

AN ACT

To amend sections 1751.02 to 1751.04, 1751.12, 1751.13, 3901.04, 3901.041, 3901.16, 3924.10, 4121.121, 4123.01, 4123.25, 4123.35, and 4123.512 and to enact sections 1751.521, 1751.73 to 1751.75, 1751.77 to 1751.86, 1753.01, 1753.03 to 1753.10, 1753.14, 1753.16, 1753.21, 1753.23, 1753.24, 1753.28, and 1753.30 of the Revised Code to adopt the Physician-Health Plan Partnership Act, to authorize the Administrator of Workers' Compensation to transfer surplus computers and computer equipment directly to an accredited public school within Ohio, to specify circumstances under which a board of county commissioners may be granted status as a self-insuring employer for purposes of the Workers' Compensation Law, and to declare an emergency.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 1751.02, 1751.03, 1751.04, 1751.12, 1751.13, 3901.04, 3901.041, 3901.16, 3924.10, 4121.121, 4123.01, 4123.25, 4123.35, and 4123.512 be amended and sections 1751.521, 1751.73, 1751.74, 1751.75, 1751.77, 1751.78, 1751.79, 1751.80, 1751.81, 1751.82, 1751.83, 1751.84, 1751.85, 1751.86, 1753.01, 1753.03, 1753.04, 1753.05, 1753.06, 1753.07, 1753.08, 1753.09, 1753.10, 1753.14, 1753.16, 1753.21, 1753.23, 1753.24, 1753.28, and 1753.30 of the Revised Code be enacted to read as follows:

Sec. 1751.02. (A) Notwithstanding any law in this state to the contrary, any corporation, as defined in section 1751.01 of the Revised Code, may apply to the superintendent of insurance for a certificate of authority to establish and operate a health insuring corporation. If the corporation applying for a certificate of authority is a foreign corporation domiciled in a state without laws similar to those of this chapter, the corporation must form

a domestic corporation to apply for, obtain, and maintain a certificate of authority under this chapter.

(B) No person shall establish, operate, or perform the services of a health insuring corporation in this state without obtaining a certificate of authority under this chapter.

(C) Except as provided by division (D) of this section, no political subdivision or department, office, or institution of this state, or corporation formed by or on behalf of any political subdivision or department, office, or institution of this state, shall establish, operate, or perform the services of a health insuring corporation. Nothing in this section shall be construed to preclude a board of county commissioners, a county board of mental retardation and 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, or a public entity formed by or on behalf of any of these boards, from using managed care techniques in carrying out the board's or public entity's duties pursuant to the requirements of Chapters 307., 329., 340., and 5126. of the Revised Code. However, no such board or public entity may operate so as to compete in the private sector with health insuring corporations holding certificates of authority under this chapter.

(D) A corporation formed by or on behalf of a publicly owned, operated, or funded hospital or health care facility may apply to the superintendent for a certificate of authority under division (A) of this section to establish and operate a health insuring corporation.

(E) A health insuring corporation shall operate in this state in compliance with this chapter and Chapter 1753. Of the Revised Code, and with sections 3702.51 to 3702.62 of the Revised Code, and shall operate in conformity with its filings with the superintendent under this chapter, including filings made pursuant to sections 1751.03, 1751.11, 1751.12, and 1751.31 of the Revised Code.

(F) An insurer licensed under Title XXXIX of the Revised Code need not obtain a certificate of authority as a health insuring corporation to offer an open panel plan as long as the providers and health care facilities participating in the open panel plan receive their compensation directly from the insurer. If the providers and health care facilities participating in the open panel plan receive their compensation from any person other than the insurer, or if the insurer offers a closed panel plan, the insurer must obtain a certificate of authority as a health insuring corporation.

(G) An intermediary organization need not obtain a certificate of authority as a health insuring corporation, regardless of the method of

bursement to the intermediary organization, as long as a health insuring corporation or a self-insured employer maintains the ultimate responsibility to assure delivery of all health care services required by the contract between the health insuring corporation and the subscriber and the laws of this state or between the self-insured employer and its employees.

Nothing in this section shall be construed to require any health care facility, provider, health delivery network, or intermediary organization that contracts with a health insuring corporation or self-insured employer, regardless of the method of reimbursement to the health care facility, provider, health delivery network, or intermediary organization, to obtain a certificate of authority as a health insuring corporation under this chapter, unless otherwise provided, in the case of contracts with a self-insured employer, by operation of the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 1001, as amended.

(H) Any health delivery network doing business in this state that is not required to obtain a certificate of authority under this chapter shall certify to the superintendent annually, not later than the first day of July, and shall provide a statement signed by the highest ranking official which includes the following information:

(1) The health delivery network's full name and the address of its principal place of business;

(2) A statement that the health delivery network is not required to obtain a certificate of authority under this chapter to conduct its business.

(I) The superintendent shall not issue a certificate of authority to a health insuring corporation that is a provider sponsored organization unless all health care plans to be offered by the health insuring corporation provide basic health care services. Substantially all of the physicians and hospitals with ownership or control of the provider sponsored organization, as defined in division (W) of section 1751.01 of the Revised Code, shall also be participating providers for the provision of basic health care services for health care plans offered by the provider sponsored organization. If a health insuring corporation that is a provider sponsored organization offers health care plans that do not provide basic health care services, the health insuring corporation shall be deemed, for purposes of section 1751.35 of the Revised Code, to have failed to substantially comply with this chapter.

Except as specifically provided in this division and in division (C) of section 1751.28 of the Revised Code, the provisions of this chapter shall apply to all health insuring corporations that are provider sponsored organizations in the same manner that these provisions apply to all health insuring corporations that are not provider sponsored organizations.

(J) Nothing in this section shall be construed to apply to any multiple employer welfare arrangement operating pursuant to Chapter 1739. of the Revised Code.

(K) Any person who violates division (B) of this section, and any health delivery network that fails to comply with division (H) of this section, is subject to the penalties set forth in section 1751.45 of the Revised Code.

Sec. 1751.03. (A) Each application for a certificate of authority under this chapter shall be verified by an officer or authorized representative of the applicant, shall be in a format prescribed by the superintendent of insurance, and shall set forth or be accompanied by the following:

(1) A certified copy of the applicant's articles of incorporation and all amendments to the articles of incorporation;

(2) A copy of any regulations adopted for the government of the corporation, any bylaws, and any similar documents, and a copy of all amendments to these regulations, bylaws, and documents. The corporate secretary shall certify that these regulations, bylaws, documents, and amendments have been properly adopted or approved.

(3) A list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant, including all members of the board, the principal officers, and the person responsible for completing or filing financial statements with the department of insurance, accompanied by a completed original biographical affidavit and release of information for each of these persons on forms acceptable to the department;

(4) A full and complete disclosure of the extent and nature of any contractual or other financial arrangement between the applicant and any provider or a person listed in division (A)(3) of this section, including, but not limited to, a full and complete disclosure of the financial interest held by any such provider or person in any health care facility, provider, or insurer that has entered into a financial relationship with the health insuring corporation;

(5) A description of the applicant, its facilities, and its personnel, including, but not limited to, the location, hours of operation, and telephone numbers of all contracted facilities;

(6) The applicant's projected annual enrollee population over a three-year period;

(7) A clear and specific description of the health care plan or plans to be used by the applicant, including a description of the proposed providers, procedures for accessing care, and the form of all proposed and existing contracts relating to the administration, delivery, or financing of health care services;

(8) A copy of each type of evidence of coverage and identification card or similar document to be issued to subscribers;

(9) A copy of each type of individual or group policy, contract, or agreement to be used;

(10) The schedule of the proposed contractual periodic prepayments or premium rates, or both, accompanied by appropriate supporting data;

(11) A financial plan which provides a three-year projection of operating results, including the projected expenses, income, and sources of working capital;

(12) The enrollee complaint procedure to be utilized as required under section 1751.19 of the Revised Code;

(13) A description of the procedures and programs to be implemented on an ongoing basis to assure the quality of health care services delivered to enrollees, including, if applicable, a description of a quality assurance program complying with the requirements of sections 1751.73 to 1751.75 Of the Revised Code;

(14) A statement describing the geographic area or areas to be served, by county;

(15) A copy of all solicitation documents;

(16) A balance sheet and other financial statements showing the applicant's assets, liabilities, income, and other sources of financial support;

(17) A description of the nature and extent of any reinsurance program to be implemented, and a demonstration that errors and omission insurance and, if appropriate, fidelity insurance, will be in place upon the applicant's receipt of a certificate of authority;

(18) Copies of all proposed or in force related-party or intercompany agreements with an explanation of the financial impact of these agreements on the applicant. If the applicant intends to enter into a contract for managerial or administrative services, with either an affiliated or an unaffiliated person, the applicant shall provide a copy of the contract and a detailed description of the person to provide these services. The description shall include that person's experience in managing or administering health care plans, a copy of that person's most recent audited financial statement, and a completed biographical affidavit on a form acceptable to the superintendent for each of that person's principal officers and board members and for any additional employee to be directly involved in providing managerial or administrative services to the health insuring corporation. If the person to provide managerial or administrative services is affiliated with the health insuring corporation, the contract must provide for payment for services based on actual costs.

(19) A statement from the applicant's board that the admitted assets of the applicant have not been and will not be pledged or hypothecated;

(20) A statement from the applicant's board that the applicant will submit monthly financial statements during the first year of operations;

(21) The name and address of the applicant's Ohio statutory agent for service of process, notice, or demand;

(22) Copies of all documents the applicant filed with the secretary of state;

(23) The location of those books and records of the applicant that must be maintained in Ohio;

(24) The applicant's federal identification number, corporate address, and mailing address;

(25) An internal and external organizational chart;

(26) A list of the assets representing the initial net worth of the applicant;

(27) If the applicant has a parent company, the parent company's guaranty, on a form acceptable to the superintendent, that the applicant will maintain Ohio's minimum net worth. If no parent company exists, a statement regarding the availability of future funds if needed.

(28) The names and addresses of the applicant's actuary and external auditors;

(29) If the applicant is a foreign corporation, a copy of the most recent financial statements filed with the insurance regulatory agency in the applicant's state of domicile;

(30) If the applicant is a foreign corporation, a statement from the insurance regulatory agency of the applicant's state of domicile stating that the regulatory agency has no objection to the applicant applying for an Ohio license and that the applicant is in good standing in the applicant's state of domicile;

(31) Any other information that the superintendent may require.

(B)(1) A health insuring corporation, unless otherwise provided for in this chapter, shall file a timely notice with the superintendent describing any change to the corporation's articles of incorporation or regulations, or any major modification to its operations as set out in the information required by division (A) of this section that affects any of the following:

(a) The solvency of the health insuring corporation;

(b) The health insuring corporation's continued provision of services that it has contracted to provide;

(c) The manner in which the health insuring corporation conducts its business.

(2) If the change or modification is to be the result of an action to be taken by the health insuring corporation, the notice shall be filed with the superintendent prior to the health insuring corporation taking the action. The action shall be deemed approved if the superintendent does not disapprove it within sixty days of filing.

(C)(1) No health insuring corporation shall expand its approved service area until a copy of the request for expansion, accompanied by documentation of the network of providers, enrollment projections, plan of operation, and any other changes have been filed with the superintendent.

(2) Within ten calendar days after receipt of a complete filing under division (C)(1) of this section, the superintendent shall refer the appropriate jurisdictional issues to the director of health pursuant to section 1751.04 of the Revised Code.

(3) Within seventy-five days after the superintendent's receipt of a complete filing under division (C)(1) of this section, the superintendent shall determine whether the plan for expansion is lawful, fair, and reasonable. The superintendent may not make a determination until the superintendent has received the director's certification of compliance, which the director shall furnish within forty-five days after referral under division (C)(2) of this section. The director shall not certify that the requirements of section 1751.04 of the Revised Code are not met, unless the applicant has been given an opportunity for a hearing as provided in division (D) of section 1751.04 of the Revised Code. The forty-five-day and seventy-five-day review periods provided for in division (C)(3) of this section shall cease to run as of the date on which the notice of the applicant's right to request a hearing is mailed and shall remain suspended until the director issues a final certification.

(4) If the superintendent has not approved or disapproved all or a portion of a service area expansion within the seventy-five-day period provided for in division (C)(3) of this section, the filing shall be deemed approved.

(5) Disapproval of all or a portion of the filing shall be effected by written notice, which shall state the grounds for the order of disapproval and shall be given in accordance with Chapter 119. of the Revised Code.

Sec. 1751.04. (A) Upon the receipt by the superintendent of insurance of a complete application for a certificate of authority to establish or operate a health insuring corporation, which application sets forth or is accompanied by the information and documents required by division (A) of section 1751.03 of the Revised Code, the superintendent shall transmit copies of the application and accompanying documents to the director of health.

(B) The director shall review the application and accompanying documents and make findings as to whether the applicant for a certificate of authority has done all of the following with respect to any basic health care services and supplemental health care services to be furnished:

(1) Demonstrated the willingness and potential ability to ensure that all basic health care services and supplemental health care services described in the evidence of coverage will be provided to all its enrollees as promptly as is appropriate and in a manner that assures continuity;

(2) Made effective arrangements to ensure that its enrollees have reliable access to qualified providers in those specialties that are generally available in the geographic area or areas to be served by the applicant and that are necessary to provide all basic health care services and supplemental health care services described in the evidence of coverage;

(3) Made appropriate arrangements for the availability of short-term health care services in emergencies within the geographic area or areas to be served by the applicant, twenty-four hours per day, seven days per week, and for the provision of adequate coverage whenever an out-of-area emergency arises;

(4) Made appropriate arrangements for an ongoing evaluation and assurance of the quality of health care services provided to enrollees, including, if applicable, the development of a quality assurance program complying with the requirements of sections 1751.73 to 1751.75 Of the Revised Code, and the adequacy of the personnel, facilities, and equipment by or through which the services are rendered;

(5) Developed a procedure to gather and report statistics relating to the cost and effectiveness of its operations, the pattern of utilization of its services, and the quality, availability, and accessibility of its services.

(C) Within ninety days of the director's receipt of the application for issuance of a certificate of authority, the director shall certify to the superintendent whether or not the applicant meets the requirements of division (B) of this section and sections 3702.51 to 3702.62 of the Revised Code. If the director certifies that the applicant does not meet these requirements, the director shall specify in what respects it is deficient. However, the director shall not certify that the requirements of this section are not met unless the applicant has been given an opportunity for a hearing.

(D) If the applicant requests a hearing, the director shall hold a hearing before certifying that the applicant does not meet the requirements of this section. The hearing shall be held in accordance with Chapter 119. of the Revised Code.

(E) The ninety-day review period provided for under division (C) of this

section shall cease to run as of the date on which the notice of the applicant's right to request a hearing is mailed and shall remain suspended until the director issues a final certification order.

Sec. 1751.12. (A)(1) No contractual periodic prepayment and no premium rate for nongroup and conversion policies for health care services, or any amendment to them, may be used by any health insuring corporation at any time until the contractual periodic prepayment and premium rate, or amendment, have been filed with the superintendent of insurance, and shall not be effective until the expiration of sixty days after their filing unless the superintendent sooner gives approval. The superintendent shall disapprove the filing, if the superintendent determines within the sixty-day period that the contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. The superintendent shall notify the health insuring corporation of the disapproval, and it shall thereafter be unlawful for the health insuring corporation to use the contractual periodic prepayment or premium rate, or amendment.

(2) No contractual periodic prepayment for group policies for health care services shall be used until the contractual periodic prepayment has been filed with the superintendent. The superintendent may reject a filing made under division (A)(2) of this section at any time, with at least thirty days' written notice to a health insuring corporation, if the contractual periodic prepayment is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees.

(3) At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw the approval given under division (A)(1) of this section, deemed or actual, of any contractual periodic prepayment or premium rate, or amendment, based on information that either of the following applies:

(a) The contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles.

(b) The contractual periodic prepayment or premium rate, or amendment, is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees.

(4) Any disapproval under division (A)(1) of this section, any rejection of a filing made under division (A)(2) of this section, or any withdrawal of approval under division (A)(3) of this section, shall be effected by a written notice, which shall state the specific basis for the disapproval, rejection, or

withdrawal and shall be issued in accordance with Chapter 119. of the Revised Code.

(B) Notwithstanding division (A) of this section, a health insuring corporation may use a contractual periodic prepayment or premium rate for policies used for the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare risk contract or medicare cost contract, or for policies used for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or for policies used for the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the Ohio department of human services under Chapter 5111. of the Revised Code, or for policies used for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, if both of the following apply:

(1) The contractual periodic prepayment or premium rate has been approved by the United States department of health and human services, the United States office of personnel management, or the Ohio department of human services.

(2) The contractual periodic prepayment or premium rate is filed with the superintendent prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, or the Ohio department of human services.

(C) The administrative expense portion of all contractual periodic prepayment or premium rate filings submitted to the superintendent for review must reflect the actual cost of administering the product. The superintendent may require that the administrative expense portion of the filings be itemized and supported.

(D)(1) Copayments and deductibles must be reasonable and must not be a barrier to the necessary utilization of services by enrollees.

(2) A health insuring corporation may not impose copayment charges on basic health care services that exceed thirty per cent of the total cost of providing any single covered health care service, except for physician office visits, emergency health services, and urgent care services. The total cost of providing a health care service is the cost to the health insuring corporation of providing the health care service to ~~the enrollee~~ its enrollees as reduced by any applicable provider discount. An open panel plan may not impose copayments on out-of-network benefits that exceed fifty per cent of the total

cost of providing any single covered health care service.

(3) To ensure that copayments are not a barrier to the utilization of basic health care services, a health insuring corporation may not impose, in any contract year, on any subscriber or enrollee, copayments that exceed two hundred per cent of the total annual premium rate to the subscriber or enrollees. This limitation of two hundred per cent does not include any reasonable copayments that are not a barrier to the necessary utilization of health care services by enrollees and that are imposed on physician office visits, emergency health services, urgent care services, supplemental health care services, or specialty health care services.

(E) A health insuring corporation shall not impose lifetime maximums on basic health care services. However, a health insuring corporation may establish a benefit limit for inpatient hospital services that are provided pursuant to a policy, contract, certificate, or agreement for supplemental health care services.

Sec. 1751.13. (A)(1)(a) A health insuring corporation shall, either directly or indirectly, enter into contracts for the provision of health care services with a sufficient number and types of providers and health care facilities to ensure that all covered health care services will be accessible to enrollees from a contracted provider or health care facility.

(b) A health insuring corporation shall not refuse to contract with a physician for the provision of health care services or refuse to recognize a physician as a specialist on the basis that the physician attended an educational program or a residency program approved or certified by the American Osteopathic Association. A health insuring corporation shall not refuse to contract with a health care facility for the provision of health care services on the basis that the health care facility is certified or accredited by the American Osteopathic Association or that the health care facility is an osteopathic hospital as defined in section 3702.51 of the Revised Code.

(c) Nothing in division (A)(1)(b) of this section shall be construed to require a health insuring corporation to make a benefit payment under a closed panel plan to a physician or health care facility with which the health insuring corporation does not have a contract, provided that none of the bases set forth in that division are used as a reason for failing to make a benefit payment.

(2) When a health insuring corporation is unable to provide a covered health care service from a contracted provider or health care facility, the health insuring corporation must provide that health care service from a noncontracted provider or health care facility consistent with the terms of the enrollee's policy, contract, certificate, or agreement. The health insuring

corporation shall either ensure that the health care service be provided at no greater cost to the enrollee than if the enrollee had obtained the health care service from a contracted provider or health care facility, or make other arrangements acceptable to the superintendent of insurance.

(3) Nothing in this section shall prohibit a health insuring corporation from entering into contracts with out-of-state providers or health care facilities that are licensed, certified, accredited, or otherwise authorized in that state.

(B)(1) A health insuring corporation shall, either directly or indirectly, enter into contracts with all providers and health care facilities through which health care services are provided to its enrollees.

(2) A health insuring corporation, upon written request, shall assist its contracted providers in finding stop-loss or reinsurance carriers.

(C) A health insuring corporation shall file an annual certificate with the superintendent certifying that all provider contracts and contracts with health care facilities through which health care services are being provided contain the following:

(1) A description of the method by which the provider or health care facility will be notified of the specific health care services for which the provider or health care facility will be responsible, including any limitations or conditions on such services;

(2) The specific hold harmless provision specifying protection of enrollees set forth as follows:

"[Provider/Health Care Facility] agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall [Provider/Health Care Facility] bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the covered enrollee, for health care services provided pursuant to this agreement. This does not prohibit [Provider/Health Care Facility] from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor."

(3) Provisions requiring the provider or health care facility to continue to provide covered health care services to enrollees in the event of the health insuring corporation's insolvency or discontinuance of operations. The provisions shall require the provider or health care facility to continue to

provide covered health care services to enrollees as needed to complete any medically necessary procedures commenced but unfinished at the time of the health insuring corporation's insolvency or discontinuance of operations. If an enrollee is receiving necessary inpatient care at a hospital, the provisions may limit the required provision of covered health care services relating to that inpatient care in accordance with division (D)(3) of section 1751.11 of the Revised Code, and may also limit such required provision of covered health care services to the period ending thirty days after the health insuring corporation's insolvency or discontinuance of operations.

The provisions required by division (C)(3) of this section shall not require any provider or health care facility to continue to provide any covered health care service after the occurrence of any of the following:

(a) The end of the thirty-day period following the entry of a liquidation order under Chapter 3903. of the Revised Code;

(b) The end of the enrollee's period of coverage for a contractual prepayment or premium;

(c) The enrollee obtains equivalent coverage with another health insuring corporation or insurer, or the enrollee's employer obtains such coverage for the enrollee;

(d) The enrollee or the enrollee's employer terminates coverage under the contract;

(e) A liquidator effects a transfer of the health insuring corporation's obligations under the contract under division (A)(8) of section 3903.21 of the Revised Code.

(4) A provision clearly stating the rights and responsibilities of the health insuring corporation, and of the contracted providers and health care facilities, with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs;

(5) A provision regarding the availability and confidentiality of those health records maintained by providers and health care facilities to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to enrollees. The provision shall include terms requiring the provider or health care facility to make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of enrollees, and requiring the provider or health care facility to comply with applicable state and federal laws related to the confidentiality

of medical or health records.

(6) A provision that states that contractual rights and responsibilities may not be assigned or delegated by the provider or health care facility without the prior written consent of the health insuring corporation;

(7) A provision requiring the provider or health care facility to maintain adequate professional liability and malpractice insurance. The provision shall also require the provider or health care facility to notify the health insuring corporation not more than ten days after the provider's or health care facility's receipt of notice of any reduction or cancellation of such coverage.

(8) A provision requiring the provider or health care facility to observe, protect, and promote the rights of enrollees as patients;

(9) A provision requiring the provider or health care facility to provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the provider or health care facility appropriately does not render services due to limitations arising from the provider's or health care facility's lack of training, experience, or skill, or due to licensing restrictions.

(10) A provision containing the specifics of any obligation on the provider or health care facility to provide, or to arrange for the provision of, covered health care services twenty-four hours per day, seven days per week;

(11) A provision setting forth procedures for the resolution of disputes arising out of the contract;

(12) A provision stating that the hold harmless provision required by division (C)(2) of this section shall survive the termination of the contract with respect to services covered and provided under the contract during the time the contract was in effect, regardless of the reason for the termination, including the insolvency of the health insuring corporation;

(13) A provision requiring those terms that are used in the contract and that are defined by this chapter, be used in the contract in a manner consistent with those definitions.

(D)(1) No health insuring corporation contract with a provider or health care facility shall ~~do either~~ contain any of the following:

~~(1) Offer~~ (a) A provision that directly or indirectly offers an inducement to the provider or health care facility, ~~directly or indirectly~~, to reduce or limit medically necessary health care services to a covered enrollee;

~~(2) Penalize~~ (b) A provision that penalizes a provider or health care facility that assists an enrollee to seek a reconsideration of the health insuring corporation's decision to deny or limit benefits to the enrollee;

(c) A provision that limits or otherwise restricts the provider's or health care facility's ethical and legal responsibility to fully advise enrollees about their medical condition and about medically appropriate treatment options;

(d) A provision that penalizes a provider or health care facility for principally advocating for medically necessary health care services;

(e) A PROVISION THAT PENALIZES A PROVIDER OR HEALTH CARE FACILITY FOR PROVIDING INFORMATION OR TESTIMONY TO A LEGISLATIVE OR REGULATORY BODY OR AGENCY. THIS SHALL NOT BE CONSTRUED TO PROHIBIT A HEALTH INSURING CORPORATION FROM PENALIZING A PROVIDER OR HEALTH CARE FACILITY THAT PROVIDES INFORMATION OR TESTIMONY THAT IS LIBELOUS OR SLANDEROUS OR THAT DISCLOSES TRADE SECRETS WHICH THE PROVIDER OR HEALTH CARE FACILITY HAS NO PRIVILEGE OR PERMISSION TO DISCLOSE.

(2) Nothing in this division shall be construed to prohibit a health insuring corporation from doing either of the following:

(a) Making a determination not to reimburse or pay for a particular medical treatment or other health care service;

(b) Enforcing reasonable peer review or utilization review protocols, or determining whether a particular provider or health care facility has complied with these protocols.

(E) Any contract between a health insuring corporation and an intermediary organization shall clearly specify that the health insuring corporation must approve or disapprove the participation of any provider or health care facility with which the intermediary organization contracts.

(F) If an intermediary organization that is not a health delivery network contracting solely with self-insured employers subcontracts with a provider or health care facility, the subcontract with the provider or health care facility shall do all of the following:

(1) Contain the provisions required by divisions (C) and (G) of this section, as made applicable to an intermediary organization, without the inclusion of inducements or penalties described in division (D) of this section;

(2) Acknowledge that the health insuring corporation is a third-party beneficiary to the agreement;

(3) Acknowledge the health insuring corporation's role in approving the participation of the provider or health care facility, pursuant to division (E)

of this section.

(G) Any provider contract or contract with a health care facility shall clearly specify the health insuring corporation's statutory responsibility to monitor and oversee the offering of covered health care services to its enrollees.

(H)(1) A health insuring corporation shall maintain its provider contracts and its contracts with health care facilities at one or more of its places of business in this state, and shall provide copies of these contracts to facilitate regulatory review upon written notice by the superintendent of insurance.

(2) Any contract with an intermediary organization shall include provisions requiring the intermediary organization to provide the superintendent with regulatory access to all books, records, financial information, and documents related to the provision of health care services to subscribers and enrollees under the contract. The contract shall require the intermediary organization to maintain such books, records, financial information, and documents at its principal place of business in this state and to preserve them for at least three years in a manner that facilitates regulatory review.

(I) A health insuring corporation shall provide notice of the termination of any contract with a primary care physician or hospital.

(J) Divisions (A) and (B) of this section do not apply to any health insuring corporation that, on ~~the effective date of this section~~ June 4, 1997, holds a certificate of authority or license to operate under Chapter 1740. of the Revised Code.

(K) Nothing in this section shall restrict the governing body of a hospital from exercising the authority granted it pursuant to section 3701.351 Of the Revised Code.

Sec. 1751.521. If an enrollee signs a medical information release upon the request of a health insuring corporation, the release shall clearly explain what information may be disclosed under the terms of the release. If a health insuring corporation utilizes this release to request medical information from a health care facility or provider, the health insuring corporation shall provide a copy of the enrollee's release to the health care facility or provider, upon request.

Sec. 1751.73. Each health insuring corporation PROVIDING BASIC HEALTH CARE SERVICES SHALL IMPLEMENT A QUALITY ASSURANCE PROGRAM FOR USE IN CONNECTION WITH THOSE POLICIES, CONTRACTS, AND AGREEMENTS PROVIDING BASIC HEALTH CARE SERVICES. EACH HEALTH INSURING

PORATION REQUIRED TO IMPLEMENT A QUALITY ASSURANCE PROGRAM shall annually file a certificate with the superintendent of insurance certifying that its quality assurance program does all of the following:

(A) Identifies a corporate board or committee or designates an executive staff person responsible for program implementation and compliance;

(B) Includes a process enabling the selection and retention of quality providers and health care facilities through credentialing, recredentialing, and monitoring procedures;

(C) Provides for ongoing monitoring of the quality assurance program;

(D) Assures a process for compliance by any entity or entities with which the health insuring corporation contracts for services;

(E) Includes a process to take remedial action to correct quality problems.

Sec. 1751.74. (A) To implement a quality assurance program required by section 1715.73 Of the Revised Code, a health insuring corporation shall do both of the following:

(1) Develop and maintain the appropriate infrastructure and disclosure systems necessary to measure and report, on a regular basis, the quality of health care services provided to enrollees, based on a systematic collection, analysis, and reporting of relevant data. The health insuring corporation shall assure that a committee that includes participating physicians have the opportunity to participate in developing, implementing, and evaluating the quality assurance program and all other programs implemented by the health insuring corporation that relate to the utilization of health care services. A committee that includes participating physicians shall also have the opportunity to participate in the derivation of data assessments, statistical analyses, and outcome interpretations from programs monitoring the utilization of health care services.

(2) Develop and maintain an organizational program for designing, measuring, assessing, and improving the processes and outcomes of health care.

(B) A quality assurance program shall:

(1) Establish an internal system capable of identifying opportunities to improve health care, which system is structured to identify practices that result in improved health care outcomes, to identify problematic utilization patterns, and to identify those providers that may be responsible for either exemplary or problematic patterns. The quality assurance program shall use the findings generated by the system to work on a continuing basis with participating providers and other staff to improve the quality of health care

services provided to enrollees.

(2) Develop a written statement of its objectives, lines of authority and accountability, evaluation tools, and performance improvement activities;

(3) Require an annual effectiveness review of the program;

(4) Provide a description of how the health insuring corporation intends to do all of the following:

(a) Analyze both processes and outcomes of health care, including focused review of individual cases as appropriate, to discern the causes of variation;

(b) Identify the targeted diagnoses and treatments to be reviewed by the quality assurance program each year, based on consideration of practices and diagnoses that affect a substantial number of the health insuring corporation's enrollees or that could place enrollees at serious risk;

(c) Use a range of appropriate methods to analyze quality of health care, including collection and analysis of information on over-utilization and under-utilization of health care services; evaluation of courses of treatment and outcomes based on current medical research, knowledge, standards, and practice guidelines; and collection and analysis of information specific to enrollees or providers;

(d) Compare quality assurance program findings with past performance, internal goals, and external standards;

(e) Measure the performance of participating providers and conduct peer review activities;

(f) Utilize treatment protocols and practice parameters developed with appropriate clinical input;

(g) Implement improvement strategies related to quality assurance program findings;

(h) Evaluate periodically, but not less than annually, the effectiveness of the improvement strategies.

Sec. 1751.75. A health insuring corporation may present evidence of compliance with the requirements of sections 1751.73 and 1751.74 Of the Revised Code by submitting certification to the superintendent of insurance of its accreditation by an independent, private accrediting organization, such as the national committee on quality assurance, the national quality health council, the joint commission on accreditation of health care organizations, or the American accreditation healthcare commission/utilization review accreditation commission. The superintendent, upon review of the organization's accreditation process, may determine that such accreditation constitutes compliance by the health insuring corporation with the requirements of these sections.

Sec. 1751.77. As used in sections 1751.77 to 1751.86 Of the Revised Code, unless otherwise specifically provided:

(A) "Adverse determination" means a determination by a health insuring corporation or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service covered under a policy, contract, or agreement of the health insuring corporation has been reviewed and, based upon the information provided, the health care service does not meet the health insuring corporation's requirements for benefit payment, and is therefore denied, reduced, or terminated.

(B) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(C) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other specified health conditions.

(D) "Certification" means a determination by a health insuring corporation or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service covered under a policy, contract, or agreement of the health insuring corporation has been reviewed and, based upon the information provided, the health care service satisfies the health insuring corporation's requirements for benefit payment.

(E) "Clinical peer" means a physician when an evaluation is to be made of the clinical appropriateness of health care services provided by a physician. If an evaluation is to be made of the clinical appropriateness of health care services provided by a provider who is not a physician, "clinical peer" means either a physician or a provider holding the same license as the provider who provided the health care services.

(F) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health insuring corporation to determine the necessity and appropriateness of health care services.

(G) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(H) "Discharge planning" means the formal process for determining, prior to a patient's discharge from a health care facility, the coordination and management of the care that the patient is to receive following discharge from a health care facility.

(I) "Participating provider" means a provider or health care facility that, under a contract with a health insuring corporation or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an

expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health insuring corporation.

(J) "Physician" means a provider authorized under chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(K) "Prospective review" means utilization review that is conducted prior to an admission or a course of treatment.

(L) "Retrospective review" means utilization review of medical necessity that is conducted after health care services have been provided to a patient. "Retrospective review" does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

(M) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for proposed health care services to assess the clinical necessity and appropriateness of the proposed health care services.

(N) "Utilization review" means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

(O) "Utilization review organization" means an entity that conducts utilization review, other than a health insuring corporation performing a review of its own health care plans.

Sec. 1751.78. (A)(1) Sections 1751.77 to 1751.86 of the Revised Code apply to any health insuring corporation that provides or performs utilization review services in connection with its policies, contracts, and agreements providing basic health care services and to any designee of the health insuring corporation, or to any utilization review organization that performs utilization review functions on behalf of the health insuring corporation in connection with policies, contracts, or agreements of the health insuring corporation providing basic health care services.

(2) NOTHING IN SECTIONS 1751.77 TO 1751.82 OR SECTION 1751.85 OF THE REVISED CODE SHALL BE CONSTRUED TO REQUIRE A HEALTH INSURING CORPORATION TO PROVIDE OR PERFORM UTILIZATION REVIEW SERVICES IN CONNECTION WITH HEALTH CARE SERVICES PROVIDED UNDER A POLICY, PLAN, OR AGREEMENT OF SUPPLEMENTAL HEALTH CARE SERVICES OR SPECIALTY HEALTH CARE SERVICES.

(B)(1) Each health insuring corporation shall be responsible for monitoring all utilization review activities carried out by, or on behalf of, the health insuring corporation and for ensuring that all requirements of sections 1751.77 to 1751.86 of the Revised Code, and any rules adopted thereunder, are met. The health insuring corporation shall also ensure that appropriate personnel have operational responsibility for the conduct of the health insuring corporation's utilization review program.

(2) If a health insuring corporation contracts to have a utilization review organization or other entity perform the utilization review functions required by sections 1751.77 to 1751.86 of the Revised Code, and any rules adopted thereunder, the superintendent of insurance shall hold the health insuring corporation responsible for monitoring the activities of the utilization review organization or other entity and for ensuring that the requirements of those sections and rules are met.

Sec. 1751.79. A health insuring corporation that conducts utilization review shall prepare a written utilization review program that describes all review activities, both delegated and nondelegated, for covered health care services provided, including the following:

(A) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;

(B) The use of data sources and clinical review criteria in making decisions;

(C) Mechanisms to ensure consistent application of criteria and compatible decisions;

(D) Data collection processes and analytical methods used in assessing utilization of health care services;

(E) Mechanisms for assuring confidentiality of clinical and proprietary information;

(F) The periodic assessment of utilization review activities, and the reporting of these assessments to the health insuring corporation's board, by a utilization review committee, a quality assurance committee, or any similar committee;

(G) The functional responsibility for day-to-day program management by staff;

(H) Defined methods by which guidelines are approved and communicated to providers and health care facilities.

Sec. 1751.80. The utilization review program of a health insuring corporation shall be implemented in accordance with all of the following:

(A) The program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure

ngoing efficacy. A health insuring corporation may develop its own clinical review criteria or may purchase or license such criteria from qualified vendors. A health insuring corporation shall make its clinical review rationale available upon request to authorized government agencies. The rationale made available to authorized government agencies is confidential and is not a public record as defined in section 149.43 of the Revised Code.

(B) Qualified providers shall administer the program and oversee review determinations. A clinical peer in the same, or in a similar, specialty as typically manages the medical condition, procedure, or treatment under review shall evaluate the clinical appropriateness of adverse determinations that are the subject of an appeal.

(C) The health insuring corporation shall issue utilization review determinations in a timely manner pursuant to the requirements of sections 1751.81 and 1751.82 of the Revised Code and the enrollee grievance requirements. The health insuring corporation shall obtain information required to make a utilization review determination, including pertinent clinical information, and shall establish a process to ensure that utilization reviewers apply clinical review criteria consistently.

(D) If the health insuring corporation delegates any utilization review activities to a utilization review organization, the health insuring corporation shall maintain adequate oversight, including a process by which the health insuring corporation evaluates the performance of the organization, and shall maintain copies of both of the following:

(1) A written description of the organization's activities and responsibilities, including reporting requirements;

(2) Evidence of formal approval of the organization's program by the health insuring corporation.

(E) The health insuring corporation or its designee utilization review organization shall provide enrollees and participating providers with access to its review staff by means of a toll-free telephone number or collect-call telephone line.

(F) When conducting prospective or concurrent review, the health insuring corporation or its designee utilization review organization shall collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency, and duration of health care services.

(G) Compensation to persons providing utilization review services for the health insuring corporation shall not contain incentives, direct or indirect, for them to make inappropriate review decisions.

Sec. 1751.81. (A) As used in this section:

(1) "Enrollee" includes the representative of an enrollee.

(2) "Necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(B) A health insuring corporation shall maintain written procedures for making utilization review determinations and for notifying enrollees, and participating providers and health care facilities acting on behalf of enrollees, of its determinations.

(C) For initial determinations, a health insuring corporation shall make the determination within two business days after obtaining all necessary information regarding a proposed admission, procedure, or health care service requiring a review determination.

(1) In the case of a determination to certify an admission, procedure, or health care service, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone within three business days after making the initial certification, and shall provide written or electronic confirmation of the telephone notification to the enrollee and the provider or health care facility within two business days after making the telephone notification.

(2) In the case of an adverse determination, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone within three business days after making the adverse determination, and shall provide written or electronic confirmation of the telephone notification to the enrollee and the provider or health care facility within one business day after making the telephone notification.

(D) For concurrent review determinations, a health insuring corporation shall make the determination within one business day after obtaining all necessary information.

(1) In the case of a determination to certify an extended stay or additional health care services, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone within one business day after making the certification, and shall provide written or electronic confirmation to the enrollee and the provider or health care facility within one business day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days of health care services approved, and the date of admission or initiation of health care services.

(2) In the case of an adverse determination, the health insuring corporation shall notify the provider or health care facility rendering the health care service by telephone within one business day after making the adverse determination, and shall provide written or electronic confirmation to the enrollee and the provider or health care facility within one business

day after the telephone notification. The health care service to the enrollee shall be continued, with standard copayments and deductibles, if applicable, until the enrollee has been notified of the determination.

(E) For retrospective review determinations, a health insuring corporation shall make the determination within thirty business days after receiving all necessary information.

(1) In the case of a certification, the health insuring corporation may notify the enrollee and the provider or health care facility rendering the health care service in writing.

(2) In the case of an adverse determination, the health insuring corporation shall notify the enrollee and the provider or health care facility rendering the health care service, in writing, within five business days after making the adverse determination.

(E) The time frames set forth in divisions (C), (D), and (E) of this section for determinations and notifications shall prevail unless the seriousness of the medical condition of the enrollee otherwise requires a more timely response from the health insuring corporation. The health insuring corporation shall maintain written procedures for making expedited utilization review determinations and notifications of enrollees and providers or health care facilities when warranted by the medical condition of the enrollee.

(G) A written notification of an adverse determination shall include the principal reason or reasons for the determination, instructions for initiating an appeal or reconsideration of the determination, and instructions for requesting a written statement of the clinical rationale used to make the determination. A health insuring corporation shall provide the clinical rationale for an adverse determination in writing to any party who received notice of the adverse determination and who follows the instructions for a request.

(H) A health insuring corporation shall have written procedures to address the failure or inability of a health care facility, provider, or enrollee to provide all necessary information for review. If the health care facility, provider, or enrollee will not release necessary information, the health insuring corporation may deny certification.

Sec. 1751.82. (A) In a case involving an initial determination or a concurrent review determination, a health insuring corporation shall give the provider or health care facility rendering the health care service an opportunity to request in writing on behalf of the enrollee a reconsideration of an adverse determination by the reviewer making the adverse determination. The reconsideration shall occur within three business days

after the health insuring corporation's receipt of the written request for reconsideration, and shall be conducted between the provider or health care facility rendering the health care service and the reviewer who made the adverse determination. If that reviewer cannot be available within three business days, the reviewer may designate another reviewer.

(B) If the reconsideration process described in division (A) of this section does not resolve the difference of opinion, the adverse determination may be appealed by the enrollee or the provider or health care facility on behalf of the enrollee.

(C) Reconsideration is not a prerequisite to a standard or expedited appeal of an adverse determination.

(D) The time period allowed by division (A) of this section for a reconsideration of an adverse determination shall not apply if the seriousness of the medical condition of the enrollee requires a more expedited reconsideration. The health insuring corporation shall maintain written procedures for making such an expedited reconsideration.

Sec. 1751.83. A health insuring corporation may present evidence of compliance with the requirements of sections 1751.77 to 1751.82 Of the Revised Code by submitting evidence to the Superintendent of insurance of its accreditation by an independent, private accrediting organization, such as the national committee on quality assurance, the national quality health council, the joint commission on accreditation of health care organizations, or the American accreditation healthcare commission/utilization review accreditation commission. The superintendent, upon review of the organization's accreditation process, may determine that such accreditation constitutes compliance by the health insuring corporation with the requirements of these sections.

Sec. 1751.84. Each participating provider or health care facility submitting a claim shall cooperate with the utilization review program of a health insuring corporation or utilization review organization and shall provide the health insuring corporation or its designee access to an enrollee's medical records during regular business hours, or copies of those records at a reasonable cost.

Sec. 1751.85. A health insuring corporation shall annually file a certificate with the superintendent of insurance certifying its compliance with sections 1751.77 to 1751.82 of the Revised Code.

Sec. 1751.86. (A) No health insuring corporation shall fail to comply with sections 1751.77 to 1751.82 of the Revised Code.

(B) Whoever violates division (A) of this section is deemed to have engaged in an unfair and deceptive act or practice in the business of

insurance under sections 3901.19 to 3901.26 of the Revised Code.

Sec. 1753.01. As used in this chapter:

(A) "Economic profiling" means a health insuring corporation's use of economic performance data and economic information in determining whether to contract with a provider for the provision of covered health care services to enrollees as a participating provider.

(B) "Basic health care services," "enrollee," "Health care Facility," "health care services," "health insuring corporation," "medical record," "provider," and "supplemental health care services" have the same meanings as in section 1751.01 of the Revised Code.

Sec. 1753.03. The superintendent of insurance shall prescribe a standard credentialing form to be used by all health insuring corporations when credentialing providers in connection with policies, contracts, and agreements providing basic health care services. The Director of Health may make recommendations to the superintendent for such a standard credentialing form. If the director makes such recommendations, the Director shall take into consideration the standard credentialing forms developed by the National Association of Insurance Commissioners, the American Medical Association, the American Association of Health Plans, and any other national organization that has developed such a form. in prescribing a standard credentialing form, the Superintendent shall consider any recommendations made by the Director. The superintendent may amend or revise the prescribed standard credentialing form as necessary.

Sec. 1753.04. Beginning one hundred twenty days after the superintendent of insurance prescribes a standard credentialing form under section 1753.03 of the Revised Code, no health insuring corporation shall fail to use the prescribed standard credentialing form when initially credentialing or recredentialing providers in connection with policies, contracts, and agreements providing basic health care services. If the superintendent amends or revises the standard credentialing form, a health insuring corporation shall use the amended or revised form to credential or recredential providers.

A health insuring corporation may request such information from a provider, in addition to that information to be provided on the standard credentialing form, as necessitated by the health insuring corporation's credentialing standards.

Sec. 1753.05. (A) A Health insuring corporation may use economic profiling as a factor in credentialing a provider, however, such economic profiling shall take into consideration the case mix, severity of illness, and age of patients.

(B) For an initial applicant, a health insuring corporation may request information necessary to perform an economic profile. If information on case mix, severity of illness, and age of patients is requested by a health insuring corporation and not produced by the applicant, the health insuring corporation is not required to take these factors into consideration in its economic profile of the provider.

(C) Nothing in this section prohibits a health insuring corporation from taking into consideration the quality and appropriateness of care provided by a provider when deciding whether to employ, contract with, or terminate the provider.

Sec. 1753.06. A health insuring corporation shall notify a provider seeking to enter into a participation contract with the health insuring corporation of the status of the provider's application within one hundred twenty days after the health insuring corporation's receipt of the provider's completed application. That time period may be extended by a health insuring corporation if, due to extenuating circumstances, the health insuring corporation needs additional time to consider the application and notifies the provider of the reason for the delay.

Sec. 1753.07. (A) Prior to entering into a participation contract with a provider under section 1751.13 of the Revised Code, a health insuring corporation shall disclose basic information regarding its programs and procedures to the provider, upon the provider's request. The information shall include all of the following:

(1) How a participating provider is reimbursed for the participating provider's services, including the range and structure of any financial risk sharing arrangements, a description of any incentive plans, and, if reimbursed according to a type of fee-for-service arrangement, the level of reimbursement for the participating provider's services;

(2) How referrals to other participating providers or to nonparticipating providers are made;

(3) The availability of dispute resolution procedures and the potential for cost to be incurred;

(4) How a participating provider's name and address will be used in marketing materials.

(B) A health insuring corporation shall provide all of the following to a participating provider:

(1) Any material incorporated by reference into the participation contract, that is not otherwise available as a public record, if such material affects the participating provider;

(2) Administrative manuals related to provider participation, if any;

(3) A signed and dated copy of the final participation contract.

Sec. 1753.08. (A) A health insuring corporation shall notify a participating provider prior to the effective date of an amendment to the participating provider's contract with the health insuring corporation, and prior to the effective date of an amendment to any document incorporated by reference into the contract if the amendment of the document directly and materially affects the participating provider. Such amendments shall not be effective with regard to a participating provider until the participating provider has had reasonable time, as defined in the contract, to exercise the participating provider's right to terminate its participation status in accordance with the terms and conditions of the contract.

(B) Division (A) of this section does not apply if the delay caused by compliance with that division could result in imminent harm to an enrollee or if the amendment is required by state or federal law, rule, or regulation.

Sec. 1753.09. (A) Except as provided in division (D) of this section, prior to terminating the participation of a provider on the basis of the participating provider's failure to meet the health insuring corporation's standards for quality or utilization in the delivery of health care services, a health insuring corporation shall give the participating provider notice of the reason or reasons for its decision to terminate the provider's participation and an opportunity to take corrective action. The health insuring corporation shall develop a performance improvement plan in conjunction with the participating provider. If after being afforded the opportunity to comply with the performance improvement plan, the participating provider fails to do so, the health insuring corporation may terminate the participation of the provider.

(B)(1) A participating provider whose participation has been terminated under division (A) of this section may appeal the termination to the appropriate medical director of the health insuring corporation. The medical director shall give the participating provider an opportunity to discuss with the medical director the reason or reasons for the termination.

(2) If a satisfactory resolution of a participating provider's appeal cannot be reached under division (B)(1) of this section, the participating provider may appeal the termination to a panel composed of participating providers who have comparable or higher levels of education and training than the participating provider making the appeal. A representative of the participating provider's specialty shall be a member of the panel, if possible. This panel shall hold a hearing, and shall render its recommendation in the appeal within thirty days after holding the hearing. The recommendation shall be presented to the medical director and to the participating provider.

(3) The medical director shall review and consider the panel's recommendation before making a decision. The decision rendered by the medical director shall be final.

(C) A provider's status as a participating provider shall remain in effect during the appeal process set forth in division (B) of this section unless the termination was based on any of the reasons listed in division (D) of this section.

(D) Notwithstanding division (A) of this section, a provider's participation may be immediately terminated if the participating provider's conduct presents an imminent risk of harm to an enrollee or enrollees; or if there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, or loss of authority to practice in the participating provider's field; or if a governmental action has impaired the participating provider's ability to practice.

(E) Divisions (A) to (D) of this section apply only to providers who are natural persons.

(F)(1) Nothing in this section prohibits a health insuring corporation from rejecting a provider's application for participation, or from terminating a participating provider's contract, if the health insuring corporation determines that the health care needs of its enrollees are being met and no need exists for the provider's or participating provider's services.

(2) Nothing in this section shall be construed as prohibiting a health insuring corporation from terminating a participating provider who does not meet the terms and conditions of the participating provider's contract.

(G) The superintendent of insurance may adopt rules as necessary to implement and enforce sections 1753.04 to 1753.09 of the Revised Code. Such rules shall be adopted in accordance with Chapter 119. of the Revised Code. The director of health may make recommendations to the superintendent for rules necessary to implement and enforce sections 1753.04 to 1753.09 of the Revised Code. In adopting any rules pursuant to this division, the Superintendent shall consider the recommendations of the Director.

Sec. 1753.10. Nothing in this chapter or Chapter 1751. of the Revised Code requires a health insuring corporation to employ or contract with, or prohibits a health insuring corporation from employing or contracting with, any category of provider for the provision of basic or supplemental health care services, which health care services are within the recognized scope of practice of that category of provider.

Sec. 1753.14. (A) A health insuring corporation that does not allow

ct access to all specialists shall establish and implement a procedure by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if a primary care provider determines in consultation with a specialist that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health insuring corporation in consultation with the primary care provider, a specialist, and the enrollee. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care provider with regular reports on the health care provided to the enrollee.

(B) A health insuring corporation shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist who has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care. The procedure shall provide for such a referral if a primary care provider determines in consultation with the specialist that the enrollee needs the specialist's expertise. The referral shall be made pursuant to a treatment plan approved by the health insuring corporation in consultation with the primary care provider, the specialist, and the enrollee. After the referral is made, the specialist is authorized to provide health care services to the enrollee in the same manner as the enrollee's primary care provider, subject to the terms of the treatment plan.

(C) The determinations described in divisions (A) and (B) of this section shall be made within three business days after a request for the determination is made by the enrollee or the enrollee's primary care provider and all appropriate medical records and other items of information necessary to make the determination have been provided.

(D) Once a determination in favor of a referral is made, the referral shall be made within four business days after the determination. This time period does not apply to standing referrals involving a rare or unusual condition for which appropriate specialists are limited in number or otherwise difficult to identify.

Divisions (A) and (B) of this section do not require a health insuring corporation to permit an enrollee to elect referral to a specialist who is not employed by or under contract with the health insuring corporation for the provision of health care services to the health insuring corporation's enrollees.

Sec. 1753.16. A health insuring corporation or utilization review organization that authorizes a proposed admission, treatment, or health care service by a participating provider based upon the complete and accurate submission of all necessary information relative to an eligible enrollee shall not retroactively deny this authorization if the provider renders the health care service in good faith and pursuant to the authorization and all of the terms and conditions of the provider's contract with the health insuring corporation.

Sec. 1753.21. (A) If a policy, contract, or agreement of a health insuring corporation uses a restricted formulary of prescription drugs, the health insuring corporation shall do both of the following:

(1) Develop such a formulary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of the members of which are physicians affiliated with the health insuring corporation who may prescribe prescription drugs and pharmacists affiliated with the health insuring corporation; or in consultation with and with the approval of a pharmacy and therapeutics committee that is independent of the health insuring corporation consisting of physicians who may prescribe prescription drugs in their state of licensure and pharmacists who are authorized to practice in their state of licensure;

(2) Establish a procedure by which an enrollee may obtain, without penalty or additional cost sharing beyond that provided for formulary drugs under the enrollee's contract with the health insuring corporation, coverage of a specific nonformulary drug when the prescriber documents in the enrollee's medical record and certifies that the formulary alternative has been ineffective in the treatment of the enrollee's disease or condition, or that the formulary alternative causes or is reasonably expected by the prescriber to cause a harmful or adverse reaction in the enrollee.

(B) Nothing in this section shall be construed to require a health insuring corporation to place any particular pharmaceutical product or therapeutic class of product on any formulary, or to prohibit a health insuring corporation from restricting payments for any specific pharmaceutical product or therapeutic class of product, including, but not limited to, a requirement that the product be prescribed only by a defined specialist or subspecialist.

Sec. 1753.23. A health insuring corporation that provides basic health care services shall establish or use an internal technology assessment process for assessing whether a drug, device, protocol, procedure, or other therapy is proven to be safe and efficacious for a particular indication or condition when compared to alternative therapies, or whether it remains

experimental or investigational. The health insuring corporation's internal technology assessment process shall meet all of the following criteria:

(A) Decisions are made by medical professionals, including physicians.

(B) The process includes a review of relevant medical evidence, including the following, if available:

(1) Peer-reviewed medical and scientific literature on the subject;

(2) published opinions, actions, and other relevant documents of independent, external research organizations such as the national institute of health, the national cancer institute, the United States food and drug administration, the health care finance administration, and the agency for health care policy and research;

(3) published opinions of medical experts or affected specialty societies.

(C) general coverage decisions, made pursuant to this process, that exclude drugs, devices, protocols, procedures, or other therapies on the basis that they are not safe or efficacious and remain experimental or investigational, are reviewed and updated as new scientific evidence becomes available.

(D) a description of the health insuring corporation's internal technology assessment process is made available to participating providers and enrollees, upon request.

(E) A copy of the health insuring corporation's specific coverage protocols and procedures is made available to participating providers and enrollees upon the request of an enrollee who has been denied coverage for a drug, device, protocol, procedure, or other therapy on the basis that it has been assessed as not being safe or efficacious for a particular indication or condition. Specific coverage protocols and procedures shall include a description of the evidence upon which the protocol or procedure is based, and shall contain the date the protocol or procedure was adopted.

(F) A drug or device that has received full market approval by the United States food and drug administration for treatment of a particular indication or condition cannot, for purposes of this assessment process, be considered experimental or investigational for that indication or condition.

Sec. 1753.24. (A) Each health insuring corporation shall establish a reasonable external, independent review process to examine the health insuring corporation's coverage decisions for enrollees who meet all of the following criteria:

(1) The enrollee has a terminal condition that, according to the current diagnosis of the enrollee's physician, has a high probability of causing death within two years.

(2) The enrollee's physician certifies that the enrollee has the condition

described in division (A)(1) of this section and any of the following situations are applicable:

(a) Standard therapies have not been effective in improving the condition of the enrollee;

(b) Standard therapies are not medically appropriate for the enrollee;

(c) There is no standard therapy covered by the health insuring corporation that is more beneficial than therapy described in division (A)(3) of this section.

(3) The enrollee's physician has recommended a drug, device, procedure, or other therapy that the physician certifies, in writing, is likely to be more beneficial to the enrollee, in the physician's opinion, than standard therapies, or, the enrollee has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.

(4) The enrollee has been denied coverage by the health insuring corporation for a drug, device, procedure, or other therapy recommended or requested pursuant to division (A)(3) of this section, and has exhausted all internal appeals.

(5) The drug, device, procedure, or other therapy, recommended or requested pursuant to division (A)(3) of this section, would be a covered health care service except for the health insuring corporation's determination that the drug, device, procedure, or other therapy is experimental or investigational.

(B) The external, independent review process established by a health insuring corporation shall meet all of the following criteria:

(1) Except as provided in division (C) of this section, the process shall offer all enrollees who meet the criteria set forth in division (A) of this section the opportunity to have the health insuring corporation's decision to deny coverage of the recommended or requested therapy reviewed under the process. Each eligible enrollee shall be notified of that opportunity within five business days after the health insuring corporation denies coverage.

(2) The review of the health insuring corporation's decision shall be conducted by experts selected by an independent entity that has been retained by the health insuring corporation for this purpose. The independent entity shall be either an academic medical center or an entity that has as its primary function, and that receives a majority of its revenue from, the provision of expert reviews and related services.

The independent entity shall select a panel to conduct the review, which panel shall be composed of at least three physicians or other providers who are experts in the treatment of the enrollee's medical condition and

knowledgeable about the recommended or requested therapy. If the independent entity retained by the health insuring corporation is an academic medical center, the panel may include experts affiliated with or employed by the academic medical center.

In either of the following circumstances, An exception may be made to the requirement that the review be conducted by an expert panel composed of a minimum of three physicians or other providers:

(a) A review may be conducted by an expert panel composed of only two physicians or other providers if an enrollee has consented in writing to a review by the smaller panel;

(b) A review may be conducted by a single expert physician or other provider if only one expert physician or other provider is available for the review.

(3) Neither the health insuring corporation nor the enrollee shall choose, or control the choice of, the physician or other provider experts.

(4) Neither the experts nor the independent entity arranging for the experts' review shall have any professional, familial, or financial affiliation with the health insuring corporation, except that experts affiliated with academic medical centers who provide healthcare services to enrollees of the health insuring corporation may serve as experts on the review panel. This nonaffiliation provision does not preclude a health insuring corporation from paying for the experts' review, as specified in division (B)(5) of this section. The experts shall have no patient-physician relationship or other affiliation with an enrollee whose request for therapy is under review or with a provider whose recommendation for therapy is under review.

(5) Enrollees shall not be required to pay for the external, independent review. The costs of the review shall be borne by the health insuring corporation.

(6) The health insuring corporation shall provide to the independent entity arranging for the experts' review and to the enrollee and the enrollee's physician a copy of those medical records in the health insuring corporation's possession that are relevant to the enrollee's condition for which therapy has been recommended or requested. The medical records shall be disclosed solely to the expert reviewers and shall be used solely for the purpose of this section.

(7) The opinions of the experts on the panel shall be rendered within thirty days after the enrollee's request for review. If the enrollee's physician determines that a therapy would be significantly less effective if not promptly initiated, the opinions shall be rendered within seven days after the enrollee's request for review.

(8) Each expert on the panel shall provide the independent entity with a professional opinion as to whether there is sufficient evidence to demonstrate that the recommended or requested therapy is likely to be more beneficial to the enrollee than standard therapies.

(9) Each expert's opinion shall be presented in written form and shall include the following information:

(a) A description of the enrollee's condition;

(b) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested therapy is more likely than not to be more beneficial to the enrollee than standard therapies;

(c) A description and analysis of any relevant findings published in peer-reviewed medical or scientific literature or the published opinions of medical experts or specialty societies;

(d) A description of the enrollee's suitability to receive the recommended or requested therapy according to a treatment protocol in a clinical trial, if applicable.

(10) The independent entity shall provide the health insuring corporation with the opinions of the experts. The health insuring corporation shall make the experts' opinions available to the enrollee and the enrollee's physician, upon request.

(11) The decision of the majority of the experts on the panel, rendered pursuant to division (B)(8) of this section, is binding on the health insuring corporation with respect to that enrollee. If the opinions of the experts on the panel are evenly divided as to whether the therapy should be covered, then the health insuring corporation's final decision shall be in favor of coverage. If less than a majority of the experts on the panel recommend coverage of the therapy, the health insuring corporation may, in its discretion, cover the therapy. However, any coverage provided pursuant to division (B)(11) of this section is subject to the terms and conditions of the enrollee's contract with the health insuring corporation.

(12) The health insuring corporation shall have written policies describing the external, independent review process. The health insuring corporation shall disclose the availability of the external, independent review process in the health insuring corporation's evidence of coverage and disclosure forms.

(C) IF A HEALTH INSURING CORPORATION'S INITIAL DENIAL OF COVERAGE FOR A THERAPY RECOMMENDED OR REQUESTED PURSUANT TO DIVISION (A)(3) OF THIS SECTION IS BASED UPON AN EXTERNAL, INDEPENDENT REVIEW OF THAT

THERAPY MEETING THE REQUIREMENTS OF DIVISION (B) OF THIS SECTION, THIS SECTION SHALL NOT BE A BASIS FOR REQUIRING A SECOND EXTERNAL, INDEPENDENT REVIEW OF THE RECOMMENDED OR REQUESTED THERAPY.

(D) The health insuring corporation shall annually file a certificate with the Superintendent of Insurance certifying its compliance with the requirements of this section.

Sec. 1753.28. (A) As used in this section:

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

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

(b) Serious impairment to bodily functions;

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

(2) "Emergency services" means the following:

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

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

(3)(a) "Stabilize" means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

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

(ii) Serious impairment to bodily functions;

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

(b) In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

(4) "Transfer" has the same meaning as in section 1867 of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1395dd, as amended.

(B) A health insuring corporation policy, contract, or agreement

providing coverage of basic health care services shall cover emergency services for enrollees with emergency medical conditions without regard to the day or time the emergency services are rendered or to whether the enrollee, the hospital's emergency department where the services are rendered, or an emergency physician treating the enrollee, obtained prior authorization for the emergency services.

(C) A health insuring corporation policy, contract, or agreement providing coverage of basic health care services shall cover both of the following:

(1) Emergency services provided to an enrollee at a participating hospital's emergency department if the enrollee presents self with an emergency medical condition;

(2) Emergency services provided to an enrollee at a nonparticipating hospital's emergency department if the enrollee presents self with an emergency medical condition and one of the following circumstances applies:

(a) Due to circumstances beyond the enrollee's control, the enrollee was unable to utilize a participating hospital's emergency department without serious threat to life or health.

(b) A prudent layperson with an average knowledge of health and medicine would have reasonably believed that, under the circumstances, the time required to travel to a participating hospital's emergency department could result in one or more of the adverse health consequences described in division (A)(1) of this section.

(c) A person authorized by the health insuring corporation refers the enrollee to an emergency department and does not specify a participating hospital's emergency department.

(d) An ambulance takes the enrollee to a nonparticipating hospital other than at the direction of the enrollee.

(e) The enrollee is unconscious.

(f) A natural disaster precluded the use of a participating emergency department.

(g) The status of a hospital changed from participating to nonparticipating with respect to emergency services during a contract year and no good faith effort was made by the health insuring corporation to inform enrollees of this change.

(D) A health insuring corporation that provides coverage for emergency services shall inform enrollees of all of the following:

(1) The scope of coverage for emergency services;

(2) The appropriate use of emergency services, including the use of the

9-1-1 system and any other telephone access systems utilized to access prehospital emergency services;

(3) Any cost sharing provisions for emergency services;

(4) The procedures for obtaining emergency services and other medical services, so that enrollees are familiar with the location of the emergency departments of participating hospitals and with the location and availability of other participating facilities or settings at which they could receive medical services.

Sec. 1753.30. Nothing in this chapter shall prevent or otherwise affect the application to any health care plan of those provisions of Title XVII or XXXIX of the Revised Code that would otherwise apply.

Sec. 3901.04. (A) As used in this section:

(1) "Laws of this state relating to insurance" include but are not limited to Chapter 1751. notwithstanding section 1751.08, Chapter 1753., Title XXXIX, sections 5725.18 to 5725.25, and Chapter 5729. of the Revised Code.

(2) "Person" has the meaning defined in division (A) of section 3901.19 of the Revised Code.

(B) Whenever it appears to the superintendent of insurance, from the superintendent's files, upon complaint or otherwise, that any person has engaged in, is engaged in, or is about to engage in any act or practice declared to be illegal or prohibited by the laws of this state relating to insurance, or defined as unfair or deceptive by such laws, or when the superintendent believes it to be in the best interest of the public and necessary for the protection of the people in this state, the superintendent or anyone designated by the superintendent under the superintendent's official seal may do any one or more of the following:

(1) Require any person to file with the superintendent, on a form that is appropriate for review by the superintendent, an original or additional statement or report in writing, under oath or otherwise, as to any facts or circumstances concerning the person's conduct of the business of insurance within this state and as to any other information that the superintendent considers to be material or relevant to such business;

(2) Administer oaths, summon and compel by order or subpoena the attendance of witnesses to testify in relation to any matter which, by the laws of this state relating to insurance, is the subject of inquiry and investigation, and require the production of any book, paper, or document pertaining to such matter. A subpoena, notice, or order under this section may be served by certified mail, return receipt requested. If the subpoena, notice, or order is returned because of inability to deliver, or if no return is

received within thirty days of the date of mailing, the subpoena, notice, or order may be served by ordinary mail. If no return of ordinary mail is received within thirty days after the date of mailing, service shall be deemed to have been made. If the subpoena, notice, or order is returned because of inability to deliver, the superintendent may designate a person or persons to effect either personal or residence service upon the witness. Service of any subpoena, notice, or order and return may also be made in any manner authorized under the Rules of Civil Procedure. Such service shall be made by an employee of the department designated by the superintendent, a sheriff, a deputy sheriff, an attorney, or any person authorized by the Rules of Civil Procedure to serve process.

In the case of disobedience of any notice, order, or subpoena served on a person or the refusal of a witness to testify to a matter regarding which the person may lawfully be interrogated, the court of common pleas of the county where venue is appropriate, on application by the superintendent, may compel obedience by attachment proceedings for contempt, as in the case of disobedience of the requirements of a subpoena issued from such court, or a refusal to testify therein. Witnesses shall receive the fees and mileage allowed by section 2335.06 of the Revised Code. All such fees, upon the presentation of proper vouchers approved by the superintendent, shall be paid out of the appropriation for the contingent fund of the department of insurance. The fees and mileage of witnesses not summoned by the superintendent or the superintendent's designee shall not be paid by the state.

(3) In a case in which there is no administrative procedure available to the superintendent to resolve a matter at issue, request the attorney general to commence an action for a declaratory judgment under Chapter 2721. of the Revised Code with respect to the matter.

(4) Initiate criminal proceedings by presenting evidence of the commission of any criminal offense established under the laws of this state relating to insurance to the prosecuting attorney of any county in which the offense may be prosecuted. At the request of the prosecuting attorney, the attorney general may assist in the prosecution of the violation with all the rights, privileges, and powers conferred by law on prosecuting attorneys including, but not limited to, the power to appear before grand juries and to interrogate witnesses before grand juries.

Sec. 3901.041. The superintendent of insurance shall adopt, amend, and rescind rules and make adjudications, necessary to discharge the superintendent's duties and exercise the superintendent's powers, including, but not limited to, the superintendent's duties and powers under Chapter

hapters 1751. and 1753. and Title XXXIX of the Revised Code, subject to Chapter 119. of the Revised Code.

Sec. 3901.16. Any association, company, or corporation, including a health insuring corporation, which violates any law relating to the superintendent of insurance, any provision of Chapter 1751. or 1753. of the Revised Code, or any insurance law of this state, for the violation of which no forfeiture or penalty is elsewhere provided in the Revised Code, shall forfeit and pay not less than one thousand nor more than ten thousand dollars, to be recovered by an action in the name of the state and on collection to be paid to the superintendent, who shall pay such sum into the state treasury.

Sec. 3924.10. (A) The board of directors of the Ohio health reinsurance program shall design the SEHC plan which, when offered by a carrier, is eligible for reinsurance under the program. The board shall establish the form and level of coverage to be made available by carriers in their SEHC plan. In designing the plan the board shall also establish benefit levels, deductibles, coinsurance factors, exclusions, and limitations for the plan. The forms and levels of coverage established by the board shall specify which components of a health benefit plan offered by a carrier may be reinsured. The SEHC plan is subject to division (C) of section 3924.02 of the Revised Code and to the provisions in Chapters 1751., 1753., 3923., and any other chapter of the Revised Code that require coverage or the offer of coverage of a health care service or benefit.

(B) The board shall adopt the SEHC plan within one hundred eighty days after its appointment. The plan may include cost containment features including any of the following:

(1) Utilization review of health care services, including review of the medical necessity of hospital and physician services;

(2) Case management benefit alternatives;

(3) Selective contracting with hospitals, physicians, and other health care providers;

(4) Reasonable benefit differentials applicable to participating and nonparticipating providers;

(5) Employee assistance program options that provide preventive and early intervention mental health and substance abuse services;

(6) Other provisions for the cost-effective management of the plan.

(C) An SEHC plan established for use by health insuring corporations shall be consistent with the basic method of operation of such corporations.

(D) Each carrier shall certify to the superintendent of insurance, in the form and manner prescribed by the superintendent, that the SEHC plan filed

by the carrier is in substantial compliance with the provisions of the board SEHC plan. Upon receipt by the superintendent of the certification, the carrier may use the certified plan.

(E) Each carrier shall, on and after sixty days after the date that the program becomes operational and as a condition of transacting business in this state, renew coverage provided to any individual or group under its SEHC plan.

Sec. 4121.121. (A) There is hereby created the bureau of workers' compensation, which shall be administered by the administrator of workers' compensation. A person appointed to the position of administrator shall possess significant management experience in effectively managing an organization or organizations of substantial size and complexity. The governor shall appoint the administrator as provided in section 121.03 of the Revised Code, and the administrator shall serve at the pleasure of the governor. The governor shall fix the administrator's salary on the basis of the administrator's experience and the administrator's responsibilities and duties under this chapter and Chapter 4123., 4127., and 4131. of the Revised Code. The governor shall not appoint to the position of ~~administrator~~ administrator any person who has, or whose spouse has, given a contribution to the campaign committee of the governor in an amount greater than one thousand dollars during the two-year period immediately preceding the date of the appointment of the administrator. After August 31, 2000, the workers' compensation oversight commission shall appoint the administrator as provided in division (F)(9) of section 4121.12 of the Revised Code, and the administrator shall serve at the pleasure of the oversight commission. The oversight commission shall fix the administrator's salary on the basis of the administrator's experience and the administrator's responsibilities and duties under this chapter and Chapters 4123., 4127., and 4131. of the Revised Code.

The administrator shall hold no other public office and shall devote full time to the duties of administrator. Before entering upon the duties of the office, the administrator shall take an oath of office as required by sections 3.22 and 3.23 of the Revised Code, and shall file in the office of the secretary of state, a bond signed by the administrator and by surety approved by the governor, for the sum of fifty thousand dollars payable to the state, conditioned upon the faithful performance of the administrator's duties.

(B) The administrator is responsible for the management of the bureau of workers' compensation and for the discharge of all administrative duties imposed upon the administrator in this chapter and Chapters 4123., 4127., and 4131. of the Revised Code, and in the discharge thereof shall do all of

the following:

(1) Establish the overall administrative policy of the bureau for the purposes of this chapter and Chapters 4123., 4127., and 4131. of the Revised Code, and perform all acts and exercise all authorities and powers, discretionary and otherwise that are required of or vested in the bureau or any of its employees in this chapter and Chapters 4123., 4127., and 4131. of the Revised Code, except the acts and the exercise of authority and power that is required of and vested in the oversight commission or the industrial commission pursuant to those chapters. The treasurer of state shall honor all warrants signed by the administrator, or by one or more of the administrator's employees, authorized by the administrator in writing, or bearing the facsimile signature of the administrator or such employee under sections 4123.42 and 4123.44 of the Revised Code.

(2) Employ, direct, and supervise all employees required in connection with the performance of the duties assigned to the bureau by this chapter and Chapters 4123., 4127., and 4131. of the Revised Code, and may establish job classification plans and compensation for all employees of the bureau provided that this grant of authority shall not be construed as affecting any employee for whom the state employment relations board has established an appropriate bargaining unit under section 4117.06 of the Revised Code. All positions of employment in the bureau are in the classified civil service except those employees the administrator may appoint to serve at the administrator's pleasure in the unclassified civil service pursuant to section 124.11 of the Revised Code. The administrator shall fix the salaries of employees the administrator appoints to serve at the administrator's pleasure, including the chief operating officer, staff physicians, and other senior management personnel of the bureau and shall establish the compensation of staff attorneys of the bureau's legal section and their immediate supervisors, and take whatever steps are necessary to provide adequate compensation for other staff attorneys.

The administrator may appoint a person holding a certified position in the classified service to any state position in the unclassified service of the bureau of workers' compensation. A person so appointed shall retain the right to resume the position and status held by the person in the classified service immediately prior to the person's appointment in the unclassified service. If the position the person previously held has been filled or placed in the unclassified service, or is otherwise unavailable, the person shall be appointed to a position in the classified service within the bureau that the department of administrative services certifies is comparable in compensation to the position the person previously held. Reinstatement to a

position in the classified service shall be to a position substantially equal to that held previously, as certified by the department of administrative services. Service in the position in the unclassified service shall be counted as service in the position in the classified service held by the person immediately prior to the person's appointment in the unclassified service. when a person is reinstated to a position in the classified service as provided in this section, the person is entitled to all rights, status, and benefits accruing to the position during the person's time of service in the position in the unclassified service.

(3) Reorganize the work of the bureau, its sections, departments, and offices to the extent necessary to achieve the most efficient performance of its functions and to that end may establish, change, or abolish positions and assign and reassign duties and responsibilities of every employee of the bureau. All persons employed by the commission in positions that, after November 3, 1989, are supervised and directed by the administrator under this section are transferred to the bureau in their respective classifications but subject to reassignment and reclassification of position and compensation as the administrator determines to be in the interest of efficient administration. The civil service status of any person employed by the commission is not affected by this section. Personnel employed by the bureau or the commission who are subject to Chapter 4117. of the Revised Code shall retain all of their rights and benefits conferred pursuant to that chapter as it presently exists or is hereafter amended and nothing in this chapter or Chapter 4123. of the Revised Code shall be construed as eliminating or interfering with Chapter 4117. of the Revised Code or the rights and benefits conferred under that chapter to public employees or to any bargaining unit.

(4) Provide offices, equipment, supplies, and other facilities for the bureau. The administrator also shall provide suitable office space in the service offices for the district hearing officers, the staff hearing officers, and commission employees as requested by the commission.

(5) Prepare and submit to the oversight commission information the administrator considers pertinent or the oversight commission requires, together with the administrator's recommendations, in the form of administrative rules, for the advice and consent of the oversight commission, for classifications of occupations or industries, for premium rates and contributions, for the amount to be credited to the surplus fund, for rules and systems of rating, rate revisions, and merit rating. The administrator shall obtain, prepare, and submit any other information the oversight commission requires for the prompt and efficient discharge of its

duties.

(6) Keep the accounts required by division (A) of section 4123.34 of the Revised Code and all other accounts and records necessary to the collection, administration, and distribution of the workers' compensation funds and shall obtain the statistical and other information required by section 4123.19 of the Revised Code.

(7) Exercise the investment powers vested in the administrator by section 4123.44 of the Revised Code in accordance with the investment objectives, policies, and criteria established by the oversight commission pursuant to section 4121.12 of the Revised Code. The administrator shall not engage in any prohibited investment activity specified by the oversight commission pursuant to division (F)(6) of section 4121.12 of the Revised Code. All business shall be transacted, all funds invested, all warrants for money drawn and payments made, and all cash and securities and other property held, in the name of the bureau, or in the name of its nominee, provided that nominees are authorized by the administrator solely for the purpose of facilitating the transfer of securities, and restricted to the administrator and designated employees.

(8) Make contracts for and supervise the construction of any project or improvement or the construction or repair of buildings under the control of the bureau.

(9) Purchase supplies, materials, equipment, and services; make contracts for, operate, and superintend the telephone, other telecommunication, and computer services for the use of the bureau; and make contracts in connection with office reproduction, forms management, printing, and other services. Notwithstanding sections 125.12 to 125.14 Of the Revised Code, the administrator may transfer surplus computers and computer equipment directly to an accredited public school within the state. The computers and computer equipment may be repaired or refurbished prior to the transfer.

(10) Separately from the budget the industrial commission submits, prepare and submit to the director of budget and management a budget for each biennium. The budget submitted shall include estimates of the costs and necessary expenditures of the bureau in the discharge of any duty imposed by law as well as the costs of furnishing office space to the district hearing officers, staff hearing officers, and commission employees under division (D) of this section.

(11) As promptly as possible in the course of efficient administration, decentralize and relocate such of the personnel and activities of the bureau as is appropriate to the end that the receipt, investigation, determination, and

payment of claims may be undertaken at or near the place of injury or the residence of the claimant and for that purpose establish regional offices, in such places as the administrator considers proper, capable of discharging as many of the functions of the bureau as is practicable so as to promote prompt and efficient administration in the processing of claims. All active and inactive lost-time claims files shall be held at the service office responsible for the claim. A claimant, at the claimant's request, shall be provided with information by telephone as to the location of the file pertaining to claim. The administrator shall ensure that all service office employees report directly to the director for their service office.

(12) Provide a written binder on new coverage where the administrator considers it to be in the best interest of the risk. The administrator, or any other person authorized by the administrator, shall grant the binder upon submission of a request for coverage by the employer. A binder is effective for a period of thirty days from date of issuance and is nonrenewable. Payroll reports and premium charges shall coincide with the effective date of the binder.

(13) Set standards for the reasonable and maximum handling time of claims payment functions, ensure, by rules, the impartial and prompt treatment of all claims and employer risk accounts, and establish a secure, accurate method of time stamping all incoming mail and documents hand delivered to bureau employees.

(14) Ensure that all employees of the bureau follow the orders and rules of the commission as such orders and rules relate to the commission's overall adjudicatory policy-making and management duties under this chapter and Chapters 4123., 4127., and 4131. of the Revised Code.

(15) Manage and operate a data processing system with a common data base for the use of both the bureau and the commission and, in consultation with the commission, using electronic data processing equipment, shall develop a claims tracking system that is sufficient to monitor the status of a claim at any time and that lists appeals that have been filed and orders or determinations that have been issued pursuant to section 4123.511 or 4123.512 of the Revised Code, including the dates of such filings and issuances.

(16) Establish and maintain a medical section within the bureau. The medical section shall do all of the following:

(a) Assist the administrator in establishing standard medical fees, approving medical procedures, and determining eligibility and reasonableness of the compensation payments for medical, hospital, and nursing services, and in establishing guidelines for payment policies which

recognize usual, customary, and reasonable methods of payment for covered services;

(b) Provide a resource to respond to questions from claims examiners for employees of the bureau;

(c) Audit fee bill payments;

(d) Implement a program to utilize, to the maximum extent possible, electronic data processing equipment for storage of information to facilitate authorizations of compensation payments for medical, hospital, drug, and nursing services;

(e) Perform other duties assigned to it by the administrator.

(17) Appoint, as the administrator determines necessary, panels to review and advise the administrator on disputes arising over a determination that a health care service or supply provided to a claimant is not covered under this chapter or Chapter 4123. of the Revised Code or is medically unnecessary. If an individual health care provider is involved in the dispute, the panel shall consist of individuals licensed pursuant to the same section of the Revised Code as such health care provider.

(18) Pursuant to section 4123.65 of the Revised Code, approve applications for the final settlement of claims for compensation or benefits under this chapter and Chapters 4123., 4127., and 4131. of the Revised Code as the administrator determines appropriate, except in regard to the applications of self-insuring employers and their employees.

(19) Comply with section 3517.13 of the Revised Code, and except in regard to contracts entered into pursuant to the authority contained in section 4121.44 of the Revised Code, comply with the competitive bidding procedures set forth in the Revised Code for all contracts into which the administrator enters provided that those contracts fall within the type of contracts and dollar amounts specified in the Revised Code for competitive bidding and further provided that those contracts are not otherwise specifically exempt from the competitive bidding procedures contained in the Revised Code.

(20) Adopt, with the advice and consent of the oversight commission, rules for the operation of the bureau.

(21) Prepare and submit to the oversight commission information the administrator considers pertinent or the oversight commission requires, together with the administrator's recommendations, in the form of administrative rules, for the advice and consent of the oversight commission, for the health partnership program and the qualified health plan system, as provided in sections 4121.44, 4121.441, and 4121.442 of the Revised Code.

(C) The administrator, with the advice and consent of the senate, shall appoint a chief operating officer who has significant experience in the field of workers' compensation insurance or other similar insurance industry experience if the administrator does not possess such experience. The chief operating officer shall not commence the chief operating officer's duties until after the senate consents to the chief operating officer's appointment. The chief operating officer shall serve in the unclassified civil service of the state.

Sec. 4123.01. As used in this chapter:

(A)(1) "Employee" means:

(a) Every person in the service of the state, or of any county, municipal corporation, township, or school district therein, including regular members of lawfully constituted police and fire departments of municipal corporations and townships, whether paid or volunteer, and wherever serving within the state or on temporary assignment outside thereof, and executive officers of boards of education, under any appointment or contract of hire, express or implied, oral or written, including any elected official of the state, or of any county, municipal corporation, or township, or members of boards of education;

(b) Every person in the service of any person, firm, or private corporation, including any public service corporation, that (i) employs one or more persons regularly in the same business or in or about the same establishment under any contract of hire, express or implied, oral or written, including aliens and minors, household workers who earn one hundred sixty dollars or more in cash in any calendar quarter from a single household and casual workers who earn one hundred sixty dollars or more in cash in any calendar quarter from a single employer, or (ii) is bound by any such contract of hire or by any other written contract, to pay into the state insurance fund the premiums provided by this chapter.

(c) Every person who performs labor or provides services pursuant to a construction contract, as defined in section 4123.79 of the Revised Code, if at least ten of the following criteria apply:

(i) The person is required to comply with instructions from the other contracting party regarding the manner or method of performing services;

(ii) The person is required by the other contracting party to have particular training;

(iii) The person's services are integrated into the regular functioning of the other contracting party;

(iv) The person is required to perform the work personally;

(v) The person is hired, supervised, or paid by the other contracting

party;

(vi) A continuing relationship exists between the person and the other contracting party that contemplates continuing or recurring work even if the work is not full time;

(vii) The person's hours of work are established by the other contracting party;

(viii) The person is required to devote full time to the business of the other contracting party;

(ix) The person is required to perform the work on the premises of the other contracting party;

(x) The person is required to follow the order of work set by the other contracting party;

(xi) The person is required to make oral or written reports of progress to the other contracting party;

(xii) The person is paid for services on a regular basis such as hourly, weekly, or monthly;

(xiii) The person's expenses are paid for by the other contracting party;

(xiv) The person's tools and materials are furnished by the other contracting party;

(xv) The person is provided with the facilities used to perform services;

(xvi) The person does not realize a profit or suffer a loss as a result of the services provided;

(xvii) The person is not performing services for a number of employers at the same time;

(xviii) The person does not make the same services available to the general public;

(xix) The other contracting party has a right to discharge the person;

(xx) The person has the right to end the relationship with the other contracting party without incurring liability pursuant to an employment contract or agreement.

Every person in the service of any independent contractor or subcontractor who has failed to pay into the state insurance fund the amount of premium determined and fixed by the administrator of workers' compensation for the person's employment or occupation or if a self-insuring employer has failed to pay compensation and benefits directly to the employer's injured and to the dependents of the employer's killed employees as required by section 4123.35 of the Revised Code, shall be considered as the employee of the person who has entered into a contract, whether written or verbal, with such independent contractor unless such employees or their legal representatives or beneficiaries elect, after injury or

death, to regard such independent contractor as the employer.

(2) "Employee" does not mean:

(a) A duly ordained, commissioned, or licensed minister or assistant or associate minister of a church in the exercise of ministry; or

(b) Any officer of a family farm corporation.

Any employer may elect to include as an "employee" within this chapter, any person excluded from the definition of "employee" pursuant to division (A)(2) of this section. If an employer is a partnership, sole proprietorship, or family farm corporation, such employer may elect to include as an "employee" within this chapter, any member of such partnership, the owner of the sole proprietorship, or the officers of the family farm corporation. In the event of an election, the employer shall serve upon the bureau of workers' compensation written notice naming the persons to be covered, include such employee's remuneration for premium purposes in all future payroll reports, and no person excluded from the definition of "employee" pursuant to division (A)(2) of this section, proprietor, or partner shall be deemed an employee within this division until the employer has served such notice.

For informational purposes only, the bureau shall prescribe such language as it considers appropriate, on such of its forms as it considers appropriate, to advise employers of their right to elect to include as an "employee" within this chapter a sole proprietor, any member of a partnership, the officers of a family farm corporation, or a person excluded from the definition of "employee" under division (A)(2)(a) of this section, that they should check any health and disability insurance policy, or other form of health and disability plan or contract, presently covering them, or the purchase of which they may be considering, to determine whether such policy, plan, or contract excludes benefits for illness or injury that they might have elected to have covered by workers' compensation.

(B) "Employer" means:

(1) The state, including state hospitals, each county, municipal corporation, township, school district, and hospital owned by a political subdivision or subdivisions other than the state;

(2) Every person, firm, and private corporation, including any public service corporation, that (a) has in service one or more employees regularly in the same business or in or about the same establishment under any contract of hire, express or implied, oral or written, or (b) is bound by any such contract of hire or by any other written contract, to pay into the insurance fund the premiums provided by this chapter.

All such employers are subject to this chapter. Any member of a firm or

association, who regularly performs manual labor in or about a mine, factory, or other establishment, including a household establishment, shall be considered an employee in determining whether such person, firm, or private corporation, or public service corporation, has in its service, one or more employees and the employer shall report the income derived from such labor to the bureau as part of the payroll of such employer, and such member shall thereupon be entitled to all the benefits of an employee.

(C) "Injury" includes any injury, whether caused by external accidental means or accidental in character and result, received in the course of, and arising out of, the injured employee's employment. "Injury" does not include:

(1) Psychiatric conditions except where the conditions have arisen from an injury or occupational disease;

(2) Injury or disability caused primarily by the natural deterioration of tissue, an organ, or part of the body;

(3) Injury or disability incurred in voluntary participation in an employer-sponsored recreation or fitness activity if the employee signs a waiver of the employee's right to compensation or benefits under this chapter prior to engaging in the recreation or fitness activity.

(D) "Child" includes a posthumous child and a child legally adopted prior to the injury.

(E) "Family farm corporation" means a corporation founded for the purpose of farming agricultural land in which the majority of the voting stock is held by and the majority of the stockholders are persons or the spouse of persons related to each other within the fourth degree of kinship, according to the rules of the civil law, and at least one of the related persons is residing on or actively operating the farm, and none of whose stockholders are a corporation. A family farm corporation does not cease to qualify under this division where, by reason of any devise, bequest, or the operation of the laws of descent or distribution, the ownership of shares of voting stock is transferred to another person, as long as that person is within the degree of kinship stipulated in this division.

(F) "Occupational disease" means a disease contracted in the course of employment, which by its causes and the characteristics of its manifestation or the condition of the employment results in a hazard which distinguishes the employment in character from employment generally, and the employment creates a risk of contracting the disease in greater degree and in a different manner from the public in general.

(G) "Self-insuring employer" means any of the following categories of employers if granted the privilege of paying compensation and benefits

directly under section 4123.35 of the Revised Code:

- (1) Any employer mentioned in division (B)(2) of this section;
- (2) A board of county hospital trustees;
- (3) A publicly owned utility;
- (4) A board of county commissioners for the sole purpose of constructing a sports facility as defined in section 307.696 Of the Revised Code, provided that the electors of the county in which the sports facility is to be built have approved construction of a sports facility by ballot election no later than November 6, 1997.

Sec. 4123.25. (A) No employer shall misrepresent to the bureau of workers' compensation the amount of payroll upon which the premium under this chapter is based. Whoever violates this division shall be liable to the state in ten times the amount of the difference in premium paid and the amount the employer should have paid. The liability to the state under this division shall be enforced in a civil action in the name of the state, and all sums collected under this division shall be paid into the state insurance fund.

(B) No self-insuring employer shall misrepresent the amount of paid compensation paid by such employer for purposes of the assessments provided under this chapter and Chapter 4121. of the Revised Code as required by section 4123.35 of the Revised Code. Whoever violates this division is liable to the state in an amount assessed by the self-insuring employers evaluation board pursuant to division (C) of section 4123.352 of the Revised Code or ten times the amount of the difference between the assessment paid and the amount of the assessment that should have been paid along with any other penalty as determined by the board. The liability to the state under this division may be enforced in a civil action in the name of the state and all sums collected under this division shall be paid into the self-insurance assessment fund created pursuant to division ~~(J)~~(K) of section 4123.35 of the Revised Code.

Sec. 4123.35. (A) Except as provided in this section, every employer mentioned in division (B)(2) of section 4123.01 of the Revised Code, and every publicly owned utility shall pay semiannually in the months of January and July into the state insurance fund the amount of annual premium the administrator of workers' compensation fixes for the employment or occupation of the employer, the amount of which premium to be paid by each employer to be determined by the classifications, rules, and rates made and published by the administrator. The employer shall pay semiannually a further sum of money into the state insurance fund as may be ascertained to be due from the employer by applying the rules of the administrator, and a receipt or certificate certifying that payment has been

made shall be mailed immediately to the employer by the bureau of workers' compensation. The receipt or certificate is prima facie evidence of the payment of the premium.

The bureau of workers' compensation shall verify with the secretary of state the existence of all corporations and organizations making application for workers' compensation coverage and shall require every such application to include the employer's federal identification number.

An employer as defined in division (B)(2) of section 4123.01 of the Revised Code who has contracted with a subcontractor is liable for the unpaid premium due from any subcontractor with respect to that part of the payroll of the subcontractor that is for work performed pursuant to the contract with the employer.

Division (A) of this section ~~4123.35 of the Revised Code~~ providing for the payment of premiums semiannually does not apply to any employer who was a subscriber to the state insurance fund prior to January 1, 1914, or who may first become a subscriber to the fund in any month other than January or July. Instead, the semiannual premiums shall be paid by those employers from time to time upon the expiration of the respective periods for which payments into the fund have been made by them.

The administrator shall adopt rules to permit employers to make periodic payments of the semiannual premium due under this division. The rules shall include provisions for the assessment of interest charges, where appropriate, and for the assessment of penalties when an employer fails to make timely premium payments. An employer who timely pays the amounts due under this division is entitled to all of the benefits and protections of this chapter. Upon receipt of payment, the bureau immediately shall mail a receipt or certificate to the employer certifying that payment has been made, which receipt is prima-facie evidence of payment. Workers' compensation coverage under this chapter continues uninterrupted upon timely receipt of payment under this division.

Every employer mentioned in division (B)(1) of section 4123.01 of the Revised Code, except boards of county hospital trustees that are self-insuring employers under this section, shall comply with sections 4123.38 to 4123.41, and 4123.48 of the Revised Code in regard to the contribution of moneys to the public insurance fund.

(B) Provided, that employers mentioned in division (B)(2) of section 4123.01 of the Revised Code, boards of county hospital trustees, and publicly owned utilities who will abide by the rules of the administrator and who may be of sufficient financial ability to render certain the payment of compensation to injured employees or the dependents of killed employees,

and the furnishing of medical, surgical, nursing, and hospital attention and services and medicines, and funeral expenses, equal to or greater than is provided for in sections 4123.52, 4123.55 to 4123.62, and 4123.64 to 4123.67 of the Revised Code, and who do not desire to insure the payment thereof or indemnify themselves against loss sustained by the direct payment thereof, upon a finding of such facts by the administrator, may be granted the privilege to pay individually compensation, and furnish medical, surgical, nursing, and hospital services and attention and funeral expenses directly to injured employees or the dependents of killed employees, thereby being granted status as a self-insuring employer. The administrator may charge employers, boards of county hospital trustees, or publicly owned utilities who apply for the status as a self-insuring employer a reasonable application fee to cover the bureau's costs in connection with processing and making a determination with respect to an application. All employers granted such status shall demonstrate sufficient financial and administrative ability to assure that all obligations under this section are promptly met. The administrator shall deny the privilege where the employer is unable to demonstrate the employer's ability to promptly meet all the obligations imposed on the employer by this section. The administrator shall consider, but is not limited to, the following factors, where applicable, in determining the employer's ability to meet all of the obligations imposed on the employer by this section:

(1) The employer employs a minimum of five hundred employees in this state;

(2) The employer has operated in this state for a minimum of two years, provided that an employer who has purchased, acquired, or otherwise succeeded to the operation of a business, or any part thereof, situated in this state that has operated for at least two years in this state, also shall qualify;

(3) Where the employer previously contributed to the state insurance fund or is a successor employer as defined by bureau rules, the amount of the buy-out, as defined by bureau rules;

(4) The sufficiency of the employer's assets located in this state to insure the employer's solvency in paying compensation directly;

(5) The financial records, documents, and data, certified by a certified public accountant, necessary to provide the employer's full financial disclosure. The records, documents, and data include, but are not limited to, balance sheets and profit and loss history for the current year and previous four years.

(6) The employer's organizational plan for the administration of the workers' compensation law;

(7) The employer's proposed plan to inform employees of the change from a state fund insurer to a self-insuring employer, the procedures the employer will follow as a self-insuring employer, and the employees' rights to compensation and benefits; and

(8) The employer has either an account in a financial institution in this state, or if the employer maintains an account with a financial institution outside this state, ensures that workers' compensation checks are drawn from the same account as payroll checks or the employer clearly indicates that payment will be honored by a financial institution in this state.

The administrator may waive the requirements of divisions (B)(1) and (2) of this section and the requirement of division (B)(5) of this section that the financial records, documents, and data be certified by a certified public accountant. The administrator shall adopt rules establishing the criteria that an employer shall meet in order for the administrator to waive the requirement of division (B)(5) of this section. Such rules may require additional security of that employer pursuant to division (E) of section 4123.351 of the Revised Code. The administrator shall not grant the status of self-insuring employer to any public employer, other than publicly owned utilities and boards of county hospital trustees.

(C) Provided, that a board of county commissioners mentioned in division (G)(4) of section 4123.01 of the Revised Code, as an employer, that will abide by the rules of the administrator and that may be of sufficient financial ability to render certain the payment of compensation to injured employees or the dependents of killed employees, and the furnishing of medical, surgical, nursing, and hospital attention and services and medicines, and funeral expenses, equal to or greater than is provided for in sections 4123.52, 4123.55 to 4123.62, and 4123.64 to 4123.67 of the Revised Code, and that does not desire to insure the payment thereof or indemnify itself against loss sustained by the direct payment thereof, upon a finding of such facts by the administrator, may be granted the privilege to pay individually compensation, and furnish medical, surgical, nursing, and hospital services and attention and funeral expenses directly to injured employees or the dependents of killed employees, thereby being granted status as a self-insuring employer. The administrator may charge a board of county commissioners mentioned in division (G)(4) of section 4123.01 of the Revised Code that applies for the status as a self-insuring employer a reasonable application fee to cover the bureau's costs in connection with processing and making a determination with respect to an application. All employers granted such status shall demonstrate sufficient financial and administrative ability to assure that all obligations under this section are

promptly met. The administrator shall deny the privilege where the employer is unable to demonstrate the employer's ability to promptly meet all the obligations imposed on the employer by this section. The administrator shall consider, but is not limited to, the following factors, where applicable, in determining the employer's ability to meet all of the obligations imposed on the board as an employer by this section:

(1) The board as an employer employs a minimum of five hundred employees in this state;

(2) The board has operated in this state for a minimum of two years;

(3) Where the board previously contributed to the state insurance fund or is a successor employer as defined by bureau rules, the amount of the buy-out, as defined by bureau rules;

(4) The sufficiency of the board's assets located in this state to insure the board's solvency in paying compensation directly;

(5) The financial records, documents, and data, certified by a certified public accountant, necessary to provide the board's full financial disclosure. The records, documents, and data include, but are not limited to, balance sheets and profit and loss history for the current year and previous four years.

(6) The board's organizational plan for the administration of the workers' compensation law;

(7) The board's proposed plan to inform employees of the proposed self-insurance, the procedures the board will follow as a self-insuring employer, and the employees' rights to compensation and benefits;

(8) The board has either an account in a financial institution in this state, OR IF THE BOARD MAINTAINS AN ACCOUNT WITH A FINANCIAL INSTITUTION OUTSIDE THIS STATE, ENSURES THAT WORKERS' COMPENSATION CHECKS ARE DRAWN FROM THE SAME ACCOUNT AS PAYROLL CHECKS OR THE BOARD CLEARLY INDICATES THAT PAYMENT WILL BE HONORED BY A FINANCIAL INSTITUTION IN THIS STATE;

(9) The board shall provide the administrator a surety bond in an amount equal to one hundred twenty-five per cent of the projected losses as determined by the administrator.

(D) The administrator shall require a surety bond from all self-insuring employers, issued pursuant to section 4123.351 of the Revised Code, that is sufficient to compel, or secure to injured employees, or to the dependents of employees killed, the payment of compensation and expenses, which shall in no event be less than that paid or furnished out of the state insurance fund in similar cases to injured employees or to dependents of killed employees

whose employers contribute to the fund, except when an employee of the employer, who has suffered the loss of a hand, arm, foot, leg, or eye prior to the injury for which compensation is to be paid, and thereafter suffers the loss of any other of the members as the result of any injury sustained in the course of and arising out of the employee's employment, the compensation to be paid by the self-insuring employer is limited to the disability suffered in the subsequent injury, additional compensation, if any, to be paid by the bureau out of the surplus created by section 4123.34 of the Revised Code.

~~(D)~~(E) In addition to the requirements of this section, the administrator shall make and publish rules governing the manner of making application and the nature and extent of the proof required to justify a finding of fact by the administrator as to granting the status of a self-insuring employer, which rules shall be general in their application, one of which rules shall provide that all self-insuring employers shall pay into the state insurance fund such amounts as are required to be credited to the surplus fund in division (B) of section 4123.34 of the Revised Code.

Employers shall secure directly from the bureau central offices application forms upon which the bureau shall stamp a designating number. Prior to submission of an application, an employer shall make available to the bureau, and the bureau shall review, the information described in divisions (B)(1) to (8) of this section. An employer shall file the completed application forms with an application fee, which shall cover the costs of processing the application, as established by the administrator, by rule, with the bureau at least ninety days prior to the effective date of the employer's new status as a self-insuring employer. The application form is not deemed complete until all the required information is attached thereto. The bureau shall only accept applications that contain the required information.

~~(E)~~(F) The bureau shall review completed applications within a reasonable time. If the bureau determines to grant an employer the status as a self-insuring employer, the bureau shall issue a statement, containing its findings of fact, that is prepared by the bureau and signed by the administrator. If the bureau determines not to grant the status as a self-insuring employer, the bureau shall notify the employer of the determination and require the employer to continue to pay its full premium into the state insurance fund. The administrator also shall adopt rules establishing a minimum level of performance as a criterion for granting and maintaining the status as a self-insuring employer and fixing time limits beyond which failure of the self-insuring employer to provide for the necessary medical examinations and evaluations may not delay a decision on a claim.

~~(F)~~(G) The administrator shall adopt rules setting forth procedures for auditing the program of self-insuring employers. The bureau shall conduct the audit upon a random basis or whenever the bureau has grounds for believing that an employer is not in full compliance with bureau rules or this chapter.

The administrator shall monitor the programs conducted by self-insuring employers, to ensure compliance with bureau requirements and for that purpose, shall develop and issue to self-insuring employers standardized forms for use by the employer in all aspects of the employers' direct compensation program and for reporting of information to the bureau.

The bureau shall receive and transmit to the employer all complaints concerning any self-insuring employer. In the case of a complaint against a self-insuring employer, the administrator shall handle the complaint through the self-insurance division of the bureau. The bureau shall maintain a file by employer of all complaints received that relate to the employer. The bureau shall evaluate each complaint and take appropriate action.

The administrator shall adopt as a rule a prohibition against any self-insuring employer from harassing, dismissing, or otherwise disciplining any employee making a complaint, which rule shall provide for a financial penalty to be levied by the administrator payable by the offending employer.

~~(G)~~(H) For the purpose of making determinations as to whether to grant status as a self-insuring employer, the administrator may subscribe to and pay for a credit reporting service that offers financial and other business information about individual employers. The costs in connection with the bureau's subscription or individual reports from the service about an applicant may be included in the application fee charged employers under this section.

~~(H)~~(I) The administrator, notwithstanding other provisions of this chapter, may permit a self-insuring employer to resume payment of premiums to the state insurance fund with appropriate credit modifications to the employer's basic premium rate as such rate is determined pursuant to section 4123.29 of the Revised Code.

~~(I)~~(J) On the first day of July of each year, the administrator shall calculate separately each self-insuring employer's assessments for the safety and hygiene fund, administrative costs pursuant to section 4123.342 of the Revised Code, and for the portion of the surplus fund under division (B) of section 4123.34 of the Revised Code that is not used for handicapped reimbursement, on the basis of the paid compensation attributable to the individual self-insuring employer according to the following calculation:

(1) The total assessment against all self-insuring employers as a class

for each fund and for the administrative costs for the year that the assessment is being made, as determined by the administrator, divided by the total amount of paid compensation for the previous calendar year attributable to all amenable self-insuring employers;

(2) Multiply the quotient in division ~~(H)~~(J)(1) of this section by the total amount of paid compensation for the previous calendar year that is attributable to the individual self-insuring employer for whom the assessment is being determined. Each self-insuring employer shall pay the assessment that results from this calculation, unless the assessment resulting from this calculation falls below a minimum assessment, which minimum assessment the administrator shall determine on the first day of July of each year with the advice and consent of the workers' compensation oversight commission, in which event, the self-insuring employer shall pay the minimum assessment.

In determining the total amount due for the total assessment against all self-insuring employers as a class for each fund and the administrative assessment, the administrator shall reduce proportionately the total for each fund and assessment by the amount of money in the self-insurance assessment fund as of the date of the computation of the assessment.

The administrator shall calculate the assessment for the portion of the surplus fund under division (B) of section 4123.34 of the Revised Code that is used for handicapped reimbursement in the same manner as set forth in divisions ~~(H)~~(J)(1) and (2) of this section except that the administrator shall calculate the total assessment for this portion of the surplus fund only on the basis of those self-insuring employers that retain participation in the handicapped reimbursement program and the individual self-insuring employer's proportion of paid compensation shall be calculated only for those self-insuring employers who retain participation in the handicapped reimbursement program. The administrator, as the administrator determines appropriate, may determine the total assessment for the handicapped portion of the surplus fund in accordance with sound actuarial principles.

The administrator shall calculate the assessment for the portion of the surplus fund under division (B) of section 4123.34 of the Revised Code that under division (D) of section 4121.66 of the Revised Code is used for rehabilitation costs in the same manner as set forth in divisions ~~(H)~~(J)(1) and (2) of this section, except that the administrator shall calculate the total assessment for this portion of the surplus fund only on the basis of those self-insuring employers who have not made the election to make payments directly under division (D) of section 4121.66 of the Revised Code and an individual self-insuring employer's proportion of paid compensation only for

those self-insuring employers who have not made that election.

An employer who no longer is a self-insuring employer in this state or who no longer is operating in this state, shall continue to pay assessments for administrative costs and for the portion of the surplus fund under division (B) of section 4123.34 of the Revised Code that is not used for handicapped reimbursement, based upon paid compensation attributable to claims that occurred while the employer was a self-insuring employer within this state.

~~(J)~~(K) There is hereby created in the state treasury the self-insurance assessment fund. All investment earnings of the fund shall be deposited in the fund. The administrator shall use the money in the self-insurance assessment fund only for administrative costs as specified in section 4123.341 of the Revised Code.

~~(K)~~(L) Every self-insuring employer shall certify, in affidavit form subject to the penalty for perjury, to the bureau the amount of the self-insuring employer's paid compensation for the previous calendar year. In reporting paid compensation paid for the previous year, a self-insuring employer shall exclude from the total amount of paid compensation any reimbursement the employer receives in the previous calendar year from the surplus fund pursuant to section 4123.512 of the Revised Code for any paid compensation. The self-insuring employer also shall exclude from the paid compensation reported any amount recovered under section 4123.93 of the Revised Code and any amount that is determined not to have been payable to or on behalf of a claimant in any final administrative or judicial proceeding. The self-insuring employer shall exclude such amounts from the paid compensation reported in the reporting period subsequent to the date the determination is made. The administrator shall adopt rules, in accordance with Chapter 119. of the Revised Code, establishing the date by which self-insuring employers must submit such information and the amount of the assessments provided for in division ~~(H)~~(J) of this section for employers who have been granted self-insuring status within the last calendar year.

The administrator shall include any assessment that remains unpaid for previous assessment periods in the calculation and collection of any assessments due under this division or division ~~(H)~~(J) of this section.

~~(L)~~(M) As used in this section, "paid compensation" means all amounts paid by a self-insuring employer for living maintenance benefits, all amounts for compensation paid pursuant to sections 4121.63, 4121.67, 4123.56, 4123.57, 4123.58, 4123.59, 4123.60, and 4123.64 of the Revised Code, all amounts paid as wages in lieu of such compensation, all amounts

paid in lieu of such compensation under a nonoccupational accident and sickness program fully funded by the self-insuring employer, and all amounts paid by a self-insuring employer for a violation of a specific safety standard pursuant to Section 35 of Article II, Ohio Constitution and section 4121.47 of the Revised Code.

~~(M)~~(N) Should any section of this chapter or Chapter 4121. of the Revised Code providing for self-insuring employers' assessments based upon compensation paid be declared unconstitutional by a final decision of any court, then that section of the Revised Code declared unconstitutional shall revert back to the section in existence prior to November 3, 1989, providing for assessments based upon payroll.

~~(N)~~(O) The administrator may grant a self-insuring employer the privilege to self-insure a construction project entered into by the self-insuring employer that is scheduled for completion within six years after the date the project begins, and the total cost of which is estimated to exceed one hundred million dollars. The administrator may waive such cost and time criteria and grant a self-insuring employer the privilege to self-insure a construction project regardless of the time needed to complete the construction project and provided that the cost of the construction project is estimated to exceed fifty million dollars. A self-insuring employer who desires to self-insure a construction project shall submit to the administrator an application listing the dates the construction project is scheduled to begin and end, the estimated cost of the construction project, the contractors and subcontractors whose employees are to be self-insured by the self-insuring employer, the provisions of a safety program that is specifically designed for the construction project, and a statement as to whether a collective bargaining agreement governing the rights, duties, and obligations of each of the parties to the agreement with respect to the construction project exists between the self-insuring employer and a labor organization.

A self-insuring employer may apply to self-insure the employees of either of the following:

(1) All contractors and subcontractors who perform labor or work or provide materials for the construction project;

(2) All contractors and, at the administrator's discretion, a substantial number of all the subcontractors who perform labor or work or provide materials for the construction project.

Upon approval of the application, the administrator shall mail a certificate granting the privilege to self-insure the construction project to the self-insuring employer. The certificate shall contain the name of the

self-insuring employer and the name, address, and telephone number of the self-insuring employer's representatives who are responsible for administering workers' compensation claims for the construction project. The self-insuring employer shall post the certificate in a conspicuous place at the site of the construction project.

The administrator shall maintain a record of the contractors and subcontractors whose employees are covered under the certificate issued to the self-insured employer. A self-insuring employer immediately shall notify the administrator when any contractor or subcontractor is added or eliminated from inclusion under the certificate.

Upon approval of the application, the self-insuring employer is responsible for the administration and payment of all claims under this chapter and Chapter 4121. of the Revised Code for the employees of the contractor and subcontractors covered under the certificate who receive injuries or are killed in the course of and arising out of employment on the construction project, or who contract an occupational disease in the course of employment on the construction project. For purposes of this chapter and Chapter 4121. of the Revised Code, a claim that is administered and paid in accordance with this division is considered a claim against the self-insuring employer listed in the certificate. A contractor or subcontractor included under the certificate shall report to the self-insuring employer listed in the certificate, all claims that arise under this chapter and Chapter 4121. of the Revised Code in connection with the construction project for which the certificate is issued.

A self-insuring employer who complies with this division is entitled to the protections provided under this chapter and Chapter 4121. of the Revised Code with respect to the employees of the contractors and subcontractors covered under a certificate issued under this division for death or injuries that arise out of, or death, injuries, or occupational diseases that arise in the course of, those employees' employment on that construction project, as if the employees were employees of the self-insuring employer, provided that the self-insuring employer also complies with this section. No employee of the contractors and subcontractors covered under a certificate issued under this division shall be considered the employee of the self-insuring employer listed in that certificate for any purposes other than this chapter and Chapter 4121. of the Revised Code. Nothing in this division gives a self-insuring employer authority to control the means, manner, or method of employment of the employees of the contractors and subcontractors covered under a certificate issued under this division.

The contractors and subcontractors included under a certificate issued

under this division are entitled to the protections provided under this chapter and Chapter 4121. of the Revised Code with respect to the contractor's or subcontractor's employees who are employed on the construction project which is the subject of the certificate, for death or injuries that arise out of, or death, injuries, or occupational diseases that arise in the course of, those employees' employment on that construction project.

The contractors and subcontractors included under a certificate issued under this division shall identify in their payroll records the employees who are considered the employees of the self-insuring employer listed in that certificate for purposes of this chapter and Chapter 4121. of the Revised Code, and the amount that those employees earned for employment on the construction project that is the subject of that certificate. Notwithstanding any provision to the contrary under this chapter and Chapter 4121. of the Revised Code, the administrator shall exclude the payroll that is reported for employees who are considered the employees of the self-insuring employer listed in that certificate, and that the employees earned for employment on the construction project that is the subject of that certificate, when determining those contractors' or subcontractors' premiums or assessments required under this chapter and Chapter 4121. of the Revised Code. A self-insuring employer issued a certificate under this division shall include in the amount of paid compensation it reports pursuant to division ~~(K)~~(L) of this section, the amount of paid compensation the self-insuring employer paid pursuant to this division for the previous calendar year.

Nothing in this division shall be construed as altering the rights of employees under this chapter and Chapter 4121. of the Revised Code as those rights existed prior to ~~the effective date of this amendment~~ September 17, 1996. Nothing in this division shall be construed as altering the rights devolved under sections 2305.31 and 4123.82 of the Revised Code as those rights existed prior to ~~the effective date of this amendment~~ September 17, 1996.

As used in this division, "privilege to self-insure a construction project" means privilege to pay individually compensation, and to furnish medical, surgical, nursing, and hospital services and attention and funeral expenses directly to injured employees or the dependents of killed employees.

~~(O)~~(P) A self-insuring employer whose application is granted under division ~~(N)~~(Q) of this section shall designate a safety professional to be responsible for the administration and enforcement of the safety program that is specifically designed for the construction project that is the subject of the application.

A self-insuring employer whose application is granted under division

~~(N)~~(O) of this section shall employ an ombudsperson for the construction project that is the subject of the application. The ombudsperson shall have experience in workers' compensation or the construction industry, or both. The ombudsperson shall perform all of the following duties:

(1) Communicate with and provide information to employees who are injured in the course of, or whose injury arises out of employment on the construction project, or who contract an occupational disease in the course of employment on the construction project;

(2) Investigate the status of a claim upon the request of an employee to do so;

(3) Provide information to claimants, third party administrators, employers, and other persons to assist those persons in protecting their rights under this chapter and Chapter 4121. of the Revised Code.

A self-insuring employer whose application is granted under division ~~(N)~~(O) of this section shall post the name of the safety professional and the ombudsperson and instructions for contacting the safety professional and the ombudsperson in a conspicuous place at the site of the construction project.

~~(P)~~(Q) The administrator may consider all of the following when deciding whether to grant a self-insuring employer the privilege to self-insure a construction project as provided under division ~~(N)~~(O) of this section:

(1) Whether the self-insuring employer has an organizational plan for the administration of the workers' compensation law;

(2) Whether the safety program that is specifically designed for the construction project provides for the safety of employees employed on the construction project, is applicable to all contractors and subcontractors who perform labor or work or provide materials for the construction project, and has a component, a safety training program that complies with standards adopted pursuant to the "Occupational Safety and Health Act of 1970," 84 Stat. 1590, 29 U.S.C.A. 651, and provides for continuing management and employee involvement;

(3) Whether granting the privilege to self-insure the construction project will reduce the costs of the construction project;

(4) Whether the self-insuring employer has employed an ombudsperson as required under division ~~(O)~~(P) of this section;

(5) Whether the self-insuring employer has sufficient surety to secure the payment of claims for which the self-insuring employer would be responsible pursuant to the granting of the privilege to self-insure a construction project under division ~~(N)~~(O) of this section.

Sec. 4123.512. (A) The claimant or the employer may appeal an order

of the industrial commission made under division (E) of section 4123.511 of the Revised Code in any injury or occupational disease case, other than a decision as to the extent of disability to the court of common pleas of the county in which the injury was inflicted or in which the contract of employment was made if the injury occurred outside the state, or in which the contract of employment was made if the exposure occurred outside the state. If no common pleas court has jurisdiction for the purposes of an appeal by the use of the jurisdictional requirements described in this division, the appellant may use the venue provisions in the Rules of Civil Procedure to vest jurisdiction in a court. If the claim is for an occupational disease the appeal shall be to the court of common pleas of the county in which the exposure which caused the disease occurred. Like appeal may be taken from an order of a staff hearing officer made under division (D) of section 4123.511 of the Revised Code from which the commission has refused to hear an appeal. The appellant shall file the notice of appeal with a court of common pleas within sixty days after the date of the receipt of the order appealed from or the date of receipt of the order of the commission refusing to hear an appeal of a staff hearing officer's decision under division (D) of section 4123.511 of the Revised Code. The filing of the notice of the appeal with the court is the only act required to perfect the appeal.

If an action has been commenced in a court of a county other than a court of a county having jurisdiction over the action, the court, upon notice by any party or upon its own motion, shall transfer the action to a court of a county having jurisdiction.

Notwithstanding anything to the contrary in this section, if the commission determines under section 4123.522 of the Revised Code that an employee, employer, or their respective representatives have not received written notice of an order or decision which is appealable to a court under this section and which grants relief pursuant to section 4123.522 of the Revised Code, the party granted the relief has sixty days from receipt of the order under section 4123.522 of the Revised Code to file a notice of appeal under this section.

(B) The notice of appeal shall state the names of the claimant and the employer, the number of the claim, the date of the order appealed from, and the fact that the appellant appeals therefrom.

The administrator, the claimant, and the employer shall be parties to the appeal and the court, upon the application of the commission, shall make the commission a party. The administrator shall notify the employer that if ~~he~~ the employer fails to become an active party to the appeal, then the administrator may act on behalf of the employer and the results of the appeal

could have an adverse effect upon the employer's premium rates.

(C) The attorney general or one or more of ~~his~~ the attorney general's assistants or special counsel designated by ~~him~~ the attorney general shall represent the administrator and the commission. In the event the attorney general or ~~his~~ the attorney general's designated assistants or special counsel are absent, the administrator or the commission shall select one or more of the attorneys in the employ of the administrator or the commission as ~~his~~ the administrator's attorney or ~~its~~ the commission's attorney in the appeal. Any attorney so employed shall continue ~~his~~ the representation during the entire period of the appeal and in all hearings thereof except where the continued representation becomes impractical.

(D) Upon receipt of notice of appeal the clerk of courts shall provide notice to all parties who are appellees and to the commission.

The claimant shall, within thirty days after the filing of the notice of appeal, file a petition containing a statement of facts in ordinary and concise language showing a cause of action to participate or to continue to participate in the fund and setting forth the basis for the jurisdiction of the court over the action. Further pleadings shall be had in accordance with the Rules of Civil Procedure, provided that service of summons on such petition shall not be required. The clerk of the court shall, upon receipt thereof, transmit by certified mail a copy thereof to each party named in the notice of appeal other than the claimant. Any party may file with the clerk prior to the trial of the action a deposition of any physician taken in accordance with the provisions of the Revised Code, which deposition may be read in the trial of the action even though the physician is a resident of or subject to service in the county in which the trial is had. The bureau of workers' compensation shall pay the cost of the stenographic deposition filed in court and of copies of the stenographic deposition for each party from the surplus fund and charge the costs thereof against the unsuccessful party if the claimant's right to participate or continue to participate is finally sustained or established in the appeal. In the event the deposition is taken and filed, the physician whose deposition is taken is not required to respond to any subpoena issued in the trial of the action. The court, or the jury under the instructions of the court, if a jury is demanded, shall determine the right of the claimant to participate or to continue to participate in the fund upon the evidence adduced at the hearing of the action.

(E) The court shall certify its decision to the commission and the certificate shall be entered in the records of the court. Appeals from the judgment are governed by the law applicable to the appeal of civil actions.

(F) The cost of any legal proceedings authorized by this section,

ncluding an attorney's fee to the claimant's attorney to be fixed by the trial judge, based upon the effort expended, in the event the claimant's right to participate or to continue to participate in the fund is established upon the final determination of an appeal, shall be taxed against the employer or the commission if the commission or the administrator rather than the employer contested the right of the claimant to participate in the fund. The attorney's fee shall not exceed twenty-five hundred dollars.

(G) If the finding of the court or the verdict of the jury is in favor of the claimant's right to participate in the fund, the commission and the administrator shall thereafter proceed in the matter of the claim as if the judgment were the decision of the commission, subject to the power of modification provided by section 4123.52 of the Revised Code.

(H) An appeal from an order issued under division (E) of section 4123.511 of the Revised Code or any action filed in court in a case in which an award of compensation has been made shall not stay the payment of compensation under the award or payment of compensation for subsequent periods of total disability during the pendency of the appeal. If, in a final administrative or judicial action, it is determined that payments of compensation or benefits, or both, made to or on behalf of a claimant should not have been made, the amount thereof shall be charged to the surplus fund under division (B) of section 4123.34 of the Revised Code. In the event the employer is a state risk, the amount shall not be charged to the employer's experience. In the event the employer is a self-insuring employer, the self-insuring employer shall deduct the amount from the paid compensation ~~he~~ the self-insuring employer reports to the administrator under division ~~(K)~~(L) of section 4123.35 of the Revised Code. All actions and proceedings under this section which are the subject of an appeal to the court of common pleas or the court of appeals shall be preferred over all other civil actions except election causes, irrespective of position on the calendar.

This section applies to all decisions of the commission or the administrator on November 2, 1959, and all claims filed thereafter are governed by sections 4123.511 and 4123.512 of the Revised Code.

Any action pending in common pleas court or any other court on January 1, 1986, under this section is governed by former sections 4123.514, 4123.515, 4123.516, and 4123.519 and section 4123.522 of the Revised Code.

SECTION 2. That existing sections 1751.02, 1751.03, 1751.04, 1751.12, 1751.13, 3901.04, 3901.041, 3901.16, 3924.10, 4121.121, 4123.01, 4123.25, 4123.35, and 4123.512 of the Revised Code are hereby repealed.

SECTION 3. Sections 1 and 2 of this act, except for sections 1751.12, 4121.121, 4123.01, 4123.25, 4123.35, and 4123.512 of the Revised Code, as amended by this act, shall take effect October 1, 1998. Sections 1751.12 and 4121.121 of the Revised Code, as amended by this act, shall take effect on the ninetieth day after the effective date of this act.

SECTION 4. This act is hereby declared to be an emergency measure necessary for the immediate preservation of the public peace, health, and safety. The reason for such necessity is that immediate action is necessary to ensure that a board of county commissioners may reserve necessary revenues at the earliest possible time in order to self-insure the construction of a recent voter-approved sports stadium and to assure the effective operation of this fund. Therefore, this act shall go into immediate effect.

Speaker _____ of the House of Representatives.

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the
____ day of _____, A. D. 20____.

Secretary of State.

File No. _____ Effective Date _____