As Introduced

132nd General Assembly
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S. B. No. 154

Senators Schiavoni, Yuko
Cosponsors: Senators Brown, Sykes, Skindell, O'Brien, Tavares

A BILL

To amend sections 109.90, 1739.05, 1751.01, 3715.89, 4729.54, 4729.69, 4729.99, 5119.49, 5167.12 and to enact sections 1751.692, 1751.76, 3301.97, 3707.60, 3901.80, 3901.801, 3923.046, 3923.852, 5119.368, 5164.092, and 5164.7512 of the Revised Code to provide for the prevention and treatment of opioid addiction, to make an appropriation, and to declare an emergency.

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

Section 1. That sections 109.90, 1739.05, 1751.01, 3715.89, 4729.54, 4729.69, 4729.99, 5119.49, and 5167.12 be amended and sections 1751.692, 1751.76, 3301.97, 3707.60, 3901.80, 3901.801, 3923.046, 3923.852, 5119.368, 5164.092, and 5164.7512 of the Revised Code be enacted to read as follows:

Sec. 109.90. (A) The attorney general shall collaborate with the state board of pharmacy and director of mental health and addiction services in the establishment and administration of one or more drug take-back programs, including the Ohio drug take-back program, as provided under section 4729.69 of the
Revised Code. The office of the attorney general is solely responsible for the costs incurred in the establishment and administration of the program.

(B) The attorney general may accept grants, gifts, or donations for purposes of the program. Money received under this division or section 5119.49 or 4729.69 of the Revised Code shall be deposited into the state treasury to the credit of the drug take-back program fund, which is hereby created. Money credited to the fund shall be used solely for purposes of the program.

Sec. 1739.05. (A) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program may be established only if any of the following applies:

(1) The arrangement has and maintains a minimum enrollment of three hundred employees of two or more employers.

(2) The arrangement has and maintains a minimum enrollment of three hundred self-employed individuals.

(3) The arrangement has and maintains a minimum enrollment of three hundred employees or self-employed individuals in any combination of divisions (A)(1) and (2) of this section.

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 3901.491, 3902.01 to 3902.14, 3923.041, 3923.046, 3923.24,
3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.602, 3923.63, 3923.80, 3923.84, 3923.85, 3923.851, 3923.852, 3924.031, 3924.032, and 3924.27 of the Revised Code.

(C) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall solicit enrollments only through agents or solicitors licensed pursuant to Chapter 3905. of the Revised Code to sell or solicit sickness and accident insurance.

(D) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall provide benefits only to individuals who are members, employees of members, or the dependents of members or employees, or are eligible for continuation of coverage under section 1751.53 or 3923.38 of the Revised Code or under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C.A. 1161, as amended.

(E) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code is subject to, and shall comply with, sections 3903.81 to 3903.93 of the Revised Code in the same manner as other life or health insurers, as defined in section 3903.81 of the Revised Code.

Sec. 1751.01. As used in this chapter:

(A)(1) "Basic health care services" means the following services when medically necessary:

(a) Physician's services, except when such services are supplemental under division (B) of this section;

(b) Inpatient hospital services;

(c) Outpatient medical services;
(d) Emergency health services;

(e) Urgent care services;

(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;

(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses;

(h) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care;

(i) Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code.

"Basic health care services" does not include experimental procedures.

Except as provided by divisions (A)(2) and (3) of this section in connection with the offering of coverage for diagnostic and treatment services for biologically based mental illnesses, a health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all listed basic health care services. However, this requirement does not apply to the coverage of beneficiaries enrolled in medicare pursuant to a medicare contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of medicaid recipients, or to the coverage of beneficiaries under any federal health care program regulated by a federal
regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

(2) A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses without offering coverage for all other basic health care services. A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses alone or in combination with one or more supplemental health care services. However, a health insuring corporation that offers coverage for any other basic health care service shall offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services.

(3) A health insuring corporation that offers coverage for basic health care services is not required to offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services if all of the following apply:

(a) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.
(b) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (A)(3)(a) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(c) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (A)(3)(a) and (b) of this section:

(i) Incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

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

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

(B)(1) "Supplemental health care services" means any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes:

(a) Services of facilities for intermediate or long-term
care, or both;

(b) Dental care services;

(c) Vision care and optometric services including lenses and frames;

(d) Podiatric care or foot care services;

(e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses;

(f) Short-term outpatient evaluative and crisis-intervention mental health services;

(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction;

(h) Home health services;

(i) Prescription drug services;

(j) Nursing services;

(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code;

(l) Physical therapy services;

(m) Chiropractic services;

(n) Any other category of services approved by the superintendent of insurance.

(2) If a health insuring corporation offers prescription drug services under this division, the coverage shall include prescription drug services for the treatment of biologically based mental illnesses on the same terms and conditions as other physical diseases and disorders.
(C) "Specialty health care services" means one of the supplemental health care services listed in division (B) of this section, when provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services.

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

(E) "Closed panel plan" means a health care plan that requires enrollees to use participating providers.

(F) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.

(G) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.

(H) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state.

(I) "Emergency health services" means those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity
payments or service agreements for out-of-area coverage.

(J) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation.

(K) "Evidence of coverage" means any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage and other rights to which such person is entitled under a health care plan.

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

(M) "Health care services" means basic, supplemental, and specialty health care services.

(N) "Health delivery network" means any group of providers or health care facilities, or both, or any representative thereof, that have entered into an agreement to offer health care services in a panel rather than on an individual basis.

(O) "Health insuring corporation" means a corporation, as defined in division (H) of this section, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.
"Health insuring corporation" does not include a limited liability company formed pursuant to Chapter 1705. of the Revised Code, an insurer licensed under Title XXXIX of the Revised Code if that insurer offers only open panel plans under which all providers and health care facilities participating receive their compensation directly from the insurer, a corporation formed by or on behalf of a political subdivision or a department, office, or institution of the state, or a public entity formed by or on behalf of a board of county commissioners, a county board of developmental disabilities, an alcohol and drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, as those terms are used in Chapters 340. and 5126. of the Revised Code. Except as provided by division (D) of section 1751.02 of the Revised Code, or as otherwise provided by law, no board, commission, agency, or other entity under the control of a political subdivision may accept insurance risk in providing for health care services. However, nothing in this division shall be construed as prohibiting such entities from purchasing the services of a health insuring corporation or a third-party administrator licensed under Chapter 3959. of the Revised Code.

(P) "Intermediary organization" means a health delivery network or other entity that contracts with licensed health insuring corporations or self-insured employers, or both, to provide health care services, and that enters into contractual arrangements with other entities for the provision of health care services for the purpose of fulfilling the terms of its contracts with the health insuring corporations and self-insured employers.

(Q) "Intermediate care" means residential care above the
level of room and board for patients who require personal assistance and health-related services, but who do not require skilled nursing care.

(R) "Medical record" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment.

(S)(1) "Open panel plan" means a health care plan that provides incentives for enrollees to use participating providers and that also allows enrollees to use providers that are not participating providers.

(2) No health insuring corporation may offer an open panel plan, unless the health insuring corporation is also licensed as an insurer under Title XXXIX of the Revised Code, the health insuring corporation, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1736. or 1740. of the Revised Code, or an insurer licensed under Title XXXIX of the Revised Code is responsible for the out-of-network risk as evidenced by both an evidence of coverage filing under section 1751.11 of the Revised Code and a policy and certificate filing under section 3923.02 of the Revised Code.

(T) "Osteopathic hospital" means a hospital registered under section 3701.07 of the Revised Code that advocates osteopathic principles and the practice and perpetuation of osteopathic medicine by doing any of the following:

(1) Maintaining a department or service of osteopathic medicine or a committee on the utilization of osteopathic principles and methods, under the supervision of an osteopathic physician;

(2) Maintaining an active medical staff, the majority of
which is comprised of osteopathic physicians;

(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members.

(U) "Panel" means a group of providers or health care facilities that have joined together to deliver health care services through a contractual arrangement with a health insuring corporation, employer group, or other payor.

(V) "Person" has the same meaning as in section 1.59 of the Revised Code, and, unless the context otherwise requires, includes any insurance company holding a certificate of authority under Title XXXIX of the Revised Code, any subsidiary and affiliate of an insurance company, and any government agency.

(W) "Premium rate" means any set fee regularly paid by a subscriber to a health insuring corporation. A "premium rate" does not include a one-time membership fee, an annual administrative fee, or a nominal access fee, paid to a managed health care system under which the recipient of health care services remains solely responsible for any charges accessed for those services by the provider or health care facility.

(X) "Primary care provider" means a provider that is designated by a health insuring corporation to supervise, coordinate, or provide initial care or continuing care to an enrollee, and that may be required by the health insuring corporation to initiate a referral for specialty care and to maintain supervision of the health care services rendered to the enrollee.

(Y) "Provider" means any natural person or partnership of natural persons who are licensed, certified, accredited, or
otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code, provided that nothing in this chapter or other provisions of law shall be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health insuring corporation from employing certified nurse practitioners, certified nurse anesthetists, clinical nurse specialists, certified nurse-midwives, dietitians, physician assistants, dental assistants, dental hygienists, optometric technicians, or other allied health personnel who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services.

(Z) "Provider sponsored organization" means a corporation, as defined in division (H) of this section, that is at least eighty per cent owned or controlled by one or more hospitals, as defined in section 3727.01 of the Revised Code, or one or more physicians licensed to practice medicine or surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code, or any combination of such physicians and hospitals. Such control is presumed to exist if at least eighty per cent of the voting rights or governance rights of a provider sponsored organization are directly or indirectly owned, controlled, or otherwise held by any combination of the physicians and hospitals described in this division.

(AA) "Solicitation document" means the written materials provided to prospective subscribers or enrollees, or both, and used for advertising and marketing to induce enrollment in the health care plans of a health insuring corporation.

(BB) "Subscriber" means a person who is responsible for
making payments to a health insuring corporation for participation in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health insuring corporation.

(CC) "Urgent care services" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements.

Sec. 1751.692. (A) As used in this section:

(1) "Abuse-deterrent" means a labeling claim approved by the United States food and drug administration indicating properties expected to deter or reduce drug abuse.

(2) "Cost-sharing" has the same meaning as in section 1751.69 of the Revised Code.

(3) "Opioid analgesic" has the same meaning as in section 3719.01 of the Revised Code.

(B) Notwithstanding section 3901.71 of the Revised Code, an individual or group health insuring corporation policy, contract, or agreement that provides coverage for prescription drugs shall provide coverage for abuse-deterrent opioid analgesics. All of the following apply to the policy, contract, or agreement:

(1) It shall not deny reimbursement of an abuse-deterrent opioid analgesic solely because a generically equivalent drug is available at a lower cost.
(2) It shall not require treatment with an opioid analgesic that is not abuse-deterrent before providing coverage of an abuse-deterrent opioid analgesic.

(3) It shall not impose cost-sharing requirements on an abuse-deterrent opioid analgesic that exceed the lowest cost-sharing requirements imposed on any opioid analgesic that is not abuse-deterrent and shall not increase cost-sharing requirements to obtain compliance with division (B)(3) of this section.

Sec. 1751.76. (A) As used in this section:

(1) "Medication-assisted treatment" means alcohol and drug addiction services that are accompanied by medication approved by the United States food and drug administration for the treatment of alcoholism or drug addiction, prevention of relapse of alcoholism or drug addiction, or both.

(2) "Prior authorization requirement" has the same meaning as in section 1751.72 of the Revised Code.

(B) Notwithstanding section 3901.71 of the Revised Code, an individual or group health insuring corporation policy, contract, or agreement that provides basic health services shall provide coverage for medical or psychological treatment and referral services for alcohol and drug abuse or addiction, including medication-assisted treatment. All of the following apply to the policy, contract, or agreement:

(1) It shall not impose any prior authorization requirement on the treatment and referral services;

(2) It shall provide coverage for drugs prescribed for the treatment of alcohol and drug abuse or addiction, including buprenorphine and naltrexone.
(3) It shall provide coverage for the treatment and referral services as long as they are needed.

(C) This section does not prohibit a policy, contract, or agreement from imposing copayments, coinsurance, or deductibles for the treatment and referral services described in division (B) of this section.

Sec. 3301.97. (A) The department of education shall establish a grant program to fund school-based initiatives that seek to educate students about opioid dependence and addiction prevention.

(B) In awarding grants, the department shall give priority to initiatives that do both of the following:

(1) Collaborate with individuals, organizations, or entities engaged in activities at the local level to prevent or treat opioid dependence and addiction, including health care professionals, treatment providers, and law enforcement officials;

(2) Concentrate efforts on students enrolled in grades kindergarten through eight.

(C) The department of education may adopt rules as it considers necessary to implement this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 3707.60. (A) As used in this section, "board of health" means the board of health of a city or general health district or authority having the duties of a board of health under section 3709.05 of the Revised Code.

(B) Each board of health shall establish an awareness program regarding safe drug disposal, including promoting
awareness of collection locations, state and national drug take-back days, and drug repository programs. The awareness program shall do at least the following:

(1) Provide information to pharmacies, manufacturers of dangerous drugs, health care facilities, and government entities regarding the drug repository program established by the state board of pharmacy under section 3715.87 of the Revised Code.

(2) Encourage law enforcement agencies to participate in drug take-back days.

Sec. 3715.89. (A) Subject to divisions (B) and (C) of this section, any manufacturer of dangerous drugs, terminal distributor of dangerous drugs, or wholesale distributor of dangerous drugs may donate a dangerous drug, including a dangerous drug that has expired, to a pharmacy school.

(B) A dangerous drug donation to a pharmacy school shall meet all of the following requirements:

1. The dangerous drug is not a controlled substance.

2. Each container in which a dangerous drug is donated contains a single national drug code number of that drug and no other drugs.

3. If the dangerous drug is of a type that deteriorates with time, the container in which the drug is contained is plainly marked with the drug’s expiration date.

4. If the dangerous drug is a controlled substance, the donor and recipient comply with all state and federal laws applicable to the donation, possession, or use of such drugs.

(C) A dangerous drug donation to a pharmacy school shall be accompanied by a form signed by a representative of the
manufacturer, terminal distributor, or wholesale distributor
donating the drug. On delivery, a representative of the pharmacy
school accepting the drug donation shall also sign the form. The
form shall do both of the following:

(1) Confirm the acceptance of the dangerous drug donation
by the pharmacy school;

(2) Confirm that both the manufacturer, terminal
distributor, or wholesale distributor donating the dangerous
drug and the pharmacy school accepting the donation understand
the immunity provisions of section 3719.92 of the Revised Code.

Sec. 3901.80. (A) As used in this section and section
3901.801 of the Revised Code, "health plan issuer" means a
sickness and accident insurer, health insuring corporation, or
multiple employer welfare arrangement.

(B) Not later than January 1, 2019, the superintendent of
insurance shall establish and administer a program of
reinsurance to reimburse health plan issuers for costs incurred
when providing coverage as described in sections 1751.76 and
3923.046 of the Revised Code.

(C) Each health plan issuer subject to section 1751.76 or
3923.046 of the Revised Code shall participate in the program.

(D) The superintendent shall do all of the following with
regard to the program:

(1) Establish standards and procedures for health plan
issuers to seek and obtain reimbursement under the program;

(2) Employ staff to administer the program;

(3) Set levels of reinsurance that are adequate to ensure
minimal losses for health plan issuers.
(E) The superintendent may fulfill the requirements of this section by contracting with a reinsurer accredited under section 3901.62 of the Revised Code.

(F) The superintendent shall adopt rules as necessary to implement this section. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 3901.801. There is hereby created in the state treasury the opioid overdose and treatment reinsurance fund. Any funds the department of insurance receives for the purposes of the reinsurance program established under section 3901.80 of the Revised Code shall be deposited into the fund. Money in the fund shall be used to reimburse participating health plan issuers as described in section 3901.80 of the Revised Code.

Sec. 3923.046. (A) As used in this section:

(1) "Medication-assisted treatment" means alcohol and drug addiction services that are accompanied by medication approved by the United States food and drug administration for the treatment of alcoholism or drug addiction, prevention of relapse of alcoholism or drug addiction, or both.

(2) "Prior authorization" means any practice in which coverage of a health care service, device, or drug is dependent on a covered person or health care provider obtaining approval from the insurer prior to the service, device, or drug being performed, received, or prescribed. "Prior authorization" includes prospective or utilization review procedures conducted prior to a health care service, device, or drug being provided.

(B) Notwithstanding section 3901.71 of the Revised Code, a policy of sickness and accident insurance, or a public employee benefit plan, that provides basic hospital and surgical
coverage, basic medical coverage, or major medical coverage shall provide coverage for medical or psychological treatment and referral services for alcohol and drug abuse or addiction, including medication-assisted treatment. All of the following apply to the policy or plan:

(1) It shall not impose any prior authorization requirement on the treatment and referral services.

(2) It shall provide coverage for drugs prescribed for the treatment of alcohol and drug abuse or addiction, including buprenorphine and naltrexone.

(3) It shall provide coverage for the treatment and referral services as long as they are needed.

(C) This section does not prohibit a policy or plan from imposing copayments, coinsurance, or deductibles for the treatment and referral services described in division (B) of this section.

Sec. 3923.852. (A) As used in this section:

(1) "Abuse-deterrent" means a labeling claim approved by the United States food and drug administration indicating properties expected to deter or reduce drug abuse.

(2) "Cost-sharing" has the same meaning as in section 3923.602 of the Revised Code.

(3) "Opioid analgesic" has the same meaning as in section 3719.01 of the Revised Code.

(B) Notwithstanding section 3901.71 of the Revised Code, an individual or group policy of sickness and accident insurance or public employee benefit plan that provides coverage for prescription drugs shall provide coverage for abuse-deterrent
opioid analgesics. All of the following apply to the policy or plan:

(1) It shall not deny reimbursement of an abuse-deterrent opioid analgesic solely because a generically equivalent drug is available at a lower cost.

(2) It shall not require treatment with an opioid analgesic that is not abuse-deterrent before providing coverage for an abuse-deterrent opioid analgesic.

(3) It shall not impose cost-sharing requirements on an abuse-deterrent opioid analgesic that exceed the lowest cost-sharing requirements imposed on any opioid analgesic that is not abuse-deterrent and shall not increase cost-sharing requirements to comply with division (B)(3) of this section.

Sec. 4729.54. (A) As used in this section:

(1) "Category I" means single-dose injections of intravenous fluids, including saline, Ringer's lactate, five per cent dextrose and distilled water, and other intravenous fluids or parenteral solutions included in this category by rule of the state board of pharmacy, that have a volume of one hundred milliliters or more and that contain no added substances, or single-dose injections of epinephrine to be administered pursuant to sections 4765.38 and 4765.39 of the Revised Code.

(2) "Category II" means any dangerous drug that is not included in category I or III.

(3) "Category III" means any controlled substance that is contained in schedule I, II, III, IV, or V.

(4) "Emergency medical service organization" has the same meaning as in section 4765.01 of the Revised Code.
(5) "Person" includes an emergency medical service organization.

(6) "Schedule I, schedule II, schedule III, schedule IV, and schedule V" mean controlled substance schedules I, II, III, IV, and V, respectively, as established pursuant to section 3719.41 of the Revised Code and as amended.

(B)(1) A person who desires to be licensed as a terminal distributor of dangerous drugs shall file with the executive director of the state board of pharmacy a verified application. After it is filed, the application may not be withdrawn without approval of the board.

(2) An application shall contain all the following that apply in the applicant's case:

(a) Information that the board requires relative to the qualifications of a terminal distributor of dangerous drugs set forth in section 4729.55 of the Revised Code;

(b) A statement that the person wishes to be licensed as a category I, category II, category III, limited category I, limited category II, or limited category III terminal distributor of dangerous drugs;

(c) If the person wishes to be licensed as a limited category I, limited category II, or limited category III terminal distributor of dangerous drugs, a notarized list of the dangerous drugs that the person wishes to possess, have custody or control of, and distribute, which list shall also specify the purpose for which those drugs will be used and their source;

(d) If the person is an emergency medical service organization, the information that is specified in division (C)(1) of this section;
(e) Except for an emergency medical service organization, the identity of the one establishment or place at which the person intends to engage in the sale or other distribution of dangerous drugs at retail, and maintain possession, custody, or control of dangerous drugs for purposes other than the person's own use or consumption;

(f) If the application pertains to a pain management clinic, information that demonstrates, to the satisfaction of the board, compliance with division (A) of section 4729.552 of the Revised Code;

(g) If the application pertains to a facility, clinic, or other location described in division (B) of section 4729.553 of the Revised Code that must hold a category III terminal distributor of dangerous drugs license with an office-based opioid treatment classification, information that demonstrates, to the satisfaction of the board, compliance with division (C) of that section.

(C)(1) An emergency medical service organization that wishes to be licensed as a terminal distributor of dangerous drugs shall list in its application for licensure the following additional information:

(a) The units under its control that the organization determines will possess dangerous drugs for the purpose of administering emergency medical services in accordance with Chapter 4765. of the Revised Code;

(b) With respect to each such unit, whether the dangerous drugs that the organization determines the unit will possess are in category I, II, or III.

(2) An emergency medical service organization that is
licensed as a terminal distributor of dangerous drugs shall file a new application for such licensure if there is any change in the number, or location of, any of its units or any change in the category of the dangerous drugs that any unit will possess.

(3) A unit listed in an application for licensure pursuant to division (C)(1) of this section may obtain the dangerous drugs it is authorized to possess from its emergency medical service organization or, on a replacement basis, from a hospital pharmacy. If units will obtain dangerous drugs from a hospital pharmacy, the organization shall file, and maintain in current form, the following items with the pharmacist who is responsible for the hospital's terminal distributor of dangerous drugs license:

(a) A copy of its standing orders or protocol;

(b) A list of the personnel employed or used by the organization to provide emergency medical services in accordance with Chapter 4765. of the Revised Code, who are authorized to possess the drugs, which list also shall indicate the personnel who are authorized to administer the drugs.

(D) Each emergency medical service organization that applies for a terminal distributor of dangerous drugs license shall submit with its application the following:

(1) A notarized copy of its standing orders or protocol, which orders or protocol shall be signed by a physician and specify the dangerous drugs that its units may carry, expressed in standard dose units;

(2) A list of the personnel employed or used by the organization to provide emergency medical services in accordance with Chapter 4765. of the Revised Code.
An emergency medical service organization that is licensed as a terminal distributor shall notify the board immediately of any changes in its standing orders or protocol.

(E) There shall be six categories of terminal distributor of dangerous drugs licenses, which categories shall be as follows:

(1) Category I license. A person who obtains this license may possess, have custody or control of, and distribute only the dangerous drugs described in category I.

(2) Limited category I license. A person who obtains this license may possess, have custody or control of, and distribute only the dangerous drugs described in category I that were listed in the application for licensure.

(3) Category II license. A person who obtains this license may possess, have custody or control of, and distribute only the dangerous drugs described in category I and category II.

(4) Limited category II license. A person who obtains this license may possess, have custody or control of, and distribute only the dangerous drugs described in category I or category II that were listed in the application for licensure.

(5) Category III license, which may include a pain management clinic classification issued under section 4729.552 of the Revised Code. A person who obtains this license may possess, have custody or control of, and distribute the dangerous drugs described in category I, category II, and category III. If the license includes a pain management clinic classification, the person may operate a pain management clinic.

(6) Limited category III license. A person who obtains this license may possess, have custody or control of, and
distribute only the dangerous drugs described in category I, category II, or category III that were listed in the application for licensure.

(F) Except for an application made on behalf of an animal shelter, if an applicant for licensure as a limited category I, II, or III terminal distributor of dangerous drugs intends to administer dangerous drugs to a person or animal, the applicant shall submit, with the application, a notarized copy of its protocol or standing orders, which protocol or orders shall be signed by a licensed health professional authorized to prescribe drugs, specify the dangerous drugs to be administered, and list personnel who are authorized to administer the dangerous drugs in accordance with federal law or the law of this state. An application made on behalf of an animal shelter shall include a notarized list of the dangerous drugs to be administered to animals and the personnel who are authorized to administer the drugs to animals in accordance with section 4729.532 of the Revised Code. After obtaining a terminal distributor license, a licensee shall notify the board immediately of any changes in its protocol or standing orders, or in such personnel.

(G)(1) Except as provided in division (G)(2) of this section, each applicant for licensure as a terminal distributor of dangerous drugs shall submit, with the application, a license fee determined as follows:

(a) For a category I or limited category I license, forty-five dollars;

(b) For a category II or limited category II license, one hundred twelve dollars and fifty cents;

(c) For a category III license, including a license with a
pain management clinic classification issued under section 4729.552 of the Revised Code, or a limited category III license, one hundred fifty dollars.

(2)(a) Except as provided in division (G)(2)(b) of this section, for a person who is required to hold a license as a terminal distributor of dangerous drugs pursuant to division (D) of section 4729.541 of the Revised Code, the fee shall be sixty dollars.

(b) For a professional association, corporation, partnership, or limited liability company organized for the purpose of practicing veterinary medicine, the fee shall be forty dollars.

(3) Fees assessed under divisions (G)(1) and (2) of this section shall not be returned if the applicant fails to qualify for registration.

(H)(1) The board shall issue a terminal distributor of dangerous drugs license to each person who submits an application for such licensure in accordance with this section, pays the required license fee, is determined by the board to meet the requirements set forth in section 4729.55 of the Revised Code, and satisfies any other applicable requirements of this section.

(2) The license of a person other than an emergency medical service organization shall describe the one establishment or place at which the licensee may engage in the sale or other distribution of dangerous drugs at retail and maintain possession, custody, or control of dangerous drugs for purposes other than the licensee's own use or consumption. The one establishment or place shall be that which is described in
the application for licensure.

No such license shall authorize or permit the terminal distributor of dangerous drugs named in it to engage in the sale or other distribution of dangerous drugs at retail or to maintain possession, custody, or control of dangerous drugs for any purpose other than the distributor's own use or consumption, at any establishment or place other than that described in the license, except that an agent or employee of an animal shelter may possess and use dangerous drugs in the course of business as provided in division (D) of section 4729.532 of the Revised Code.

(3) The license of an emergency medical service organization shall cover and describe all the units of the organization listed in its application for licensure.

(4) The license of every terminal distributor of dangerous drugs shall indicate, on its face, the category of licensure. If the license is a limited category I, II, or III license, it shall specify, and shall authorize the licensee to possess, have custody or control of, and distribute only, the dangerous drugs that were listed in the application for licensure, except that the licensee may also possess and have custody and control over all drugs that are deposited in a lock box or kiosk on the licensee's premises as part of the Ohio drug take-back program established under section 4729.69 of the Revised Code.

(I) All licenses issued pursuant to this section shall be effective for a period of twelve months from the first day of April of each year. A license shall be renewed by the board for a like period, annually, according to the provisions of this section, and the standard renewal procedure of Chapter 4745. of the Revised Code. A person who desires to renew a license shall
submit an application for renewal and pay the required fee on or before the thirty-first day of March each year. The fee required for the renewal of a license shall be the same as the fee paid for the license being renewed, and shall accompany the application for renewal.

A license that has not been renewed during March in any year and by the first day of May of the same year may be reinstated only upon payment of the required renewal fee and a penalty fee of fifty-five dollars.

(J)(1) No emergency medical service organization that is licensed as a terminal distributor of dangerous drugs shall fail to comply with division (C)(2) or (3) of this section.

(2) No emergency medical service organization that is licensed as a terminal distributor of dangerous drugs shall fail to comply with division (D) of this section.

(3) No licensed terminal distributor of dangerous drugs shall possess, have custody or control of, or distribute dangerous drugs that the terminal distributor is not entitled to possess, have custody or control of, or distribute by virtue of its category of licensure, except that a licensed terminal distributor of dangerous drugs that is a retail pharmacy, as defined in section 4729.69 of the Revised Code, may possess or have custody and control over all drugs deposited in a lock box or kiosk as part of the Ohio drug take-back program established under section 4729.69 of the Revised Code.

(4) No licensee that is required by division (F) of this section to notify the board of changes in its protocol or standing orders, or in personnel, shall fail to comply with that division.
Sec. 4729.69. (A) As used in this section, "retail pharmacy" means an establishment or place described pursuant to division (H)(2) of section 4729.54 of the Revised Code in a terminal distributor of dangerous drugs license, except that "retail pharmacy" does not include any of the following: an emergency medical service organization, mail-order pharmacy, pharmacy operated by a government entity, or pharmacy in which the majority of prescriptions filled are for patients of a drug treatment facility, hospital, intermediate care facility, nursing home, or other health care facility in which inpatient care is provided on a routine basis.

(B) The state board of pharmacy, in collaboration with the director of mental health and addiction services and the attorney general, shall establish and administer the Ohio drug take-back program. Under the program, drug manufacturers shall be required to supply secure lock boxes or secure kiosks in which individual consumers may dispose of drugs at retail pharmacies. The program shall not be used for the disposal of drugs by institutional consumers, including hospitals, ambulatory surgical facilities, veterinary clinics, nursing homes, correctional facilities, physician offices, pharmacies, or manufacturers of dangerous drugs.

The state board of pharmacy, in collaboration with the director of mental health and addiction services and attorney general, shall establish and administer a drug take-back program under which drugs are collected from the community for the purpose of destruction or disposal of the drugs.

(B) The program shall be established and administered in such a manner that it does both of the following:

(1) Complies with any state or federal laws regarding the
collection, destruction, or disposal of drugs, including controlled substances as defined in section 3719.01 of the Revised Code;

(2) Maintains the confidentiality of individuals who submit or otherwise provide drugs under the program.

(C) In consultation with the director of mental health and addiction services and attorney general, the board shall adopt rules governing the program. The rules shall be adopted in accordance with Chapter 119. of the Revised Code. In adopting the rules, the board shall specify all of the following:

(1) The entities that may participate in determining which manufacturer of dangerous drugs is responsible for supplying a lock box or kiosk to each retail pharmacy based on the objectives of achieving the efficient collection and destruction of unused drugs and having manufacturers bear the costs on an equitable basis;

(2) Guidelines and responsibilities for accepting drugs by participating entities;

(3) Drugs that may be collected;

(4) Record-keeping requirements;

(5) Proper methods to destroy unused drugs; Standards for the proper removal, transport, or destruction of drugs deposited in each lock box or kiosk that comply with state and federal laws and with guidelines, if any, adopted by the United States food and drug administration and United States environmental protection agency;

(6) Privacy protocols and security standards;

(7) Drug transportation procedures; A schedule of fees to be
charged to manufacturers to cover the cost to the board of establishing and administering the program;

(8) The schedule, duration, and frequency of the collections of drugs, except that the first collection shall occur not later than one year after May 20, 2011;

(9) Any other standards and procedures the board considers necessary for purposes of governing the program.

(D) (1) Under the program, each retail pharmacy shall have a secure and prominently displayed and labeled lock box or secure kiosk supplied by a drug manufacturer into which individual consumers may deposit drugs. Manufacturers of dangerous drugs shall pay all administrative and operational costs associated with the program, including the cost of removing, transporting, and destroying drugs and associated packaging.

(2) No person may charge a consumer a fee associated with the program either at the time of the sale of a drug or when a consumer deposits a drug in a lock box or kiosk.

(E) In accordance with state and federal law, the board may adopt rules to allow an entity participating in the program to return any unused drugs to the pharmacy that originally dispensed the drug. The rules shall include procedures to be followed to maintain the confidentiality of the person for whom the drug was dispensed.

(F) Rules adopted under this section may not do any of the following:

(1) Require any entity to establish, fund, or operate a drug take-back program;
(2) Except as provided in division (D)(1) of this section, establish any new licensing requirement or fee to participate in the program;

(3) Require any entity to compile data on drugs collected.

(F) The board may compile data on the amount and type of drugs collected under the program. For purposes of this division, the board may cooperate with a public or private entity in obtaining assistance in the compilation of data. An entity providing the assistance shall not be reimbursed under the program for any costs incurred in providing the assistance.

(G) If the board compiles data under division (F) of this section, the board shall submit a report to the governor and, in accordance with section 101.68 of the Revised Code, the general assembly. The report, to the extent possible, shall include the following information:

1. Total weight of drugs collected, both with and without packaging;
2. The weight of controlled substances;
3. The amount of all of the following as a per cent of total drugs collected:
   a. Controlled substances;
   b. Brand name drugs;
   c. Generic drugs;
   d. Prescription drugs;
   e. Non-prescription drugs.
4. The amount of vitamins, herbal supplements, and personal care products collected;
(5) If provided by the person who submitted or otherwise donated drugs to the program, the reasons why the drugs were returned or unused.

(H) No entity is required to participate in a drug take-back program established under this section, and no entity shall be subject to civil liability or professional disciplinary action for declining to participate.

(I) The board may accept grants, gifts, or donations for purposes of the program. Money received under this division shall be deposited into the drug take-back program fund established under section 109.90 of the Revised Code.

(J) The state board of pharmacy may continue to administer a drug take-back program established prior to the effective date of this amendment to the extent that the program is not inconsistent with this section.

(K) No person shall knowingly fail to comply with this section.

(J) The board, in an adjudication under Chapter 119. of the Revised Code, may impose a fine of not more than one thousand dollars per day for each violation of division (K) of this section. On the request of the board, the attorney general shall bring and prosecute to judgment a civil action to collect any fine imposed under this division that remains unpaid. All amounts collected under this division shall be deposited in the drug take-back program fund established under section 109.90 of the Revised Code.

A fine may be imposed under this division in addition to any action taken under section 4729.99 of the Revised Code.

Sec. 4729.99. (A) Whoever violates division (H) of section
4729.16, division (G) of section 4729.38, section 4729.57, or division (F) of section 4729.96 of the Revised Code is guilty of a minor misdemeanor, unless a different penalty is otherwise specified in the Revised Code. Each day's violation constitutes a separate offense.

(B) Whoever violates section 4729.27, 4729.28, or 4729.36 of the Revised Code is guilty of a misdemeanor of the third degree. Each day's violation constitutes a separate offense. If the offender previously has been convicted of or pleaded guilty to a violation of this chapter, that person is guilty of a misdemeanor of the second degree.

(C) Whoever violates section 4729.32, 4729.33, or 4729.34 or division (K) of section 4729.69 of the Revised Code is guilty of a misdemeanor.

(D) Whoever violates division (A), (B), (C), (D), (F), or (G) of section 4729.51 of the Revised Code is guilty of a misdemeanor of the first degree.

(E)(1) Whoever violates section 4729.37, division (E)(1) (b) of section 4729.51, division (J) of section 4729.54, division (B) or (D) of section 4729.553, or section 4729.61 of the Revised Code is guilty of a felony of the fifth degree. If the offender previously has been convicted of or pleaded guilty to a violation of this chapter or a violation of Chapter 2925. or 3719. of the Revised Code, that person is guilty of a felony of the fourth degree.

(2) If an offender is convicted of or pleads guilty to a violation of section 4729.37, division (E) of section 4729.51, division (J) of section 4729.54, or section 4729.61 of the Revised Code, if the violation involves the sale, offer to sell,
or possession of a schedule I or II controlled substance, with
the exception of marihuana, and if the court imposing sentence
upon the offender finds that the offender as a result of the
violation is a major drug offender, as defined in section
2929.01 of the Revised Code, and is guilty of a specification of
the type described in section 2941.1410 of the Revised Code, the
court, in lieu of the prison term authorized or required by
division (E)(1) of this section and sections 2929.13 and 2929.14
of the Revised Code and in addition to any other sanction
imposed for the offense under sections 2929.11 to 2929.18 of the
Revised Code, shall impose upon the offender, in accordance with
division (B)(3) of section 2929.14 of the Revised Code, the
mandatory prison term specified in that division.

(3) Notwithstanding any contrary provision of section
3719.21 of the Revised Code, the clerk of court shall pay any
fine imposed for a violation of section 4729.37, division (E) of
section 4729.51, division (J) of section 4729.54, or section
4729.61 of the Revised Code pursuant to division (A) of section
2929.18 of the Revised Code in accordance with and subject to
the requirements of division (F) of section 2925.03 of the
Revised Code. The agency that receives the fine shall use the
fine as specified in division (F) of section 2925.03 of the
Revised Code.

(F) Whoever violates section 4729.531 of the Revised Code
or any rule adopted thereunder or section 4729.532 of the
Revised Code is guilty of a misdemeanor of the first degree.

(G) Whoever violates division (E)(1)(a) of section 4729.51
of the Revised Code is guilty of a felony of the fourth degree.
If the offender has previously been convicted of or pleaded
guilty to a violation of this chapter, or of a violation of
Chapter 2925. or 3719. of the Revised Code, that person is guilty of a felony of the third degree.

(H) Whoever violates division (E)(1)(c) of section 4729.51 of the Revised Code is guilty of a misdemeanor of the first degree. If the offender has previously been convicted of or pleaded guilty to a violation of this chapter, or of a violation of Chapter 2925. or 3719. of the Revised Code, that person is guilty of a felony of the fifth degree.

(I)(1) Whoever violates division (A) of section 4729.95 of the Revised Code is guilty of unauthorized pharmacy-related drug conduct. Except as otherwise provided in this section, unauthorized pharmacy-related drug conduct is a misdemeanor of the second degree. If the offender previously has been convicted of or pleaded guilty to a violation of division (A), (B), or (C) of that section, unauthorized pharmacy-related drug conduct is a misdemeanor of the first degree on a second offense and a felony of the fifth degree on a third or subsequent offense.

(2) Whoever violates division (B) or (C) of section 4729.95 of the Revised Code is guilty of permitting unauthorized pharmacy-related drug conduct. Except as otherwise provided in this section, permitting unauthorized pharmacy-related drug conduct is a misdemeanor of the second degree. If the offender previously has been convicted of or pleaded guilty to a violation of division (A), (B), or (C) of that section, permitting unauthorized pharmacy-related drug conduct is a misdemeanor of the first degree on a second offense and a felony of the fifth degree on a third or subsequent offense.

(3) Notwithstanding any contrary provision of section 3719.21 of the Revised Code or any other provision of law that governs the distribution of fines, the clerk of the court shall
As Introduced

pay any fine imposed pursuant to division (I)(1) or (2) of this section to the state board of pharmacy if the board has adopted a written internal control policy under division (F)(2) of section 2925.03 of the Revised Code that addresses fine moneys that it receives under Chapter 2925. of the Revised Code and if the policy also addresses fine moneys paid under this division. The state board of pharmacy shall use the fines so paid in accordance with the written internal control policy to subsidize the board's law enforcement efforts that pertain to drug offenses.

(J)(1) Whoever violates division (A)(1) of section 4729.86 of the Revised Code is guilty of a misdemeanor of the third degree. If the offender has previously been convicted of or pleaded guilty to a violation of division (A)(1), (2), or (3) of section 4729.86 of the Revised Code, that person is guilty of a misdemeanor of the first degree.

(2) Whoever violates division (A)(2) of section 4729.86 of the Revised Code is guilty of a misdemeanor of the first degree. If the offender has previously been convicted of or pleaded guilty to a violation of division (A)(1), (2), or (3) of section 4729.86 of the Revised Code, that person is guilty of a felony of the fifth degree.

(3) Whoever violates division (A)(3) of section 4729.86 of the Revised Code is guilty of a felony of the fifth degree. If the offender has previously been convicted of or pleaded guilty to a violation of division (A)(1), (2), or (3) of section 4729.86 of the Revised Code, that person is guilty of a felony of the fourth degree.

(K) A person who violates division (C) of section 4729.552 of the Revised Code is guilty of a misdemeanor of the first
degree. If the person previously has been convicted of or pleaded guilty to a violation of division (C) of section 4729.552 of the Revised Code, that person is guilty of a felony of the fifth degree.

Sec. 5119.49. (A) The director of mental health and addiction services shall collaborate with the state board of pharmacy and attorney general in the establishment and administration of one or more drug take-back programs, including the Ohio drug take-back program, as provided under section 4729.69 of the Revised Code.

(B) The department may accept grants, gifts, or donations for purposes of the programs. Money received under this division shall be deposited into the drug take-back program fund established under section 109.90 of the Revised Code.

Sec. 5119.368. The department of mental health and addiction services shall establish and maintain a web portal to monitor the availability of services and supports from community addiction services providers. The department may contract with a separate entity to establish and maintain all or any part of the web portal on behalf of the department.

The web portal shall allow information regarding the availability of services and supports to be updated instantaneously and be presented by county.

Each community addiction services provider shall submit to the department any information the department determines necessary for maintaining the web portal.

Sec. 5164.092. (A) As used in this section:

(1) "Abuse-deterrent" means a labeling claim approved by the United States food and drug administration indicating
properties expected to deter or reduce drug abuse.

(2) "Opioid analgesic" has the same meaning as in section 3719.01 of the Revised Code.

(B) With respect to the coverage of prescribed drugs under the medicaid program, the department of medicaid shall provide coverage for abuse-deterrent opioid analgesics.

(C) All of the following apply to the medicaid program's coverage of abuse-deterrent opioid analgesics:

(1) The department shall not deny reimbursement of an abuse-deterrent opioid analgesic solely on the basis of the drug's cost.

(2) The department shall not require treatment with an opioid analgesic that is not abuse-deterrent before providing coverage for an abuse-deterrent opioid analgesic.

(3) The department shall not institute cost-sharing requirements under section 5162.20 of the Revised Code for an abuse-deterrent opioid analgesic that exceed the lowest cost-sharing requirements imposed on any opioid analgesic that is not abuse-deterrent. The department shall not increase cost-sharing requirements to obtain compliance with division (C)(3) of this section.

Sec. 5164.7512. (A) As used in this section:

(1) "Medication-assisted treatment" means alcohol and drug addiction services that are accompanied by medication approved by the United States food and drug administration for the treatment of alcoholism or drug addiction, prevention of relapse of alcoholism or drug addiction, or both.

(2) "Prior authorization requirement" means any practice
in which coverage of a health care service, device, or drug is
dependent on a medicaid recipient or medicaid provider obtaining
approval from the medicaid program prior to the service, device,
or drug being performed, received, or prescribed. "Prior
authorization" includes prospective or utilization review
procedures conducted prior to a health care service, device, or
drug being provided.

(B) The medicaid program shall provide coverage for
medical or psychological treatment and referral services for
alcohol and drug abuse or addiction, including medication-assisted treatment. All of the following apply to the department
of medicaid with regard to this coverage:

(1) The department shall not impose any prior
authorization requirement on the treatment and referral
services.

(2) The department shall provide coverage for drugs
prescribed for the treatment of alcohol and drug abuse or
addiction, including buprenorphine and naltrexone.

(3) The department shall provide coverage for treatment
for as long as it is needed.

(C) This section does not prohibit the department from
imposing cost-sharing requirements on the treatment and referral
services.

Sec. 5167.12. (A) When contracting under section 5167.10
of the Revised Code with a managed care organization that is a
health insuring corporation, the department of medicaid shall
require the health insuring corporation to provide coverage of
prescribed drugs for medicaid recipients enrolled in the health
insuring corporation. In providing the required coverage, the
health insuring corporation may use strategies for the
management of drug utilization, but any such strategies are
subject to divisions (B) and (E) of this section and the
department's approval.

(B) The department shall not permit a health insuring
corporation to impose a prior authorization requirement in the
case of a drug to which all of the following apply:

(1) The drug is an antidepressant or antipsychotic.

(2) The drug is administered or dispensed in a standard
tablet or capsule form, except that in the case of an
antipsychotic, the drug also may be administered or dispensed in
a long-acting injectable form.

(3) The drug is prescribed by either of the following:

(a) A physician whom the health insuring corporation,
pursuant to division (C) of section 5167.10 of the Revised Code,
has credentialed to provide care as a psychiatrist;

(b) A psychiatrist practicing at a community mental health
services provider whose mental health services are certified by
the department of mental health and addiction services under
section 5119.36 of the Revised Code.

(4) The drug is prescribed for a use that is indicated on
the drug's labeling, as approved by the federal food and drug
administration.

(C) Subject to division (E) of this section, the
department shall authorize a health insuring corporation to
develop and implement a pharmacy utilization management program
under which prior authorization through the program is
established as a condition of obtaining a controlled substance
pursuant to a prescription.

(D) The department shall require a health insuring corporation to comply with section 5164.7511 of the Revised Code with respect to medication synchronization.

(E) The department shall require a health insuring corporation to comply with sections 5164.091, 5164.092, and 5164.7512 of the Revised Code as if the health insuring corporation were the department.

Section 2. That existing sections 109.90, 1739.05, 1751.01, 3715.89, 4729.54, 4729.69, 4729.99, 5119.49, and 5167.12 of the Revised Code are hereby repealed.

Section 3. All items in this section are hereby appropriated as designated out of any moneys in the state treasury to the credit of the designated fund. For all appropriations made in this act, those in the first column are for fiscal year 2018 and those in the second column are for fiscal year 2019. The appropriations made in this act are in addition to any other appropriations made for the FY 2018-FY 2019 biennium.

EDU DEPARTMENT OF EDUCATION

General Revenue Fund

GRF 200597 Education Program Support $2,000,000 $2,000,000

TOTAL GRF General Revenue Fund $2,000,000 $2,000,000

TOTAL ALL BUDGET FUND GROUPS $2,000,000 $2,000,000

EDUCATION PROGRAM SUPPORT

The foregoing appropriation item 200597, Education Program Support, shall be used to provide grants in accordance with
MHA DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

General Revenue Fund

GRF 336421 Continuum of Care Services $100,000,000 $0

TOTAL GRF General Revenue Fund $100,000,000 $0

TOTAL ALL BUDGET FUND GROUPS $100,000,000 $0

CONTINUUM OF CARE SERVICES

(A) Of the foregoing appropriation item 336421, Continuum of Care Services, $10,000,000 in fiscal year 2018 shall be allocated by the Department of Mental Health and Addiction Services to boards of alcohol, drug addiction, and mental health services to assist in data collection. Each board shall use these funds to provide the following data to the Department of Mental Health and Addiction Services within ninety days of the effective date of this section:

(1) A list and description of programs and services available within the board's jurisdiction to address opioid addiction;

(2) The number of individuals each board is serving by program or service;

(3) The number of individuals each board is capable of serving by program or service; and

(4) An estimate of the number of individuals addicted to opioids within the board's jurisdiction.

(B) Of the foregoing appropriation item 336421, Continuum of Care Services, $90,000,000 in fiscal year 2018 shall be distributed to programs that provide treatment for opioid
addiction. Any programs that receive funds shall use the funds
to increase the number of facilities providing opioid addiction
treatment or to increase the number of beds within such a
facility. Programs that receive funds shall provide services to
individuals regardless of an individual's county of residence.
The Department of Mental Health and Addiction Services shall
give priority to programs that:

   (1) Are currently in operation and scalable statewide; and

   (2) Provide transportation for individuals receiving
treatment services.

  RDF STATE REVENUE DISTRIBUTIONS

Revenue Distribution Fund Group

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LOCAL GOVERNMENT FUND SUPPLEMENT

(A) Of the foregoing appropriation item 110969, Local
Government Fund, up to $100,000,000 in fiscal year 2018 shall be
allocated to counties in fiscal year 2018. On the effective date
of this section, or as soon as possible thereafter, the Tax
Commissioner shall determine amounts to be distributed to each
county based on the county's calendar year 2015 undivided local
government fund distributions as a percentage of the total
calendar year 2015 undivided local government fund distributions
made to all counties. The Tax Commissioner shall distribute the
amounts to each county treasurer for deposit into the county
undivided local government fund and shall separately identify to
each county treasurer the amount to be allocated to the county
As Introduced

under this section.

(B) Moneys received by each county under this section shall be expended only for the following purposes: ADAMHS Boards; law enforcement purposes; Child Protective Services; Kinship Care; purposes of first responders; or establishing or expanding Drug Courts. Within six months after the effective date of this act, each county shall prepare a written report to the Department of Mental Health and Addiction Services regarding its expenditures related to moneys received under this section.

Section 4. Within the limits set forth in this act, the Director of Budget and Management shall establish accounts indicating the source and amount of funds for each appropriation made in this act, and shall determine the form and manner in which appropriation accounts shall be maintained. Expenditures from appropriations contained in this act shall be accounted for as though made in the main operating appropriations act of the 132nd General Assembly.

The appropriations made in this act are subject to all provisions of the main operating appropriations act of the 132nd General Assembly that are generally applicable to such appropriations.

Section 5. Notwithstanding any provision of law to the contrary, on the effective date of this section, or as soon as possible thereafter, the Director of Budget and Management shall transfer $100,000,000 cash from the Budget Stabilization Fund (Fund 7013) to the General Revenue Fund and $100,000,000 cash from Fund 7013 to the Local Government Fund (Fund 7069).

Section 6. Sections 1739.05, 1751.692, and 1751.76 of the Revised Code, as amended or enacted by this act, apply only to
arrangements, policies, contracts, and agreements that are created, delivered, issued for delivery, or renewed in this state on or after January 1, 2019. Sections 3923.046 and 3923.852 of the Revised Code, as enacted by this act, apply only to policies of sickness and accident insurance delivered, issued for delivery, or renewed in this state on or after January 1, 2019, and only to public employee benefit plans that are established or modified in this state on or after January 1, 2019. Sections 5164.092, 5164.7512, and 5167.12 of the Revised Code, as amended or enacted by this act, apply to the Medicaid program and health insuring corporations under contract with the Department of Medicaid on or after January 1, 2019.

Section 7. Not later than July 1, 2018, the Superintendent of Insurance shall conduct an actuarial survey to determine the estimated cost for the reinsurance program to be established and administered under section 3901.80 of the Revised Code. The Superintendent may fulfill the requirements of this section by contracting with an actuary to conduct the survey.

Section 8. This act is hereby declared to be an emergency measure necessary for the immediate preservation of the public peace, health, or safety. The reason for such necessity is the increasing prevalence of opioid abuse, as evidenced by the rising rate of unintentional opioid overdose deaths, and the growing need to both prevent and treat opioid addiction. Therefore, this act shall go into immediate effect.