Greg Schwab *Legislative Service Commission*

Bill Analysis

S.B. 263

125th General Assembly
(As Introduced)

Sens. Hagan, Miller, Fedor, Brady

BILL SUMMARY

- Establishes and provides for the operation of the Ohio Health Care Plan, providing universal health care coverage to all Ohio residents.

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CONTENT AND OPERATION

Creation of the Ohio Health Care Plan and Ohio Health Care Agency

(sec. 3922.02(A))

The bill creates the Ohio Health Care Plan, the Ohio Health Care Agency (*see "**Ohio Health Care Agency; personnel**,"* below), and the Ohio Health Care Board (*see "**Creation and membership of the Ohio Health Care Board**,"* below). The Ohio Health Care Plan is administered by the Ohio Health Care Agency under the direction of the Ohio Health Care Board. The Ohio Health Care Plan is charged with providing universal and affordable health care coverage to all Ohio residents, consisting of a "comprehensive benefit package that includes benefits for prescription drugs," while simultaneously working "to control health care costs, control health care spending, achieve measurable improvement in health care outcomes, increase all parties' satisfaction with the health care system, implement policies that strengthen and improve culturally and linguistically sensitive care, and develop an integrated health care database to support health care planning."

Creation and membership of the Ohio Health Care Board; administration; duties

(secs. 3922.01(A), 3922.03, 3922.04, and 3922.13)

Creation and membership of the Ohio Health Care Board

The bill creates the Ohio Health Care Board, consisting of 15 voting members. The 15 members include the Director of Health and 14 members elected by Regional Health Advisory Committees. The Director of Health serves as a voting ex officio member of the Ohio Health Care Board.

For purposes of representation on the Ohio Health Care Board, the bill divides Ohio into seven regions. The regions are composed of designated counties, as follows:

Region 1: Ashtabula, Cuyahoga, Geauga, Lake, and Lorain.

Region 2: Allen, Auglaize, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Williams, and Wood.

Region 3: Athens, Belmont, Coshocton, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Pike, Ross, Scioto, Vinton, and Washington.

Region 4: Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren.

Region 5: Crawford, Delaware, Fairfield, Fayette, Franklin, Hardin, Knox, Licking, Logan, Madison, Marion, Morrow, Pickaway, Union, and Wyandot.

Region 6: Ashland, Carroll, Columbiana, Holmes, Mahoning, Medina, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas, and Wayne.

Region 7: Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby.

The bill requires the health commissioner of the most populous county in each of the seven regions to convene a meeting of all county and city health commissioners in that region within 90 days following the bill's effective date. If there are two or more health districts wholly or partially in the most populous county of the region, the health commissioner of the health district with the largest territorial jurisdiction in that county is responsible for convening the initial meeting of the region's county and city health commissioners. At the meetings, each region's county and city health commissioners must elect one resident from each county in the region to represent the county on a Regional Health Advisory Committee established for that region. The county and city health commissioners also must set a date for the initial meeting of the Regional Health Advisory Committee, no sooner than 100 days and no later than 110 days after the bill's effective date. Following the initial meetings of county and city health commissioners in each region, the county and city health commissioners in each region are required to convene biennial meetings to elect new representatives to that region's Regional Health Advisory Committee. The biennial meetings must be held within five days of the same day of the same month as the initial meeting.

Each representative elected to a Regional Health Advisory Committee serves on the Committee for a term of two years, starting on the date of the representative's election. Any individual appointed to fill a vacancy on a Regional Health Advisory Committee occurring prior to the end of the term for which a representative was elected serves on the Committee for the remainder of the predecessor's term.

The bill requires each of the seven Regional Health Advisory Committees to elect a chairperson from among the representatives to their Committees. The chairperson must convene and preside over the initial meeting of the Regional Health Advisory Committee. At that initial meeting, the representatives to each Regional Health Care Advisory Committee must elect two residents from the region to represent that region as members of the Ohio Health Care Board. One of the two residents elected to the Ohio Health Care Board must be a resident of the region's most populous county. The other resident must be a resident of any county in the region other than the region's most populous county. Following the initial meeting of each Regional Health Advisory Committee, the chairperson of each Committee must convene biennial meetings within five calendar days of the same date of the same month as the initial meeting in order to elect two residents from the region to represent the region as members of the Ohio Health Care Board. If a vacancy occurs on the Ohio Health Care Board for any reason, resulting in a region being without full representation on the Board, that region's Ohio Health Advisory Committee must elect a resident from the region, from a suitable county, to serve on the Board for the remainder of the departed member's term. A serving member of the Ohio Health Care Board continues to serve following the expiration of the member's term until a successor takes office or a period of 90 days has elapsed, whichever occurs first. Members of the Ohio Health Care Board receive an annual salary and benefits, established by the Governor.

In addition to meeting for the election of Ohio Health Care Board members, the Regional Health Advisory Committees are to meet as necessary to fulfill any functions and responsibilities assigned to the Committees by the bill. The meetings are to be held at the call of the chairperson and as provided by procedures adopted by each Regional Health Advisory Committee.

Under the bill, the seven Regional Health Advisory Committees act as advisory bodies to the Ohio Health Care Board, representing their individual regions. The Regional Health Advisory Committees oversee the management of consumer and provider complaints originating in their respective regions and must hold a hearing on each of the complaints. The Regional Health Advisory Committees must offer assistance to resolve consumer and provider disputes. Regional Health Advisory Committees must seek the agreement of all parties to a dispute, in order to submit the dispute to negotiation or binding arbitration. A Regional Health Advisory Committee must transfer any dispute that is not resolved at the regional level within six months to the Director of the Ohio Health Care Agency's Department of Consumer Affairs. A Committee may, however, vote to transfer individual disputes at an earlier date.

Administration

The bill requires the Director of Health to set the time, place, and date for the initial meeting of the Ohio Health Care Board and requires the Director to preside over the Board's initial meeting. The Director of Health must set the date of the initial meeting for a date no less than 115 days and no later than 125 days after the bill's effective date. Two-thirds of the members of the Ohio Health Care Board constitute a quorum at meetings of the Board and a majority vote of the Ohio Health Care Board is required for decisions.

Annually, the members of the Ohio Health Care Board must elect a member of the Board to serve as chairperson. After the initial meeting, the meetings of the Ohio Health Care Board are held upon the call of the chairperson and as may be provided by procedures prescribed by the Ohio Health Care Board.

The bill requires that the meetings of the Ohio Health Care Board be open to the public. However, the Ohio Health Care Board may go into closed executive session when there are issues of patient confidentiality.

The bill bars members of the Ohio Health Care Board and employees of the Ohio Health Care Agency, and their immediate families, from:

(1) Holding any pecuniary interest in any business with a contract, or in negotiation for a contract, with either the Ohio Health Care Board or Ohio Health Care Agency, or that is subject to the Ohio Health Care Board's oversight;

(2) Receiving remuneration for health care services of any kind during the member's or employee's term of service or employment;

(3) Receiving consulting fees of any kind from any source that is directly or indirectly related to the delivery of health care services pursuant to the Ohio Health Care Plan;

(4) Owning stock in and from investing in mutual funds holding stock in, pharmaceutical companies, health maintenance organizations, or other businesses that relate directly or indirectly to the delivery of health care services, unless the stock or mutual funds are in a blind trust ("[A]n independently managed trust in which the beneficiary has no management rights and in which the beneficiary is not given notice of alterations in or other dispositions of the stock, mutual funds, or other property subject to the trust." R.C. 3922.011(A)).

No member of the Ohio Health Care Board other than the Director of Health may hold any other salaried public position with the state, either elected or appointed, during the member's tenure on the board. The Director of Health also

may not receive any salary or benefits by virtue of the Director's service on the Ohio Health Care Board.

The chairperson of the Ohio Health Care Board may conduct hearings to determine if there has been a violation of any of the provisions listed above concerning conflicts of interest. Notice of any hearing, the conduct of the hearing, and all other matters relating to the holding of the hearing are governed by the Administrative Procedure Act, Chapter 119. of the Revised Code. If a member of the Ohio Health Care Board, or of the member's immediate family, is found to have violated any of the listed prohibitions, the bill requires the Director of Health to remove the member from the Ohio Health Care Board. If an employee of the Ohio Health Care Agency, or of the employee's immediate family, is found to have violated any of the listed prohibitions, the Ohio Health Care Agency must take appropriate disciplinary action against the employee, which may include termination of employment.

The bill exempts the Ohio Health Care Board and the Regional Health Advisory Committees from the sunset review provisions of Chapter 101. of the Revised Code.

Duties and functions of the Ohio Health Care Board

The Ohio Health Care Board is responsible for directing the Ohio Health Care Agency in the performance of all duties, the exercise of all powers, and the assumption and discharge of all functions vested in the Ohio Health Care Agency. The Ohio Health Care Board must adopt rules in accordance with the Administrative Procedure Act, Chapter 119. of the Revised Code, as needed to carry out the purposes of, and to enforce, the provisions of this bill.

The duties and functions of the Ohio Health Care Board include, but are not limited to, the following:

(1) Implementing statutory eligibility standards for benefits;

(2) Annually adopting a benefits package for participants of the Ohio Health Care Plan;

(3) Acting directly or through one or more contractors as the single payer for all claims for health care services made under the Ohio Health Care Plan;

(4) Developing and implementing separate formula for determining specified budgets that the bill requires be recommended annually to the General Assembly;

(5) Annually reviewing the formulae for determining the appropriateness and sufficiency of rates, fees, and prices;

(6) Providing for timely payments to providers through a structure that is well organized and that eliminates unnecessary administrative costs;

(7) Implementing, to the extent permitted by federal law, standardized claims and reporting methods for use by the Ohio Health Care Plan;

(8) Developing a system of centralized electronic claims and payments;

(9) Establishing an enrollment system that will ensure that all eligible Ohio residents, including those who travel frequently, those who cannot read, and those who do not speak English, are aware of their right to health care and are formally enrolled in the Ohio Health Care Plan;

(10) Reporting annually to the General Assembly and to the Governor, on or before the first day of October, on the performance of the Ohio Health Care Plan, the fiscal condition of the Ohio Health Care Plan, any need for rate adjustments, recommendations for statutory changes, the receipt of payments from the federal government, whether current year goals and priorities were met, future goals and priorities, and major new technology or prescription drugs that may affect the cost of the health care services provided by the Ohio Health Care Plan;

(11) Administering the revenues of the Ohio Health Care Fund;

(12) Obtaining appropriate liability and other forms of insurance to provide coverage for the Ohio Health Care Plan, the Ohio Health Care Board, the Ohio Health Care Agency, and their employees and agents;

(13) Establishing, appointing, and funding appropriate staff for the Ohio Health Care Agency throughout Ohio;

(14) Procuring requisite office space and administrative support;

(15) Administering all aspects of the Ohio Health Care Agency by taking actions that include, but are not limited to, all of the following:

(a) Establishing standards and criteria for the allocation of operating funds;

(b) Meeting regularly with the Executive Director and administrators of the Ohio Health Care Agency to review the impact of the Agency and its policies on the regional districts established by the bill;

(c) Establishing goals for the health care system established pursuant to the Ohio Health Care Plan in measurable terms;

(d) Establishing statewide health care databases to support health care services planning;

(e) Implementing policies, and developing mechanisms and incentives, to assure culturally and linguistically sensitive care;

(f) Establishing standards and criteria for the determination of appropriate compensation and training for residents of Ohio who are displaced from work due to the implementation of the Ohio Health Care Plan;

(g) Establishing methods for the recovery of costs for health care services provided pursuant to the Ohio Health Care Plan to a participant that are covered under the terms of a policy of insurance, a health benefit plan, or other collateral source available to the participant under which the participant has a right of action for compensation. Receipt of health care services pursuant to the Ohio Health Care Plan is deemed an assignment by the participant of any right to payment for services from any other policy, plan, or other source. A participant's other source of health care benefits must pay to the Ohio Health Care Fund all amounts it is obligated to pay to the participant for covered health care services. The Ohio Health Care Agency is subrogated to all rights of a participant who has received benefits, or who has a right to benefits, under any other policy or contract of health care and may commence any action necessary to recover the amounts due.

(16) Appointing a Technical and Medical Advisory Board. The members of the Technical and Medical Advisory Board must represent a cross section of the medical and provider community and consumers, and must include two persons, one being a provider and the other representing consumers, from each regional district established by the bill. The members of the Technical and Medical Advisory Board must be reimbursed for actual and necessary expenses incurred in the performance of their duties. The bill exempts the Technical and Medical Advisory Board from the sunset review provisions of Chapter 101. of the Revised Code.

The Technical and Medical Advisory Board's duties include all of the following:

(a) Advising the Ohio Health Care Board on the establishment of policy on medical issues, population-based public health issues, research priorities, scope of services, expanding access to health care services, and evaluating the performance of the Ohio Health Care Plan;

(b) Investigating proposals for innovative approaches to the promotion of health, the prevention of disease and injury, patient education, research, and health care delivery;

(c) Advising the Ohio Health Care Board on the establishment of standards and criteria to evaluate requests from health care facilities for capital improvements.

The bill requires the Ohio Health Care Board to employ and fix the compensation of Ohio Health Care Agency personnel, with the approval of the Department of Administrative Services, as needed by the Agency to properly discharge the Agency's duties. The employment of personnel by the Ohio Health Care Board is subject to the civil service laws of Ohio. The Ohio Health Care Board must employ personnel including, but not limited to, the following:

(1) Executive director;

(2) Administrator for planning, research, and development;

(3) Administrator for finance;

(4) Administrator for quality assurance;

(5) Administrator for consumer affairs;

(6) Legal counsel. The legal counsel represents the Board in any legal action brought by or against the Board under or pursuant to any provision of the Revised Code under the Board's jurisdiction.

Members of the Ohio Health Care Board and individuals on the staff of the Ohio Health Care Board or Ohio Health Care Agency are prohibited from using for personal benefit any information filed with or obtained by the Ohio Health Care Board that is not then readily available to the public. Members of the Ohio Health Care Board also are prohibited from using or attempting to use their position to influence a decision of any other governmental body.

Ohio Health Care Agency; personnel

(secs. 3922.02(B), 3922.05, and 3922.06)

Pursuant to the bill, the Ohio Health Care Agency administers the Ohio Health Care Plan. The Executive Director of the Ohio Health Care Agency is the chief administrator of the Ohio Health Care Plan and is responsible for administering and enforcing the provisions of this bill, including overseeing the operation of the Ohio Health Care Agency. The bill exempts the Ohio Health Care Agency from the sunset review provisions of Chapter 101. of the Revised Code.

The Ohio Health Care Agency is the sole agency authorized to accept applicable grants-in-aid from Ohio and the federal government. All grants-in-aid

accepted by the Ohio Health Care Agency must be deposited into the Ohio Health Care Fund established by the bill (*see* "***The Ohio Health Care Fund***," below) and the agency must use the funds to secure full compliance with federal and state laws and to carry out the purpose and provisions of the bill.

The administrators of the Ohio Health Care Agency and their duties are prescribed by the bill, as follows:

The administrator of planning, research, and development

The duties of the administrator of planning, research, and development are determined by the Executive Director of the Ohio Health Care Agency and include, but are not limited to, all of the following:

(1) Establishing policy on medical issues, population-based public health issues, research priorities, scope of services, the expansion of participants' access to health care services, and evaluating the performance of the Ohio Health Care Plan;

(2) Investigating proposals for innovative approaches for the promotion of health, the prevention of disease and injury, patient education, research, and the delivery of health care services;

(3) Establishing standards and criteria for evaluating applications from health care facilities for capital improvements.

The administrator of consumer affairs

The duties of the administrator of consumer affairs are determined by the Executive Director and include, but are not limited to, all of the following:

(1) Developing educational and informational guides for consumers that describe consumer rights and responsibilities and that inform consumers of effective ways to exercise consumer rights to obtain health care services. The guides must be easy to read and understand and available in English and in other languages. The Ohio Health Care Agency must make the guide available to the public through public outreach and educational programs and through the Internet web site of the Ohio Health Care Agency;

(2) Establishing a toll-free telephone number to receive questions and complaints regarding the Ohio Health Care Agency and the Agency's services. The Ohio Health Care Agency's Internet web site must provide complaint forms and instructions;

(3) Examining suggestions from the public;

(4) Making recommendations for improvements to the Ohio Health Care Board;

(5) Examining the extent to which individual health care facilities meet the needs of the community in which they are located;

(6) Receiving, investigating, and responding to all complaints about any aspect of the Ohio Health Care Plan and referring the results of all investigations into the provision of health care services by providers or facilities to the appropriate provider or health care facility licensing board, or when appropriate, to a law enforcement agency;

(7) Publishing an annual report for the public and the General Assembly that contains a statewide evaluation of the Ohio Health Care Agency and of the delivery of health care services in each region established under the bill;

(8) Holding public hearings within each region, at least annually, for public suggestions and complaints.

The administrator of consumer affairs is required to work closely with the seven Regional Health Advisory Committees on the resolution of complaints. In the discharge of the administrator's duties, the administrator has unlimited access to all nonconfidential and nonprivileged documents in the custody and control of the Ohio Health Care Agency. Nothing in this bill prohibits a consumer or class of consumers, or the administrator of consumer affairs, from seeking relief through the courts.

The administrator of quality assurance

The duties of the administrator of quality assurance are determined by the Executive Director in consultation with the Technical and Medical Advisory Board and include, but are not limited to, all of the following:

(1) Studying and reporting on the efficacy of health care treatments and medications for particular conditions;

(2) Identifying causes of medical errors and devising procedures to decrease medical errors;

(3) Establishing an evidence-based formulary;

(4) Identifying treatments and medications that are unsafe or have no proven value;

(5) Establishing a process for soliciting information on medical standards from providers and consumers.

The administrator of finance

The duties of the administrator of finance are determined by the Executive Director and include, but are not limited to, all of the following:

(1) Administering the Ohio Health Care Fund;

(2) Making prompt payments to providers;

(3) Developing a system of centralized claims and payments;

(4) Communicating to the Treasurer of State when funds are needed for the operation of the Ohio Health Care Plan;

(5) Developing information systems for utilization review;

(6) Investigating possible provider or consumer fraud.

The Ohio Health Care Plan; eligibility, benefits, and appeals

(secs. 3922.07, 3922.08, 3922.10, and 3922.12)

Eligibility

All Ohio residents and individuals employed in Ohio, including the homeless and migrant workers, are eligible for coverage under the Ohio Health Care Plan. The bill requires the Ohio Health Care Board to establish standards and a simplified procedure to demonstrate proof of residency. The Ohio Health Care Board also must establish a procedure to enroll eligible residents and employees and to provide each individual covered under the Ohio Health Care Plan with identification that providers can use to determine the individual's eligibility for health care services under the Ohio Health Care Plan. However, if waivers are not obtained from the Medicaid and Medicare programs, or whenever the necessary waivers are not in effect, the Medicaid and Medicare programs serve as the primary insurance for Ohio's residents and workers, and the Ohio Health Care Plan serves as the secondary or supplemental plan of health coverage.

Under the bill, a plan of employee health coverage provided by an out-of-state employer to an Ohio resident working outside of Ohio serves as the employee's primary plan of health coverage and the Ohio Health Care Plan serves as the employee's secondary plan of health coverage. The Ohio Health Care Agency must bill out-of-state employers or the employers' insurers for the cost of covered health care services provided under the Ohio Health Care Plan to Ohio residents employed by the out-of-state employer when the health care services provided are covered under the terms of the employer's plan of employee health coverage. The Ohio Health Care Plan must reimburse Ohio Health Care Board

approved providers practicing outside of Ohio at Ohio Health Care Plan rates for health care services rendered to a plan participant while the participant is out of Ohio.

The bill permits any employer operating in Ohio to purchase coverage under the Ohio Health Care Plan for an employee who lives outside of Ohio but who works in Ohio. The bill also permits any institution of higher education (as defined in R.C. 2741.01) located in Ohio to purchase coverage under the Ohio Health Care Plan for a student who otherwise lacks status as a resident of Ohio.

Any employer operating in Ohio and providing employees with benefits under a public or private health care policy, plan, or agreement as of the date that benefits are initially provided pursuant to this bill, which benefits are less valuable than those provided by the Ohio Health Care Plan, may participate in the Ohio Health Care Plan, or, alternatively, must provide additional benefits so that, until the expiration of the policy, plan, or agreement, the benefits provided by the employer at least equal that amount and scope of the benefits provided by the Ohio Health Care Plan. If an employer chooses to provide the additional benefits, the additional benefits must include the employer's payment of any employee premium contributions, copayments, and deductible payments called for by the policy, contract, or agreement. The bill exempts employers from all health taxes imposed under the bill until the expiration of the policy, plan, or agreement, at which point the employer and the employer's employees become participants in the Ohio Health Care Plan. Any person covered by a health care policy, contract, or agreement that has premiums paid for in any part with public money, including money from the state, a political subdivision, state educational institution, public school, or other entity, is covered under the Ohio Health Care Plan on the day that benefits become available under the Plan.

Health care insurers, health insuring corporations, and other parties selling or providing health care benefits, may deliver, issue for delivery, renew, or provide health benefit packages that do not duplicate the health benefit package provided by the Ohio Health Care Plan, but may not, except as provided for in connection with the implementation of the Ohio Health Care Plan, deliver, issue for delivery, renew, or provide health benefit packages that duplicate the health benefit package provided by the Ohio Health Care Plan.

Under the bill, any individual who arrives at a health care facility unconscious or otherwise unable due to their mental or physical condition to document their eligibility for coverage is presumed to be eligible for coverage under the Ohio Health Care Plan.

Benefits

The bill requires the Ohio Health Care Board to establish a single health benefits package that includes, but is not limited to, all of the following:

(1) Inpatient and outpatient provider care, both primary and secondary;

(2) Emergency services, as defined in section 3923.65 of Ohio's Sickness and Accident Insurance Law, 24 hours per day, on a prudent lay person standard. Residents who are temporarily out of state may receive benefits for emergency services rendered in that state. The Ohio Health Care Agency must make timely emergency services, including hospital care and triage, available to all Ohio residents, including all residents not enrolled in the Ohio Health Care Plan;

(3) Emergency and other transportation services to covered health care services.

The Ohio Health Care Plan must reimburse independent transportation providers who provide transportation to covered health care services on a fee-for-service basis. Fee schedules for covered transportation may take into account the recognized cost differences among geographic areas. For this purpose, a transportation benefits account is created within the Ohio Health Care Fund.

(4) Rehabilitation services, including speech, occupational, and physical therapy;

(5) Inpatient and outpatient mental health services and substance abuse treatment;

(6) Hospice care;

(7) Prescription drugs and prescribed medical nutrition;

(8) Vision care, aids, and equipment;

(9) Hearing care, hearing aids, and equipment;

(10) Diagnostic medical tests, including laboratory tests and imaging procedures;

(11) Medical supplies and prescribed medical equipment, both durable and non-durable;

(12) Immunizations, preventive care, health maintenance care, and screening;

(13) Dental care;

(14) Home health care services.

The bill prohibits the Ohio Health Care Plan from excluding or limiting coverage of its participants' preexisting conditions. Participants have free choice between the providers eligible to participate in the Ohio Health Care Plan. Residents enrolled in the Ohio Health Care Plan are not subject to copayments, point-of-service charges, or any other fee or charge, and may not be directly billed by providers for covered health care services provided to the resident.

The Ohio Health Care Board, with the consent of the Technical and Medical Advisory Board, may remove or exclude procedures and treatments, equipment, and prescription drugs from the Ohio Health Care Plan's benefit package that the Board finds unsafe, experimental, of no proven value, or which add no therapeutic value. The Ohio Health Care Board must exclude coverage for any surgical, orthodontic, or other medical procedure, or prescription drug, that the Technical and Medical Advisory Board determines was or will be provided primarily for cosmetic purposes, unless required to correct a congenital defect, to restore or correct disfigurements resulting from injury or disease, or that is determined to be medically necessary by a qualified, licensed provider.

Providers may not be compelled by the Ohio Health Care Agency to offer any particular service, as long as the provider does not discriminate among patients in providing health care services, and the bill also prohibits the Ohio Health Care Plan and its participating providers from discriminating on the basis of race, color, national origin, gender, age, religion, sexual orientation, health status, mental or physical disability, employment status, veteran status, or occupation.

Appeals

The bill requires the Ohio Health Care Board to establish written procedures for the receipt and resolution of disputes and grievances. The procedures must provide for an initial hearing before the appropriate Regional Health Advisory Committee. The Ohio Health Care Board must accord plaintiffs the right to be heard at the hearing. Ohio Health Care Plan beneficiaries and providers, and businesses selling medical equipment and supplies, may submit appeals of denied claims to the Ohio Health Care Board. The Ohio Health Care Board must conduct hearings on the appeals in compliance with its written procedures and Ohio and federal laws. Any party aggrieved by an order or decision issued pursuant to the Ohio Health Care Board's written procedures has the right to appeal the order or decision to the Court of Common Pleas. The appellant must file a notice of appeal with the Ohio Health Care Board within 15 days after filing of the appeal with the Court.

Provider participation

(secs. 3922.01(B) and (C) and 3922.14)

The bill permits all providers to participate in the Ohio Health Care Plan. As used in the bill:

(1) "Provider" means a hospital or other health care facility, and physicians, podiatrists, dentists, pharmacists, chiropractors, and other health care personnel, licensed, certified, accredited, or otherwise authorized to furnish health care services in Ohio.

(2) "Health care facility" means any facility, except a health care practitioner's office, that provides preventive, diagnostic, therapeutic, acute convalescent, rehabilitation, mental health, mental retardation, intermediate care, or skilled nursing services.

The bill requires the Ohio Health Care Board and the Technical and Medical Advisory Board to assess the number of primary and specialty providers needed to supply adequate health care services to all participants in the Ohio Health Care Plan and to develop a plan to meet that need. The Ohio Health Care Board must develop incentives for providers designed to increase resident's access to health care services in unserved or underserved areas of Ohio. Additionally, the Ohio Health Care Board annually must evaluate residents' access to trauma care and establish measures to ensure that participants have equitable access to trauma care and specialized medical procedures and technologies.

The Ohio Health Care Board, with the advice of the Technical and Medical Advisory Board and the Ohio Health Care Agency's administrator of quality assurance, must define performance criteria and goals for the Ohio Health Care Plan and report to the General Assembly at least annually on the Plan's performance. The Board also must establish a system to monitor the quality of health care and patient and provider satisfaction with that care, and a system to devise improvements to the provision of health care services. All providers subject to the Ohio Health Care Plan must provide data, upon request, to the Board, when the data is needed by the Board to devise methods to maintain and improve the provision of health care services.

The Ohio Health Care Board, with the advice of the Technical and Medical Advisory Board, must coordinate the Ohio Health Care Plan's operations and benefits with any other state or local agency that provides health care services directly to its residents.

Ohio Health Care Fund

(sec. 3922.09)

The bill establishes the Ohio Health Care Fund in the state treasury and assigns the administrator of finance for the Ohio Health Care Agency responsibility to administer and monitor the Fund. All moneys collected and received by the Ohio Health Care Plan must be transmitted to the Treasurer of State for deposit into the Ohio Health Care Fund, to be used to finance the Ohio Health Care Plan and to pay the costs of compensation and training for workers displaced as a result of the implementation and operation of the Ohio Health Care Plan. The Treasurer of State may invest the interest earned by the Ohio Health Care Fund in any manner authorized by the Revised Code for the investment of state money. Any revenue or interest earned from the investments must be credited to the Ohio Health Care Fund.

All provider claims for payment for health care services rendered under the Ohio Health Care Plan must be transmitted to the Ohio Health Care Fund by the provider or the provider's agent. The format of and the method of transmitting provider claims is determined by the Ohio Health Care Board. All payments for health care services rendered under the Ohio Health Care Plan are disbursed from the Ohio Health Care Fund.

The administrator of finance of the Ohio Health Care Agency must establish a reserve account within the Ohio Health Care Fund. When the revenue available to the Ohio Health Care Plan in any biennium exceeds the total amount expended or obligated during that biennium, the excess revenue is transferred to the reserve account. The Ohio Health Care Board may use the money in the reserve account for the expenses of the Ohio Health Care Agency or the Ohio Health Care Plan. The administrator of finance of the Ohio Health Care Agency must notify the Ohio Health Care Board when the annual expenditures or anticipated future expenditures of the Ohio Health Care Plan appear to be in excess of revenues or anticipated revenues for the same period. The Ohio Health Care Board then is required to implement appropriate cost control measures based on the administrator's notification, and the Board must seek a special appropriation for the Ohio Health Care Fund if the cost control measures implemented do not reduce the Ohio Health Care Plan's expenditures to an amount that may be covered by the Plan's revenues.

Liability for service to Ohio Health Care Plan boards and agencies

(sec. 3922.15)

In the absence of fraud or bad faith, the bill provides county and city health commissioners, Regional Health Advisory Committees, and the Ohio Health Care

Board and Ohio Health Care Agency and their employees and members, with immunity from liability in relation to the performance of their duties and responsibilities under this Chapter. The bill also states that Ohio incurs no liability in relation to its implementation and operation of the Ohio Health Care Plan.

Compensation and training for workers displaced by the Ohio Health Care Plan

(sec. 3922.11)

The bill requires the Department of Job and Family Services to determine which residents of Ohio employed by a health care insurer, health insuring corporation, or other health-care-related business, have lost employment as a result of the implementation and operation of the Ohio Health Care Plan. The Department must determine the amount of monthly wages that these residents lost due to the implementation of the Ohio Health Care Plan. The Department must attempt to position the displaced workers in positions of comparable employment within the Ohio Health Care Agency.

The Department of Job and Family Services must forward the information it obtains on the amount of monthly wages lost by displaced workers to the Ohio Health Care Agency. The Ohio Health Care Agency must determine the amount of compensation and training that each displaced worker is entitled to receive and must submit a claim to the Ohio Health Care Fund for the payment. A displaced worker, however, may not receive compensation from the Ohio Health Care Fund in excess of $60,000 per year for two years. Compensation paid to the displaced worker under the bill serves as a supplement to any other compensation that the worker receives from the Department of Job and Family Services.

Federal financial participation

(secs. 3922.31, 3922.32, and 3922.33)

Under the bill, at the request of the Ohio Health Care Board the Ohio Health Care Agency's Executive Director must seek federal financial participation in the Ohio Health Care Plan, including funding otherwise available under Medicare, Medicaid, CHIP, and the Federal Employees Health Benefits Program. The Executive Director is directed to request that the amount of the federal financial participation be at least equal to the Medicaid federal financial participation rate in effect for Ohio on the bill's effective date.

The following terms are defined for purposes of these sections of the bill:

(1) "CHIP" means the Children's Health Insurance Program parts I and II, provided for in R.C. 5105.50 to 5105.5110.

(2) "Federal Employees Health Benefits Program" means the program of health insurance benefits available to the employees of the federal government that the United States Office of Personnel Management is authorized to contract for under 5 U.S.C. 8902 of the United States Code.

(3) "Medicaid" means the program provided for under Title XIX of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended.

(4) "Medicare" means the program provided for under Title XVII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended.

The bill requires the Executive Director to periodically seek adjustments to the federal financial participation rate for the Ohio Health Care Plan to reflect changes in Ohio's domestic gross product, population, age groups, and the number of residents with incomes below the federal poverty guidelines as revised annually by the United States Department of Health and Human Services for a family size equal to the size of the resident's family.

At the request of the Ohio Health Care Board, the Ohio Health Care Agency's Executive Director must negotiate with the United States Office of Personnel Management to have the Ohio residents who would otherwise be covered by the Federal Employees Health Benefits Program included in the Ohio Health Care Plan. As part of the negotiations, the Executive Director must seek to have the federal government provide the Ohio Health Care Plan with amounts equal to the amount that those federal employees participating in the Ohio Health Care Plan would otherwise pay as premiums under the Federal Employees Health Benefits Program. The Ohio Health Care Board may require the Director of the Department of Job and Family Services to seek any federal waivers necessary for the Ohio Health Care Plan to receive federal financial participation under these sections that is otherwise available under Medicaid and CHIP. Notwithstanding any conflicting provisions of CHIP and the Medicaid Law, the Director of the Department of Job and Family Services must cease to implement both Medicaid and CHIP in Ohio upon the implementation of federal waivers authorizing the use of federal Medicaid and CHIP funds for the Ohio Health Care Plan, if necessary for the implementation of the waivers.

Funding sources and budget

(secs. 3922.21 to 3922.28)

Funding

Under the bill, funding of the Ohio Health Care Plan is obtained from the following sources:

(1) Funds made available to the Ohio Health Care Plan pursuant to sections 3922.31 to 3922.33 of the Revised Code (*see* "***Federal Financial Participation***, above);

(2) Funds obtained from other federal, state, and local governmental sources and programs;

(3) Receipts from taxes levied on employers' payrolls, paid by the employers;

(4) Receipts from taxes levied on businesses' gross receipts. The tax rate in the first year may not exceed 3% of gross receipts;

(5) Receipts from additional income taxes, equal to 6.2% of an individual's compensation in excess of the amount subject to the Social Security payroll tax;

(6) Receipts from additional income taxes, equal to 5% of all of an individual's Ohio adjusted gross income, less the exemptions allowed under section 5747.025 of Ohio's Income Tax Law, in excess of $200,000.

Budget

The bill requires the Ohio Health Care Board to prepare and recommend to the General Assembly an annual budget for health care, which specifies and establishes a limit on total annual expenditures for health care provided under the Ohio Health Care Plan. The budget must include all of the following components:

(1) A system budget covering all expenditures for the system;

(2) Provider and facility budgets for the fee-for-service and integrated health delivery systems and for individual health care facilities and their associated clinics;

(3) A capital investment budget;

(4) A purchasing budget;

(5) A research and innovation budget.

In preparing the budget, the bill requires the Ohio Health Care Board to consider anticipated increased expenditures and savings, including, but not limited to the following:

(1) Projected increases in expenditures due to improved access for underserved populations and improved reimbursement for primary care;

(2) Projected administrative savings under the single-payer mechanism;

(3) Projected savings in prescription drug expenditures under competitive bidding and single-buyer plans;

(4) Projected savings due to the provision of primary care rather than emergency room treatment.

System budget

Under the bill, the system budget encompasses the cost of the system, the services and benefits provided, administration, data gathering, planning and other activities, and revenues deposited with the system account of the Ohio Health Care Fund. The Ohio Health Care Board must limit administrative costs to 5% of the system budget and must annually evaluate methods designed to reduce administrative costs and report the results of that evaluation to the General Assembly. The Ohio Health Care Board must limit the growth of health care costs in the system budget by reference to changes in Ohio's gross domestic product, population, employment rates, and other demographic indicators, as appropriate. Money in the Ohio Health Care Fund's reserve account is not available as revenue for purposes of preparing the system budget.

The cost control measures implemented by the Ohio Health Care Board under this section may not limit access to care that is needed on an emergency basis or that is determined by a patient's provider to be medically appropriate considering the patient's condition.

Under the bill, mandatory cost control measures may include, but are not limited to, the following:

(1) Postponement of the introduction of new benefits or benefit improvements;

(2) Postponement of new capital investment;

(3) Adjustment of provider budgets to correct for inappropriate provider utilization;

(4) Establishment of a limit on provider reimbursement above a specified amount of aggregate billing;

(5) Deferred funding of the reserve account;

(6) Establishment of a limit on aggregate reimbursements to pharmaceutical manufacturers;

(7) Imposition of an eligibility waiting period in the event of substantial influx of individuals into Ohio for the purpose of obtaining health care from the Ohio Health Care Plan.

Facility and provider budgets

The bill requires that the facility and provider budgets prepared by the Ohio Health Care Board include allocations for fee-for-service providers, health facilities and associated clinics that are not part of the capitated provider network, and capitated providers. The allocations are to consider the relative usage of fee-for-service providers, capitated providers, and health care facilities and associated clinics that are not part of a capitated provider network. The annual facility and provider budgets must include adjustments to reflect changes in the utilization of services and the addition or exclusion of covered services made by the Ohio Health Care Board upon the recommendation of the Technical and Medical Advisory Board.

Providers and facilities are required under the bill to choose whether they are to be compensated as fee-for-service providers or as part of a capitated provider network. The budget for fee-for-service providers is divided among categories of licensed providers in order to establish a total annual budget for each category. Each of the budgets must be sufficient to cover all included services anticipated to be required by eligible individuals choosing fee-for-service at the rates negotiated or set by the Ohio Health Care Board, except as necessary for cost containment. The Ohio Health Care Board is required to negotiate fee-for-service reimbursement rates or salaries for licensed providers. In the event negotiations are not concluded in a timely manner, the Board establishes the reimbursement rates on its own. The reimbursement rates must reflect the goals of the system.

The facility and provider budgets encompass all operating expenses for health care facilities or clinics that are not part of a capitated provider network. In preparing a facility budget, the Ohio Health Care Board must develop and utilize separate formulae that reflect the differences in the cost of primary, secondary, and tertiary care services and health care services provided by academic medical centers. The Ohio Health Care Board must negotiate reimbursement rates with facilities and clinics, which rates reflect the goals of the system. The budget for capitated providers must be sufficient to cover all eligible individuals choosing an integrated health care delivery system at the rates negotiated and set by the Ohio Health Care Board.

The bill requires the Ohio Health Care Board to prepare an annual operating budget for all care provided by facilities, group practices, and integrated health care systems, including the labor costs of providing care. All facilities, group practices, and integrated health care systems must submit annual operating

budget requests to the Ohio Health Care Board and may choose to be reimbursed through a global facility budget or on a capitated basis. The Ohio Health Care Board is required to adjust the budgets on the basis of the health risk of enrollees; the scope of services provided; proposed innovative programs that improve quality, workplace safety, or consumer, provider, or employee satisfaction; costs of providing care for nonmembers; and an appropriate operating margin.

Providers and facilities that choose to operate a facility on a capitated basis may not be paid additionally on a fee-for-service basis unless the provider or facility is providing services in a separate private medical practice or facility. Providers and facilities that operate on a capitated basis must report any projected operating deficits to the Ohio Health Care Board immediately. The Ohio Health Care Board is required to determine whether the projected deficit reflects appropriate increases in health care needs, in which case the Board must adjust the provider or facility budget appropriately. If the Ohio Health Care Board determines that the deficit is not justifiable, the bill prohibits an adjustment to the budget. The bill permits the Ohio Health Care Board to terminate the funding for facilities, group practices, and integrated health care systems, or for particular services, if the facilities, group practices, integrated health care systems, or services fail to meet the standards of care and practice established by the Board. Future funding is contingent on measurable improvements in quality of care and health care outcomes.

The Ohio Health Care Board must prohibit charges to the Ohio Health Care Plan or patients for covered health care services other than those established by regulation, negotiation, or the appeals process. Licensed providers and facilities that provide services not covered by the Ohio Health Care Plan may charge patients for those services.

Capital investment budget

The bill requires the Ohio Health Care Board to prepare the capital investment budget with the advice of the Technical and Medical Advisory Board and its staff. The budget must provide for capital maintenance and development. In preparing the capital investment budget, the Ohio Health Care Board is required to determine capital investment priorities and evaluate whether the capital investment program has improved access to services and eliminated redundant capital investments. All capital investments valued at $500,000 or greater, including the costs of studies, surveys, design plans, working drawing specifications, and other activities essential to the planning and execution of capital investment, and all capital investments that change the bed capacity of a health care facility or add a new service or license category incurred by any health system entity, requires the approval of the Ohio Health Care Board. Under the bill, if a facility or individual acting on behalf of a facility, or any other purchaser,

obtains by lease or comparable arrangement, any facility or part of a facility, or any equipment for a facility the market value of which would have been a capital expenditure, the lease or arrangement is considered to be a capital expenditure for purposes of the Ohio Health Care Plan. Health care facilities must provide the Ohio Health Care Board with at least three months advance notice of any planned capital investment of more than $50,000 but less than $500,000. These capital investments must minimize unneeded expansion of facilities and services based on the priorities and goals for capital investment established by the Ohio Health Care Board.

The bill prohibits capital investments from being undertaken using funds from a facility operating budget.

Purchasing budget

The bill requires a purchasing budget to provide for the purchase of prescription drugs and durable and nondurable medical equipment for the system. The Ohio Health Care Board must purchase all prescription drugs and durable and nondurable medical equipment for the system with this budget.

Research and innovation budget

The bill requires the research and innovation budget to support any research and innovation recommended by the Ohio Health Care Board, the Technical and Medical Advisory Board, and the Ohio Health Care Agency's administrator of consumer affairs. The research and innovation budget may include, but is not limited to, methods for improving the administration of the system, improving the quality of health care, educating patients, and improving communication among providers.

Capital account

The Ohio Health Care Board must establish a capital account in the Ohio Health Care Fund. Money in the account may be used solely to pay for the establishment and maintenance of a loan program for facilities and equipment for use by providers desiring to establish practices in areas of Ohio in which, according to criteria established by the Ohio Health Care Board, the level of health care services is inadequate.

Implementation schedule

(Section 2)

Uncodified language in the bill provides that in the first two years following the bill's enactment, the Ohio Health Care Board must prepare for the

delivery of universal, affordable health care coverage to all eligible Ohio residents and individuals employed in Ohio. The Ohio Health Care Board must appoint a Transition Advisory Group to assist with the transition to the provision of health care under the Ohio Health Care Plan. The Transition Advisory Group must include, but is not limited to, a broad selection of experts in health care finance and administration, providers from a variety of medical fields, representatives of Ohio's counties, employers and employees, representatives of hospitals and clinics, and representatives from Ohio's regulatory bodies. Members of the Transition Advisory Group must be reimbursed for necessary and actual expenses incurred in the performance of their duties as members.

HISTORY

ACTION	DATE	JOURNAL ENTRY
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