

OHIO

House

of

Representatives

JOURNAL

CORRECTED VERSION
TUESDAY, DECEMBER 16, 2014

TWO HUNDRED FIFTEENTH DAY
Hall of the House of Representatives, Columbus, Ohio
Tuesday, December 16, 2014, 9:00 o'clock a.m.

The House met pursuant to adjournment.

Pursuant to House Rule No. 23, the Clerk called the House to order.

Representative Buchy was selected to preside under the Rule.

The journal of the previous legislative day was read and approved.

INTRODUCTION OF BILLS

The following bill was introduced:

H. B. No. 685-Representatives Foley, Hagan, R.

Cosponsor: Representative Ramos.

To amend sections 1509.02, 1509.34, 1509.50, 1513.08, 1513.182, 1514.11, 5705.27, 5705.32, 5731.02, 5731.19, 5731.21, 5731.39, 5731.48, 5747.02, 5747.03, 5749.01, 5749.02, 5749.06, and 5749.11 and to enact sections 321.50 and 3745.15 of the Revised Code to create the State Environmental Restoration Authority, to use revenue from an increase in the income tax rate on the highest income bracket to fund the Authority, to replace existing oil and gas severance taxes with a tax on the first sale of oil or gas and use the revenue to fund local governments, oil and gas regulation, and the Authority, and to levy a tax on decedents' estates and use the revenue to fund local governments and the Authority.

Said bill was considered the first time.

**REPORTS OF STANDING AND SELECT COMMITTEES AND BILLS
FOR SECOND CONSIDERATION**

Representative Ramos reported for the Rules and Reference committee, recommending that the following House Bills and Senate Bills be considered for the second time and referred to the following committees for consideration:

H.B. No. 680 – Representative Heard

TO CREATE THE "JUVENILE DIABETES RESEARCH FOUNDATION"
LICENSE PLATE.

To the committee on Transportation, Public Safety, and Homeland Security

H.B. No. 681 – Representative Reece

TO REGULATE THE COMMERCIAL SALE, MODIFICATION, AND
PUBLIC DISPLAY OF IMITATION FIREARMS AND THE DISGUISED

OF A FIREARM AS AN IMITATION FIREARM.
To the committee on Policy and Legislative Oversight

H.B. No. 682 – Representatives Pillich and Lundy
RELATIVE TO THE EXTENSION OF CONSUMER CREDIT TO
MEMBERS AND VETERANS OF THE U.S. ARMED FORCES,
INCLUDING THE RESERVES, OR OF THE NATIONAL GUARD, AND
TO MEMBERS OF THEIR IMMEDIATE FAMILIES.

To the committee on Military and Veterans Affairs

H.B. No. 683 – Representative Gonzales
REGARDING THE MEDICAID SCHOOL PROGRAM.

To the committee on Health and Aging

H.B. No. 684 – Representatives Foley and Ramos
REGARDING WIND FARM SETBACK DISTANCES, ALTERNATIVE
ENERGY RESOURCES, AND ENERGY EFFICIENCY STANDARDS,
AND TO INCREASE THE ANNUAL RENEWABLE ENERGY
BENCHMARKS.

To the committee on Public Utilities

Sub. S.B. No. 250 – Senators Jones and LaRose
TO REQUIRE THAT CERTAIN PRE-BIRTH ADOPTION
NOTIFICATIONS BE SENT TO EACH PUTATIVE FATHER; TO
REDUCE THE TIME WITHIN WHICH A PUTATIVE FATHER MUST
REGISTER WITH THE PUTATIVE FATHER REGISTRY; TO REDUCE
THE PERIOD OF TIME TO APPEAL AN ADOPTION DECREE; TO
PERMIT CERTAIN ENTITIES TO ADVERTISE REGARDING THE
ADOPTION OF CHILDREN; TO DEFINE FOR PURPOSES OF AN
ADOPTION "LIVING EXPENSES" OF A BIRTH MOTHER AND TO
SPECIFY HOW THEY MUST BE PAID; AND TO INCREASE THE
ADOPTION INCOME TAX CREDIT.

To the committee on Health and Aging

Am. Sub. S.B. No. 386 – Senator Burke
TO ENABLE INDIVIDUALS TO PURCHASE AND USE CONSUMER
GRADE FIREWORKS, TO EXTEND TO DECEMBER 15, 2018, THE
MORATORIUM ON ISSUING FIREWORKS MANUFACTURER AND
WHOLESALE LICENSES, TO ELIMINATE, BEGINNING JANUARY 1,
2016, THE MORATORIUM ON GEOGRAPHIC TRANSFER OF
FIREWORKS MANUFACTURER AND WHOLESALE LICENSES, AND
TO IMPOSE A FEE ON THE RETAIL SALE OF CONSUMER GRADE
FIREWORKS IN THIS STATE.

To the committee on Health and Aging

Am. Sub. S.B. No. 344 – Senator Setitz
TO PROVIDE TRANSPARENCY IN CONTRACTS BETWEEN THE
STATE AND PRIVATE ATTORNEYS.

To the committee on Judiciary

MATT HUFFMAN
ANDREW BRENNER
DOROTHY PELANDA
TRACY HEARD

BILL HAYES
JIM BUCHY
ROBERT HACKETT
DAN RAMOS

Representative Brenner moved that the House and Constitutional Rules requiring bills to be considered by each house on three different days be suspended as to the second consideration of all House Bills and Senate Bills contained in the report of the committee on Rules and Reference.

The motion was agreed to without objection.

The report was agreed to.

Said House Bills and Senate Bills were considered the second time and referred as recommended.

MOTIONS AND RESOLUTIONS

Representative Ramos reported for the Rules and Reference committee recommending that the following House Concurrent Resolution be introduced and referred to the following committee for consideration:

H.C.R. No. 64 – Representatives Boose and Patterson
TO SUPPORT THE EFFORTS OF THE OHIO DEPARTMENT OF
TAXATION TO CONTINUE TO SEEK VIABLE SOLUTIONS TO
DRAMATIC INCREASES IN THE TAXABLE VALUE OF
AGRICULTURAL PROPERTY VALUED ACCORDING TO ITS
CURRENT AGRICULTURAL USE.

To the committee on Ways and Means

Add the name: Brenner

/s/MATT HUFFMAN
Matt Huffman, Chair

Representative Brenner moved that the Rules and Reference committee report on resolutions be agreed to and that the House Concurrent Resolution contained therein be introduced and referred as recommended.

The motion was agreed to.

Said House Concurrent Resolution was introduced and referred as recommended.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the adoption of the following joint resolution:

Am. Sub. H. J. R. No. 12-Representatives Huffman, Sykes
Cosponsors: Representatives Amstutz, Anielski, Ashford, Baker, Brown, Burkley, Clyde, Duffey, Grossman, Hackett, Hagan, C., Hayes, Kunze, Letson, McClain, McGregor, Patmon, Scherer, Schuring, Stebelton, Wachtmann, Speaker Batchelder Senators Faber, Coley, Bacon, Balderson, Beagle, Burke, Eklund, Gardner, Gentile, Hite, LaRose, Lehner, Peterson, Sawyer, Schiavoni, Turner, Widener

Proposing to enact new Sections 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10 of Article XI and to repeal Sections 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15 of Article XI of the Constitution of the State of Ohio to revise the redistricting process for General Assembly districts.

As a substitute joint resolution with the following additional amendment, in which the concurrence of the House is requested.

In line 273, delete the first underlined comma

Attest:

Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Am. H. B. No. 326 -Representatives Roegner, Reece
Cosponsors: Representatives Hood, Stebelton, Wachtmann, Thompson, Huffman, Becker, Mallory, Buchy, Sheehy, DeVitis, Young, Duffey, Landis, Adams, R., Amstutz, Anielski, Antonio, Ashford, Baker, Barborak, Barnes, Beck, Blair, Blessing, Brown, Budish, Burkley, Celebrezze, Cera, Curtin, Damschroder, Driehaus, Fedor, Gerberry, Green, Hackett, Hagan, R., Hall, Letson, Milkovich, O'Brien, Patterson, Perales, Pillich, Rogers, Scherer, Sears, Slesnick, Smith, Sprague, Stinziano, Strahorn, Williams, Winburn, Speaker Batchelder Senators Bacon, Burke, Hughes, LaRose, Manning, Patton

To amend section 4779.02 of the Revised Code to add pharmacists to the professional license exception to the Orthotist, Prosthetist, and Pedorthist

Licensing Law.

With the following additional amendments, in which the concurrence of the House is requested.

In line 13, after "4723.," insert " 4729.,"

In line 33, delete the underlined semicolon

Delete lines 34 through 49

In line 50, delete " the national commission for certifying agencies"

Delete line 2 of the title and insert "add pharmacists to the professional license exception to the Orthotist, Prosthetist, and Pedorthist Licensing Law."

Attest:

Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Am. Sub. H. B. No. 394-Representatives Smith, Antonio
Cosponsors: Representatives Wachtmann, Brown, Hagan, R., Schuring, Sears, Sprague, Barnes, Ramos, Baker, Beck, Bishoff, Buchy, Fedor, Hackett, Heard, Hill, Letson, McClain, Milkovich, Patmon, Rogers, Rosenberger, Scherer, Sheehy, Speaker Batchelder Senators Bacon, Balderson, Beagle, Eklund, Hite, Jones, Kearney, Lehner, Manning, Oelslager, Patton, Peterson, Seitz, Tavares, Uecker, Widener

To amend sections 2925.02, 3701.63, 3701.64, 3719.01, 3719.061, 3729.05, 4715.14, 4715.30, 4723.28, 4723.481, 4723.486, 4725.16, 4725.19, 4729.12, 4729.16, 4729.18, 4729.41, 4729.85, 4729.86, 4730.25, 4730.41, 4730.48, 4731.22, 4731.281, 4773.03, 4773.08, 5104.015, 5104.017, 5104.018, 5165.08, 5165.513, 5165.515, and 5165.99; to enact sections 3701.66, 3701.67, 3701.68, 3702.40, and 5104.014; and to repeal sections 4715.15, 4723.433, 4730.093, and 4731.77 of the Revised Code to modify the authority of pharmacists and pharmacy interns to administer immunizations; to require the inclusion of certain information in mammography report summaries; to revise the law governing the licensure of recreational vehicle parts, recreation camps, combined park-camps, and temporary park-camps; to generally require immunizations for children enrolled in child care; to create the Commission on

Infant Mortality and require the establishment of infant safe sleep procedures and policies; to modify the offense of "corrupting another with drugs"; to require the State Board of Pharmacy to prepare semiannual reports on opioid prescriptions; to revise the laws governing the Ohio Automated Rx Reporting System and opioid prescriptions issued for minors; to require under certain conditions the reinstatement of licenses to practice certain radiologic professions; to eliminate patient notice requirements concerning Lyme disease testing; to revise certain laws on nursing facility admission policies and exclusions from Medicaid provider agreements; to amend the versions of sections 4715.30, 4715.302, 4723.28, 4723.487, 4725.092, 4725.19, 4730.25, 4730.53, 4731.055, and 4731.22 of the Revised Code that are scheduled to take effect April 1, 2015, to continue the provisions of this act on and after that effective date; and to declare an emergency.

As a substitute bill with the following additional amendment, in which the concurrence of the House is requested.

Delete lines 521 through 530

Attest:

Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Sub. H. B. No. 440 -Representative Brown

Cosponsors: Representatives Damschroder, Ruhl, Mallory, Celebrezze, DeVitis, Green, Hagan, R., Milkovich, Patmon, Perales, Adams, R., Anielski, Antonio, Baker, Barborak, Barnes, Beck, Blair, Blessing, Boose, Boyce, Buchy, Budish, Burkley, Butler, Carney, Clyde, Derickson, Dovilla, Driehaus, Duffey, Fedor, Foley, Gerberry, Grossman, Hackett, Hagan, C., Hall, Hayes, Heard, Henne, Hill, Hottinger, Huffman, Johnson, Kunze, Landis, Letson, Lundy, Lynch, Maag, McClain, O'Brien, Patterson, Pelanda, Pillich, Redfern, Reece, Retherford, Roegner, Rogers, Romanchuk, Rosenberger, Scherer, Schuring, Sears, Sheehy, Slaby, Sprague, Stautberg, Stebelton, Stinziano, Strahorn, Terhar, Wachtmann, Winburn, Speaker Batchelder Senators LaRose, Cafaro, Bacon, Balderson, Beagle, Brown, Burke, Coley, Eklund, Faber, Gardner, Gentile, Hite, Hughes, Jones, Jordan, Kearney, Lehner, Manning, Obhof, Oelslager, Patton, Peterson, Sawyer, Schaffer, Schiavoni, Seitz, Skindell, Smith, Tavares, Turner, Uecker, Widener

To amend section 5533.636 and to enact sections 5533.053, 5533.255, 5533.311, 5533.464, 5533.511, 5533.641, 5533.679, 5533.781, 5533.782, 5533.783, 5533.812, 5534.03, 5534.04, 5534.07, 5534.08, 5534.09, 5534.10, 5534.11, 5534.12, 5534.13, 5534.14, 5534.40, 5534.41, and 5534.42 of the Revised Code to designate a number of memorial highways and bridges in honor of members of the armed forces of the United States and first responders.

As a substitute bill, in which the concurrence of the House is requested.

Attest: Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Sub. H. B. No. 463 -Representative Johnson

Cosponsors: Representatives Duffey, Roegner, Scherer, Milkovich, Blessing, Schuring, Bishoff, Young, Hackett, Stinziano, Smith, Stebelton, Rosenberger, Adams, R., Grossman, Celebrezze, Sears, Barnes, Hill, Amstutz, Perales, Terhar, Thompson, Retherford, Lundy, Barborak, Wachtmann, Sprague, Antonio, Baker, Beck, Boose, Brown, Buchy, Budish, Burkley, Butler, Cera, DeVitis, Dovilla, Driehaus, Green, Hagan, C., Hall, Hayes, Landis, Letson, Mallory, McClain, O'Brien, Patterson, Rogers, Romanchuk, Ruhl, Sheehy, Slaby, Strahorn, Sykes, Winburn, Speaker Batchelder Senators Gardner, Balderson, Beagle, Brown, Eklund, Hughes, Jones, LaRose, Lehner, Obhof, Oelslager, Patton, Peterson, Schaffer, Tavares, Uecker

To amend sections 3333.61, 4715.031, 4715.037, 4715.10, 4715.13, 4715.22, 4715.23, 4715.24, 4715.363, 4715.366, 4715.371, 4715.373, 4715.39, 4715.56, 4715.64, and 4715.66 and to enact sections 3702.96, 3702.961, 3702.962, 3702.963, 3702.964, 3702.965, 3702.966, 3702.967, and 4715.421 of the Revised Code to make changes to the laws governing dental professionals.

As a substitute bill, in which the concurrence of the House is requested.

Attest: Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Am. Sub. H. B. No. 494 -Representative Schuring
Cosponsors: Representatives Hagan, C., Slesnick, Slaby, Amstutz, Landis, Barborak, Blair, Boose, Brown, Burkley, Damschroder, Grossman, Hackett, Hill, Maag, Young, Adams, R., Hottinger, Williams, Rogers, Adams, J., Anielski, Antonio, Beck, Blessing, Green, Huffman, Johnson, McClain, Milkovich, Patterson, Romanchuk, Ruhl, Scherer, Sheehy, Terhar, Thompson
Senators Beagle, Burke, Cafaro, Eklund, Lehner, Patton, Peterson, Schiavoni, Seitz

To amend sections 133.01, 715.70, 715.71, 715.74, 4301.80, 4303.181, 4504.08, 4504.09, 5747.24, 5747.331, and 5751.52, to enact sections 4504.22 and 5595.01 to 5595.13 of the Revised Code, to amend Section 9 of Am. Sub. H.B. 386 of the 129th General Assembly, as subsequently amended, to amend Section 363.487 of Am. Sub. H.B. 59 of the 130th General Assembly, and to amend Section 363.10 of Am. Sub. H.B. 59 of the 130th General Assembly, as subsequently amended, to authorize counties to undertake regional transportation improvement projects funded by the issuance of securities and by revenue pledges from the state and political subdivisions and taxing districts located within the cooperating counties, to increase the amount of time a person may spend in Ohio before being presumed to be a resident for state income tax purposes, to authorize taxpayers eligible to claim a tax credit for qualified research and development loan payments to claim the credit, retroactive to taxable years beginning in 2008, against the income tax, to authorize municipal corporations and townships to create a community entertainment district as part of a joint economic development district contract, to make changes to video lottery terminal facilities, and to make an appropriation.

As a substitute bill with the following additional amendments, in which the concurrence of the House is requested.

After line 2732, insert:

"Section 8. That Section 9 of Am. Sub. H.B. 386 of the 129th General Assembly, as amended by Am. Sub. H.B. 59 of the 130th General Assembly, be amended to read as follows:

Sec. 9. (A) As used in this section, "permit holder" and "track" have the

same meanings as in Section 7 of this act.

~~(B) The Governor, in consultation with the State Racing Commission, shall discuss, negotiate in good faith, and reach an agreement with necessary parties regarding providing five Five hundred thousand dollars per year, for three years, with the first payment by December 31, 2014, and annually thereafter, shall be paid to the municipal corporations or townships receiving moneys from the Casino Operator Settlement Fund under Section 10 of Am. Sub. H.B. 386 of the 129th General Assembly, as subsequently amended in which a track was relocated, and not exempted from a relocation fee, under Sub. H.B. 277 of the 129th General Assembly. One-half of each annual payment shall be paid by the permit holder of the track to that municipal corporation or township. The remaining one-half shall be paid from the Casino Operator Settlement Fund. If a permit holder fails to make any of the annual payments required under this section, the State Lottery Commission, after affording the permit holder an opportunity for an adjudication under Chapter 119. of the Revised Code, shall revoke the permit holder's license to operate as a lottery sales agent that operates video lottery terminal games under Chapter 3770. of the Revised Code.~~

Section 9. That existing Section 9 of Am. Sub. H.B. 386 of the 129th General Assembly, as amended by Am. Sub. H.B. 59 of the 130th General Assembly, is hereby repealed."

In line 4 of the title, after the comma insert "to amend Section 9 of Am. Sub. H.B. 386 of the 129th General Assembly, as subsequently amended,"

In line 23 of the title, after the comma insert "to make changes to video lottery terminal facilities,"

Attest:

Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Am. Sub. H. B. No. 178-Representative Phillips

Cosponsors: Representatives Hayes, Mallory, Strahorn, Reece, Fedor, Heard, Antonio, Bishoff, Amstutz, Anielski, Ashford, Baker, Barborak, Barnes, Beck, Boyce, Boyd, Brenner, Brown, Budish, Burkley, Carney, Celebrezze, Cera, Clyde, Curtin, Derickson, DeVitis, Driehaus, Grossman, Hottinger, Huffman, Kunze, Letson, Lundy, Milkovich, O'Brien, Patmon, Patterson, Pillich, Roegner, Rogers, Ruhl, Sheehy, Stebelton, Winburn, Young, Speaker
Batchelder Senators Gentile, Hughes, Patton, Sawyer, Skindell, Turner

To amend sections 3313.976, 3314.03, 3326.11, 3328.24, and 3737.73 and to enact section 3319.46 of the Revised Code and to amend Sections 263.10 and 263.230 of Am. Sub. H.B. 59 of the 130th General Assembly, as subsequently amended, with respect to school safety drills in public and private schools; the use of seclusion and physical restraint on students and positive behavior intervention supports in public schools; and the qualification of private schools that are located within the boundaries of a city, local, or exempted village school district adjacent to the pilot project school district for the Pilot Project Scholarship Program and to make an appropriation.

As a substitute bill with the following additional amendments, in which the concurrence of the House is requested.

In line 25, strike through "is"

In line 26, delete " Located" and insert " Offers any of grades kindergarten through twelve and is located"

In line 28, delete " Located" and insert " Offers any of grades nine through twelve and is located"

In line 29, delete " adjacent" and insert " that is both:

(i) Located in a municipal corporation with a population of fifty thousand or more;

(ii) Adjacent

Attest:

Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Am. Sub. H. B. No. 201-Representative Butler

Cosponsors: Representatives Adams, J., Terhar, Thompson, Hayes, Adams, R., Amstutz, Anielski, Beck, Bishoff, Blair, Blessing, Boyce, Budish, Burkley, Conditt, Green, Hood, Huffman, Letson, Milkovich, Perales, Retherford, Strahorn, Sykes, Winburn, Speaker Batchelder Senators Burke, Coley, Eklund, Jordan, Patton, Seitz

To amend sections 1739.061, 1751.14, 1751.69, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 3923.65, 3923.83, 3923.85,

3924.01, and 5301.36 and to enact sections 505.377, 737.082, 737.222, and 5301.361 of the Revised Code to make changes relative to entries of satisfaction, to clarify the status of volunteer firefighters for purposes of the Patient Protection and Affordable Care Act, to make changes regarding coverage for a dependent child under a parent's health insurance plan and the hours of work needed to qualify for coverage under a small employer health benefit plan, to increase the duration of the health insurance considered to be short-term under certain insurance laws, and to make changes to the chemotherapy parity law.

As a substitute bill with the following additional amendments, in which the concurrence of the House is requested.

In line 4, delete the first "section" and insert "sections 1739.061, 1751.14, 1751.69, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 3923.65, 3923.83, 3923.85, 3924.01, and"; delete the second "section" and insert "sections 505.377, 737.082, 737.222, and"

Between lines 5 and 6, insert:

" **Sec. 505.377.** A volunteer firefighter appointed pursuant to this chapter is a bona fide volunteer and not an employee for purposes of section 513 of the "Patient Protection and Affordable Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for providing those fire protection services, the volunteer receives any of the benefits provided in Chapter 146., 4121., or 4123. or section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised Code.

Sec. 737.082. A volunteer firefighter appointed pursuant to this chapter is a bona fide volunteer and not an employee for purposes of section 513 of the "Patient Protection and Affordable Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for providing those fire protection services, the volunteer receives any of the benefits provided in Chapter 146., 4121., or 4123. or section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised Code.

Sec. 737.222. A volunteer firefighter appointed pursuant to this chapter is a bona fide volunteer and not an employee for purposes of section 513 of the "Patient Protection and Affordable Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for providing those fire protection services, the volunteer receives any of the benefits provided in Chapter 146., 4121., or 4123. or section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised Code.

Sec. 1739.061. (A)(1) This section applies to both of the following:

(a) A multiple employer welfare arrangement that issues or requires the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims;

(b) A person or entity that a multiple employer welfare arrangement contracts with to issue a standardized identification card or an electronic

technology described in division (A)(1)(a) of this section.

(2) Notwithstanding division (A)(1) of this section, this section does not apply to the issuance or required use of a standardized identification card or an electronic technology for the submission and routing of prescription drug claims in connection with any of the following:

(a) Any program or arrangement covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time-limited-duration policy ~~of not longer than six~~ twelve months; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) Coverage provided under the medicaid program.

(c) Coverage provided under an employer's self-insurance plan or by any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of this section to the plan and its administrators.

(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1) or (2) of this section.

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology.

(2) If the multiple employer welfare arrangement or person under contract with it to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information:

(a) The name of the multiple employer welfare arrangement;

(b) The individual's name, group number, and identification number;

(c) A telephone number to inquire about pharmacy-related issues;

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";

(e) The processor's control number, labeled as "RxPCN";

(f) The individual's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp."

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims.

(D) Each multiple employer welfare arrangement described in division (A) of this section shall annually file a certificate with the superintendent of insurance certifying that it or any person it contracts with to issue a standardized identification card or electronic technology for submission and routing of prescription drug claims complies with this section.

(E)(1) Except as provided in division (E)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an individual, the multiple employer welfare arrangement or person under contract with it to issue a standardized identification card or an electronic technology shall issue a new card or electronic technology to the individual.

(2) A multiple employer welfare arrangement or person under contract with it is not required under division (E)(1) of this section to issue a new card or electronic technology to an individual more than once during a twelve-month period.

(F) Nothing in this section shall be construed as requiring a multiple employer welfare arrangement to produce more than one standardized identification card or one electronic technology for use by individuals accessing health care benefits provided under a multiple employer welfare arrangement.

Sec. 1751.14. (A) Notwithstanding section 3901.71 of the Revised Code, any policy, contract, or agreement for health care services authorized by this chapter that is issued, delivered, or renewed in this state and that provides that coverage of an unmarried dependent child will terminate upon attainment of the limiting age for dependent children specified in the policy, contract, or agreement, shall also provide in substance both of the following:

(1) Once an unmarried child has attained the limiting age for dependent children, as provided in the policy, contract, or agreement, upon the request of the subscriber, the health insuring corporation shall offer to cover the unmarried child until the child attains ~~twenty-eight~~ twenty-six years of age if all of the following are true:

(a) The child is the natural child, stepchild, or adopted child of the subscriber.

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

(c) The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage.

(d) The child is not eligible for coverage under the medicaid program or the medicare program.

(2) That attainment of the limiting age for dependent children shall not operate to terminate the coverage of a dependent child if the child is and continues to be both of the following:

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

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

(B) Proof of incapacity and dependence for purposes of division (A)(2) of this section shall be furnished to the health insuring corporation within thirty-one days of the child's attainment of the limiting age. Upon request, but not more frequently than annually, the health insuring corporation may require proof satisfactory to it of the continuance of such incapacity and dependency.

(C) Nothing in this section shall do any of the following:

(1) Require that any policy, contract, or agreement offer coverage for dependent children or provide coverage for an unmarried dependent child's children as dependents on the policy, contract, or agreement;

(2) Require an employer to pay for any part of the premium for an unmarried dependent child that has attained the limiting age for dependents, as provided in the policy, contract, or agreement;

(3) Require an employer to offer health insurance coverage to the dependents of any employee.

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

(E) As used in this section, "health benefit plan" has the same meaning as in section 3924.01 of the Revised Code and also includes both of the following:

(1) A public employee benefit plan;

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

Sec. 1751.69. (A) As used in this section, "cost sharing" means the cost to an individual insured under an individual or group health insuring corporation policy, contract, or agreement according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the policy, contract, or agreement.

(B) Notwithstanding section 3901.71 of the Revised Code and subject to division (D) of this section, no individual or group health insuring corporation policy, contract, or agreement providing basic health care services or prescription drug services that is delivered, issued for delivery, or renewed in this state, if the policy, contract, or agreement provides coverage for cancer chemotherapy treatment, shall fail to comply with either of the following:

(1) The policy, contract, or agreement shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected cancer medications.

(2) The policy, contract, or agreement shall not comply with division (B)(1) of this section by imposing an increase in cost sharing solely for orally administered, intravenously administered, or injected cancer medications.

(C) Notwithstanding any provision of this section to the contrary, an individual or group health insuring corporation policy, contract, or agreement shall be deemed to be in compliance with this section if the cost sharing imposed under such a policy, contract, or agreement for orally administered cancer treatments does not exceed one hundred dollars per prescription fill. The cost sharing limit of one hundred dollars per prescription fill shall apply to a high deductible plan, as defined in 26 U.S.C. 223, or a catastrophic plan, as defined in 42 U.S.C. 18022, only after the deductible has been met.

(D) The prohibitions in division (B) of this section do not preclude an individual or group health insuring corporation policy, contract, or agreement from requiring an enrollee to obtain prior authorization before orally administered cancer medication is dispensed to the enrollee.

(E) A health insuring corporation that offers coverage for basic health care services is not required to comply with division (B) of this section if all of the following apply:

(1) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that compliance with division (B)(1) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(2) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(3)(a) The superintendent of insurance makes the following

determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section:

(i) Compliance with division (B)(1) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code.

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

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

(b) "Administrative expense" does not include any amounts collected, or administrative expenses incurred, by an insurer for the administration of an employee health benefit plan subject to regulation by the federal "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended. "Amounts collected or administrative expenses incurred" means the total 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~~ that is less than six ~~twelve~~ 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, 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 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 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 related to the insurer's payment of commissions;

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

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

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

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

(D) No insurer shall fail to comply with this section.

(E) If the superintendent determines that an insurer has violated this section, the superintendent, pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code, may order the suspension of the insurer's license to do the business of sickness and accident insurance in this state until the superintendent is satisfied that the insurer is in compliance with this section. If the insurer continues to do the business of sickness and accident insurance in this state while under the suspension order, the superintendent shall order the insurer to pay one thousand dollars for each day of the violation.

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

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

Sec. 3923.24. (A) Notwithstanding section 3901.71 of the Revised Code, every certificate furnished by an insurer in connection with, or pursuant to any provision of, any group sickness and accident insurance policy delivered, issued for delivery, renewed, or used in this state on or after January 1, 1972, every policy of sickness and accident insurance delivered, issued for delivery, renewed, or used in this state on or after January 1, 1972, and every multiple employer welfare arrangement offering an insurance program, which provides that coverage of an unmarried dependent child of a parent or legal guardian will terminate upon attainment of the limiting age for dependent children specified in the contract shall also provide in substance both of the following:

(1) Once an unmarried child has attained the limiting age for dependent children, as provided in the policy, upon the request of the insured, the insurer shall offer to cover the unmarried child until the child attains ~~twenty-eight~~ twenty-six years of age if all of the following are true:

(a) The child is the natural child, stepchild, or adopted child of the insured.

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

(c) The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage.

(d) The child is not eligible for the medicaid program or the medicare program.

(2) That attainment of the limiting age for dependent children shall not operate to terminate the coverage of a dependent child if the child is and continues to be both of the following:

(a) Incapable of self-sustaining employment by reason of mental

retardation or physical handicap;

(b) Primarily dependent upon the policyholder or certificate holder for support and maintenance.

(B) Proof of such incapacity and dependence for purposes of division (A)(2) of this section shall be furnished by the policyholder or by the certificate holder to the insurer within thirty-one days of the child's attainment of the limiting age. Upon request, but not more frequently than annually after the two-year period following the child's attainment of the limiting age, the insurer may require proof satisfactory to it of the continuance of such incapacity and dependency.

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

(D) Nothing in this section shall do any of the following:

(1) Require that any policy offer coverage for dependent children or provide coverage for an unmarried dependent child's children as dependents on the policy;

(2) Require an employer to pay for any part of the premium for an unmarried dependent child that has attained the limiting age for dependents, as provided in the policy;

(3) Require an employer to offer health insurance coverage to the dependents of any employee.

(E) This section does not apply to any policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy ~~of not longer than six~~ that is less than six twelve months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(F) As used in this section, "health benefit plan" has the same meaning as in section 3924.01 of the Revised Code and also includes both of the following:

(1) A public employee benefit plan;

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

Sec. 3923.241. (A) Notwithstanding section 3901.71 of the Revised Code, any public employee benefit plan that provides that coverage of an unmarried dependent child will terminate upon attainment of the limiting age for dependent children specified in the plan shall also provide in substance both of the following:

(1) Once an unmarried child has attained the limiting age for dependent children, as provided in the plan, upon the request of the employee, the public employee benefit plan shall offer to cover the unmarried child until the child attains ~~twenty-eight~~ twenty-six years of age if all of the following are true:

(a) The child is the natural child, stepchild, or adopted child of the employee.

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

(c) The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage.

(d) The child is not eligible for the medicaid program or the medicare program.

(2) That attainment of the limiting age for dependent children shall not operate to terminate the coverage of a dependent child if the child is and continues to be both of the following:

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

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

(B) Proof of incapacity and dependence for purposes of division (A)(2) of this section shall be furnished to the public employee benefit plan within thirty-one days of the child's attainment of the limiting age. Upon request, but not more frequently than annually, the public employee benefit plan may require proof satisfactory to it of the continuance of such incapacity and dependency.

(C) Nothing in this section shall do any of the following:

(1) Require that any public employee benefit plan offer coverage for dependent children or provide coverage for an unmarried dependent child's children as dependents on the public employee benefit plan;

(2) Require an employer to pay for any part of the premium for an unmarried dependent child that has attained the limiting age for dependents, as provided in the plan;

(3) Require an employer to offer health insurance coverage to the

dependents of any employee.

(D) This section does not apply to any public employee benefit plan covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy ~~of not longer than six~~ twelve months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(E) As used in this section, "health benefit plan" has the same meaning as in section 3924.01 of the Revised Code and also includes both of the following:

(1) A public employee benefit plan;

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

Sec. 3923.281. (A) As used in this section:

(1) "Biologically based mental illness" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

(2) "Policy of sickness and accident insurance" has the same meaning as in section 3923.01 of the Revised Code, but excludes any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy ~~of not longer than six~~ twelve months, supplemental benefit, or other policy that provides coverage for specific diseases or accidents only; any policy that provides coverage for workers' compensation claims compensable pursuant to Chapters 4121. and 4123. of the Revised Code; and any policy that provides coverage to medicaid recipients.

(B) Notwithstanding section 3901.71 of the Revised Code, and subject to division (E) of this section, every policy of sickness and accident insurance shall provide benefits for the diagnosis and treatment of biologically based mental illnesses on the same terms and conditions as, and shall provide benefits no less extensive than, those provided under the policy of sickness and accident insurance for the treatment and diagnosis of all other physical diseases and disorders, if both of the following apply:

(1) The biologically based mental illness is clinically diagnosed by a physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; a psychologist licensed under Chapter 4732. of the Revised Code; a licensed professional clinical counselor, licensed professional counselor, independent social worker, or

independent marriage and family therapist licensed under Chapter 4757. of the Revised Code; or a clinical nurse specialist or certified nurse practitioner licensed under Chapter 4723. of the Revised Code whose nursing specialty is mental health.

(2) The prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards.

(C) Division (B) of this section applies to all coverages and terms and conditions of the policy of sickness and accident insurance, including, but not limited to, coverage of inpatient hospital services, outpatient services, and medication; maximum lifetime benefits; copayments; and individual and family deductibles.

(D) Nothing in this section shall be construed as prohibiting a sickness and accident insurance company from taking any of the following actions:

(1) Negotiating separately with mental health care providers with regard to reimbursement rates and the delivery of health care services;

(2) Offering policies that provide benefits solely for the diagnosis and treatment of biologically based mental illnesses;

(3) Managing the provision of benefits for the diagnosis or treatment of biologically based mental illnesses through the use of pre-admission screening, by requiring beneficiaries to obtain authorization prior to treatment, or through the use of any other mechanism designed to limit coverage to that treatment determined to be necessary;

(4) Enforcing the terms and conditions of a policy of sickness and accident insurance.

(E) An insurer that offers any policy of sickness and accident insurance is not required to provide benefits for the diagnosis and treatment of biologically based mental illnesses pursuant to division (B) of this section if all of the following apply:

(1) The insurer submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(2) The insurer submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and

disorders.

(3) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section:

(a) Incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(b) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders.

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For purposes of this section, any policy issued pursuant to division (C) of section 3923.13 of the Revised Code in connection with a public or private college or university student health insurance program is considered to be issued to a bona fide association.

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

This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare

supplement, long-term care, disability income, one-time-limited-duration policy ~~of no longer than six~~ twelve months, or other policy that offers only supplemental benefits.

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

(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," and "MEWA" have the same meanings as in section 3924.01 of the Revised Code.

(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, carriers in the business of issuing health benefit plans to individuals and nonemployer groups, except individual health benefit plans issued pursuant to 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. 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) A carrier shall offer to any individual accepted under this section the Ohio health care basic and standard plans 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.

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 the amounts specified below:

(1) For calendar years 2010 and 2011, an amount that is two 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;

(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.

(F) In offering health benefit plans under this section, 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.

(G)(1) A carrier shall not be required to accept new applicants under this section 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 (L) of this section 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 nonemployer group insureds in this state, 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 enrollment limit established by division (G)(1)(a) 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.

(2) An officer of the carrier shall certify to the department of insurance when it has met the enrollment limit set forth in division (G)(1) of this section. Upon providing such certification, the carrier shall be relieved of its open enrollment requirement under this section as long as the carrier continues to meet the open enrollment limit. If the total number of the carrier's current insureds with open enrollment coverage issued under this section falls below the enrollment limit, the carrier shall accept new applicants. A carrier may establish a waiting list if the carrier has met the open enrollment limit and shall notify the superintendent if the carrier has a waiting list in effect.

(H) A carrier shall not be required to accept under this section applicants

who, at the time of enrollment, are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the carrier if the applicants were accepted. A carrier shall not be required to make the effective date of benefits for individuals accepted under this section earlier than ninety days after the date of acceptance, except that when the individual had prior coverage with a health benefit plan that was terminated by a carrier because the carrier exited the market and the individual was accepted for open enrollment under this section within sixty-three days of that termination, the effective date of benefits shall be the date of enrollment.

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

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

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

(K) 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.

(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~~ twelve months, or other policy that offers only supplemental benefits.

(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:

(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;

(2) Within the service area of the network plan, deny the 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. 3923.601. (A)(1) This section applies to both of the following:

(a) A sickness and accident insurer that issues or requires the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims pursuant to a policy, contract, or agreement for health care services;

(b) A person that a sickness and accident insurer contracts with to issue a standardized identification card or an electronic technology described in division (A)(1)(a) of this section.

(2) Notwithstanding division (A)(1) of this section, this section does not apply to the issuance or required use of a standardized identification card or an electronic technology for the submission and routing of prescription drug claims in connection with any of the following:

(a) Any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time-limited-duration policy ~~of not longer than six~~ twelve months; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any

liability insurance policy or equivalent self-insurance.

(b) Coverage provided under the medicaid program.

(c) Coverage provided under an employer's self-insurance plan or by any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of this section to the plan and its administrators.

(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1) or (2) of this section.

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology.

(2) If the insurer or person under contract with the insurer to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information:

(a) The insurer's name;

(b) The insured's name, group number, and identification number;

(c) A telephone number to inquire about pharmacy-related issues;

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";

(e) The processor's control number, labeled as "RxPCN";

(f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp."

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims.

(D) Each sickness and accident insurer described in division (A) of this section shall annually file a certificate with the superintendent of insurance certifying that it or any person it contracts with to issue a standardized identification card or electronic technology for submission and routing of

prescription drug claims complies with this section.

(E)(1) Except as provided in division (E)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an insured, the insurer or person under contract with the insurer to issue a standardized identification card or an electronic technology shall issue a new card or electronic technology to the insured.

(2) An insurer or person under contract with the insurer is not required under division (E)(1) of this section to issue a new card or electronic technology to an insured more than once during a twelve-month period.

(F) Nothing in this section shall be construed as requiring an insurer to produce more than one standardized identification card or one electronic technology for use by insureds accessing health care benefits provided under a policy of sickness and accident insurance.

Sec. 3923.65. (A) As used in this section:

(1) "Emergency medical condition" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

(a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) Serious impairment to bodily functions;

(c) Serious dysfunction of any bodily organ or part.

(2) "Emergency services" means the following:

(a) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;

(b) Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

(B) Every individual or group policy of sickness and accident insurance that provides hospital, surgical, or medical expense coverage shall cover emergency services without regard to the day or time the emergency services are rendered or to whether the policyholder, the hospital's emergency department where the services are rendered, or an emergency physician treating the policyholder, obtained prior authorization for the emergency services.

(C) Every individual policy or certificate furnished by an insurer in connection with any sickness and accident insurance policy shall provide

information regarding the following:

(1) The scope of coverage for emergency services;

(2) The appropriate use of emergency services, including the use of the 9-1-1 system and any other telephone access systems utilized to access prehospital emergency services;

(3) Any copayments for emergency services.

(D) This section does not apply to any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time limited duration policy ~~of no longer~~ that is less than six twelve months; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Sec. 3923.83. (A)(1) This section applies to both of the following:

(a) A public employee benefit plan that issues or requires the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims pursuant to a policy, contract, or agreement for health care services;

(b) A person or entity that a public employee benefit plan contracts with to issue a standardized identification card or an electronic technology described in division (A)(1)(a) of this section.

(2) Notwithstanding division (A)(1) of this section, this section does not apply to the issuance or required use of a standardized identification card or an electronic technology for the submission and routing of prescription drug claims in connection with either of the following:

(a) Any individual or group policy of insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time-limited-duration policy ~~of not longer~~ that is less than six twelve months; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) Coverage provided under the medicaid program.

(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1)

or (2) of this section.

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology.

(2) If the public employee benefit plan or person under contract with the plan to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information:

- (a) The plan's name;
- (b) The insured's name, group number, and identification number;
- (c) A telephone number to inquire about pharmacy-related issues;
- (d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";
- (e) The processor's control number, labeled as "RxPCN";
- (f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp."

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims.

(D)(1) Except as provided in division (D)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an insured, the public employee benefit plan or person under contract with the plan to issue a standardized identification card or electronic technology shall issue a new card or electronic technology to the insured.

(2) A public employee benefit plan or person under contract with the plan is not required under division (D)(1) of this section to issue a new card or electronic technology to an insured more than once during a twelve-month period.

(E) Nothing in this section shall be construed as requiring a public employee benefit plan to produce more than one standardized identification card or one electronic technology for use by insureds accessing health care benefits

provided under a health benefit plan.

Sec. 3923.85. (A) As used in this section, "cost sharing" means the cost to an individual insured under an individual or group policy of sickness and accident insurance or a public employee benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the policy or plan.

(B) Notwithstanding section 3901.71 of the Revised Code and subject to division (D) of this section, no individual or group policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state and no public employee benefit plan that is established or modified in this state shall fail to comply with either of the following:

(1) The policy or plan shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intravenously administered or injected cancer medications.

(2) The policy or plan shall not comply with division (B)(1) of this section by imposing an increase in cost sharing solely for orally administered, intravenously administered, or injected cancer medications.

(C) Notwithstanding any provision of this section to the contrary, a policy or plan shall be deemed to be in compliance with this section if the cost sharing imposed under such a policy or plan for orally administered cancer treatments does not exceed one hundred dollars per prescription fill. The cost sharing limit of one hundred dollars per prescription fill shall apply to a high deductible plan, as defined in 26 U.S.C. 223, or a catastrophic plan, as defined in 42 U.S.C. 18022, only after the deductible has been met.

(D)(1) The prohibitions in division (B) of this section do not preclude an individual or group policy of sickness and accident insurance or public employee benefit plan from requiring an insured or plan member to obtain prior authorization before orally administered cancer medication is dispensed to the insured or plan member.

(2) Division (B) of this section does not apply to the offer or renewal of any individual or group policy of sickness and accident insurance that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, disability income, or other policy that offers only supplemental benefits.

(E) An insurer that offers any sickness and accident insurance or any public employee benefit plan that offers coverage for basic health care services is not required to comply with division (B) of this section if all of the following apply:

(1) The insurer or plan submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that compliance with division (B)(1) of this section for a

period of at least six months independently caused the insurer or plan's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(2) The insurer or plan submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer or plan for the coverage of basic health care services.

(3)(a) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section:

(i) Compliance with division (B)(1) of this section for a period of at least six months independently caused the insurer or plan's costs for claims and administrative expenses for the coverage of basic health care services to increase more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the insurer or plan for the coverage of basic health care services.

(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code.

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

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

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

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

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

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

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

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

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

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

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

(K) "Midpoint rate" means, for small employers with similar case

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

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

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

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

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

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

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

In line 134, delete "section" and insert "sections 1739.061, 1751.14, 1751.69, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 3923.65, 3923.83, 3923.85, 3924.01, and"

In line 135, delete "is" and insert "are"

After line 135, insert:

"Section 3. Section 1751.14 and division (G) of section 3924.01 of the Revised Code, as amended by this act, apply only to policies, contracts, and agreements that are delivered, issued for delivery, or renewed in this state on or after January 1, 2016. Division (A)(1) of section 3923.24 and division (A)(1) of section 3923.241 of the Revised Code, as amended by this act, apply only to policies of sickness and accident insurance delivered, issued for delivery, or renewed in this state and public employee benefit plans or multiple employer welfare arrangement contracts and certificates that are established or modified in this state on or after January 1, 2016.

Section 4. The General Assembly declares that the amendments made to section 3923.58 of the Revised Code by this act are not to supersede the suspension of the operation of this section enacted by Section 3 of Sub. S.B. 9 of the 130th General Assembly. Rather, it is the intent of the General Assembly to ensure consistency in Ohio Insurance Law should this suspension be nullified."

In line 1 of the title, delete the first "section" and insert "sections 1739.061, 1751.14, 1751.69, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 3923.65, 3923.83, 3923.85, 3924.01, and"; delete the second "section" and insert "sections 505.377, 737.082, 737.222, and"

In line 3 of the title, after "satisfaction" insert ", to clarify the status of volunteer firefighters for purposes of the Patient Protection and Affordable Care Act, to make changes regarding coverage for a dependent child under a parent's health insurance plan and the hours of work needed to qualify for coverage under a small employer health benefit plan, to increase the duration of the health insurance considered to be short-term under certain insurance laws, and to make changes to the chemotherapy parity law"

Attest:

Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Sub. H. B. No. 247-Representative Stebelton

Cosponsors: Representatives Huffman, Butler, Sears, Becker, Lynch, Antonio, Barnes, Bishoff, Brown, Carney, Schuring, Adams, R., Amstutz, Anielski, Beck, Blair, Boose, Buchy, Burkley, Celebrezze, DeVitis, Dovilla, Duffey, Green, Grossman, Hackett, Hagan, C., Hall, Hayes, Heard, Hill, Hottinger,

Johnson, Landis, Maag, Mallory, McClain, Milkovich, O'Brien, Roegner, Rogers, Ruhl, Slaby, Smith, Sprague, Stinziano, Winburn, Speaker Batchelder, Senators Brown, Tavares, Bacon, Balderson, Beagle, Coley, Eklund, Faber, Gardner, Hite, Hughes, Jones, Jordan, Kearney, LaRose, Lehner, Obhof, Patton, Peterson, Sawyer, Schaffer, Seitz, Turner, Uecker

To amend sections 2305.235, 3701.85, 5122.11, and 5122.111 of the Revised Code to make clear that any person may perform automated external defibrillation, to extend qualified immunity from civil liability to premises owners and other persons involved with automated external defibrillator placement and use, to allow proceedings for a mentally ill person subject to court order to be in a probate court in any county, rather than in the county where the mentally ill person subject to court order resides, and to modify the form of the affidavit used to initiate proceedings for court-ordered treatment of a mentally ill person.

As a substitute bill, in which the concurrence of the House is requested.

Attest: Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Sub. H. B. No. 258 -Representative Gonzales
Cosponsors: Representatives Becker, Grossman, Hood, Retherford, Roegner, Wachtmann, Brown, Schuring, Amstutz, Anielski, Antonio, Beck, Burkley, Damschroder, Duffey, Hackett, Reece, Sears, Speaker Batchelder Senator Lehner

To amend sections 4725.40 and 4725.51 and to enact section 4725.411 of the Revised Code regarding licensed spectacle dispensing opticians.

As a substitute bill, in which the concurrence of the House is requested.

Attest: Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Sub. H. B. No. 290-Representative Stebelton

Cosponsors: Representatives Becker, Smith, Huffman, Grossman, Adams, J., Terhar, Blessing, Scherer, Hood, Buchy, Brenner, Fedor, Perales, Maag, Antonio, Baker, Barnes, Beck, Burkley, Driehaus, Green, Milkovich, Phillips, Sheehy, Stautberg, Speaker Batchelder Senators Coley, Patton, Seitz, Uecker

To amend sections 2305.113, 2901.12, 3313.75, 3313.76, 3313.77, 3313.78, 3721.02, and 5165.67 and to enact sections 1901.028, 1907.04, 2301.04, 2501.20, and 3313.791 of the Revised Code regarding the use of school district premises by members of the public and immunity from civil liability for a school district and schools when permitting members of the public to use school premises, regarding the use of results of an inspection of a nursing home or the results of a Medicare or Medicaid survey of a nursing facility in an advertisement, regarding the continued orderly operation of the courts in case of a disaster, civil disorder, or other extraordinary circumstance, and regarding the limitation of claims arising out of skilled nursing care or personal care services provided in a home.

As a substitute bill, in which the concurrence of the House is requested.

Attest:

Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Sub. H. B. No. 367-Representatives Driehaus, Sprague

Cosponsors: Representatives Antonio, Butler, Fedor, Hackett, Perales, Smith, Phillips, Bishoff, Adams, R., Anielski, Ashford, Baker, Barnes, Beck, Blair, Blessing, Boose, Boyce, Buchy, Burkley, Carney, Celebrezze, Cera, Conditt, Curtin, Damschroder, Derickson, DeVitis, Dovilla, Duffey, Foley, Gerberry, Green, Hagan, C., Hagan, R., Hall, Hayes, Henne, Hill, Hottinger, Huffman, Johnson, Landis, Letson, Lundy, Lynch, Mallory, McClain, Milkovich, O'Brien, Patmon, Patterson, Pillich, Ramos, Reece, Rogers, Romanchuk,

Rosenberger, Ruhl, Schuring, Sears, Sheehy, Slaby, Stebelton, Stinziano, Strahorn, Sykes, Terhar, Thompson, Wachtmann, Williams, Winburn, Young, Speaker Batchelder Senators Bacon, Balderson, Brown, Eklund, Hite, Hughes, Jones, LaRose, Lehner, Manning, Obhof, Patton, Peterson, Sawyer, Seitz, Turner

To amend sections 3301.0711, 3301.0712, 3301.0715, 3313.60, 3313.603, 3313.608, 3313.618, 3313.672, 3313.68, 3314.06, 3317.034, 3319.227, 3319.261, 4729.291, and 4729.541 and to enact section 4731.056 of the Revised Code and to amend Sections 263.20 and 263.320 of Am. Sub. H.B. 59 of the 130th General Assembly, as subsequently amended, and Section 9 of Am. Sub. H.B. 487 of the 130th General Assembly to require the health curriculum of each school district to include instruction in prescription opioid abuse prevention, to establish requirements regarding controlled substances containing buprenorphine used for the purpose of treating drug dependence or addiction, to revise the law regarding state assessments and academic performance reporting, to make other changes regarding primary and secondary education programs, and to make an appropriation.

As a substitute bill, in which the concurrence of the House is requested.

Attest: Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Sub. H. B. No. 663 -Representatives Buchy, Huffman
Cosponsors: Representatives Brenner, Maag, Scherer, Wachtmann, Speaker Batchelder Senators Coley, Eklund, Hughes, Patton, Seitz

To amend sections 120.33, 149.43, 2317.02, 2941.51, 2945.10, and 2953.21 and to enact sections 2949.221 and 2949.222 of the Revised Code to provide confidentiality and license protection for persons and entities involved in executing a sentence of capital punishment by lethal injection, to provide for a schedule of fees to be paid to appointed counsel in a capital case as set by the Supreme Court, to provide that the attorney client privilege does not apply if the case is a capital case and the client subsequently claims ineffective assistance of counsel regarding the case, to provide for written jury instructions in capital cases, to provide for a joint legislative study committee to study the manner in which families of homicide victims can best be

supported, to extend to 365 days the time for filing a postconviction relief petition, and to amend the version of section 149.43 of the Revised Code that is scheduled to take effect on March 20, 2015, to continue the provisions of this act on and after that date.

As a substitute bill, in which the concurrence of the House is requested.

Attest: Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Am. Sub. H. B. No. 109 -Representative Damschroder
Cosponsors: Representatives Adams, R., Ruhl, Stinziano, Brenner, Gonzales, Buchy, Maag, Barnes, Bishoff, Brown, Carney, Schuring, Smith, Barborak, Hagan, C., Mallory, Milkovich, Pillich, Speaker Batchelder Senators Bacon, Burke, Coley, Hughes

To amend sections 1345.30 and 1345.99 of the Revised Code to specify individuals who are permitted to recommend and fit hearing aids and to prohibit specified sales of hearing aids via mail.

With the following additional amendments, in which the concurrence of the House is requested.

Delete lines 18 through 20

In line 28, delete " evidence"

In line 30, after " (C)" delete the balance of the line

Delete lines 29 and 30

In line 31, delete " aid pursuant to division (B) of this section" and insert "received a written acknowledgment from the ultimate consumer that the ultimate consumer was advised that an in-person examination by a licensed professional is recommended"

Delete lines 31 through 33

In line 34, delete " (D)"

In line 42, delete " (E)" and insert " (D)"

In line 71, delete " (F)" and insert " (E)"

In line 83, delete " (F)" and insert " (E)"

In line 86, delete " (E)" and insert " (D)"

In line 107, delete " (D)" and insert " (C)"

Attest:

Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Sub. H. B. No. 131 -Representatives Johnson, Stinziano

Cosponsors: Representatives Antonio, Beck, Boyd, Dovilla, Driehaus, Duffey, Fedor, Grossman, Hagan, C., Hagan, R., Letson, Ramos, Ruhl, Slaby, Stebelton, Wachtmann, Bishoff, Anielski, Baker, Butler, Carney, Kunze, Mallory, Milkovich, O'Brien, Rogers, Sprague, Terhar Senators Kearney, Hite, Lehner, Seitz, Turner

To amend sections 4713.01, 4713.08, and 4713.64 and to enact sections 4713.50 and 4713.51 of the Revised Code regarding the use and regulation of tanning facilities.

As a substitute bill, in which the concurrence of the House is requested.

Attest:

Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Sub. H. B. No. 552-Representative Stautberg

Cosponsors: Representatives Beck, Becker, Driehaus, Grossman, Milkovich, Rosenberger, Ruhl, Slaby, Stinziano, Bishoff, Brown, Sprague, Wachtmann, Amstutz, Anielski, Antonio, Ashford, Baker, Barborak, Blessing, Boose, Boyce, Buchy, Butler, Carney, Celebrezze, Cera, Conditt, Curtin, Damschroder, Derickson, DeVitis, Dovilla, Duffey, Fedor, Gerberry, Green, Hackett, Hagan, C., Hall, Hayes, Huffman, Johnson, Kunze, Landis, Letson, Lundy, Maag, Mallory, McClain, McGregor, O'Brien, Patterson, Pelanda, Perales, Reece, Roegner, Rogers, Romanchuk, Schuring, Sears, Sheehy, Smith, Strahorn, Terhar, Thompson, Williams, Winburn, Speaker Batchelder
Senators Bacon, Balderson, Beagle, Brown, Burke, Eklund, Faber, Gardner, Gentile, Hite, Hughes, Jones, Kearney, LaRose, Lehner, Manning, Obhof, Patton, Peterson, Sawyer, Schiavoni, Seitz, Skindell, Turner, Uecker, Widener

To enact sections 9.57 and 3701.69 of the Revised Code to require the distribution of information on Down syndrome under certain conditions and to establish language standards for signs containing the international symbol of access.

As a substitute bill, in which the concurrence of the House is requested.

Attest:

Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.

Message from the Senate

Mr. Speaker:

I am directed to inform the House of Representatives that the Senate has concurred in the passage of the following bill:

Am. H. B. No. 474 -Representatives Dovilla, Pelanda

Cosponsors: Representatives Brenner, Ramos, Derickson, Stebelton, Blessing, Damschroder, Ruhl, Mallory, Celebrezze, DeVitis, Green, Hagan, R., Perales, Adams, R., Anielski, Antonio, Baker, Barborak, Beck, Brown, Buchy, Budish, Burkley, Fedor, Hackett, Hagan, C., Hall, Hayes, Hill, Johnson, Kunze, Landis, Letson, Milkovich, Patterson, Roegner, Rogers, Schuring, Sheehy, Smith, Sprague, Strahorn, Thompson, Wachtmann, Young, Speaker Batchelder
Senators LaRose, Gentile, Balderson, Brown, Cafaro, Coley,

Faber, Gardner, Hite, Hughes, Kearney, Manning, Patton, Peterson, Schaffer, Turner, Uecker

To amend sections 4501.21 and 4503.499 and to enact sections 4503.576 and 5533.242 of the Revised Code to create the "Ohio State Beekeepers Association" license plate, to alter the law governing the pediatric brain tumor awareness license plate, and to designate a portion of Interstate Route 75 in Hamilton County as the "William L. Mallory, Sr. Memorial Highway."

With the following additional amendments, in which the concurrence of the House is requested.

In line 4, delete "section" and insert "sections"; after "4501.21" insert "and 4503.499"

In line 4, delete the second "section" and insert "sections"

In line 5, after "4503.576" insert "and 5533.242"

Between lines 316 and 317, insert:

"Sec. 4503.499. (A) The owner or lessee of any passenger car, noncommercial motor vehicle, recreational vehicle, or other vehicle of a class approved by the registrar of motor vehicles may apply to the registrar for the registration of the vehicle and issuance of pediatric brain tumor awareness license plates. An application made under this section may be combined with a request for a special reserved license plate under section 4503.40 or 4503.42 of the Revised Code. Upon receipt of the completed application and compliance by the applicant with divisions (B) and (C) of this section, the registrar shall issue to the applicant the appropriate vehicle registration and a set of pediatric brain tumor awareness license plates and a validation sticker, or a validation sticker alone when required by section 4503.191 of the Revised Code.

In addition to the letters and numbers ordinarily inscribed on the license plates, pediatric brain tumor awareness license plates shall be inscribed with identifying words or markings that are designed by the children's glioma cancer foundation and are approved by the registrar. Pediatric brain tumor awareness license plates shall display county identification stickers that identify the county of registration by name or number.

(B) The pediatric brain tumor awareness license plates and a validation sticker, or validation sticker alone, shall be issued upon receipt of a contribution as provided in division (C) of this section and upon payment of the regular license tax as prescribed under section 4503.04 of the Revised Code, any applicable motor vehicle license tax levied under Chapter 4504. of the Revised Code, any applicable additional fee prescribed by section 4503.40 or 4503.42 of the Revised Code, a fee of ten dollars for the purpose of compensating the bureau of motor vehicles for additional services required in the issuing of pediatric brain tumor awareness license plates, and compliance with all other applicable laws relating to the registration of motor vehicles.

(C) For each application for registration and registration renewal notice the registrar receives under this section, the registrar shall collect a contribution of thirty-five dollars. The registrar shall transmit this contribution to the treasurer of state for deposit in the license plate contribution fund created in section 4501.21 of the Revised Code.

The registrar shall transmit the additional fee of ten dollars paid to compensate the bureau for the additional services required in the issuing of pediatric brain tumor awareness license plates to the treasurer of state for deposit into the state treasury to the credit of the state bureau of motor vehicles fund created by section 4501.25 of the Revised Code.

(D) If the issuance of the license plates under this section has been terminated under section 4503.77 of the Revised Code prior to the effective date of this amendment, the bureau shall begin issuing pediatric brain tumor license plates on and after the effective date of this amendment even if the sponsor of the license plate does not comply with the requirements of section 4503.78 of the Revised Code. However, after the effective date of this amendment, the license plate may be terminated as provided in section 4503.77 of the Revised Code."

Between lines 362 and 363, insert:

" **Sec. 5533.242.** In addition to any other name prescribed in the Revised Code or otherwise, that portion of the highway known as interstate route seventy-five, running in a northerly and southerly direction between the Freeman avenue exit and the Hopple street viaduct exit, in Hamilton county, shall be known as the "William L. Mallory, Sr. Memorial Highway."

The director of transportation may erect suitable markers along the highway indicating its name."

In line 363, delete "section" and insert "sections"; after "4501.21" insert "and 4503.499"

In line 364, delete "is" and insert "are"

In line 1 of the title, delete "section" and insert "sections"; after "4501.21" insert "and 4503.499"

In line 1 of the title, delete the second "section" and insert "sections"

In line 2 of the title, after "4503.576" insert "and 5533.242"

In line 3 of the title, after "plate" insert "and to designate a portion of Interstate Route 75 in Hamilton County as the "William L. Mallory, Sr. Memorial Highway.""

In line 3 of the title, after "plate" insert "and to alter the law governing the pediatric brain tumor awareness license plate"

Attest:

Vincent L. Keeran,
Clerk.

The Senate amendments were laid over under the Rule.
On motion of Representative Brenner, the House recessed.
The House met pursuant to recess.

Representative Butler moved that the House revert to the fifth order of business, being reports of standing and select committees and bills for second consideration.

The motion was agreed to.

REPORTS OF STANDING AND SELECT COMMITTEES AND BILLS FOR SECOND CONSIDERATION

Representative Lundy submitted the following report:

The standing committee on Policy and Legislative Oversight to which was referred **H. C. R. No. 63**-Representative Perales, et al., having had the same under consideration, reports it back and recommends its adoption.

RE: CONNECTICUT CLAIM-GUSTAVE WHITEHEAD FLEW FIRST AIRCRAFT FLIGHT-REPUDIATE

- | | |
|-----------------|--------------|
| MIKE DOVILLA | JIM BUCHY |
| ANDREW BRENNER | MATT HUFFMAN |
| DOROTHY PELANDA | RICK PERALES |
| KATHLEEN CLYDE | MATT LUNDY |

The report was agreed to.

The concurrent resolution was ordered to be engrossed and placed on the calendar.

Representative Lundy submitted the following report:

The standing committee on Policy and Legislative Oversight to which was referred **S. C. R. No. 27**-Senator Seitz, et al., having had the same under consideration, reports it back and recommends its adoption.

RE: SUSPEND/REVOKE DRIVER'S LICENSE FOR DRUG CONVICTION-OPPOSE FEDERAL MANDATE REQUIRING

- | | |
|-----------------|--------------|
| MIKE DOVILLA | JIM BUCHY |
| ANDREW BRENNER | MATT HUFFMAN |
| DOROTHY PELANDA | RICK PERALES |
| KATHLEEN CLYDE | MATT LUNDY |

The report was agreed to.

The concurrent resolution was ordered to be engrossed and placed on the calendar.

MESSAGE FROM THE SPEAKER

Pursuant to House Rules 13, 28, and 30, the Speaker hereby makes the following changes to the standing committee on Judiciary:

Remove Representative Lynch; appoint Representative Perales.

On motion of Representative Butler, the House adjourned until Wednesday, December 17, 2014 at 9:00 o'clock a.m.

Attest:

BRADLEY J. YOUNG,
Clerk.