Bill Analysis

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(As Introduced)

Reps. Raussen, Huffman, Peterson, Wolpert, Blessing, Widowfield

BILL SUMMARY

INSURANCE

- Repeals the Ohio Health Reinsurance Program, creates the I-Ohio Reinsurance Program administered by the Superintendent of Insurance, and creates the I-Ohio Reinsurance Advisory Board.

- Requires the Department of Job and Family Services to establish the Health Insurance Credit Program, details the eligibility requirements and application procedures for the Program, and specifies how the credits are to be paid.

- Establishes the Health Insurance Credit Program Board and specifies the membership and duties of the Board.

- Requires the Department of Job and Family Services to apply to the United States Secretary of Health and Human Services for a waiver of federal Medicaid requirements if a waiver is necessary for Medicaid funds to be used for the Program.

- Diverts all taxes collected on insurance premiums from the General Revenue Fund to the Health Insurance Credit Fund, created by the bill.

- Specifies that the money in the Health Insurance Credit Fund is to be allocated between the Health Insurance Credit Program and the I-Ohio Reinsurance Program.

- Requires every public employee benefit plan established or modified in Ohio to include coverage for chronic care management.

- Prohibits health benefit plans from limiting or excluding an insured's coverage for a loss that is otherwise covered under the plan if the loss is the result of the insured's use of alcohol or other drugs or both.

- Requires health insurers to offer to cover dependent children beyond the insurer's normal age limitations until the age of 29 if certain circumstances exist.

- Requires sickness and accident insurance and health insuring corporations to provide for direct payments for 9-1-1 emergency services to certain or all providers of those services.

- Prohibits third-party payers from refusing to accept and honor a validly executed assignment of benefits with a physician, physician group, physician partnership, or physician professional corporation by a beneficiary for medically necessary physician services provided on an emergency basis.

TAXATION

- Converts the existing income tax deduction for self-paid health insurance premiums into an income tax credit of up to $1,000.

- Allows the new credit to be claimed for insurance covering some older children whose coverage does not currently qualify for the existing deduction.

- Authorizes a new income tax deduction to offset any income imputed to a taxpayer under federal law because an employer-paid health benefit plan covers older children who are not considered "dependents" under federal law.

- Permits taxpayers to include, in the computation of deductible medical expenses, self-paid medical expenses on behalf of some older children.

- Requires any tax-exempt hospital whose Medicaid inpatient utilization rate is less than 35% in a given year to publish on its web site the cost of charity care the hospital provided and the property tax and sales tax savings arising from the hospital's tax-exempt status.

- Requires a hospital whose rate is greater than 35% to report its Medicaid inpatient utilization rate to the Auditor of State.

PHARMACEUTICALS

- Creates the Office of Pharmaceutical Purchasing Coordination in the Department of Administrative Services.

- Specifies that the Office's purpose is to maximize the purchasing power of, and value of pharmacy benefit management programs to, the participants in the Office's program (the Director of Job and Family Services, each managed care organization that contracts with the Director of Job and Family Services to arrange for or provide health care services to Medicaid recipients, the Administrator of Workers' Compensation, each public school district, and each state retirement system) so that reimbursement rates for prescription drug claims filed under Medicaid or Workers' Compensation Law, contracts or policies offered to state retirement system retirants, or claims made under insurance or coverage procured or paid for by school districts, are minimized.

- Requires the Office to (1) conduct a review of the pharmacy benefit management programs, if any, the participants maintained on or immediately prior to the bill's effective date and to submit a report to the Governor and General Assembly summarizing the results of the review, and (2) except when a participant is exempted from participation, negotiate and enter into one or more contracts on behalf of each participant with a pharmacy benefits manager.

- Requires the Office to select the participants' pharmacy benefits manager through a competitive bidding process.

- Requires a contract a participant has with a pharmacy benefits manager on the effective date of the bill to expire in accordance with the contract's terms and prohibits the contract from being renewed or extended.

- Permits a participant to be exempted from a contract negotiated by the Office if the participant provides written evidence, as determined sufficient by the Director of Administrative Services in the Director's sole discretion, that the participant is able to secure lower reimbursement rates for claims it pays without being included in a contract negotiated by the Office.

- Requires the participants to cooperate with the Office and the Department of Health to provide any information the Office needs regarding prescription drugs or other scientific matters.

- Requires the Director of Job and Family Services to determine whether a waiver of federal Medicaid requirements is necessary to fulfill the bill's requirements for the Office and if so, to notify the Office of this fact and apply for the waiver.

- Requires the Office to continuously work with each participant and the pharmacy benefits manager selected to ensure that the terms of each contract are being fulfilled.

- Requires the Departments of Rehabilitation and Correction and Youth Services to contract with federally qualified health centers to provide health services, including prescription drug services.

BWC OHIO HEALTH ADVANTAGE PROGRAM

- Creates the Ohio Health Advantage Program (OHAP) under the Workers' Compensation Law and establishes the health and wellness premium discount program and the qualifying health plan premium discount program under the OHAP.

- Requires the Administrator of Workers' Compensation, subject to the approval of the Bureau of Workers' Compensation Board of Directors, to offer discounts on premiums of employers who participate in the OHAP.

- Allows an employer who participates in the OHAP and offers health and wellness programs in accordance with the bill's requirements to receive up to a 5% discount on the employer's premium, not to exceed the cost incurred for establishing and maintaining those programs.

- Allows an employer who participates in the OHAP and offers a qualifying health plan in accordance with the bill's requirements to receive a 15% discount on the employer's premium, not to exceed the cost incurred for providing the plan.

- Allows an employer who offers health and wellness programs and provides a qualifying health plan to receive up to a 20% discount on the

employer's premium, not to exceed the cost incurred for establishing and maintaining the programs and for providing the plan.

- Specifies the types of health and wellness programs an employer must establish and maintain to participate in the health and wellness premium discount program under the OHAP.

- Requires the Administrator and the Director of Health to jointly adopt rules to specify requirements an employer must satisfy to participate in the health and wellness premium discount program under the OHAP.

- Lists factors the Administrator must consider to determine the amount of an employer's premium discount if the employer participates in the health and wellness premium discount program.

- Specifies requirements an employer must satisfy to participate in the qualifying health plan discount program under the OHAP.

- Limits an employer's participation in the qualifying health plan discount program under the OHAP to three years from the date the Administrator approves the employer to participate in the program.

HOSPITALS AND AMBULATORY SURGICAL FACILITIES

- Eliminates exceptions to a requirement that a hospital that participates in Medicaid but is not under contract with a particular Medicaid managed care organization provide a service, other than an emergency service, for which the organization refers a Medicaid recipient to the hospital and reduces the amount a hospital is to accept for providing the service.

- Provides that a disproportionate share hospital may receive more funds under the Hospital Care Assurance Program (HCAP) than the minimum necessary to satisfy federal Medicaid law concerning disproportionate share hospitals only if the hospital has a contract with each Medicaid managed care organization that manages the health care of Medicaid recipients who reside in the region in which the hospital is located.

- Provides that a hospital that is not a disproportionate share hospital may not receive any HCAP funds unless the hospital has a contract with each Medicaid managed care organization managing the health care of

Medicaid recipients who reside in the region in which the hospital is located.

- Requires ambulatory surgical facilities to annually report certain data to the Director of Health.

DENTAL HYGIENISTS

- Permits a dental hygienist to enter into a collaboration agreement with a dentist employed by, or under contract with, a public health facility, under which the dental hygienist may provide certain services at public health facilities without the dentist being physically present and without prior examination by the dentist.

- Requires a dental hygienist to submit written evidence of meeting certain educational requirements to the dentist who is to be the collaborating dentist under the agreement and permits the dentist to personally observe the hygienist perform the services to be provided.

- Requires collaboration agreements to have certain characteristics, be maintained by both the dental hygienist and dentist, be possessed by each facility where a dental hygienist practices under an agreement, and be provided to the State Dental Board at the Board's request.

- Requires a dental hygienist, before performing services on a patient under a collaboration agreement, to provide the patient or the patient's representative with a consent to treatment form and to secure the patient's or representative's signature or mark on it.

- Requires a dental hygienist to refer the patient to the collaborating dentist following the provision of services under an agreement.

- Limits to three the number of agreements a dentist can be a party to at any one time, unless the State Dental Board determines that the dentist meets certain criteria established by the Board to enter into additional agreements.

- Requires the State Dental Board to adopt rules to implement certain requirements of the bill.

NURSE INSTRUCTOR SALARIES

- Requires a state institution of higher education that operates a prelicensure nursing education program to pay, beginning in the first state fiscal year that begins on or after the bill's effective date, a starting nursing instructor salary that is at least $10,000 higher than (1) the average starting salary paid to an instructor who began teaching in calendar year 2007, or (2) the average starting salary that, based on past practices, would have been paid had any instructor begun teaching classes at the institution during calendar year 2007.

- Requires a state institution of higher education that operates a prelicensure nursing education program to pay an individual who begins teaching classes at the institution in the second, third, fourth, or fifth years that begin on or after the bill's effective date a starting salary that is at least $5,000 higher than the starting salary noted above.

- Requires a state institution of higher education that operates a prelicensure nursing education program to pay an individual who taught nursing at the institution in the calendar year immediately prior to the bill's effective date a salary in the first five state fiscal years that begin on or after the bill's effective date a salary that is at least $5,000 more than the salary the individual earned in the calendar year immediately prior to the bill's effective date.

- Prohibits a state institution of higher education that operates a prelicensure nursing education program from (1) reducing, from the number of classes offered during calendar year 2007, the number of nursing classes offered in each of the first five calendar years that begin on or after the bill's effective date, and (2) reducing, from the number of nursing instructors employed or contracted with during calendar year 2007, the number of nursing instructors employed or contracted with in each of the first five calendar years that begin on or after the bill's effective date.

SCHOOL FOOD

- Requires each local board of education to adopt and enforce standards regarding food and beverage sales in accordance with rules the State Board of Education must adopt governing the types of, and prices for,

food and beverages sold on any school premises, including food and beverages sold by food service programs and in vending machines.

- Requires a local board, when adopting standards, to consider food and beverage nutritional values.

- Prohibits a public or community school from (1) beginning one year after the bill's effective date, selling a food or beverage containing, or prepared using, a food or substance containing artificial trans fat, or (2) selling a type of food or beverage, or charging a price for food and beverages, that is inconsistent with the rules adopted by the State Board of Education.

HEALTH INFORMATION TECHNOLOGY PILOT PROGRAM

- Requires the Ohio Department of Job and Family Services to create a pilot program regarding health information technology, establishes an advisory board, and specifies the membership and duties of the board.

LEGISLATIVE INTENT

- Expresses the General Assembly's support of the federal "Four Cornerstone's" principles of health care reform.

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INSURANCE

Ohio Health Reinsurance Program

Current law

(R.C. 1751.15, 3923.58, 3923.59, and 3924.07 to 3924.24)

The existing "Ohio Health Reinsurance Program" (sections 3924.07 to 3924.14 of the Revised Code) reinsures small employer health benefit plans and specified open enrollment plans. Small employer health benefit plans covered

under the reinsurance offer group coverage to employees of employers with at least two and up to 50 employees without regard for the employees' health status under Chapter 3924. of the Revised Code. Open enrollment plans covered under the reinsurance program are those that offer coverage to specified individuals who apply for health insurance coverage during specified "open enrollment" periods during which Ohio law requires health insuring corporations and sickness and accident insurers to accept specified applicants without regard for the applicant's health status. Under current law, the small employer and the open enrollment portions of the program must be operated and funded separately.

A board of directors administers the current Ohio Health Reinsurance Program. The Board designs the "Ohio Health Care" (OHC) plans which when offered by insurance companies to qualifying small employers and specified individuals enrolled in open enrollment plans are eligible for reinsurance under the program. Current law requires both small employer health benefit plans and open enrollment plans designed in accordance with the Board's OHC plans to meet specified premium rate restrictions.

The current Ohio Health Reinsurance Program will not provide reinsurance for any individual reinsured under the program until the individual's insurer has made $5,000 in benefit payments for services provided to that individual during a calendar year. After the $5,000 deductible, the program must reinsure the next $50,000 of benefit payments made by the insurer at 90% of claims paid on behalf of an individual in that calendar year. However, under current law, a participating member's maximum liability for one individual may not exceed $10,000 in one calendar year.

The Ohio Health Reinsurance Program is a nonprofit entity that is funded through assessments on participating insurers. Health insuring corporations and sickness and accident insurers can choose to participate in the Ohio Health Reinsurance Program for the purpose of reinsuring small employer health benefit plans, and sickness and accident insurers can opt out of participating in the program for the purpose of reinsuring certain open enrollment plans. However, current law requires health insuring corporations to participate in the program for the purpose of covering specified open enrollment plans.

Operation of the bill

(R.C. 1731.03, 1731.05, 1731.09, 1751.15, 1751.16, 3923.122, 3923.58, 3923.581, 3923.59, 3924.01, 3924.02, 3924.06 to 3924.14, and 3924.73)

The bill repeals the Ohio Health Reinsurance Program, including the Board and the OHC plan established by the Board. Under the bill, the OHC plan no

longer functions as a standard for plan coverage for any open enrollment plans or small employer benefit plans.

I-Ohio reinsurance program

(R.C. 3923.86)

The bill establishes the "I-Ohio Reinsurance Program" (hereafter, I-Ohio) to provide reinsurance to health insurers for specific policies that the insurer offers to eligible individuals who represent a high insurance risk.

Implementation of the I-Ohio

(R.C. 3923.90 and 3923.86; Section 11 of the bill)

Under the bill, the sections of the Revised Code that establish the I-Ohio will become effective July 1, 2009. Following that date, the Superintendent of Insurance must establish, by rule, three categories of individuals that represent a high insurance risk based upon the level of severity of individuals' health status factors including pre-existing conditions, diseases, chronic conditions, and any other factors the Superintendent determines to be relevant.

In the first two years of the operation of I-Ohio, I-Ohio will reinsure specified policies offered by insurers to individuals who represent a "low-high" insurance risk only. In the third and fourth years of the operation of I-Ohio, I-Ohio will reinsure specified policies offered by insurers to individuals who represent a "low-high" insurance risk and "medium-high" risk.

If the Superintendent determines that I-Ohio has sufficient funding, after the fourth year of the operation of I-Ohio, I-Ohio may reinsure specified policies offered by insurers to individuals who represent a "high-high" risk in addition to those offered to individuals who represent low-high insurance risk and medium-high risk.

The bill grants the Superintendent authority to adopt rules to administer I-Ohio.

Coverage requirements

(R.C. 3923.88 and 3923.87)

The bill requires the Superintendent to establish a basic, standard policy that includes coverage for chronic care and that, when offered by an insurer to an eligible individual, is eligible to be reinsured under I-Ohio. Under the bill, all insurers are required to offer to eligible individuals only basic, standard policies

reinsured under I-Ohio. This requirement probably would be considered a "coverage mandate" and is exempted from current law requirements that laws including mandated benefits undergo review by the Superintendent (see **COMMENT**).

The basic, standard policy established by the Superintendent may cover dependents if either of the following is true:

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

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

Eligibility criteria

(R.C. 3923.86 and 3923.88)

In order to be eligible to receive health insurance coverage under a plan that is reinsured under I-Ohio, an individual must not be employed by an employer that offers health insurance coverage, have an annual income of less than $90,000, and meet at least one of the following criteria:

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

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

(3) The premiums for the individual's most recent health benefit plan exceeded 125% of the average market premium price as determined by the Superintendent of Insurance. The bill requires the Superintendent to establish the average market premium price on the basis of the arithmetic mean of all insurers' premium rates for policies that are substantially similar to the basic, standard policy adopted by the Superintendent or any other equitable basis determined by the Superintendent.

Reinsurance limitations

(R.C. 3923.89)

I-Ohio would not provide reinsurance for any individual reinsured under I-Ohio until the individual's insurer has made $15,000 in benefit payments for services provided to that individual during a calendar year.

After the $15,000 deductible, I-Ohio would reinsure basic, standard plans offered by health insurance corporations (includes HMOs) and sickness and accident insurers at 85% of claims paid on behalf of an individual up to $50,000 of total claims paid on behalf of the individual.

Funding

(R.C. 3923.90 and 3923.91 of the bill and R.C. 5725.24)

The bill requires that I-Ohio be funded by the Health Insurance Credit Fund (see "***Health Insurance Credit Fund***" below).

Additionally, the bill requires the Superintendent to estimate the average annual cost of reinsuring each individual under I-Ohio based upon available data and appropriate actuarial assumptions and determine total eligible enrollment in I-Ohio. The bill, however, allows the Superintendent to enter into contracts with public or private entities to obtain estimates concerning the number of individuals eligible for coverage under I-Ohio and the costs of administering and implementing I-Ohio.

If the Superintendent determines that the total enrollment reported by all insurers exceeds the total eligible enrollment, under the bill, the Superintendent must suspend the enrollment of new policies and notify all insurers in writing of such suspension. Similarly, if the Superintendent determines that more than 10% of the policies reinsured by I-Ohio cover individuals who reside in a particular county in Ohio, the Superintendent must suspend the enrollment of new policies issued to individuals who reside in that county and notify all insurers of such suspension.

I-Ohio Reinsurance Advisory Board

(R.C. 3923.92)

The bill creates the I-Ohio Reinsurance Advisory Board. The Board's purpose under the bill is to study all of the following and shall make reports to the Governor and the General Assembly in January and July of every year regarding the Board's findings and the general activities of the Board:

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

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

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

The Board would consist of seven members as follows: (1) three members appointed by the Governor, two of whom must have backgrounds in the health insurance industry and one of whom must represent the Department of Insurance, (2) two members appointed by the Speaker of the House of Representatives, one of whom must represent small businesses and one of whom must be a consumer advocate with a background in health care issues, (3) two members appointed by the President of the Senate, one of whom must be an insurance underwriter and one of whom must be a physician.

The terms of the Board members are for three years. Vacancies must be filled in the manner prescribed for the original appointment. A member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed may hold office for the remainder of that term. It is the Governor's responsibility to designate one of the members the Governor appoints to the Board to serve as chairperson of the Board. The chairperson must call special meetings as needed or upon the request of four members.

The bill requires the Board to meet at least four times annually. Members of the Board serve without compensation, but may be reimbursed for reasonable and necessary expenses incurred in the discharge of their duties. However, the Department of Insurance must provide the Board with staff assistance as requested by the Board.

Definitions

(R.C. 3923.85)

The bill provides the following definitions for purposes of I-Ohio:

"Insurer" means any sickness and accident insurer or health insuring corporation.

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

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

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

(3) A public employee benefit plan;

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

"Chronic care" and "chronic conditions" have the same meanings as in section 3923.641 of the Revised Code. (See "***Insurance coverage of chronic care management***" below.)

Health Insurance Credit Program

(R.C. 5101.90 through 5101.95)

The bill requires the Department of Job and Family Services to establish the Health Insurance Credit Program.

Eligibility requirements

Generally, to be eligible for the Program, an applicant must (1) be at least 18 years old and have been an Ohio resident for at least six months prior to the date the applicant applies, (2) not be eligible for Medicaid, Medicare, or the state's disability medical assistance program, (3) not have been provided health insurance by the applicant's employer or employer of a family member of the applicant in the six months prior to the date of application, (4) meet any other requirement established by the Department in rule, and (5) meet the following specific financial eligibility requirements:

- For husband and wife applications approved from July 1, 2009, through July 1, 2011--have combined income above 90% but not exceeding 100% of the federal poverty guidelines;[1]

- For husband and wife applications approved after July 1, 2011--have combined income above 90% but not exceeding 125% of the federal poverty guidelines;

- For individual applications approved from July 1, 2009, through July 1, 2011--have income above 65% but not exceeding 100% of the federal poverty guidelines;[2]

- For individual applications approved after July 1, 2011--have income above 65% but not exceeding 125% of the federal poverty guidelines.

[1] The 2008 federal poverty guideline for an Ohio family of two is an annual income of $14,000.

[2] The 2008 federal poverty guideline for an Ohio family of one is an annual income of $10,400.

Application procedures

The bill allows an individual to apply or reapply on behalf of the individual and the individual's spouse; the guardian or custodian of an individual may apply or reapply on behalf of the individual. The application must include the name of the health insurer to which the credit is to be paid. Application and annual reapplication for the Program must be in accordance with rules adopted by the Department.

On receipt of applications (or reapplications), the Department must make eligibility determinations in accordance with rules adopted under the bill. Each determination that an applicant is eligible is valid for one year beginning on a date determined in accordance with the eligibility determination procedures. The beginning date must not precede the date on which the applicant's eligibility is determined. An eligibility determination is final and may not be appealed.

Payment procedures

The Department must pay the credits from the Health Insurance Credit Fund created by the bill (see "***Health Insurance Credit Fund***" below) to the health insurer indicated on the application. Generally, a husband and wife are eligible for a credit of $4,000 and an individual for a credit of $2,500 annually. However, the bill requires the Department to adopt rules that specify the number of credits available to individuals, and to husbands and wives who apply jointly, from the money allocated for the Program in the Health Insurance Credit Fund.

The credit must go toward paying the premium on a health insurance plan that provides, at minimum, basic health care services.[3] Any amount of money that exceeds the amount necessary to pay the Program recipient's annual premium must be credited to an individual account created on behalf of the recipient, to be administered by the health insurer. The individual account may be used to pay any copayment or deductible amounts the Program recipient may accrue. Any funds unused at the end of the year by the Program recipient must be refunded to the Department by the health insurer.

[3] "Basic health care services" generally include physician services, hospital services, urgent care services, diagnostic laboratory services and diagnostic and therapeutic radiologic services, and preventive health care services (R.C. 1751.01, not in the bill).

Health Insurance Credit Program Advisory Board

(Section 4)

The bill creates the Health Insurance Credit Program Advisory Board. The bill requires the Board to submit an annual report to the Governor and the General Assembly regarding the costs to the state associated with the Program. Three years after its first meeting, the Board ceases to exist.

The Board must consist of the following members:

(1) Two representatives from the Ohio Department of Job and Family Services, appointed by the Governor;

(2) One individual who is a consumer advocate on health care issues, appointed by the Governor;

(3) One representative from the health insurance industry, appointed by the Speaker of the House of Representatives;

(4) One representative of a Medicaid managed care company, appointed by the President of the Senate;

(5) One member of the Ohio General Assembly from the majority party, appointed by the Speaker of the House of Representatives; and

(6) One member of the Ohio General Assembly from the minority party, appointed by the President of the Senate.

The Governor must select the chairperson of the Board from among the Governor's appointees. The Board must meet at least four times per year and members are to be reimbursed for actual expenses incurred in the performance of official duties. Vacancies are to be filled in the manner provided for original appointment and any member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed is to hold office for the remainder of that term. Four members of the Board constitute a quorum. The bill requires that the Ohio Department of Job and Family Services provide staff support to the Board.

Medicaid waiver for Health Insurance Credit Program

(Section 5)

If necessary the Department of Job and Family Services is to apply to the United States Secretary of Health and Human Services for a waiver of federal

Medicaid requirements to apply Medicaid funds to the Ohio Health Insurance Credit Program. If the Department determines that Medicaid funds may be used for the Program, or receives the waiver, the bill authorizes the Department to use those funds in addition to the funds in the Health Insurance Credit Fund (see "***Health Insurance Credit Fund***").

Health Insurance Credit Fund

(R.C. 5725.24 and 5729.03)

The bill diverts all taxes collected on premiums assessed by insurers from the General Revenue Fund to a new fund, the Health Insurance Credit Fund, created in the bill. This fund is to be used to pay for the new I-Ohio and Health Care Insurance Credit programs. The bill specifies that 50% of the money in the Health Insurance Credit Fund is to be allocated to the Ohio Health Insurance Credit Program and 40% to the I-Ohio Reinsurance Program.

Insurance coverage of chronic care management

(R.C. 3923.641)

The bill requires every public employee benefit plan established or modified in Ohio to include coverage for chronic care management. This requirement probably would be considered a coverage mandate and is exempted from current law requirements that laws including coverage mandates undergo review by the Superintendent (see **COMMENT**).

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

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

Under the bill "chronic conditions include but are not limited to diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease,

substance abuse, mental illness, spinal cord injury, and hyperlipidemia (excess fat substances in the blood)."

Insurance coverage of losses resulting from the use of alcohol or other drugs

(R.C. 3923.05 and 3923.80)

Existing law prohibits a policy of sickness and accident insurance from containing a provision that disclaims the insurer's liability for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician. The bill repeals that provision and stipulates that no health benefit plan may contain a provision that limits or excludes an insured's coverage under the plan for a loss the insured sustains that is the result of the insured's use of alcohol or other drugs or both and the loss is otherwise covered under the plan. The bill's coverage requirement probably would be considered a coverage mandate and is exempted from current law requirements that coverage mandates undergo review by the Superintendent (see **COMMENT**).

The bill defines "health benefit plan" to mean any hospital or medical expense policy or certificate or any health plan provided by a carrier that is delivered, issued for delivery, renewed, or used in this state on or after the date occurring six months after the effective date of this act. "Health benefit plan" does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, Medicare supplement, specified disease, or vision care; coverage under a one-time, limited duration policy of not longer than six months; coverage issued as a supplement to liability insurance; insurance arising out of 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.

Under the bill, "carrier" means any sickness and accident insurance company or health insuring corporation authorized to issue health benefit plans in this state, a public employee benefit plan, or a multiple employer welfare arrangement as defined under ERISA, except for any arrangement which is fully insured as defined under that act.

Insurance coverage of dependent children

(R.C. 1751.15, 3923.24, and 3923.241)

Under current law health insuring corporations and sickness and accident insurers may, in their policies, set a limiting age for coverage of dependent

children. However, that limiting age may not function to deny coverage to a child if, after attainment of the limiting age, the child continues to be both (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (2) primarily dependent upon the subscriber for support and maintenance.

The bill requires health insuring corporations, sickness and accident insurers, and public employee benefit plans to offer to cover dependent children beyond the limiting age specified in the contract until age 29 if the dependent is a resident of Ohio or a full-time student at an accredited university and neither the child nor the child's spouse is employed by an employer that offers the child any health benefit. The bill specifies that health insuring corporations, sickness and accident insurers, and public employee benefit plans are not required to cover a dependent's spouse or children on the plan of the dependent's parents. However, the bill prohibits them from terminating coverage of a dependent child based solely upon the fact that the child is married. It is possible that these benefits could be considered a coverage mandate (see **COMMENT**).

The bill makes additional changes related to tax deductions for employee sponsored health care based upon the bill's requirements for dependent coverage (see "***Deduction for employer-provided coverage for older children***" and "***"Dependent" Qualification***" below).

Direct payments for 9-1-1 emergency services

(R.C. 1753.281 and 3923.651)

The bill specifies that every individual or group policy of *sickness and accident insurance* with coverage for 9-1-1 emergency services must provide that reimbursement for those services will be paid directly to the provider of the services or to the provider's assigned billing agent. Similarly, the bill specifies that a *health insuring corporation* policy, contract, or agreement with 9-1-1 emergency services coverage must provide for payment directly to a *nonparticipating* provider of the services or to that provider's billing agent. These requirements probably would be considered coverage mandates and are exempt from current law requirements that laws including mandated benefits undergo review by the Superintendent (see **COMMENT**).

The bill defines "9-1-1 emergency services" as including (1) transportation provided by an ambulance or other vehicle providing medical service that responds to a 9-1-1 call and transfers a person to a hospital emergency department and (2) all services performed by an emergency room physician that are not covered under the existing direct payment to hospitals law.

Claims for emergency physician services

(R.C. 3901.386)

The bill prohibits third-party payers from refusing to accept and honor a validly executed assignment of benefits with a physician, physician group, physician partnership, or physician professional corporation by a beneficiary for medically necessary physician services provided on an emergency basis regardless of whether the third-party payer and the physician, physician group, physician partnership, or physician professional corporation have entered into a contract regarding the provision and reimbursement of covered services.

TAXATION

Tax provisions

The bill replaces the existing income tax deduction for health care and long-term care insurance premiums with an income tax credit; authorizes an income tax deduction for income imputed to a taxpayer under federal law because the taxpayer's employer provides health care benefits covering older children who do not qualify as "dependents" for tax purposes; and permits medical expenses paid for some older children to be counted toward a taxpayer's deductible medical expenses.

Income tax credit for self-paid insurance

(R.C. 5747.01(A)(11), 5747.08, 5747.81, and 5747.98; Section 8)

Current law authorizes an income tax deduction for amounts paid for medical care insurance and long-term care insurance covering the taxpayer or the taxpayer's spouse or dependents. The medical care insurance deduction may be claimed only to the extent the premiums paid are not offset by premium refunds, reimbursements, or dividends related to the coverage. It is available only for individuals who are not eligible for coverage under an employer-subsidized health plan (either directly or through a spouse's employer) and who are not eligible for Medicare coverage.[4] Long-term care insurance premiums also are deductible if the insurance satisfies criteria for federal tax deductibility, and without regard to a person's eligibility for employer-subsidized coverage or Medicare.

The bill replaces the deduction with an income tax credit. Instead of deducting amounts paid for medical care insurance or long-term care insurance in

[4] Coverage offered by a former employer--e.g., through a retirement plan--is treated as employer-subsidized coverage.

computing taxable income, the taxpayer may subtract the amounts paid directly from the tax due. The credit equals the amount paid during a year, up to $1,000. Eligibility for the credit is the same as for the existing deduction: regarding medical care insurance, the taxpayer may not be eligible for coverage in an employer-subsidized plan or under Medicare; regarding long-term care insurance, the insurance must satisfy federal tax deductibility criteria.

To claim the credit on the basis of coverage for a child, the child must satisfy the bill's expanded definition of "dependent" as explained below.

The credit is nonrefundable, but if the credit exceeds the tax otherwise due for any year, the difference may be applied to an unlimited number of future years.

The credit is available for taxable years beginning in 2008 or thereafter. The existing deduction may not be claimed for taxable years beginning in 2008 or thereafter.

Deduction for employer-provided coverage for older children

(R.C. 5747.01(A)(27); Section 8)

Current federal income tax law excludes the value of employer-paid health coverage from an employee's gross income, so the value of the coverage is not taxable income under the federal or Ohio income tax.[5] But both the federal and Ohio exclusions apply only to plans covering the taxpayer and any spouse or dependents. Federal income tax law defines who qualifies as a "dependent," and Ohio currently applies the same definition. (The qualification criteria for dependents is described below.) If a child is covered by an employer-paid plan but does not qualify as a dependent under federal income tax law, the value of the policy to the extent of that coverage is not excluded from taxable income; the coverage of the nondependent is imputed to the taxpayer as taxable income.

The bill permits taxpayers to deduct the income imputed to a taxpayer on the basis of an employer-paid plan covering a child who, although not a "dependent" for tax purposes, nevertheless is covered under the bill's proposed extension of coverage to older children (as explained above under "***Health insurance coverage of dependent children***"). This includes any child who is younger than 30, is either a resident of Ohio or a full-time student at an institution of higher education, and is not employed by an employer offering a health benefit plan.

[5] Internal Revenue Code section 106, 26 U.S.C. 106.

The deduction applies to taxable years beginning on or after January 1, 2008.

Medical expense deduction

(R.C. 5747.01(A)(11); Section 8)

Current law authorizes taxpayers to deduct self-paid medical expenses to the extent those expenses exceed 7.5% of the taxpayer's federal adjusted gross income and are not reimbursed by a third party. Expenses are deductible if paid for medical care of the taxpayer or the taxpayer's spouse or dependents.

The bill's expanded definition of "dependent" applies to the medical expense deduction. So a taxpayer is permitted to deduct medical expenses paid on behalf of a child who is younger than 30, is an Ohio resident or a full-time student at an institution of higher education, and is not employed by an employer offering a health benefit plan, and who otherwise satisfies the federal definition of "dependent." The expanded definition of "dependent" applies to medical expense deductions taken for taxable years beginning on or after January 1, 2008.

"Dependent" qualification

Current income tax law authorizes several tax adjustments for taxpayers who have dependents, including a $20 credit and a $1,450 exemption per dependent and the existing medical care-related deductions noted above. The qualification criteria for dependent status follows the federal income tax dependent qualifications, which include age, relationship, support, habitation, disability, residency, and marital status criteria. Generally, a dependent must be either a "qualifying child" or a "qualifying relative" of the taxpayer. "Qualifying child" includes, among others, a taxpayer's child whose principal home is the taxpayer's home, who does not provide more than one-half of his or her own support, and who is younger than 19 or, if a full-time student, under 24, or, if disabled, any age. "Qualifying relative" includes, among others, a taxpayer's child of any age who receives more than one-half of his or her support from the taxpayer and whose income is less than the federal personal exemption amount ($3,400 for 2007).

The bill extends qualification as a "dependent" to older children for the purposes of the bill's proposed income tax credit for taxpayer-paid health insurance, the medical expense deduction, and the deduction for income imputed to taxpayers for employer-paid plans covering older children, as described above. To qualify under the new definition, a child must be younger than 30, must be either an Ohio resident or a full-time student at an institution of higher education, and, if employed, must not be employed by an employer offering a health benefit plan. The new definition conforms the dependency qualifications for income tax

purposes with the bill's required coverage for dependent children. The new definition does not affect who qualifies for the $20 credit or the $1,450 personal exemption.

Tax-exempt hospital charity care reporting

(R.C. 3727.51)

The bill requires each tax-exempt hospital[6] whose Medicaid inpatient utilization rate[7] is less than 35% in a given year to publish on its web sites the cost of charity care[8] the hospital provided and the property tax and sales tax savings[9] arising from the hospital's tax-exempt status. A tax-exempt hospital whose rate is greater than 35% must only report its Medicaid inpatient utilization rate to the Auditor of State. The bill requires the Auditor to adopt rules regarding the oversight and implementation of the bill's hospital reporting requirements. The Auditor must notify the Tax Commissioner and the Attorney General if a tax-exempt hospital fails to comply with the requirements.

[6] "Tax-exempt hospital" means a hospital the facilities of which are exempted from ad valorem property taxation in whole or in part (R.C. 3727.51(A)(4)).

[7] "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided during the hospital's annual accounting period to patients who, for such days, were Medicaid recipients, and the denominator of which is the total number of the hospital's inpatient days in that same period. In determining a hospital's Medicaid inpatient utilization rate, both Medicaid recipients who participate in the Medicaid managed care system and those who participate in the fee-for-service system are included. (R.C. 3727.51(A)(3).)

[8] "Cost of charity care" means direct and indirect costs incurred by a tax-exempt hospital to provide free or discounted care to individuals unable to afford to pay the cost of services, less any reimbursement received therefore, based on current federal Medicare reimbursement rates; this does not include bad debt, contractual allowances, or discounts for prompt payment (R.C. 3727.51(A)(1)).

[9] "Tax savings" means the amount of taxes that would be charged and payable against a tax-exempt hospital's hospital facilities that are exempted from ad valorem property taxes if those facilities were subject to taxation, plus the amount of sales and use taxes that would be due from the hospital if the hospital's otherwise taxable transactions were not exempt from such taxes (R.C. 3727.51(A)(5)).

PHARMACEUTICALS

Office of Pharmaceutical Purchasing Coordination

Office's creation and purpose

(R.C. 185.02 and 185.03)

The bill creates the Office of Pharmaceutical Purchasing Coordination in the Department of Administrative Services. It specifies that the Office's purpose is to maximize the purchasing power of, and value of pharmacy benefit management programs to, the participants,[10] collectively, so that reimbursement rates paid for all of the following are minimized: (1) claims for prescription drugs[11] made under the Medicaid program, (2) prescription drugs provided to claimants pursuant to compensable claims filed under Workers' Compensation Law (see below regarding effect on Workers' Compensation program; R.C. Chapters 4121., 4123., 4127., and 4131.), (3) claims for prescription drugs made under a contract or policy offered to retirants of the state retirement systems, and (4) claims for prescription drugs made under insurance or coverage procured or paid for by a school district.

Office's responsibilities

(R.C. 185.04)

The bill generally requires the Office, in furtherance of its purpose, to (1) conduct a review of the pharmacy benefit management programs, if any, the participants maintained on or immediately prior to the effective date of the bill, and (2) except when exempted as discussed in "***Exemptions from Office's authority***," below, negotiate and enter into one or more contracts on behalf of each participant with a person under which the person provides pharmacy benefits management services for the benefit of the participant for the claims described in

[10] The bill defines a "participant" as the Director of Job and Family Services, each managed care organization that contracts with the Department of Job and Family Services to arrange for or provide health care services to Medicaid recipients, the Administrator of Workers' Compensation, each public school district, and each state retirement system (The Public Employees Retirement System, Ohio Police and Fire Pension Fund, State Teachers Retirement System, School Employees Retirement System, and State Highway Patrol Retirement System (R.C. 185.01)).

[11] The bill defines "prescription drug" as a drug that may not be dispensed without a prescription from a licensed health professional authorized to prescribe drugs (R.C. 185.01).

(1) to (4), above. The bill requires the provision of pharmacy benefits management services to include, at a minimum, (1) the negotiation of prices charged for prescription drugs, and (2) unless a significant negative cost impact can be demonstrated, the maintenance of one or more multiple or regional pharmacy benefit management programs. In addition, the bill requires the Office to submit, not later than one year after the bill's effective date, a report to the Governor and General Assembly that summarizes the results of the review the Office is required to conduct. The report must contain standards, developed in consultation with the participants, for appropriate pharmacy benefit management activities to be included in the contracts negotiated by the Office.

The bill also requires the Office to work with each participant and the person selected to provide the pharmacy benefits management services to ensure that the terms of each contract are being fulfilled.

Competitive bidding; existing pharmacy benefits services contracts

(R.C. 185.05; Section 9)

The bill requires the person selected to provide the pharmacy benefit management services to be selected pursuant to a competitive bidding process. In addition, the bill requires that a contract, in existence on the effective date of the bill that is between a participant and person for pharmacy benefit management services, must expire in accordance with the terms of the contract and prohibits such a contract from being renewed or extended.

Exemptions from Office's authority

(R.C. 185.07)

The bill permits a participant to be excluded from a contract negotiated by the Office if the participant provides written evidence, as determined sufficient by the Director of Administrative Services in the Director's sole discretion, that the participant is able to secure lower reimbursement rates for claims it pays without being included in a contract negotiated by the Office.

The bill specifies that if the Director of Job and Family Services chooses to submit the written evidence described above, this evidence may include any or all of the following: (1) the value of rebates paid to the Department of Job and Family Services (ODJFS) in accordance with rebate agreements the U.S. Secretary of Health and Human Services has entered into on behalf of the states with drug manufacturers under federal Medicaid law,[12] (2) the value of supplemental rebates,

[12] 42 U.S.C. 1396r-8.

if any, paid by drug manufacturers to ODJFS in accordance with the supplemental drug rebate program ODJFS is permitted to establish under current law,[13] or (3) the savings achieved by ODJFS's establishment of the Maximum Allowable Cost Program required by current law.[14] If the Director of Job and Family Services chooses to submit the rebate information described in (1) above to the Director of Administrative Services, the bill requires that the information be submitted in a manner that does not disclose the identity of a specific manufacturer or wholesaler as prohibited by federal Medicaid law.[15]

Cooperation with the Office by participants and the Director of Health

(R.C. 185.06 and 185.08)

The bill requires cooperation by the participants and the Director of Health: each participant must provide the Office with any information the Office needs to fulfill its purpose and to enter into the contracts described above and the Director must provide information to the Office, on the Office's request, regarding prescription drugs or other scientific matters.

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[13] R.C. 5111.081. For a state to receive Medicaid payments for a covered outpatient drug, the drug's manufacturer must have entered into an agreement to rebate a specified portion of the drug's price pursuant to a state Medicaid plan approved by the U.S. Secretary of Health and Human Services (42 U.S.C. 1396r-8(a)(1)). In recent years, some states, like Ohio, have gone beyond the required Medicaid rebate agreement and enacted supplemental rebate programs to achieve additional cost savings on Medicaid purchases as well as for purchases made by other needy citizens (see *PhRMA v. Walsh*, 538 U.S. 644, 649 (2003)).

[14] R.C. 5111.082. The United States Department of Health and Human Services established the Federal Upper Limit Program in 1987 as a means of limiting the amount that Medicaid could reimburse for drugs with available generic equivalents--called "maximum allowable cost drugs" or "MAC drugs." Specifically, a "maximum allowable cost drug" is a drug for which at least three versions of the drug rated therapeutically equivalent exist and at least three suppliers for the drug are listed in the current editions of published national compendia. Under administrative rules, ODJFS cannot reimburse a pharmacy for MAC drugs, in the aggregate, at a rate higher than the Federal Upper Limit prices. The main appropriations bill of the 126th General Assembly, Am. Sub. H.B. 66, required ODJFS to establish a State Maximum Allowable Cost Program for purposes of managing reimbursement for certain prescription drugs available under Medicaid. The act required ODJFS to (1) identify and create a list of prescription drugs to be included in the Program, (2) update the list of prescription drugs described above on a weekly basis, and (3) review the state maximum allowable cost for each drug included on the list on a weekly basis.

[15] 42 U.S.C. 1396r-8(b)(3)(D).

Waiver of federal Medicaid requirements

(R.C. 185.09)

The bill requires the Director of Job and Family Services to determine whether a waiver of federal Medicaid requirements is necessary to fulfill the requirements described above and if so, notify the Office of this fact and apply for the waiver.

Changes to the payment for and reimbursement of prescription drugs provided in compensable workers' compensation claims

(R.C. 4121.44 and 4121.441)

Current law requires the Administrator of Workers' Compensation to direct the implementation of the Health Partnership Program (HPP) administered by the Bureau of Workers' Compensation (BWC). The Administrator, with the advice and consent of the Bureau of Workers' Compensation Board of Directors, must adopt rules under the Administrative Procedure Act (R.C. Chapter 119.) for the HPP to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under the Workers' Compensation Law. Those rules must include discounted pricing for all inpatient and outpatient medical services, all professional services, and all pharmaceutical services. Additionally, BWC certifies managed care organizations (MCO) to provide medical management and cost containment services in the HPP. An MCO selected by BWC, in addition to satisfying other requirements, must have a prescription drug system where pharmacies on a statewide basis have access to the eligibility and pricing, at a discounted rate, of all prescription drugs.

The bill specifies that the Administrator must adopt rules to establish discount pricing for the payment of or reimbursement for prescription drugs and the provision of pharmacy benefit management services that are in accordance with contracts negotiated and entered into by the Office pursuant to the bill, or in accordance with lower pricing negotiated by the Administrator as the bill permits (see "***Exemptions from Office's authority***" above). Similarly, the bill specifies that the pharmaceutical system used by an MCO must have access to the eligibility and pricing of all prescription drugs as established in the contract negotiated and entered into by the Office pursuant to the bill or as may otherwise be established by the Administrator pursuant to the bill.

Providing pharmacy benefit coverage for school employees

(R.C. 9.901; Section 10)

Under continuing law, all health care benefits provided to persons employed by the public school districts of Ohio must be provided by health care plans that contain best practices established pursuant to continuing law by the School Employees Health Care Board. As specified under "***Office of Pharmaceutical Purchasing Coordination***" above, under the bill, each public school district must obtain pharmacy benefit services through the contracts negotiated and entered into by the Office unless an exception applies. The bill requires the Board to include in the best practices a requirement that the provision of pharmacy benefit management services and the payment and reimbursement for prescription drugs must be in accordance with contracts negotiated and entered into by the Office or in accordance with lower pricing as may otherwise be established by a board of education pursuant to the bill.

The Public Employees' Collective Bargaining Law (R.C. Chapter 4117.; PECBL) governs collective bargaining between public employers and public employees. Under the PECBL, an agreement entered into between a public employer and an exclusive representative[16] governs the wages, hours, terms, and conditions of employment, and apart from specified exceptions, prevails over conflicting state laws (R.C. 4117.10, not in the bill). A collective bargaining agreement could include pharmacy benefit coverage for employees. The PECBL permits employees of public schools to bargain collectively for health care benefits; however, all health care benefits must include best practices prescribed by the Board (R.C. 4117.03(E), not in the bill). The bill specifies that the changes made to the best care practices described immediately above apply to collective bargaining agreements governed by the PECBL that are entered into or modified on or after the bill's effective date.

Departments of Rehabilitation and Correction and Youth Services contract for health services, including prescription drugs

(R.C. 5120.052 and 5139.031)

The bill requires the Departments of Rehabilitation and Correction and Youth Services to contract with federally qualified health centers to provide health care services, including prescription drug services, to inmates or other individuals

[16] An exclusive representative is an employee organization (union) certified by the State Employment Relations Board to represent employees in a bargaining unit.

in custody. (If there is no such center in the county where the institution is located, the institution is not required to enter into a contract.)

This contract will allow the Departments to take advantage of the federal 340b drug pricing program, which allows prescription drugs to be purchased at very low prices. The federal government places a number of restrictions on the use of 340b discounts. For example, an individual must be an established patient of the 340b center and the individual may not obtain only prescription drug services from the center.

BWC OHIO HEALTH ADVANTAGE PROGRAM

Ohio Health Advantage Program

(R.C. 4123.29 and 4123.292)

The bill creates the Ohio Health Advantage Program (OHAP) that allows employers to receive discounts on their workers' compensation premiums for offering certain health and wellness programs to their employees or providing a qualifying health plan for their employees. The Administrator of Workers' Compensation, subject to the approval of the Bureau of Workers' Compensation Board of Directors, must offer employers the discounts provided under the OHAP. Under the OHAP, if an employer satisfies the applicable criteria described under "***Health and wellness premium discount program***" or "***Qualifying health plan premium discount program***" below, an employer may receive the following discounts on the employer's premium:

(1) Up to a 5% discount on the employer's premium calculated in accordance with the requirements described under "***Health and wellness premium discount program***" below if the employer establishes and maintains a health and wellness program for the employer's employees in accordance with those requirements;

(2) A 15% discount on the employer's premium if the employer offers a qualifying health plan in accordance with the requirements described under "***Qualifying health plan premium discount program***" below;

(3) Up to a 20% discount if the employer establishes and maintains a program and the plan described in (1) and (2) above.

The discount amount an employer receives under (1) to (3) above cannot exceed the costs the employer incurred for establishing and maintaining the health and wellness program, the costs incurred for providing a qualifying health plan, or both as applicable, during the employer's reporting period. The bill requires an employer to include the employer's estimated costs in the employer's payroll report

that the employer must submit under continuing law, which is once every six months or once a year, depending upon the type of employer. The bill defines these two time periods as an employer's reporting period. If the employer is applying to participate in the program, the employer must include in the employer's application the estimated costs incurred by the employer during the six months prior to the date the employer submits the application. Under the bill, any discounts that an employer receives on the employer's premium through participation in the OHAP are in addition to any other premium discounts offered by the Administrator that the employer receives. The Administrator must apply any discount the employer receives through the OHAP each time the Administrator calculates the employer's premium during the time period that the employer participates in the OHAP.

Health and wellness premium discount program

(R.C. 4123.292(C))

Under the bill, the Administrator and the Director of Health jointly adopt rules with the advice and consent of the Board and in accordance with the Administrative Procedure Act (R.C. Chapter 119.) to establish a workers' compensation premium discount program under the OHAP that is based on an employer offering health and wellness programs to the employer's employees. The Administrator and Director must include in the rules they adopt requirements an employer must satisfy to participate in the health and wellness premium discount program, which must include a requirement that an employer establish and maintain at least one of the following programs:

(1) A program that has received accreditation from the Commission on Accreditation of Allied Health Education Programs;

(2) A program that is administered by an individual who holds a certificate under the Physician and Limited Practitioners Law (R.C. Chapter 4731.) or who is licensed under the Dietetics Law (R.C. Chapter 4759.) and that focuses on wellness, nutrition, smoking cessation, or diabetes management, or a similar program;

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

(4) A physical fitness program that is administered by an individual who has received credentials from the American College of Sports Medicine or who is certified by the National Exercise Trainers Association or the Aerobics and Fitness Association of America.

The Administrator must allow an employer who establishes and maintains at least one of the programs described under (1) to (4) immediately above for the employer's employees and satisfies all other requirements established by the Administrator and Director to participate in the health and wellness premium discount program. The bill requires the Administrator and the Director to include in the rules they adopt for the program a requirement that a participating employer create and maintain documentation or other records to demonstrate that the employer is providing a program that qualifies the employer to participate in the discount program. The rules must specify the information the employer must include in those records. A participating employer must allow employees of the Bureau of Workers' Compensation ("BWC"), upon their request, to audit that documentation or those records to verify that the employer is providing such a program.

The bill requires the Administrator to use the following factors to determine what percent, up to five, to discount the premium of an employer who participates in the health and wellness premium discount program:

- Whether onsite programs described under (1) to (4) immediately above are offered by an employer at the employer's place of business;

- The number of programs described under (1) to (4) immediately above an employer offers to the employer's employees;

- The degree to which an employer facilitates employee access to fitness equipment and dietary options;

- Any other factors the Administrator determines are relevant to the OHAP.

An employer who participates in the health and wellness premium discount program receives a discount on the employer's premium only after the employer has participated in the program for six consecutive months. The Administrator must prorate the discount for the first year the employer participates in this program, but after the first year the employer must participate in the program for a full year to receive a discount on the employer's premium for that year. The Administrator and the Director, one year after the program is created under the bill, jointly may expand or limit the scope of the program.

Qualifying health plan premium discount program

(R.C. 4123.292(A) and (D))

The bill creates another workers' compensation premium discount program in the OHAP that is based on whether an employer offers a qualifying health plan to the employer's employees. A qualifying health plan means either of the following:

- A policy of group sickness and accident insurance that is offered by any person authorized under the Insurance Law (R.C. Title 39) to engage in the business of insurance in Ohio, that provides coverage other than for specific diseases or accidents only, for hospital indemnity only, for supplemental Medicare benefits only, or for any other supplemental benefits only, and that is delivered, issued for delivery, or renewed in Ohio;

- A policy, contract, or agreement that is offered by any health insuring corporation authorized under the Health Insuring Corporation Law (R.C. Chapter 1751.) to do business in Ohio and that covers basic health care services as defined under continuing law.

To be eligible to participate in this discount program, the employer must satisfy all of the following criteria: (1) prior to applying to participate in the program, the employer, for a period of six consecutive months, did not offer to the employer's employees a qualified health plan, (2) the employer employs 2 to 50 employees within Ohio, (3) the average annual compensation of the employer's employees is below $45,000, (4) the employer's principal place of business is in Ohio, (5) the employer has operated the employer's business in Ohio for at least six months prior to applying to participate in the program, and (6) the employer offers a qualifying health plan to the employer's employees.

For purposes of determining the average annual compensation an employer pays the employer's employees under (3) immediately above, the Administrator must use the compensation paid that the employer reported on the most recent annual report of employee tax withheld that the employer filed prior to applying to participate in the program and dividing that amount by the number of employees the employer employed during the period covered by that annual report.

The bill permits an employer to participate in the qualifying health plan premium discount program under the OHAP for a period of not more than three years beginning on the date the Administrator approves the employer to participate in the program.

HOSPITALS AND AMBULATORY SURGICAL FACILITIES

Hospital services to Medicaid recipients enrolled in managed care

(R.C. 5111.162)

With one exception, a hospital that participates in Medicaid but is not under contract with a particular Medicaid managed care organization must provide a service, other than an emergency service, for which the organization refers a Medicaid recipient to the hospital. And, the hospital must accept, as payment in full, the amount derived from the reimbursement rate the Department of Job and Family Services uses to reimburse other hospitals of the same type for providing the same service to a Medicaid recipient who is not enrolled in a Medicaid managed care organization. The exception is that these requirements do not apply to a hospital that (1) is located in a county in which participants of the Medicaid managed care system are required before January 1, 2006, to be enrolled in a Medicaid managed care organization that is a health insuring corporation, (2) has entered into a contract before January 1, 2006, with at least one health insuring corporation serving such participants, and (3) remains under contract with at least one health insuring corporation serving participants in the Medicaid managed care system who are required to be enrolled in a health insuring corporation.

The bill eliminates the exception to these requirements. The bill also reduces the amount a hospital is to accept for providing the service. A hospital is to accept 95%, rather than 100%, of the amount derived from the reimbursement rate the Department uses to reimburse other hospitals of the same type for providing the same service to a Medicaid recipient who is not enrolled in a Medicaid managed care organization.

Restriction on hospital care assurance program payments

(R.C. 5112.08)

Federal law requires states' Medicaid programs, when setting the reimbursement rate for hospital services, to take into account the situation of hospitals that serve a disproportionate share of low-income patients with special needs. To satisfy this requirement, a state's Medicaid program must have a methodology to identify and make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and Medicaid patients, including such patients who receive benefits through a managed care entity, served by such hospitals.[17]

[17] 42 U.S.C. 1396a(a)(13)(A)(iv) and 42 U.S.C. 1396r-4.

The Hospital Care Assurance Program (HCAP) is the mechanism by which Ohio complies with the federal requirements regarding disproportionate share hospitals. State law authorizes the Director of Job and Family Services to adopt rules governing HCAP, including rules that define the term "disproportionate share hospital" and rules that establish the methodology for making payments under HCAP.[18] However, HCAP payments are not provided only to disproportionate share hospitals. Both of the following types of hospitals may obtain HCAP payments unless the hospital is a federal hospital, is operated by a health insuring corporation, or does not charge patients for services: (1) a hospital that is registered with the Department of Health as a general medical and surgical hospital or a pediatric general hospital and provides inpatient services and (2) a hospital that is recognized under federal Medicare law as a cancer hospital and is exempt from the Medicare prospective payment system.[19]

HCAP is funded by assessments charged to hospitals, intergovernmental transfers made by governmental hospitals, and federal matching funds made available as a result of funds distributed under HCAP. The total of these funding sources, less certain amounts that are instead deposited into the Legislative Budget Services Fund and the Health Care Services Administration Fund, is known as the indigent care pool and the payments made under HCAP are determined in part by the amount of money in the indigent care pool.[20]

The bill requires that the rules establishing a methodology for making HCAP payments to hospitals include special provisions affecting hospitals that do not contract with Medicaid managed care organizations. The rules must provide that a disproportionate share hospital may receive, for an HCAP program year,[21] more HCAP funds than exceeds the minimum necessary to satisfy federal Medicaid law concerning disproportionate share hospitals only if the hospital has,

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[18] R.C. 5112.03 (not in the bill) and 5112.08.

[19] R.C. 5112.01 (not in the bill).

[20] Continuing law requires that money in the Legislative Budget Services Fund be used solely to pay the expenses of the Legislative Budget Office of the Legislative Service Commission. (R.C. 5112.19, not in the bill.) The Director of Job and Family Services is required to use funds available in the Health Care Services Administration Fund to pay for costs associated with the administration of the Medicaid program. (R.C. 5111.94, not in the bill.)

[21] The Department of Job and Family Services is required to operate HCAP on a program year-basis. (R.C. 5112.10, not in the bill.) A program year is to run from the first day of October, or a later date designated in HCAP rules, and ending the 30th day of September, or an earlier date designated in HCAP rules. (R.C. 5112.01, not in the bill.)

for that program year, a valid Medicaid managed care contract[22] with each Medicaid managed care organization that provides, or arranges for the provision of, health care services to Medicaid recipients who reside in the Medicaid managed care region[23] in which the hospital is located. The rules must also provide that a hospital that is not a disproportionate share hospital may not receive any HCAP funds for an HCAP program year unless the hospital has, for the program year, a valid Medicaid managed care contract with each Medicaid managed care organization that provides, or arranges for the provision of, health care services to Medicaid recipients who reside in the Medicaid managed care region in which the hospital is located.

Ambulatory surgical facility reporting

(R.C. 3702.302 to 3702.305)

The bill requires ambulatory surgical facilities[24] that serve at least ten patients per year to submit certain data to the Director of Health by May 1 of each year. The information an ambulatory surgical facility must submit includes (1) type of services provided by the facility, (2) number of patients receiving each

[22] The bill defines "Medicaid managed care contract" as a contract between a hospital and a Medicaid managed care organization under which the hospital is to provide services covered by the contract to Medicaid recipients enrolled in the Medicaid managed care organization and be paid by the Medicaid managed care organization for the services in accordance with the terms of the contract.

[23] The Department of Job and Family Services has divided the state into different regions for the purpose of the Medicaid managed care program. Each region comprises a number of contiguous counties.

[24] "Ambulatory surgical facility" means a facility, whether or not part of the same organization as a hospital, that is located in a building distinct from another in which inpatient care is provided, and to which any of the following applies: (1) outpatient surgery is routinely performed and the facility functions separately from a hospital's inpatient surgical service and the offices of private physicians, podiatrists, and dentists, (2) anesthesia is administered and the facility functions separately from a hospital's inpatient surgical service and the offices of private physicians, podiatrists, and dentists, (3) the facility applies to be certified by the United States Centers for Medicare and Medicaid Services (CMS) as an ambulatory surgical center for purposes of Medicare Part B, (4) the facility applies to be certified by a national accrediting body approved by CMS for Medicare participation as an ambulatory surgical center, (5) the facility bills or receives any ambulatory surgical facility fee in addition to fees for professional services, (6) the facility is held out as an ambulatory surgical facility or similar facility. "Ambulatory surgical facility" does not include a hospital emergency department. (R.C. 3702.30(A)(1).)

type of service, and (3) mean and median of the total charges for each type of service. The bill specifically prohibits the name or social security number of a patient or physician from being included in the information submitted to the Director. The Director may audit the information at any time, and the ambulatory surgical facility may verify and provide corrections to any information submitted. The bill also requires the Director to adopt rules regarding submission of the information to the Director.

The bill requires both the ambulatory surgical facilities and the Director to make the information available to the public and permits ambulatory surgical facilities to charge for copying the information. The Director must make the information available on a web site within 90 days of receiving it, if appropriations made by the Ohio General Assembly make this possible. The web site must (1) be available to the public without charge, (2) be organized in a manner that enables the public to use it easily, (3) exclude any information that compromises patient privacy, (4) include links to web sites pertaining to ambulatory surgical facilities for the purpose of allowing the public to obtain additional information about ambulatory surgical facilities, and (5) allow other internet web sites to link to the web site for purposes of increasing the site's availability and encouraging ongoing improvement. The Director must update the web site as needed to include new information and correct errors. (R.C. 3702.304(B).) The bill allows the Director to contract with a vendor to create, maintain, and update the web site. The Director may accept gifts, grants, donations, and awards to pay fees or other costs incurred when contracting with a vendor. The Director may sell the information to any interested person or government entity for a reasonable fee.

Ambulatory surgical facilities must notify any person who requests information that the information is available from the Director of Health. However, this requirement is subject to the provision that requires the Director to establish a web site only if funds are appropriated.

The bill exempts ambulatory surgical facilities from liability for misuse or improper release of the information and specifies that the information cannot be used as evidence in any civil, criminal, or administrative proceeding.

DENTAL HYGIENISTS

Dental hygienist collaboration agreements with dentists

Overview

(R.C. 4715.22 and 4715.23)

Current law. Under current law, a dental hygienist must practice under the "supervision, order, control, and full responsibility" of a dentist licensed by the State Dental Board. A dental hygienist may practice in a dental office, public or private school, health care facility,[25] dispensary, or public institution. In general, a dental hygienist is limited to providing (1) prophylactic, preventative, and other procedures that licensed dentists are authorized by law and the State Dental Board to assign only to dental hygienists, and (2) intraoral tasks that do not require the professional competence or skill of a licensed dentist that are authorized by the Board.[26]

Subject to a couple exceptions, a dental hygienist is prohibited from providing dental hygiene services to a patient when the supervising dentist is not physically present at the location where the hygienist is practicing. The first exception to the prohibition on a hygienist practicing without a dentist being physically present is that the hygienist may provide, for not more than 15 consecutive business days, dental hygiene services to a patient when the supervising dentist is not physically present if several requirements regarding training, limits on services provided, written protocols, and patient notification are satisfied. Among these requirements is that the supervising dentist has completed and evaluated a medical and dental history of the patient not more than one year prior to the date the hygienist provides dental hygiene services to the patient and, except when the dental hygiene services are provided in a health care facility,[27] the supervising dentist determines that the patient is in a medically stable condition.

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[25] The term, "health care facility," includes hospitals registered with the Department of Health, nursing homes, and certain other long-term care facilities (R.C. 3701.07 and 3721.01).

[26] The State Dental Board must issue rules defining the procedures that may be performed by licensed dental hygienists engaged in school health activities or employed by public agencies (R.C. 4715.23).

[27] When dental hygiene services are provided in a health care facility, a doctor of medicine and surgery or doctor of osteopathic medicine and surgery who holds a current certificate from the State Medical Board or a registered nurse licensed by the Ohio Board

The second exception to the prohibition on a hygienist practicing without a dentist being physically present is that a hygienist may provide services without a dentist being physically present if the services are provided as part of a dental hygiene program that is approved by the State Dental Board and meets certain requirements regarding who operates the program and the performance of services after examination and diagnosis by the supervising dentist and in accordance with the dentist's treatment plan.

The bill. The bill generally maintains current law governing the practice of dental hygienists but enacts new law to (1) permit a dental hygienist to enter into a collaboration agreement with a dentist employed by, or under contract with, a public health facility to provide certain services at public health facilities without the dentist being physically present at the facility where the services are provided and without prior examination by the dentist, (2) govern the conditions under which a dental hygienist may practice under a collaboration agreement and the characteristics of a collaboration agreement, and (3) provide an exception from the conditions in current law governing the practice of a dental hygienist when the dental hygienist practices under a collaboration agreement.

This means that if the bill is enacted, there will be two sets of laws governing the practice of dental hygienists: one that governs the practice of a dental hygienist when the hygienist practices under a collaboration agreement and another (the existing law) that governs the practice of a dental hygienist when the hygienist is not practicing under a collaboration agreement.

Authority to enter into collaboration agreements

(R.C. 4715.222)

The bill permits a dental hygienist who has provided certain evidence described in "***Eligibility to enter into a collaboration agreement***," below, to enter into a collaboration agreement with a dentist under which the dentist authorizes all of the following:

(1) The dental hygienist to provide the services described in "***Services under a collaboration agreement***," below, to patients[28] at any public health

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of Nursing must be present in the facility when the services are provided (R.C. 4715.22(C)(9)).

[28] The bill defines "patient" as an individual who seeks dental hygiene services at a facility, a student enrolled in the facility at which the services are provided, or a resident of a facility at which the services are provided (R.C. 4715.221(E)).

facility[29] without the dentist being physically present at the facility where the services are provided.

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

(3) The dental hygienist to work with certified dental assistants who may perform only the duties they are authorized to provide without the direct supervision of a dentist.

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[29] The bill defines "public health facility" as any of the following:

(1) A public or nonpublic school.

(2) A hospital, nursing home, or other specified long-term care facility (R.C. 3701.07 and 3721.01).

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

(4) A Head Start program that is licensed as a child day-care center.

(5) A non-profit corporation, association, group, institution, society, or other organization.

(6) A special needs program operated by a school district, the governing board of an educational service center, the board of health of a city or general health district (or an authority having the duties of a board of health under current law), or a national, state, district, or local dental association.

(7) A residential facility in which persons who are mentally retarded or developmentally disabled reside, a respite care home certified under current law (R.C. 5126.01), a county home or district home operated pursuant to R.C. Chapter 5155., or a dwelling in which the only mentally retarded or developmentally disabled residents are in an independent living arrangement or are being provided supported living.

(8) A hospice care program.

(9) An institution of higher education.

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

(11) A mobile dental unit located at any location in (1) to (10), above.

The bill requires that a collaboration agreement meet the requirements in "***Required characteristics of a collaboration agreement***," below.

Eligibility to enter into collaboration agreement

(R.C. 4715.223)

The bill requires a dental hygienist to submit written evidence of all of the following to the dentist who is to be the collaborating dentist under the agreement:

(1) The dental hygienist has at least two years and a minimum of 3,000 hours of experience in the practice of dental hygiene.

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

(3) The dental hygienist holds current certification to perform basic life-support procedures as required under current law (R.C. 4715.251).

(4) The dental hygienist holds professional liability insurance.

The bill permits the dentist who is to be the collaborating dentist under the agreement to personally observe the dental hygienist provide to patients the services the dental hygienist is permitted to provide under a collaboration agreement.

Services under a collaboration agreement

(R.C. 4715.224)

The bill permits a dental hygienist who has entered into a collaboration agreement to perform the following services:

(1) Oral health promotion and disease prevention education, including information gathering, screening, and assessment.

(2) Removal of calcareous deposits or accretions from the crowns and roots of teeth.

(3) Sulcular placement of prescribed materials.

(4) Polishing of the clinical crowns of teeth, including restorations.

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

(6) Fluoride applications.

(7) Placement of sealants.

(8) Any other basic remediable intraoral dental task or procedure designated by the State Dental Board in rules it must adopt.

Required characteristics of a consent agreement

(R.C. 4715.225)

The bill requires that a collaboration agreement be in writing; contain certain terms (see "***Required terms***," below); contain a blank "consent to treatment form" that the dental hygienist can use for purposes of complying with the requirement described in "***Consent to treatment form***," below; and be signed and dated by both the dentist and the dental hygienist.

Required terms. The bill requires that a collaboration agreement contain all of the following terms:

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

(2) A procedure the dental hygienist must follow if the dental hygienist believes the patient's condition presents an emergency dental condition;

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

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

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

(6) Services described in "***Services under a collaborative agreement***," above, if any, for which the dentist requires the patient to be examined by the dentist prior to the dental hygienist providing the services or the dentist to approve a patient-specific diagnosis or treatment plan;

(7) The number of patient visits for dental hygiene services, if any, that the dentist requires the dental hygienist to provide, on an annual basis, to special needs patients[30] for a charge determined according to the sliding fee scale established by the State Dental Board in rules;

(8) A statement that the dentist and dental hygienist agree that the dental hygienist's provision of services under a collaboration agreement is neither the practice of dental hygiene in a manner that is separate or otherwise independent from the dental practice of a collaborating dentist, nor the establishment or maintenance of an office or practice that is primarily devoted to the provision of dental hygiene services.

Maintenance of a collaboration agreement

(R.C. 4715.226(A))

The bill requires that a copy of the collaboration agreement that a dental hygienist and dentist have entered into be maintained by both parties.

It also requires the dental hygienist to ensure that each public health facility where the dental hygienist provides services under a collaboration agreement has a copy of the agreement the dental hygienist works under at that facility.

Limits on number of agreements; filing with the State Dental Board

(R.C. 4715.226(B) and (C))

The bill specifies that prior approval of a collaboration agreement by the State Dental Board is not required before a dental hygienist provides services under an agreement, but it prohibits a dentist from being a party to more than three agreements at one time unless the Board determines that the dentist meets certain criteria established by the Board in rules it must adopt (see "***Rulemaking***," below).

The bill also requires a dentist or dental hygienist who is a party to a collaboration agreement to provide the State Dental Board with a copy of any agreement on the Board's request.

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[30] A special needs patient is an individual who is in a "special needs program." A "special needs program" is a program operated by any of the following: (1) a school district board of education or the governing board of an educational service center, (2) the board of health of a city or general health district or the authority having the duties of a board of health, or (3) a national, state, district, or local dental association (R.C. 4715.221(F)).

Consent to treatment form

(R.C. 4715.227)

Under the bill, a dental hygienist is required, before performing services on a patient under a collaboration agreement, to provide the patient or patient's representative with a "consent to treatment form" and secure the patient's or representative's signature or mark on the form. The bill permits the signature or mark to be provided through reasonable accommodation, including the use of assistive technology or augmentative device.

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

Required referrals to collaborating dentist

(R.C. 4715.228)

The bill requires a dental hygienist who provided services under a collaboration agreement to refer the patient to the collaborating dentist under the agreement the dental hygienist is working under at the public health facility where the patient was treated and to give the patient a completed referral form containing (1) the collaborating dentist's name, office address, and office telephone, and (2) the date the dental hygienist provided services to the patient. The bill also requires the dental hygienist to give a copy of each completed referral form and the patient's record to the collaborating dentist.

Termination of a collaboration agreement

(R.C. 4715.229)

The bill permits a collaboration agreement to be terminated by the dentist or dental hygienist who entered into the agreement by providing written notice to the opposite party. It also prohibits a dental hygienist from providing services under an agreement once notice of the termination has been given or sent to the dentist.

Rulemaking

(R.C. 4715.2210)

Under the bill, the State Dental Board is required to adopt rules to do all of the following:

(1) Designate the basic remediable intraoral dental tasks or procedures, in addition to the ones listed in the bill (see "***Services under a collaboration agreement***"), that a dental hygienist may provide under a collaboration agreement.

(2) Establish a sliding fee scale that determines the fee a patient in a special needs program is charged for dental hygiene services provided by a dental hygienist under a collaboration agreement.

(3) Establish criteria the Board must use in determining whether a dentist can be a party to more than three collaboration agreements at one time.

Dental assistants and expanded function dental auxiliaries

(R.C. 4715.39 and 4715.64)

The bill specifies that nothing in it can be construed to authorize dental assistants, other qualified personnel, or expanded function dental auxiliaries (EFDAs) to enter into collaboration agreements.

NURSE INSTRUCTOR SALARIES

Nurse instructor salaries

(Section 7)

The bill requires a state institution of higher education[31] that operates a prelicensure nursing education program approved by the Board of Nursing under current law (R.C. 4723.06) to do all of the following:

(1) Pay an individual who begins teaching nursing classes at that institution in the first state fiscal year that begins on or after the bill's effective date a starting salary that is at least $10,000 higher than whichever of the following applies: (a) the average starting salary paid to an instructor who began teaching nursing

[31] Consistent with current law (R.C. 3345.011), the bill defines a "state institution of higher education" as any state university or college (as defined in R.C. 3345.12(A)(1)), community college, state community college, university branch established under R.C. Chapter 3355., or technical college.

classes at the institution during calendar year 2007, or (b) the average starting salary that, based on past practices, would have been paid had any instructor begun teaching nursing classes at the institution during calendar year 2007.

(2) Pay an individual who begins teaching nursing classes at the institution in the second, third, fourth, or fifth state fiscal years that begin on or after the bill's effective date a starting salary that is at least $5,000 higher than the starting salary paid under (1), above.

(3) Pay an individual who taught nursing at the institution in the calendar year immediately prior to the bill's effective date a salary in the first five state fiscal years that begin on or after the bill's effective date a salary that is at least five thousand dollars more than the salary the individual earned in the calendar year immediately prior to the bill's effective date.

The bill prohibits a state institution of higher learning that operates a prelicensure nursing education program from doing either of the following:

(1) Reducing, from the number of nursing classes offered during calendar year 2007, the number of nursing classes offered in each of the first five calendar years that begin on or after the bill's effective date.

(2) Reducing, from the number of nursing instructors employed or contracted with during calendar year 2007, the number of nursing instructors employed or contracted with in each of the first five calendar years that begin on or after the bill's effective date.

SCHOOL FOOD

School food and pricing standards

(R.C. 3313.814 and 3314.181)

Current law

Under current law, each local board of education and each governing board of a community school in Ohio must adopt and enforce standards (1) governing the types of food that may be sold on the premises of its schools, and (2) specifying the time and place each type of food may be sold. In adopting these standards, a board is required to consider each food's nutritional value. A board is prohibited from selling food on any school premises unless the sales are done in accordance with standards adopted by the State Board of Education. The State Board of Education is also required to formulate and adopt guidelines, which boards of education and governing boards of community schools are permitted, but not required, to follow with respect to food sales on school premises.

The bill

The bill requires each local board of education to adopt and enforce standards regarding food *and beverage* sales in accordance with rules the State Board of Education must adopt, in accordance with the Ohio Administrative Procedure Act (R.C. Chapter 119.), governing the types of, *and prices for*, food and beverages sold on any school premises, including food and beverages sold by food service programs and in vending machines. As under current law concerning food, in adopting the standards, a local board must consider each food and beverage's nutritional value.

The bill prohibits a public or community school from (1) beginning one year after the bill is enacted, selling a food or beverage containing, or prepared using, a food or substance containing artificial trans fat, or (2) selling a type of food or beverage, or charging a price for food and beverages that is inconsistent with the rules adopted by the State Board. The bill specifies that a food or substance contains artificial trans fat if its ingredients include vegetable shortening, margarine, or any kind of partially hydrogenated vegetable oil, unless the food manufacturer's documentation or label required on the food or substance under federal regulation (21 C.F.R. 101.9) lists the trans fat content as less than one half of one gram per serving or the label includes the statement "Not a significant source of trans fat."

HEALTH INFORMATION TECHNOLOGY PILOT PROGRAM

Health Information Technology Pilot Program

(Section 3)

The bill requires the Department of Job and Family Services to establish a pilot program in Hamilton County to give certain Medicaid providers equipment, software, and any other items necessary to retain medical records of Medicaid recipients in an electronic format. Each medical record must be capable of electronically retaining information regarding a patient's wellness, preventive care, and medical history, and the record must be maintained in a format that is transferable to all Medicaid providers and to the Department.

The pilot program must begin not later than July 1, 2009, and providers must begin using the equipment not later than October 1, 2009. Not later than July 1, 2013, the Department must expand the pilot program to six additional counties, three of which are to be primarily urban and three are primarily rural. Not later than July 1, 2015, the Department must expand the pilot program to cover all counties in the state. The Department must submit a monthly report to the Health

Information Technology Advisory Board created by the bill regarding the progress of the pilot program.

The bill creates the Health Information Technology Advisory Board which consists of the following individuals:

(1) The State Chief Information Officer, who will serve as chairperson and appoint all other members of the committee;

(2) The Director of the Ohio Department of Health;

(3) One representative from the Ohio Department of Administrative Services;

(4) One representative from the Ohio Hospital Association;

(5) One representative from the Ohio State Medical Association;

(6) An individual who works for a company that provides information technology services;

(7) One representative from a regional health information organization;

(8) One representative from a quality improvement organization affiliated with the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services;

(9) One representative from an Ohio-based medical college or university;

(10) One professional representing the fields of behavioral health, pharmaceuticals, nursing, and long-term care;

(11) One representative from a consumer-oriented association;

(12) One representative of a non-partisan policy group or organization;

(13) An attorney who is an expert on the topic of health information; and

(14) A health care policy and security expert.

The bill requires the Board to meet at least six times per year. It also requires the Ohio Department of Administrative Services to provide meeting space and staff support for the Board. Board members are to be reimbursed for actual expenses incurred in the performance of official duties.

The bill specifies that Board members serve three-year terms and can be reappointed. Vacancies are to be filled by appointment by the chairperson; any member appointed to fill a vacancy occurring prior to the expiration of the term for which the member's predecessor was appointed holds office for the remainder of that term. A member continues in office subsequent to the expiration of the member's term or until a period of 60 days has elapsed, whichever occurs first. Five members of the Board constitute a quorum.

The Board is to do all of the following:

(1) Create an operational plan on how to implement the recommendations in the Ohio Health Information Security and Privacy Collaboration Implementation Plan and the Ohio Health Informational Technology Strategic Roadmap. The plan is to include possible creation of a state-level, public and private organization to coordinate ongoing efforts to implement a strategy for the adoption and use of electronic health records and exchange of health information;

(2) Identify obstacles to adoption of health information technology by providers and exchange of health information among providers and with consumers;

(3) Advise the Governor and the General Assembly on issues related to the development and implementation of an Ohio health information technology infrastructure and to the privacy and security of health information;

(4) Oversee ongoing work of the Ohio Health Information Security and Privacy Collaboration Implementation Plan;

(5) Oversee implementation of state funded health information technology and health information exchange pilot projects;

(6) Coordinate allocation of state funds to subsidize the adoption of health information technology by providers or the exchange of health information among providers;

(7) Coordinate with the entities focused on creating the broadband infrastructure needed throughout Ohio to allow for health information exchange;

(8) Oversee development of communications efforts with consumers and providers to promote health information technology;

(9) Receive grants, gifts, donations, and other contributions of private, federal, or other public moneys to fund health information technology and health information exchange efforts in Ohio;

(10) Oversee coordination of relationships with federal initiatives and agencies or with neighboring state efforts on health information technology and health information exchange.

The bill requires the Department to apply to the United States Secretary of Health and Human Services for federal matching funds through the Medicaid program or any other applicable federal program. The Department shall take all steps necessary to ensure the highest federal participation.

LEGISLATIVE INTENT

Secretary Leavitt's "Four Cornerstones" of health care

(Section 6)

The bill includes an uncodified section declaring the General Assembly's support for the federal "Four Cornerstones" principles of health care reform. The Four Cornerstones are:

(1) Promoting interoperable health information technology;

(2) Measuring and publishing quality health information;

(3) Measuring and publishing quality health price information;

(4) Promoting quality and efficiency of health care.

COMMENT

Actuarial review

Some of the benefits required by the bill may be considered "mandated benefits."[32] Pursuant to Sub. H.B. 405 of the 124th General Assembly, the chairperson of a standing committee of either house may, at any time, request that

[32] "Mandated benefit" means the following, considered in the context of a sickness and accident insurance policy or a health insuring corporation policy, contract, or agreement: (1) any required coverage for a specific medical or health-related service, treatment, medication, or practice, (2) any required coverage for the services of specific health care providers, (3) any requirement that an insurer or health insuring corporation offer coverage to specific individuals or groups, (4) any requirement that an insurer or health insuring corporation offer specific medical or health-related services, treatments, medications, or practices to existing insureds or enrollees, (5) any required expansion of, or addition to, existing coverage, and (6) any mandated reimbursement amount to specific health care providers (R.C. 103.144, not in the bill).

the Director of the Legislative Service Commission review any bill assigned to the chairperson's committee to determine whether the bill includes a mandated benefit. If the Director determines that the bill includes a mandated benefit, the presiding officer of the house that is considering the bill may request the Director to arrange for the performance of an independent healthcare actuarial review of the benefit. Not later than 60 days after the presiding officer's request for a review, the Director must submit the findings of the actuarial review to the chairperson of the committee to which the bill is assigned and to the ranking minority member of that committee. (R.C. 103.144 to 103.146, not in the bill.)

Exemption from H.B. 478 requirements

Am. Sub. H.B. 478 of the 119th General Assembly provides that no mandated health benefits legislation enacted on or after January 14, 1993, can apply to any health benefits arrangement until the Superintendent of Insurance holds a public hearing and determines that the provision can be applied fully and equally in all respects to (1) employee benefit plans subject to the Employee Retirement Income Security Act of 1974 (ERISA) and (2) employee benefit plans established or modified by the state or its political subdivisions.[33] (Section 3901.71, not in the bill.) The bill includes provisions exempting specified requirements from this restriction in sections 1751.14, 1753.281, 3923.24, 3923.241, 3923.641, 3923.651, 3923.80, and 3923.88 of the Revised Code as amended by this bill.

HISTORY

ACTION	DATE
Introduced	01-29-08

H0456-I-127.doc/jc:kl

[33] ERISA is a comprehensive federal statute governing the administration of employee benefit plans. ERISA generally precludes state regulation of benefits offered by private employers that self-insure their benefit programs. Larger employers frequently choose to establish their own health insurance plans for their employees in lieu of purchasing coverage from an insurer or health insuring corporation.