Revised Code; 177 178

(f) Services provided under the maternal and child health services block grant established under Title V of the Social Security Act. 179 180 181

(2) Any other category of hospital costs the director deems appropriate under federal law and regulations governing the medicaid program. 182 183 184

Sec. 5112.47. The director of job and family services shall implement the assessment imposed by section 5112.41 of the Revised Code in a manner that does not cause a reduction in federal financial participation for the medicaid program under 42 U.S.C. 1396b(w). 185 186 187 188 189

Sec. 5112.48. If the United States secretary of health and human services determines that the assessment imposed by section 5112.41 of the Revised Code is an impermissible health care-related tax under 42 U.S.C. 1396b(w), the director of job and family services shall take all necessary actions to cease 190 191 192 193 194

implementation of sections 5112.40 to 5112.47 of the Revised Code and shall promptly refund to each hospital the amount of money in the hospital assessment fund at the time the refund is to be made that the hospital paid under section 5112.43 of the Revised Code, plus any corresponding investment earnings on that amount." 195 196 197 198 199

Between lines 91319 and 91320, insert: 200

"**Section _____.** Sections 5112.40, 5112.41, 5112.42, 5112.43, 5112.44, 5112.45, 5112.46, 5112.47, and 5112.48 of the Revised Code are hereby repealed, effective October 1, 2011." 201 202 203

Delete lines 92081 through 92100 204

In line 97223, after the period delete the balance of the line 205 206

Delete lines 97224 through 97226 207

In line 97227, delete "section" and insert "Of the amounts deposited into the Hospital Assessment Fund created under section 5112.45 of the Revised Code, $4.4 million in fiscal year 2010, plus the corresponding federal match, and $4 million in fiscal year 2011, plus the corresponding federal match, also shall be used by the Department to pay the amounts described in divisions (B) and (D) of this section" 208 209 210 211 212 213 214

Between lines 97227 and 97228, insert: 215

"**Section _____.** HOSPITAL INPATIENT AND OUTPATIENT SUPPLEMENTAL UPPER PAYMENT LIMIT PROGRAM 216 217

(A) As used in this section: 218

(1) "Assessment program year" has the same meaning as in section 5112.40 of the Revised Code. 219 220

(2) "Hospital" has the same meaning as in Section 5112.40 of 221

the Revised Code, except that "hospital" excludes a children's hospital as defined in Section 309.30.15 of this act. 222 223

(3) "Hospital Assessment Fund" means the fund created under section 5112.45 of the Revised Code. 224 225

(B) The Director of Job and Family Services shall submit a Medicaid state plan amendment to the United States Secretary of Health and Human Services to create the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program. If the United States Secretary approves the Medicaid state plan amendment, the program shall, subject to division (D) of this section, make supplemental Medicaid payments to hospitals for medicaid-covered inpatient services and outpatient services with funds made available for the program under division (C) of this section and federal matching funds available for the program. 226 227 228 229 230 231 232 233 234 235

(C) Of the amounts deposited into the Hospital Assessment Fund for the first assessment program year beginning after the effective date of this section, nine and sixteen hundredths per cent shall be used for the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program. Of the amounts deposited into the Hospital Assessment Fund for the second assessment program year beginning after the effective date of this section, ten and twenty-nine hundredths per cent shall be used for the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program. 236 237 238 239 240 241 242 243 244 245

(D) The Director of Job and Family Services shall take all necessary actions to cease implementation of this section if the United States Secretary of Health and Human Services determines that the assessment imposed under section 5112.41 of the Revised Code is an impermissible health care-related tax under 42 U.S.C. 1396b(w). 246 247 248 249 250 251

"**Section** ____. POSTPONEMENT OF RECALIBRATION FOR HOSPITALS 252

The Director of Job and Family Services shall amend rule 253
5101:3-2-07.3 of the Administrative Code to postpone to January 1, 254
2012, the recalibration that otherwise would occur on January 1, 255
2010, under that rule and to postpone to January 1, 2013, the 256
recalibration that otherwise would occur on January 1, 2011, under 257
that rule." 258

In line 97577, delete "July" and insert "October" 259

In line 97579, after the second "services" insert "that are 260
paid under the prospective payment system established in those 261
rules" 262

In line 97581, delete "June" and insert "September" 263

Delete lines 97582 through 97921 264

Delete lines 105068 through 105079 265

In line 106546, after "5111.875," insert "5112.40, 5112.41, 266
5112.42, 5112.43, 5112.44, 5112.45, 5112.46, 5112.47, 5112.48," 267

Between lines 106556 and 106557, insert: 268

"The repeal of sections 5112.40, 5112.41, 5112.42, 5112.43, 269
5112.44, 5112.45, 5112.46, 5112.47, and 5112.48 of the Revised 270
Code takes effect October 1, 2011." 271

In line 216 of the title, after "5112.372," insert "5112.40, 272
5112.41, 5112.42, 5112.43, 5112.44, 5112.45, 5112.46, 5112.47, 273
5112.48," 274

In line 281 of the title, after the semicolon insert "to 275
repeal sections 5112.40, 5112.41, 5112.42, 5112.43, 5112.44, 276
5112.45, 5112.46, 5112.47, and 5112.48 of the Revised Code, 277
effective October 1, 2011;" 278

The motion was __________ agreed to.

SYNOPSIS

Hospital Assessments 279

R.C. 5112.40, 5112.41, 5112.42, 5112.43, 5112.44, 5112.45, 5112.46, 5112.47, and 5112.48; Sections _____ and _____ 280 281

Restores the House-passed version of the bill's provisions regarding hospital assessments with the following changes: 282 283

(1) Excludes hospitals that do not charge any of their patients for their services from the assessments; 284 285

(2) Provides that a hospital's total facility costs excludes selling, rather than buying, durable medical equipment as shown on the cost-reporting data used for purposes of determining the hospital's assessment; 286 287 288 289

(3) Provides that the amount of the assessment for the second year and each successive year (if any) is to be 1.61% of a hospital's total facility costs only if the federal government denies a waiver for a tiered assessment; 290 291 292 293

(4) Establishes the following schedule for hospitals to pay the assessments (subject to ODJFS adopting rules that establish a different payment schedule): 28% is due on the last business day of October, 31% is due on the last business day of February, and 41% is due on the last business day of May; 294 295 296 297 298

(5) Maintains the Senate-passed version of the bill's provision that provides for $4.4 million in fiscal year 2010 and $4 million in fiscal year 2011 of the money raised by the hospital assessments to be used to pay for Medicaid payments to children's hospitals for outlier claims but rewords this provision to reflect the restoration of the House-passed version of the hospital assessments; 299 300 301 302 303 304 305

(6) Provides for the provision governing the Hospital Inpatient and Outpatient Supplemental Upper Payment Limit Program (Hospital UPL Program) to be in an uncodified section of the bill as in the Senate-passed version of the bill; 306 307 308 309

(7) Provides for the Hospital UPL Program to be funded with 9.16% of the money raised by the hospital assessments in the first year of the assessments and 10.29% of that money in the second year of the assessments, plus federal matching funds available for the program; 310 311 312 313 314

(8) Excludes children's hospitals from the Hospital UPL Program as in the Senate-passed version of the bill. 315 316

Medicaid Rates for Hospital Inpatient and Outpatient Services 317

Section 309.30.73 318

Provides for the 5% Medicaid rate increase for hospital inpatient and outpatient services to begin October 1, 2009, rather than July 1, 2009, and for the rate increase to apply only to rates paid under a prospective payment system. 319 320 321 322

Medicaid Rates for Hospital Home Health, Ambulance, and Hospice Services 323 324

Sections 309.30.76, 309.30.77, and 309.30.78 325

Removes the bill's provisions that require ODJFS, subject to available funds in the Hospital Assessment Fund, to increase the Medicaid rates for hospital home health, ambulance, and hospice services. 326 327 328 329

Postponement of Recalibration for Hospitals 330

Section _____ 331

Requires ODJFS to postpone the recalibration of certain Medicaid rates for hospital services that were to occur on January 1, 2010, and January 1, 2011, to January 1, 2012, and January 1, 332 333 334

2013, respectively. 335

Medicaid Managed Long-Term Care Report 336

Section 209.45 337

Removes the bill's provision that requires the ODJFS Director 338
and Director of Aging to issue a report on the feasibility of 339
including in the Medicaid managed care program certain aged, 340
blind, and disabled Medicaid recipients who are excluded by 341
current law from the program. 342

1 128HB1-CC4971X1.docx/rs

2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4971-1
5

6 ______________________________ moved to amend as follows:

7 Between lines 98090 and 98091, insert:

8 "The Department of Job and Family Services shall transfer
9 $14,700,000 cash, during the FY 2010-FY 2011 biennium, from the
10 Medicaid Program Support Fund (Fund 5C90), to the Sale of Goods
11 and Services Fund (Fund 1490), used by the Department of Mental
12 Health. The transfer shall be made using an intrastate transfer
13 voucher."

14 In line 99159, delete "$28,700,000 $28,700,000" and
15 insert "$36,050,000 $36,050,000"

16 In line 99163, add $7,350,000 to each fiscal year

17 In line 99179, delete "$362,770,242 $345,067,320" and
18 insert "$382,835,386 $361,335,572"

19 In line 99180, add $20,065,144 to fiscal year 2010 and
20 $16,268,252 to fiscal year 2011

21 In line 99192, add $27,415,144 to fiscal year 2010 and
22 $23,618,252 to fiscal year 2011

23 The motion was ________ agreed to.

24 SYNOPSIS

25 **Transfers of IMD/DSH Cash to the Department of Mental**
26 **Health**

27 **Sections 309.32.20 and 335.10**

28 Requires ODJFS to transfer, using an intrastate transfer
29 voucher, $14.7 million during the FY 2010-FY 2011 biennium, from
30 the Medicaid Program Support Fund (Fund 5C90)to the Sale of
31 Goods and Services Fund (Fund 1490), used by the Department of
32 Mental Health. Increases the appropriation in state special
33 revenue line item 334609, Hospital Operating - Expenses, by
34 $7.35 million in each fiscal year. Increases the appropriation
35 in federal line item 335635, Community Medicaid Expansion, by
36 $20.1 million in FY 2010 and $16.3 million in FY 2011.

Am. Sub. H.B. 1
As Passed by the Senate
CC-4975
JFS076

_______________ moved to amend as follows:

In line 398, after "5101.84," insert "5103.02, 5103.03," 1

Between lines 74301 and 74302, insert: 2

"**Sec. 5103.02.** As used in sections 5103.03 to 5103.17 of the 3
Revised Code: 4

(A) ~~"Association~~ (1) Except as provided in division (A)(2) of 5
this section, "association" or "institution" includes ~~any~~ all of 6
the following: 7

(a) Any incorporated or unincorporated organization, society, 8
association, or agency, public or private, that receives or cares 9
for children for two or more consecutive weeks; ~~any~~ 10

(b) Any individual, including the operator of a foster home, 11
who, for hire, gain, or reward, receives or cares for children for 12
two or more consecutive weeks, unless the individual is related to 13
them by blood or marriage; ~~and any~~ 14

(c) Any individual not in the regular employ of a court, or 15
of an institution or association certified in accordance with 16
section 5103.03 of the Revised Code, who in any manner becomes a 17
party to the placing of children in foster homes, unless the 18
individual is related to such children by blood or marriage, ~~or~~ is 19

the appointed guardian of such children~~; provided, that any~~, or is 20
authorized pursuant to Chapter 3107. of the Revised Code. 21

(2) The following are exempt from the requirements of 22
sections 5103.03 to 5103.17 of the Revised Code: 23

(a) Any organization, society, association, school, agency, 24
child guidance center, detention or rehabilitation facility, or 25
children's clinic licensed, regulated, approved, operated under 26
the direction of, or otherwise certified by the department of 27
education, a local board of education, the department of youth 28
services, the department of mental health, or the department of 29
mental retardation and developmental disabilities~~, or any~~. This 30
exemption includes any facility under the control of the 31
department of youth services and any place of detention for 32
children established and maintained pursuant to sections 2152.41 33
to 2152.44 of the Revised Code. 34

(b) Any individual who provides care for only a single-family 35
group, placed there by their parents or other relative having 36
custody~~, shall not be considered as being within the purview of~~ 37
~~these sections~~; 38

(c) A child day-care center subject to Chapter 5104. of the 39
Revised Code. 40

(B) "Family foster home" means a foster home that is not a 41
specialized foster home. 42

(C) "Foster caregiver" means a person holding a valid foster 43
home certificate issued under section 5103.03 of the Revised Code. 44

(D) "Foster home" means a private residence in which children 45
are received apart from their parents, guardian, or legal 46
custodian, by an individual reimbursed for providing the children 47
nonsecure care, supervision, or training twenty-four hours a day. 48
"Foster home" does not include care provided for a child in the 49

home of a person other than the child's parent, guardian, or legal custodian while the parent, guardian, or legal custodian is temporarily away. Family foster homes and specialized foster homes are types of foster homes. 50 51 52 53

(E) "Medically fragile foster home" means a foster home that provides specialized medical services designed to meet the needs of children with intensive health care needs who meet all of the following criteria: 54 55 56 57

(1) Under rules adopted by the department of job and family services governing payment under Chapter 5111. of the Revised Code for long-term care services, the children require a skilled level of care. 58 59 60 61

(2) The children require the services of a doctor of medicine or osteopathic medicine at least once a week due to the instability of their medical conditions. 62 63 64

(3) The children require the services of a registered nurse on a daily basis. 65 66

(4) The children are at risk of institutionalization in a hospital, skilled nursing facility, or intermediate care facility for the mentally retarded. 67 68 69

(F) "Recommending agency" means a public children services agency, private child placing agency, or private noncustodial agency that recommends that the department of job and family services take any of the following actions under section 5103.03 of the Revised Code regarding a foster home: 70 71 72 73 74

(1) Issue a certificate; 75

(2) Deny a certificate; 76

(3) Renew a certificate; 77

(4) Deny renewal of a certificate; 78

(5) Revoke a certificate.

(G) "Specialized foster home" means a medically fragile foster home or a treatment foster home.

(H) "Treatment foster home" means a foster home that incorporates special rehabilitative services designed to treat the specific needs of the children received in the foster home and that receives and cares for children who are emotionally or behaviorally disturbed, chemically dependent, mentally retarded, developmentally disabled, or who otherwise have exceptional needs.

Sec. 5103.03. (A) The director of job and family services shall adopt rules as necessary for the adequate and competent management of institutions or associations. The director shall ensure that foster care home study rules adopted under this section align any home study content, time period, and process with any home study content, time period, and process required by rules adopted under section 3107.033 of the Revised Code.

(B)(1)(a) Except ~~for facilities under the control of the department of youth services, places of detention for children established and maintained pursuant to sections 2152.41 to 2152.44 of the Revised Code, and child day-care centers subject to Chapter 5104. of the Revised Code~~ as provided in division (B)(1)(b) of this section, the department of job and family services every ~~two~~ four years shall pass upon the fitness of every institution and association that receives, or desires to receive and care for children, or places children in private homes.

(b) The department of job and family services every two years shall pass upon the fitness of any individual, including the operator of a foster home, who, for hire, gain, or reward, receives or cares for children for two or more consecutive weeks, unless the individual is related to them by blood or marriage.

(2) When the department of job and family services is 109
satisfied as to the care given such children, and that the 110
requirements of the statutes and rules covering the management of 111
such institutions and associations are being complied with, it 112
shall issue to the institution or association a certificate to 113
that effect. A certificate issued pursuant to division (B)(1)(a) 114
of this section is valid for four years, unless sooner revoked by 115
the department. A certificate issued pursuant to division 116
(B)(1)(b) of this section is valid for two years, unless sooner 117
revoked by the department. When determining whether an institution 118
or association meets a particular requirement for certification, 119
the department may consider the institution or association to have 120
met the requirement if the institution or association shows to the 121
department's satisfaction that it has met a comparable requirement 122
to be accredited by a nationally recognized accreditation 123
organization. 124

(3) The department may issue a temporary certificate valid 125
for less than one year authorizing an institution or association 126
to operate until minimum requirements have been met. 127

(4) An institution or association that knowingly makes a 128
false statement that is included as a part of certification under 129
this section is guilty of the offense of falsification under 130
section 2921.13 of the Revised Code and the department shall not 131
certify that institution or association. 132

(5) The department shall not issue a certificate to a 133
prospective foster home or prospective specialized foster home 134
pursuant to this section if the prospective foster home or 135
prospective specialized foster home operates as a type A family 136
day-care home pursuant to Chapter 5104. of the Revised Code. The 137
department shall not issue a certificate to a prospective 138
specialized foster home if the prospective specialized foster home 139

operates a type B family day-care home pursuant to Chapter 5104. 140
of the Revised Code. 141

(C) The department may revoke a certificate if it finds that 142
the institution or association is in violation of law or rule. No 143
juvenile court shall commit a child to an association or 144
institution that is required to be certified under this section if 145
its certificate has been revoked or, if after revocation, the date 146
of reissue is less than fifteen months prior to the proposed 147
commitment. 148

(D) ~~Every two years, on~~ On a date specified by the department 149
in accordance with division (D)(1) or (2) of this section, each 150
institution or association desiring certification or 151
recertification shall submit to the department a report showing 152
its condition, management, competency to care adequately for the 153
children who have been or may be committed to it or to whom it 154
provides care or services, the system of visitation it employs for 155
children placed in private homes, and other information the 156
department requires: 157

(1) Every four years, for an institution or association that 158
receives a certificate pursuant to division (B)(1)(a) of this 159
section; 160

(2) Every two years, for an individual who receives a 161
certificate pursuant to division (B)(1)(b) of this section. 162

(E) The department shall, not less than once each year, send 163
a list of certified institutions and associations to each juvenile 164
court and certified association or institution. 165

(F) No person shall receive children or receive or solicit 166
money on behalf of such an institution or association not so 167
certified or whose certificate has been revoked. 168

(G)(1) The director may delegate by rule any duties imposed 169

on it by this section to inspect and approve family foster homes and specialized foster homes to public children services agencies, private child placing agencies, or private noncustodial agencies. 170 171 172

(2) The director shall adopt rules that require a foster caregiver or other individual certified to operate a foster home under this section to notify the recommending agency that the foster caregiver or other individual is certified to operate a type B family day-care home under Chapter 5104. of the Revised Code. 173 174 175 176 177 178

(H) If the director of job and family services determines that an institution or association that cares for children is operating without a certificate, the director may petition the court of common pleas in the county in which the institution or association is located for an order enjoining its operation. The court shall grant injunctive relief upon a showing that the institution or association is operating without a certificate. 179 180 181 182 183 184 185

(I) If both of the following are the case, the director of job and family services may petition the court of common pleas of any county in which an institution or association that holds a certificate under this section operates for an order, and the court may issue an order, preventing the institution or association from receiving additional children into its care or an order removing children from its care: 186 187 188 189 190 191 192

(1) The department has evidence that the life, health, or safety of one or more children in the care of the institution or association is at imminent risk. 193 194 195

(2) The department has issued a proposed adjudication order pursuant to Chapter 119. of the Revised Code to deny renewal of or revoke the certificate of the institution or association." 196 197 198

In line 90901, after "5101.84," insert "5103.02, 5103.03," 199

In line 145 of the title, after "5101.84," insert "5103.02, 200
5103.03," 201

The motion was __________ agreed to.

SYNOPSIS

ODJFS Review of Associations and Institutions 202

R.C. 5103.02 and 5103.03 203

Extends from two to four years the period of time within 204
which ODJFS must pass upon the fitness of an institution or 205
association that receives children, or desires to receive and care 206
for children, or places children in private homes, but retains the 207
two-year period for individuals who, for compensation, receive or 208
care for children for two or more consecutive weeks. 209

128HB1-CC4976/BGK

Am. Sub. H.B. 1
As Passed by the Senate
CC-4976
JFS075

_________________________ moved to amend as follows:

In line 398, after "5101.84," insert "5104.04,"

Between lines 74301 and 74302, insert:

"**Sec. 5104.04.** (A) The department of job and family services shall establish procedures to be followed in investigating, inspecting, and licensing child day-care centers and type A family day-care homes.

(B)(1)(a) The department shall, at least ~~twice~~ <u>once</u> during every twelve-month period of operation of a center or type A home, inspect the center or type A home. The department shall inspect a part-time center or part-time type A home at least once during every twelve-month period of operation. The department shall provide a written inspection report to the licensee within a reasonable time after each inspection. The licensee shall display all written reports of inspections conducted during the current licensing period in a conspicuous place in the center or type A home.

~~At least one inspection shall be unannounced and all inspections~~ <u>Inspections</u> may be unannounced. No person, firm, organization, institution, or agency shall interfere with the

inspection of a center or type A home by any state or local official engaged in performing duties required of the state or local official by Chapter 5104. of the Revised Code or rules adopted pursuant to Chapter 5104. of the Revised Code, including inspecting the center or type A home, reviewing records, or interviewing licensees, employees, children, or parents. 20 21 22 23 24 25

(b) Upon receipt of any complaint that a center or type A home is out of compliance with the requirements of Chapter 5104. of the Revised Code or rules adopted pursuant to Chapter 5104. of the Revised Code, the department shall investigate the center or home, and both of the following apply: 26 27 28 29 30

(i) If the complaint alleges that a child suffered physical harm while receiving child care at the center or home or that the noncompliance alleged in the complaint involved, resulted in, or poses a substantial risk of physical harm to a child receiving child care at the center or home, the department shall inspect the center or home. 31 32 33 34 35 36

(ii) If division (B)(1)(b)(i) of this section does not apply regarding the complaint, the department may inspect the center or home. 37 38 39

(c) Division (B)(1)(b) of this section does not limit, restrict, or negate any duty of the department to inspect a center or type A home that otherwise is imposed under this section, or any authority of the department to inspect a center or type A home that otherwise is granted under this section when the department believes the inspection is necessary and it is permitted under the grant. 40 41 42 43 44 45 46

(2) If the department implements an instrument-based program monitoring information system, it may use an indicator checklist to comply with division (B)(1) of this section. 47 48 49

(3) The department shall contract with a third party by the 50

first day of October in each even-numbered year to collect information concerning the amounts charged by the center or home for providing child care services for use in establishing reimbursement ceilings and payment pursuant to section 5104.30 of the Revised Code. The third party shall compile the information and report the results of the survey to the department not later than the first day of December in each even-numbered year.

(C) In the event a licensed center or type A home is determined to be out of compliance with the requirements of Chapter 5104. of the Revised Code or rules adopted pursuant to Chapter 5104. of the Revised Code, the department shall notify the licensee of the center or type A home in writing regarding the nature of the violation, what must be done to correct the violation, and by what date the correction must be made. If the correction is not made by the date established by the department, the department may commence action under Chapter 119. of the Revised Code to revoke the license. The department's commencement of an action to revoke the license is sufficient notice that the correction has not been made, and no other notice regarding the correction is required.

(D) The department may deny or revoke a license, or refuse to renew a license of a center or type A home, if the applicant knowingly makes a false statement on the application, does not comply with the requirements of Chapter 5104. or rules adopted pursuant to Chapter 5104. of the Revised Code, or has pleaded guilty to or been convicted of an offense described in section 5104.09 of the Revised Code.

(E) If the department finds, after notice and hearing pursuant to Chapter 119. of the Revised Code, that any person, firm, organization, institution, or agency licensed under section 5104.03 of the Revised Code is in violation of any provision of

Chapter 5104. of the Revised Code or rules adopted pursuant to Chapter 5104. of the Revised Code, the department may issue an order of revocation to the center or type A home revoking the license previously issued by the department. Upon the issuance of any order of revocation, the person whose license is revoked may appeal in accordance with section 119.12 of the Revised Code. 82 83 84 85 86 87

(F) The surrender of a center or type A home license to the department or the withdrawal of an application for licensure by the owner or administrator of the center or type A home shall not prohibit the department from instituting any of the actions set forth in this section. 88 89 90 91 92

(G) Whenever the department receives a complaint, is advised, or otherwise has any reason to believe that a center or type A home is providing child care without a license issued or renewed pursuant to section 5104.03 and is not exempt from licensing pursuant to section 5104.02 of the Revised Code, the department shall investigate the center or type A home and may inspect the areas children have access to or areas necessary for the care of children in the center or type A home during suspected hours of operation to determine whether the center or type A home is subject to the requirements of Chapter 5104. or rules adopted pursuant to Chapter 5104. of the Revised Code. 93 94 95 96 97 98 99 100 101 102 103

(H) The department, upon determining that the center or type A home is operating without a license, shall notify the attorney general, the prosecuting attorney of the county in which the center or type A home is located, or the city attorney, village solicitor, or other chief legal officer of the municipal corporation in which the center or type A home is located, that the center or type A home is operating without a license. Upon receipt of the notification, the attorney general, prosecuting attorney, city attorney, village solicitor, or other chief legal 104 105 106 107 108 109 110 111 112

officer of a municipal corporation shall file a complaint in the 113
court of common pleas of the county in which the center or type A 114
home is located requesting that the court grant an order enjoining 115
the owner from operating the center or type A home in violation of 116
section 5104.02 of the Revised Code. The court shall grant such 117
injunctive relief upon a showing that the respondent named in the 118
complaint is operating a center or type A home and is doing so 119
without a license. 120

(I) The department shall prepare an annual report on 121
inspections conducted under this section. The report shall include 122
the number of inspections conducted, the number and types of 123
violations found, and the steps taken to address the violations. 124
The department shall file the report with the governor, the 125
president and minority leader of the senate, and the speaker and 126
minority leader of the house of representatives on or before the 127
first day of January of each year, beginning in 1999." 128

In line 90901, after "5101.84," insert "5104.04," 129

In line 145 of the title, after "5101.84," insert "5104.04," 130

The motion was __________ agreed to.

SYNOPSIS

Child Day-care Center and Home Inspections; Notice of Failure 131
to Correct Day-care Law Violations 132

R.C. 5104.04 133

Reduces the number of mandatory inspections given to a child 134
day-care center or type A family day-care home from twice to once 135
during each 12-month period of operation and permits all 136
inspections to be unannounced. 137

Specifies that, if a center or type A home has been notified that it is in violation of the Day-care Laws and it fails to timely correct the violation, ODJFS's commencement of an action to revoke the center's or home's license is sufficient notice that the correction has not been made. 138 139 140 141 142

1 128HB1-CC4978.docx/ss

2 <u>Am. Sub. H.B. 1</u>
3 As Passed by the Senate
4 CC-4978
5 JFS073

6 ________________________________ moved to amend as follows:

7 Between lines 93994 and 93995, insert:

8 "(L) Eligible expenditures for the Early Childhood
9 Education program shall be claimed each fiscal year to help meet
10 the state's TANF maintenance of effort requirement. The
11 Superintendent of Public Instruction and the Director of Job and
12 Family Services shall enter into an interagency agreement to
13 carry out the requirements under this division, which shall
14 include developing reporting guidelines for these expenditures."

15 The motion was ________ agreed to.

16 <u>SYNOPSIS</u>

17 **Claiming Eligible Expenditures for Early Childhood**
18 **Education**

19 **Section 265.10.20**

20 Requires eligible expenditures for the Early Childhood
21 Education program to be claimed each fiscal year to help meet
22 the state's TANF maintenance of effort requirement; requires the
23 Superintendent of Public Instruction and the Director of Job and
24 Family Services to enter into an interagency agreement to carry
25 out these requirements, which shall include developing reporting
26 guidelines for these expenditures.

1 128HB1-CC4984X1.docx/ar

2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4984-1

5 _______________________ moved to amend as follows:

6 Between lines 101109 and 101110, insert:

7 "(A) Except as provided in division (D) of this section:"

8 Delete lines 101115 through 101119

9 Between lines 101129 and 101130, insert:

10 "(B)(1) As used in this section:

11 (a) "At-risk component" may include, but is not limited to:

12 (i) A first-generation college student;

13 (ii) A non-traditionally aged adult student;

14 (iii) A graduate of a low-achieving high school;

15 (iv) Any other factors the Chancellor may determine.

16 (b) "Eligible institution" means any institution described
17 in divisions (B)(2)(a) to (c) of section 3333.122 of the Revised
18 Code.

19 (c) "Type of institution" means state college or
20 university, community college, state community college,
21 university branch, technical college, or eligible private
22 nonprofit institution of higher education.

23 (d) The two "sectors" of institutions of higher education
24 consist of the following:
25 (i) State colleges and universities, community colleges,
26 state community colleges, university branches, and technical
27 colleges;
28 (ii) Eligible private nonprofit institutions of higher
29 education.
30 (2) If the Chancellor determines that the amounts
31 appropriated for support of the Ohio College Opportunity Grant
32 program are inadequate to provide grants to all eligible
33 students as calculated under division (D) of section 3333.122 of
34 the Revised Code, the Chancellor shall create a formula, subject
35 to the approval of the Controlling Board, for the distribution
36 of available funds. This formula shall be complete and
37 established before the start of the 2010-2011 academic year.
38 The formula shall be based on division (C)(1) of section
39 3333.122 of the Revised Code, but also include an at-risk
40 component and academic performance component in determining
41 distribution priority. The Chancellor may use the academic
42 performance component to increase an award for credit or course
43 completion or other factors as determined by the Chancellor.
44 (3) Each eligible institution shall collect at-risk and
45 performance data for each student eligible for a grant and
46 report that information, including a recommendation of eligible

47 students considered most at-risk, to the Chancellor by the
48 deadline set by the Chancellor.
49 (4) The Chancellor shall determine which at-risk and
50 performance components are most appropriate to use for each type
51 of institution and devise a formula for each type of institution
52 accordingly.
53 (C) Notwithstanding any other law to the contrary, the
54 Chancellor may require an eligible institution to provide
55 matching funds for students receiving Ohio College Opportunity
56 Grants. The Chancellor shall recommend a required match for
57 each eligible institution, taking into account the capacity of
58 each institution to meet the match. The Chancellor shall
59 include the recommendation as part of the formula submitted to
60 the Controlling Board for approval under division (B)(2) of this
61 section.
62 (D) Prior to determining the amount of funds available to
63 award under this section and section 3333.122 of the Revised
64 Code, the Chancellor shall use the foregoing appropriation item
65 235563, Ohio College Opportunity Grant, to pay the prior year's
66 Ohio College Opportunity Grant/Ohio Instructional Grant
67 obligations in fiscal year 2010. The Chancellor may also use
68 the foregoing appropriation item to pay for renewals or partial
69 renewals of scholarships students receive under the Ohio
70 Academic Scholarship Program under sections 3333.21 and 3333.22

71 of the Revised Code. In paying for prior obligations and
72 scholarships under this division, the Chancellor shall deduct
73 funds from the allocations made under division (A) of this
74 section proportionate to the amounts allocated to each sector
75 from the total appropriation.

76 In each fiscal year, the Chancellor shall not distribute or
77 obligate or commit to be distributed an amount greater than what
78 is appropriated under the foregoing appropriation item 235563,
79 Ohio College Opportunity Grant.

80 (E) The Chancellor shall establish, and post on the Ohio
81 Board of Regents' web site, award tables based on the formulas
82 created under division (B) of this section. The Chancellor
83 shall notify students and institutions of any reductions in
84 awards under this section."

85 In line 101135, before "Notwithstanding" insert "(F)"

86 Delete lines 101287 through 101310

87 The motion was ________ agreed to.

88 SYNOPSIS

89 **Ohio College Opportunity Grant**

90 **Sections 371.50.50. and 371.60.90**

91 Makes the following changes in the distribution of OCOG
92 awards for fiscal years 2010 and 2011:

93 (1) Adds "at-risk" and "performance" components in
94 determining awards to students if the appropriated funds are
95 insufficient to distribute to all eligible students.

96 (2) Requires eligible institutions to collect "at-risk" and
97 "performance" data on eligible students, report that information
98 to the Chancellor, and to make recommendations on students
99 considered most "at-risk."

100 (3) Allows the Chancellor to require that eligible
101 institutions provide matching funds for students receiving OCOG
102 awards.

103 (4) Requires the Chancellor first to subtract prior year's
104 OCOG/OIG obligations, and allows the Chancellor to subtract
105 funds for renewals and partial renewals of Ohio Academic
106 Scholarship awards, proportionally from the OCOG appropriation
107 before distributing OCOG awards to eligible students.

108 (5) Prohibits the Chancellor from distributing and
109 obligating or committing to be distributed an amount greater
110 than that which is appropriated.

111 (6) Removes the provision that allows the Chancellor to re-
112 allocate unexpended, unencumbered portions of General Revenue
113 Fund appropriation items to OCOG and that allows the Director of
114 Budget and Management to allocate an additional $5 million in
115 each fiscal year if the appropriated amounts and amounts
116 transferred are insufficient.

117 **Board of Regents**

118 **Section 371.50.50**

119 Eliminates the earmark of $29.0 million in each fiscal year
120 for proprietary postsecondary institutions of higher education
121 under GRF appropriation item 235563, Ohio College Opportunity
122 Grant.

2 Am. Sub. H.B. 1
3 As Passed by the Senate
4 CC-4988
5 OBM084

6 ______________________________ moved to amend as follows:

7 In line 15259, after "authority" delete the balance of the
8 line

9 Strike through line 15260

10 In line 15261, strike through "furnishing, improving,
11 extending, or enlarging any" and insert "or any prior community
12 or technical college obligations to fund, or to refund any
13 obligations issued to refund,"

14 In line 15262, strike through "of the authority"; delete
15 "or any community or technical college"

16 In line 15263, delete "district or community or technical
17 college"

18 In line 106522, after "145.298," insert "152.12,"

19 The motion was ________ agreed to.

20 SYNOPSIS

21 **Ohio Building Authority Refunding Obligations**

22 **R.C. 152.12**

23 Permits the Ohio Building Authority (OBA) to issue
24 obligations to refund prior obligations issued by OBA and
25 community and technical colleges to fund, or to refund any
26 obligations issued to refund, capital facilities.

128HB1-CC4991/RYT

Am. Sub. H.B. 1
As Passed by the Senate
CC-4991
SPA-1

_________________________ moved to amend as follows:

In line 297, after "121.07," insert "121.31,"

Between lines 5676 and 5677, insert:

"**Sec. 121.31.** There is hereby created the commission on Hispanic-Latino affairs consisting of eleven voting members appointed by the governor with the advice and consent of the senate and ~~two~~ four ex officio, nonvoting members who are members of the general assembly. The speaker of the house of representatives shall recommend to the governor two persons for appointment to the commission, the president of the senate shall recommend to the governor two such persons, and the minority leaders of the house and senate shall each recommend to the governor one such person. The governor shall make initial appointments to the commission. Of the initial appointments made to the commission, three shall be for a term ending October 7, 1978, four shall be for a term ending October 7, 1979, and four shall be for a term ending October 7, 1980. ~~One~~ Two ex officio ~~member~~ members of the commission shall be ~~a member~~ members of the house of representatives appointed by the speaker of the house of representatives and ~~one~~ two ex officio ~~member~~ members of the commission shall be ~~a member~~ members of the senate appointed by

the president of the senate. ~~When making their initial appointments, the speaker shall appoint a member of the house of representatives who is affiliated with the minority political party in the house of representatives and the president shall appoint a member of the senate who is affiliated with the majority political party in the senate; in making subsequent appointments the speaker and the president each shall alternate the political party affiliation of the members they appoint to the commission. The speaker and president shall make their initial appointments so that the initial ex officio members begin their terms October 7, 2008~~ The speaker shall appoint one member of the house of representatives from among the representatives who are affiliated with the political party having a majority in the house of representatives and one member of the house of representatives from among the representatives who are affiliated with the political party having a minority in the house of representatives. The president shall appoint one member of the senate from among the senators who are affiliated with the political party having a majority in the senate and one member of the senate from among the senators who are affiliated with the political party having a minority in the senate.

After the initial appointments by the governor, terms of office shall be for three years, except that members of the general assembly appointed to the commission shall be members of the commission only so long as they are members of the general assembly. Each term shall end on the same day of the same month of the year as did the term which it succeeds. Each member shall hold office from the date of appointment until the end of the term for which the member was appointed. Vacancies shall be filled in the same manner as the 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 such term. Any member shall continue in office subsequent to the expiration date of the member's term until the member's successor takes office, or until a period of sixty days has elapsed, whichever occurs first. At the first organizational meeting of the commission, the original eleven members shall draw lots to determine the length of the term each member shall serve. 53 54 55 56 57 58 59

All voting members of the commission shall speak Spanish, shall be of Spanish-speaking origin, and shall be American citizens or lawful, permanent, resident aliens. Voting members shall be from urban, suburban, and rural geographical areas representative of Spanish-speaking people with a numerical and geographical balance of the Spanish-speaking population throughout the state. 60 61 62 63 64 65 66

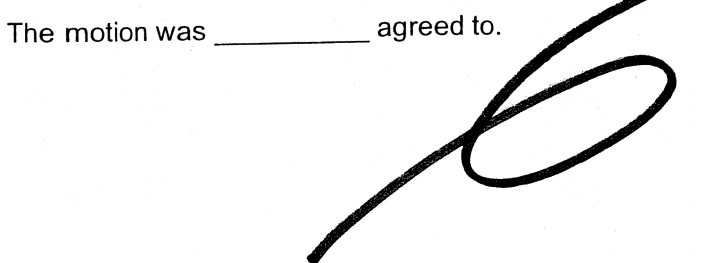
The commission shall meet not less than six times per calendar year. The commission shall elect a chairperson, vice-chairperson, and other officers from its voting members as it considers advisable. Six voting members constitute a quorum. The commission shall adopt rules governing its procedures. No action of the commission is valid without the concurrence of six members. 67 68 69 70 71 72

Each voting member shall be compensated for work as a member for each day that the member is actually engaged in the performance of work as a member. No voting member shall be compensated for more than one day each month. In addition, each voting member shall be reimbursed for all actual and necessary expenses incurred in the performance of official business." 73 74 75 76 77 78

In line 90800, after "121.07," insert "121.31," 79

In line 7 of the title, after "121.07," insert "121.31," 80

The motion was __________ agreed to.



SYNOPSIS

Commission on Hispanic-Latino Affairs 81

R.C. 121.31 82

Requires the Speaker of the House of Representatives to appoint two members of the House as nonvoting members of the Commission on Hispanic-Latino Affairs with one member being affiliated with the majority party of the House and one member being affiliated with the minority party of the House. 83 84 85 86 87

Requires the President of the Senate to appoint two members of the Senate as nonvoting members of the Commission with one member being affiliated with the majority party of the Senate and one member being affiliated with the minority party of the Senate. 88 89 90 91

Am. Sub. H.B. 1
As Passed by the Senate
CC-4993-1

_________________________ moved to amend as follows:

In line 333, after "1751.05," insert "1751.15, 1751.16, 1751.18,"

In line 373, after "3923.11," insert "3923.122, 3923.58, 3923.581,"

In line 445, after "3903.77," insert "3923.582,"

Between lines 27690 through 27691 insert:

"**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;~~ 21 22

~~(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.~~ 23 24 25 26

~~(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:~~ 27 28 29 30

~~(1) Waive the requirement for open enrollment;~~ 31

~~(2) Impose a limit on the number of applicants and their dependents that must be enrolled;~~ 32 33

~~(3) Authorize such underwriting restrictions upon open enrollment as are necessary to do any of the following:~~ 34 35

~~(a) Preserve its financial stability;~~ 36

~~(b) Prevent excessive adverse selection;~~ 37

~~(c) Avoid unreasonably high or unmarketable charges for coverage of health care services.~~ 38 39

~~(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.~~ 40 41 42 43 44 45 46 47 48

~~(2) Any action taken by the superintendent under division (C)~~ 49

~~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 of the following:~~

~~(1) Any health insuring corporation that offers only supplemental health care services or specialty health care services;~~

~~(2) Any health insuring corporation that offers plans only through medicare, medicaid, or the children's buy-in program and that has no other commercial enrollment;~~

~~(3) 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;~~

~~(4) 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~~ sections 3923.58 and 3923.581 of the Revised Code. A health insuring corporation may reinsure coverage of any ~~federally eligible~~ individual acquired under ~~that section~~ those sections 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.~~

(B) This section does not apply to any of the following: 200

(1) Any health insuring corporation that offers only supplemental health care services or specialty health care services; 201 202 203

(2) Any health insuring corporation that offers plans only through medicare, medicaid, or the children's buy-in program and that has no other commercial enrollment; 204 205 206

(3) 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; 207 208 209

(4) 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. 210 211 212 213

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: 214 215 216 217 218 219

(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. 220 221 222

(2) The subscriber is, or is eligible to be, covered for benefits at least comparable to the group contract under any of the following: 223 224 225

(a) Medicare; 226

(b) Any act of congress or law under this or any other state of the United States providing coverage at least comparable to the 227 228

benefits under division (A)(2)(a) of this section; 229

(c) Any policy of insurance or health care plan providing 230
coverage at least comparable to the benefits under division 231
(A)(2)(a) of this section. 232

(B)(1) The direct-payment contract offered by the health 233
insuring corporation pursuant to division (A) of this section 234
shall provide the following: 235

(a) In the case of an individual who is not a federally 236
eligible individual, benefits comparable to benefits in any of the 237
individual contracts then being issued to individual subscribers 238
by the health insuring corporation; 239

(b) In the case of a federally eligible individual, a basic 240
and standard plan established ~~by the board of directors of the~~ 241
~~Ohio health reinsurance program~~ under section 3924.10 of the 242
Revised Code or plans substantially similar to the basic and 243
standard plan in benefit design and scope of covered services. For 244
purposes of division (B)(1)(b) of this section, the superintendent 245
of insurance shall determine whether a plan is substantially 246
similar to the basic or standard plan in benefit design and scope 247
of covered services. The contractual periodic prepayments charged 248
for such plans may not exceed ~~an amount that is two times the~~ 249
~~midpoint of the standard~~ the amounts specified below: 250

251

(i) For calendar years 2010 and 2011, an amount that is two 252
times the base rate charged any other individual of a group to 253
which the organization is currently accepting new business and for 254
which similar copayments and deductibles are applied; 255

(ii) For calendar year 2012 and every calendar year 256
thereafter, an amount that is one and one-half times the base rate 257
charged any other individual of a group to which the health 258

insuring corporation is currently accepting new business and for 259
which similar copayments and deductibles are applied, unless the 260
superintendent of insurance determines that the amendments by this 261
act to sections 3923.58 and 3923.581 of the Revised Code, have 262
resulted in the market-wide average medical loss ratio for 263
coverage sold to individual insureds and nonemployer group 264
insureds in this state, including open enrollment insureds, to 265
increase by more than five and one quarter percentage points 266
during calendar year 2010. If the superintendent makes that 267
determination, the premium limit established by division 268
(B)(1)(b)(i) of this section shall remain in effect. 269

(2) The direct payment contract offered pursuant to division 270
(A) of this section may include a coordination of benefits 271
provision as approved by the superintendent. 272

(3) For purposes of division (B) of this section ~~"federally~~: 273

(a) "Federally eligible individual" means an eligible 274
individual as defined in 45 C.F.R. 148.103. 275

(b) "Base rate" means, as to any health benefit plan that is 276
issued by a health insuring corporation, the lowest premium rate 277
for new or existing business prescribed by the health insuring 278
corporation for the same or similar coverage under a plan or 279
arrangement covering any individual in a group with similar case 280
characteristics. 281

(C) The option for conversion shall be available: 282

(1) Upon the death of the subscriber, to the surviving spouse 283
with respect to such of the spouse and dependents as are then 284
covered by the group contract; 285

(2) To a child solely with respect to the child upon the 286
child's attaining the limiting age of coverage under the group 287
contract while covered as a dependent under the contract; 288

(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. 289 290 291

(D) No health insuring corporation shall use age <u>or health status</u> as the basis for refusing to renew a converted contract. 292 293

(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. 294 295 296 297 298 299 300 301 302 303 304 305

(F) This section does not apply to any group contract offering only supplemental health care services or specialty health care services. 306 307 308

Sec. 1751.18. (A)(1) No health insuring corporation shall cancel or fail to renew the coverage of a subscriber or enrollee because of any health status-related factor in relation to the subscriber or enrollee, the subscriber's or enrollee's requirements for health care services, or for any other reason designated under rules adopted by the superintendent of insurance. 309 310 311 312 313 314

(2) Unless otherwise required by state or federal law, no health insuring corporation, or health care facility or provider through which the health insuring corporation has made arrangements to provide health care services, shall discriminate 315 316 317 318

against any individual with regard to enrollment, disenrollment, 319
or the quality of health care services rendered, on the basis of 320
the individual's race, color, sex, age, religion, military status 321
as defined in section 4112.01 of the Revised Code, or status as a 322
recipient of medicare or medicaid, or any health status-related 323
factor in relation to the individual. However, a health insuring 324
corporation shall not be required to accept a recipient of 325
medicare or medical assistance, if an agreement has not been 326
reached on appropriate payment mechanisms between the health 327
insuring corporation and the governmental agency administering 328
these programs. Further, except ~~during a period of~~ for open 329
enrollment coverage under ~~section 1751.15~~ sections 3923.58 and 330
3923.581 of the Revised Code, a health insuring corporation may 331
reject an applicant for nongroup enrollment on the basis of any 332
health status-related factor in relation to the applicant. 333

(B) A health insuring corporation may cancel or decide not to 334
renew the coverage of an enrollee if the enrollee has performed an 335
act or practice that constitutes fraud or intentional 336
misrepresentation of material fact under the terms of the coverage 337
and if the cancellation or nonrenewal is not based, either 338
directly or indirectly, on any health status-related factor in 339
relation to the enrollee. 340

(C) An enrollee may appeal any action or decision of a health 341
insuring corporation taken pursuant to section 2742(b) to (e) of 342
the "Health Insurance Portability and Accountability Act of 1996," 343
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-42, as 344
amended. To appeal, the enrollee may submit a written complaint to 345
the health insuring corporation pursuant to section 1751.19 of the 346
Revised Code. The enrollee may, within thirty days after receiving 347
a written response from the health insuring corporation, appeal 348
the health insuring corporation's action or decision to the 349

superintendent. 350

(D) As used in this section, "health status-related factor" 351
means any of the following: 352

(1) Health status; 353

(2) Medical condition, including both physical and mental 354
illnesses; 355

(3) Claims experience; 356

(4) Receipt of health care; 357

(5) Medical history; 358

(6) Genetic information; 359

(7) Evidence of insurability, including conditions arising 360
out of acts of domestic violence; 361

(8) Disability." 362

Between lines 59382 and 59383, insert: 363

"**Sec. 3923.122.** (A) Every policy of group sickness and 364
accident insurance providing hospital, surgical, or medical 365
expense coverage for other than specific diseases or accidents 366
only, and delivered, issued for delivery, or renewed in this state 367
on or after January 1, 1976, shall include a provision giving each 368
insured the option to convert to the following: 369

(1) In the case of an individual who is not a federally 370
eligible individual, any of the individual policies of hospital, 371
surgical, or medical expense insurance then being issued by the 372
insurer with benefit limits not to exceed those in effect under 373
the group policy; 374

(2) In the case of a federally eligible individual, a basic 375
or standard plan established ~~by the board of directors of the Ohio~~ 376

~~health reinsurance program~~ in accordance with section 3924.10 of the Revised Code 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. 377 378 379 380 381 382 383

(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. 384 385 386 387 388 389

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: 390 391 392 393 394 395 396

(1) The effective date of the converted policy; 397

(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~~ the amounts specified below: 398 399 400 401 402 403

(a) For calendar years 2010 and 2011, an amount that is two times the base 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; 404 405 406 407

(b) For calendar year 2012 and every year thereafter, an amount that is one and one-half times the base 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, unless the superintendent of insurance determines that the amendments by this act to sections 3923.58 and 3923.581 of the Revised Code, have resulted in the market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than five and one quarter percentage points during calendar year 2010. If the superintendent makes that determination, the premium limit established by division (B)(2)(a) of this section shall remain in effect. 408 409 410 411 412 413 414 415 416 417 418 419 420 421

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. 422 423 424

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. 425 426 427

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. 428 429 430

(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: 431 432 433

(1) Title XVIII of the Social Security Act, as amended or superseded; 434 435

(2) Any act of congress or law under this or any other state of the United States that duplicates coverage offered under 436 437

division (C)(1) of this section; 438

(3) Any policy that duplicates coverage offered under division (C)(1) of this section; 439 440

(4) Any other group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only. 441 442 443

(D) The option for conversion shall be available: 444

(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; 445 446 447

(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; 448 449 450

(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. 451 452 453 454 455

Persons possessing the option for conversion pursuant to this division shall be considered members for the purposes of division (H) of this section. 456 457 458

(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. 459 460 461 462 463 464 465

(F) If the insurer and the group policyholder agree upon one 466

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. 467 468 469

(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. 470 471 472 473

(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. 474 475 476 477 478 479 480 481 482 483

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. 484 485 486 487 488 489 490 491

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, 492 493 494 495 496 497

the effective date of the converted policy shall be the date of application. 498 499

(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. 500 501 502 503 504

(J) The converted policy may contain: 505

(1) Any exclusion, reduction, or limitation contained in the group policy or customarily used in individual policies issued by the insurer; 506 507 508

(2) Any provision permitted in this section; 509

(3) Any other provision not prohibited by law. 510

Any provision required or permitted in this section may be made a part of any converted policy by means of an endorsement or rider. 511 512 513

(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. 514 515 516 517

(L) No insurer shall use deterioration of health as the basis for refusing to renew a converted policy. 518 519

(M) No insurer shall use age <u>or health status</u> as the basis for refusing to renew a converted policy. 520 521

(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 522 523 524 525 526

which provides benefits substantially in compliance with those required in a policy delivered in this state.

(O) As used in this section~~, "federally~~:

(1) "Base rate" means, as to any health benefit plan that is issued by an insurer in the individual market, the lowest premium rate for new or existing business prescribed by the insurer for the same or similar coverage under a plan or arrangement covering any individual of a group with similar case characteristics.

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

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

(1) ~~"Health~~ "Base rate" means, as to any health benefit plan that is issued by a carrier in the individual market, the lowest premium rate for new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any individual with similar case characteristics.

(2) "Carrier," "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) "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.

(4) "Ohio health care basic and standard plans" means those plans established under section 3924.10 of the Revised Code.

(5) "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~~ carriers in the business of issuing ~~individual policies of sickness and accident insurance as contemplated by section 3923.021 of the Revised Code~~ health benefit plans to individuals and nonemployer groups, except individual ~~policies~~ health benefit plans issued pursuant to ~~section~~ sections 1751.16 and 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~~ Carriers 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~~ A carrier 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~~ A carrier 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)(1) 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. A health insuring corporation may apply a pre-existing condition provision 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 except with respect to a newly born child who meets the requirements for coverage under section 1751.61 of the Revised Code.

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

(E) Premiums charged to individuals under this section may not exceed ~~an amount that is two and one half times the highest~~ the amounts specified below:

(1) For calendar years 2010 and 2011, an amount that is two times the base rate ~~charged~~ for coverage offered to any other individual to which the ~~insurer~~ carrier is currently accepting new business, and for which similar copayments and deductibles are applied;

(2) For calendar year 2012 and every year thereafter, an amount that is one and one-half times the base rate for coverage offered to any other individual to which the carrier is currently accepting new business and for which similar copayments and deductibles are applied, unless the superintendent of insurance determines that the amendments by this act to this section and section 3923.581 of the Revised Code, have resulted in the

market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than five and one quarter percentage points during calendar year 2010. If the superintendent makes that determination, the premium limit established by division (E)(1) of this section shall remain in effect. The superintendent's determination shall be supported by a signed letter from a member of the American academy of actuaries. 649 650 651 652 653 654 655 656 657

(F) In offering health benefit plans under this section, ~~an insurer~~ a carrier may require the purchase of health benefit plans that condition the reimbursement of health services upon the use of a specific network of providers. 658 659 660 661

(G)(1) ~~In no event shall an insurer~~ A carrier shall not be required to accept ~~annually~~ new applicants under this section if the total number of the carrier's current insureds with open enrollment coverage issued 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~~ carrier's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division (L) of this section meets the following limits: 662 663 664 665 666 667 668 669 670 671 672 673 674

(a) For calendar years 2010 and 2011, four per cent of the carrier's total number of individual or nonemployer group insureds in this state; 675 676 677

(b) For calendar year 2012 and every year thereafter, eight per cent of the carrier's total number of insured individuals and 678 679

nonemployer group insureds in this state, unless the 680
superintendent of insurance determines that the amendments by this 681
act to this section and section 3923.581 of the Revised Code, have 682
resulted in the market-wide average medical loss ratio for 683
coverage sold to individual insureds and nonemployer group 684
insureds in this state, including open enrollment insureds, to 685
increase by more than five and one quarter percentage points 686
during calendar year 2010. If the superintendent makes that 687
determination, the enrollment limit established by division 688
(G)(1)(a) of this section shall remain in effect. The 689
superintendent's determination shall be supported by a signed 690
letter from a member of the American academy of actuaries. 691

(2) An officer of the ~~insurer~~ carrier shall certify to the 692
department of insurance when it has met the enrollment limit set 693
forth in division (G)(1) of this section. Upon providing such 694
certification, the ~~insurer~~ carrier shall be relieved of its open 695
enrollment requirement under this section ~~for the remainder of the~~ 696
~~calendar year~~ as long as the carrier continues to meet the open 697
enrollment limit. If the total number of the carrier's current 698
insureds with open enrollment coverage issued under this section 699
falls below the enrollment limit, the carrier shall accept new 700
applicants. A carrier may establish a waiting list if the carrier 701
has met the open enrollment limit and shall notify the 702
superintendent if the carrier has a waiting list in effect. 703

(H) ~~An insurer~~ A carrier shall not be required to accept 704
under this section applicants who, at the time of enrollment, are 705
confined to a health care facility because of chronic illness, 706
permanent injury, or other infirmity that would cause economic 707
impairment to the ~~insurer~~ carrier if the applicants were accepted~~,~~ 708
~~or~~. A carrier shall not be required to make the effective date of 709
benefits for individuals accepted under this section earlier than 710

ninety days after the date of acceptance, except that when the 711
individual had prior coverage with a health benefit plan that was 712
terminated by a carrier because the carrier exited the market and 713
the individual was accepted for open enrollment under this section 714
within sixty-three days of that termination, the effective date of 715
benefits shall be the date of enrollment. 716

717

(I) The requirements of this section do not apply to any 718
~~insurer~~ carrier that is currently in a state of supervision, 719
insolvency, or liquidation. If ~~an insurer~~ a carrier demonstrates 720
to the satisfaction of the superintendent that the requirements of 721
this section would place the ~~insurer~~ carrier in a state of 722
supervision, insolvency, or liquidation, or would otherwise 723
jeopardize the carrier's economic viability overall or in the 724
individual market, the superintendent may waive or modify the 725
requirements of division (B) or (G) of this section. The actions 726
of the superintendent under this division shall be effective for a 727
period of not more than one year. At the expiration of such time, 728
a new showing of need for a waiver or modification by the ~~insurer~~ 729
carrier shall be made before a new waiver or modification is 730
issued or imposed. 731

(J) No hospital, health care facility, or health care 732
practitioner, and no person who employs any health care 733
practitioner, shall balance bill any individual or dependent of an 734
individual for any health care supplies or services provided to 735
the individual or dependent who is insured under a policy issued 736
under this section. The hospital, health care facility, or health 737
care practitioner, or any person that employs the health care 738
practitioner, shall accept payments made to it by the ~~insurer~~ 739
carrier under the terms of the policy or contract insuring or 740
covering such individual as payment in full for such health care 741
supplies or services. 742

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

(K) ~~An insurer shall~~ <u>A carrier may</u> pay an agent a commission in the amount of <u>not more than</u> 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 <u>not more than</u> 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) 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.

<u>(M) If a carrier offers a health benefit plan in the individual market through a network plan, the carrier may do both of the following:</u>

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

<u>(2) Within the service area of the network plan, deny the</u>

coverage to 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 to any additional individuals because of the carrier's obligations to existing group contract holders and individuals.

(b) The carrier is applying division (M)(2) of this section uniformly to all individuals without regard to any health status-related factors of those individuals.

(N) A carrier that, pursuant to division (M)(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 carrier denies the coverage.

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

(1) "Base rate" means, as to any health benefit plan that is issued by a carrier in the individual market, the lowest premium rate for new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any individual with similar case characteristics.

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

~~(2)~~ (3) "Federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

~~(3)~~ (4) "Health status-related factor" means any of the following:

(a) Health status;

(b) Medical condition, including both physical and mental illnesses; 802 803

(c) Claims experience; 804

(d) Receipt of health care; 805

(e) Medical history; 806

(f) Genetic information; 807

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; 808 809

(h) Disability. 810

~~(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.~~ 811 812 813 814 815

(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. 816 817 818 819 820

(6) "Ohio health care basic and standard plans" means those plans established under section 3924.10 of the Revised Code. 821 822

(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) of this section. 823 824 825 826 827 828

(C) No carrier shall do either of the following: 829

(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 Ohio health care basic and standard ~~plan established by the board of directors of the Ohio health reinsurance program~~ plans or plans substantially similar to the basic and standard ~~plan~~ plans 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~~ the amounts specified below:

(1) For calendar years 2010 and 2011, an amount that is two times the base rate ~~charged~~ for coverage offered to any other individual to which the carrier is currently accepting new business, and for which similar copayments and deductibles are applied;

(2) For calendar year 2012 and every calendar year thereafter, an amount that is one and one-half times the base rate for coverage offered to any other individual to which the carrier is currently accepting new business and for which similar copayments and deductibles are applied, unless the superintendent of insurance determines that the amendments by this act to this section and section 3923.58 of the Revised Code, have resulted in a market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than five and one quarter percentage points during calendar year 2010. If

the superintendent makes that determination, the premium limit established by division (E)(1) of this section shall remain in effect. The superintendent's determination shall be supported by a signed letter from a member of the American academy of actuaries.

(F) 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)(2) of this section uniformly to all federally eligible individuals without regard to any health status-related factor of those individuals.

(G) A carrier that, pursuant to division (F)(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) 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) 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) A carrier that, pursuant to division (H) 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)(1) Except as provided in division (J)(2) of this section, a carrier shall not be required to accept ~~annually~~ new applicants 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,~~ if the total number of the carrier's current insureds with open enrollment coverage issued under this section 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)~~ (L) of section 3923.58 of the Revised Code meets the following limits:

(a) For calendar years 2010 and 2011, four per cent of the carrier's total number of individual or nonemployer group insureds in this state;

(b) For calendar year 2012 and every year thereafter, eight

per cent of the carrier's total number of insured individuals and 922
nonemployer group insureds in this state, unless the 923
superintendent of insurance determines that the amendments by this 924
act to this section and section 3923.58 of the Revised Code, have 925
resulted in the market-wide average medical loss ratio for 926
coverage sold to individual insureds and nonemployer group 927
insureds in this state, including open enrollment insureds, to 928
increase by more than five and one quarter percentage points 929
during calendar year 2010. If the superintendent makes that 930
determination, the enrollment limit established by division 931
(J)(1)(a) shall remain in effect. The superintendent's 932
determination shall be supported by a signed letter from a member 933
of the American academy of actuaries. 934

(2) An officer of the carrier shall certify to the department 935
of insurance when it has met the enrollment limit set forth in 936
division (J)(1) of this section. Upon providing such 937
certification, the carrier shall be relieved of its open 938
enrollment requirement under this section for ~~the remainder of the~~ 939
~~calendar year unless, prior to the end of the calendar year,~~ as 940
long as the carrier continues to meet the open enrollment limit. 941
If the total number of the carrier's current insureds with open 942
enrollment coverage issued under this section falls below the 943
enrollment limit, the carrier shall accept new applicants. A 944
carrier may establish a waiting list if the carrier has met the 945
open enrollment limit and shall notify the superintendent if the 946
carrier has a waiting list in effect. In the event that all the 947
carriers subject to this section have individually met the 948
enrollment limit set forth in division (J)(1) of this section~~. In~~ 949
~~that event~~ in a calendar year, carriers shall again accept 950
applicants for open enrollment coverage pursuant to this section, 951
subject to ~~the~~ an additional enrollment limit equal to one-half of 952
the limitation set forth in division (J)(1) of this section. 953

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

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

(M) A carrier may pay an agent a commission in the amount of not more than 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 not more than 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.

Sec. 3923.582. (A) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code to implement sections 3923.58 and 3923.581 of the Revised Code, including, but not limited to, rules relating to both of the following:

(1) Requirements for adequate notice by carriers to consumers of the availability and premium rates of open enrollment coverage;

(2) Reporting and data collection requirements for implementation of the open enrollment program and to evaluate the performance of the open enrollment program and the individual health insurance market of this state.

(B) On or before June 30, beginning calendar year 2011 and continuing every year thereafter, the superintendent shall issue a report to the governor and the general assembly on the open enrollment program and the performance of the individual health insurance market in this state. The report shall include a determination by the superintendent, supported by a signed letter

from a member of the American academy of actuaries, as to whether the amendments by this act to sections 3923.58 and 3923.581 of the Revised Code, have caused the market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase and, if so, by how many percentage points."

In line 90835, after "1751.05," insert "1751.15, 1751.16, 1751.18,"

In line 90875, after "3923.11," insert "3923.122, 3923.58, 3923.581,"

In line 54 of the title, after "1751.05," insert "1751.15, 1751.16, 1751.18,"

In line 110 of the title, after "3923.11," insert "3923.122, 3923.58, 3923.581,"

In line 206 of the title, after "3903.77," insert "3923.582,"

The motion was __________ agreed to.

SYNOPSIS

Open Enrollment and Conversion Policies

R.C. 1751.15, 1751.16, 1751.18, 3923.122, 3923.58, 3923.581, and 3923.582

Conforms to the requirements for sickness and accident insurers and multiple employer welfare arrangements the open enrollment program requirements for Health Insurance Corporations (HICs) as they related to individuals who are not federally

eligible (under current law HICs already follow the state standards for federally eligible individuals) but maintains certain provisions concerning pre existing conditions and exceptions to enrollment requirements. 1008 1009 1010 1011

Phases in a reduction of the maximum contractual periodic prepayments and premiums that insurers may charge federally eligible individuals for individual health insurance contracts or policies that are converted from group contracts and policies, from current law's two times the midpoint of the standard rate charged other individuals for similar coverage to 2 times the base rate charged other individuals for similar coverage in 2010 and 2011, and 1 1/2 times the base rate in 2012 and subsequent years, subject to certain conditions; and prohibits insurers and health insuring corporations from using health status as a basis for refusing to renew a converted contract. 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022

1023

Requires carriers that issue nonemployer group health benefit plans to provide open enrollment coverage to individuals who are not federally eligible in addition to carriers that issue individual plans (current law already requires those carriers to provide open enrollment coverage to federally eligible individuals) and includes HIC policies that are converted from group policies to individual policies in the exception from that rule. 1024 1025 1026 1027 1028 1029 1030 1031

Phases in an increase in the number of people that carriers are required to accept for open enrollment coverage from current law's 0.5% total for sickness and accident insurers and 1% for HICs to 4% for each in 2010 and 2011 and 8% in 2012 and subsequent years if certain conditions are met. 1032 1033 1034 1035 1036

Allows carriers that offer individual health benefit plans through network plans to include the same limitations for coverage 1037 1038

for open enrollment plans under section 3923.58 as current law allows for open enrollment plans for federally eligible individuals under section 3923.581 of the Revised Code. 1039 1040 1041

Requires HICs, for purposes of determining the "base rate" in regards to conversion of group policies to individual policies, to compare the coverage to the premium rate for an individual "in a group" with similar case characteristics. 1042 1043 1044 1045

Requires carriers that meet the enrollment limitations to reopen coverage whenever the carrier's enrollment drops below the enrollment limits and allows carriers to establish waiting lists. If all carriers meet the enrollment limitation for federally eligible individuals, requires carriers to accept additional individuals. 1046 1047 1048 1049 1050 1051

Allows the Superintendent of Insurance to adopt rules to implement the open enrollment program and requires the Superintendent to prepare an annual report for the General Assembly and the Governor on the program and in the individual markets in Ohio including market-wide average loss ratio data. 1052 1053 1054 1055 1056