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Committee**

**122nd General Assembly
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Representatives Van Vyven, Garcia

A B I L L

To amend sections 1701.03, 1705.03, 1705.04, 1705.53,	1
1739.01, 1751.01, 1751.02, 1751.03, 1751.05,	2
1751.06, 1751.11, 1751.12, 1751.13, 1751.14,	3
1751.15, 1751.16, 1751.20, 1751.31, 1751.32,	4
1751.46, 1751.55, 1751.58, 1751.59, 1751.60,	5
1751.62, 1751.81, 1785.01, 1785.02, 1785.03,	6
1785.08, 1907.161, 2305.252, 3701.75, 3901.21,	7
3901.38, 3917.01, 3917.06, 3923.021, 3923.122,	8
3923.57, 3923.571, 3923.58, 3924.01, 3924.03,	9
3924.033, 3924.08, 3924.09, 3924.10, 3924.11,	10
3924.13, 3999.22, 4715.22, 4715.39, 4723.16,	11
4725.114, 4729.161, 4731.226, 4731.65, 4732.28,	12
4734.091, 4755.471, 5111.25, 5111.251, 5111.264,	13
5111.81, 5112.01, 5112.08, 5725.18, and 5729.03,	14
to enact sections 5.2217, 1751.141, 1751.321,	15
3701.18, 3702.141, and 4503.104, and to repeal	16
sections 3924.05, 5111.75, 5111.77, 5111.771, and	17
5111.811 of the Revised Code and to amend Section	18
3 of Am. Sub. S.B. 67 of the 122nd General	19
Assembly, Section 6 of Am. Sub. S.B. 154 of the	20
122nd General Assembly, and Section 194 of Am.	21
Sub. H.B. 215 of the 122nd General Assembly to	22
conform provisions in the Health Insuring	23
Corporation Law and the Sickness and Accident	24

Insurance Law with the Health Insurance	25
Portability and Accountability Act of 1996, to	26
revise other provisions in these laws, to specify	27
how health insuring corporations are to bring	28
their net worth into compliance with the Health	29
Insuring Corporation Law, to revise the premium	30
tax imposed on domestic and foreign insurance	31
companies that operate a health insuring	32
corporation as a line of business, to make related	33
revisions in the phase-in schedule for the tax, to	34
authorize a form of group life insurance as	35
conversion coverage for certain former employees	36
and members, to remove the coverage limitation on	37
group term life insurance insuring the spouse and	38
dependent children of an insured employee or	39
member, to add a member to the committee created	40
under Am. Sub. S.B. 154 of the 122nd General	41
Assembly to study the continuing education	42
requirements for insurance agents, to revise the	43
standards for using electronic signatures in	44
records of health care facilities, to specify when	45
certain existing health care facilities are	46
required to improve the structure or fixtures of	47
the facility in order to comply with the safety	48
and quality-of-care standards and quality-of-care	49
data reporting requirements established by the	50
Director of Health, to extend the Department of	51
Health's study of cardiac catheterization	52
performed without an on-site open-heart surgery	53
service, to create the Save Our Sight Fund to	54
support eye health and safety programs for	55
children, to require the Registrar of Motor	56
Vehicles and deputy registrars to request	57

contributions to the fund from applicants for 58
motor vehicle registration and renewal, to require 59
the Department of Health to develop informational 60
materials on eye care and safety, to allow a 61
dentist to authorize a dental hygienist to provide 62
dental hygiene services when the dentist is not 63
physically present if certain conditions are met, 64
to authorize the State Dental Board to adopt rules 65
allowing certified dental assistants to polish the 66
clinical crowns of teeth, to designate June as 67
"Prostate Cancer Awareness Month," to authorize 68
mechanotherapists to engage in their practice with 69
certain other health care professionals in a 70
combined form of a professional corporation, 71
limited liability company, partnership, or 72
professional association, and to change the manner 73
of determining the amount of the per day, per 74
patient reimbursement that the Department of Human 75
Services pays for the reasonable capital costs of 76
eligible nursing facilities and intermediate care 77
facilities for the mentally retarded, in specified 78
circumstances in which there is a transfer or 79
lease between related parties. 80

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

Section 1. That sections 1701.03, 1705.03, 1705.04, 1705.53, 81
1739.01, 1751.01, 1751.02, 1751.03, 1751.05, 1751.06, 1751.11, 82
1751.12, 1751.13, 1751.14, 1751.15, 1751.16, 1751.20, 1751.31, 83
1751.32, 1751.46, 1751.55, 1751.58, 1751.59, 1751.60, 1751.62, 84
1751.81, 1785.01, 1785.02, 1785.03, 1785.08, 1907.161, 2305.252, 85
3701.75, 3901.21, 3901.38, 3917.01, 3917.06, 3923.021, 3923.122, 86

3923.57, 3923.571, 3923.58, 3924.01, 3924.03, 3924.033, 3924.08, 87
3924.09, 3924.10, 3924.11, 3924.13, 3999.22, 4715.22, 4715.39, 88
4723.16, 4725.114, 4729.161, 4731.226, 4731.65, 4732.28, 4734.091, 89
4755.471, 5111.25, 5111.251, 5111.264, 5111.81, 5112.01, 5112.08, 90
5725.18, and 5729.03 be amended and sections 5.2217, 1751.141, 91
1751.321, 3701.18, 3702.141, and 4503.104 of the Revised Code be 92
enacted to read as follows: 93

Sec. 5.2217. The month of June shall be designated as 94
"Prostate Cancer Awareness Month." 95

Sec. 1701.03. (A) A corporation may be formed under this 96
chapter for any purpose or combination of purposes for which 97
individuals lawfully may associate themselves, except that, if the 98
Revised Code contains special provisions pertaining to the 99
formation of any designated type of corporation other than a 100
professional association, as defined in section 1785.01 of the 101
Revised Code, a corporation of that type shall be formed in 102
accordance with the special provisions. 103

(B) On and after July 1, 1994, a corporation may be formed 104
under this chapter for the purpose of carrying on the practice of 105
any profession, including, but not limited to, a corporation for 106
the purpose of providing public accounting or certified public 107
accounting services, a corporation for the erection, owning, and 108
conducting of a sanitarium for receiving and caring for patients, 109
medical and hygienic treatment of patients, and instruction of 110
nurses in the treatment of disease and in hygiene, a corporation 111
for the purpose of providing architectural, landscape 112
architectural, professional engineering, or surveying services or 113
any combination of those types of services, and a corporation for 114
the purpose of providing a combination of the professional 115
services, as defined in section 1785.01 of the Revised Code, of 116
optometrists authorized under Chapter 4725. of the Revised Code, 117

chiropractors authorized under Chapter 4734. of the Revised Code, 118
psychologists authorized under Chapter 4732. of the Revised Code, 119
registered or licensed practical nurses authorized under Chapter 120
4723. of the Revised Code, pharmacists authorized under Chapter 121
4729. of the Revised Code, physical therapists authorized under 122
sections 4755.40 to 4755.53 of the Revised Code, mechanotherapists 123
authorized under section 4731.151 Of the Revised Code, and doctors 124
of medicine and surgery, osteopathic medicine and surgery, or 125
podiatric medicine and surgery authorized under Chapter 4731. of 126
the Revised Code. This chapter does not restrict, limit, or 127
otherwise affect the authority or responsibilities of any agency, 128
board, commission, department, office, or other entity to license, 129
register, and otherwise regulate the professional conduct of 130
individuals or organizations of any kind rendering professional 131
services, as defined in section 1785.01 of the Revised Code, in 132
this state or to regulate the practice of any profession that is 133
within the jurisdiction of the agency, board, commission, 134
department, office, or other entity, notwithstanding that an 135
individual is a director, officer, employee, or other agent of a 136
corporation formed under this chapter and is rendering 137
professional services or engaging in the practice of a profession 138
through a corporation formed under this chapter or that the 139
organization is a corporation formed under this chapter. 140

(C) Nothing in division (A) or (B) of this section precludes 141
the organization of a professional association in accordance with 142
this chapter and Chapter 1785. of the Revised Code or the 143
formation of a limited liability company under Chapter 1705. of 144
the Revised Code with respect to a business, as defined in section 145
1705.01 of the Revised Code. 146

(D) No corporation formed for the purpose of providing a 147
combination of the professional services, as defined in section 148
1785.01 of the Revised Code, of optometrists authorized under 149

Chapter 4725. of the Revised Code, chiropractors authorized under 150
Chapter 4734. of the Revised Code, psychologists authorized under 151
Chapter 4732. of the Revised Code, registered or licensed 152
practical nurses authorized under Chapter 4723. of the Revised 153
Code, pharmacists authorized under Chapter 4729. of the Revised 154
Code, physical therapists authorized under sections 4755.40 to 155
4755.53 of the Revised Code, mechanotherapists authorized under 156
section 4731.151 Of the Revised Code, and doctors of medicine and 157
surgery, osteopathic medicine and surgery, or podiatric medicine 158
and surgery authorized under Chapter 4731. of the Revised Code 159
shall control the professional clinical judgment exercised within 160
accepted and prevailing standards of practice of a licensed, 161
certificated, or otherwise legally authorized optometrist, 162
chiropractor, psychologist, nurse, pharmacist, physical therapist, 163
mechanotherapist, or doctor of medicine and surgery, osteopathic 164
medicine and surgery, or podiatric medicine and surgery in 165
rendering care, treatment, or professional advice to an individual 166
patient. 167

This division does not prevent a hospital, as defined in 168
section 3727.01 of the Revised Code, insurer, as defined in 169
section 3999.36 of the Revised Code, or intermediary organization, 170
as defined in section 1751.01 of the Revised Code, from entering 171
into a contract with a corporation described in this division that 172
includes a provision requiring utilization review, quality 173
assurance, peer review, or other performance or quality standards. 174
Those activities shall not be construed as controlling the 175
professional clinical judgment of an individual practitioner 176
listed in this division. 177

Sec. 1705.03. (A) A limited liability company may sue and be 178
sued. 179

(B) Unless otherwise provided in its articles of 180

organization, a limited liability company may take property of any 181
description or any interest in property of any description by 182
gift, devise, or bequest and may make donations for the public 183
welfare or for charitable, scientific, or educational purposes. 184

(C) In carrying out the purposes stated in its articles of 185
organization or operating agreement and subject to limitations 186
prescribed by law or in its articles of organization or its 187
operating agreement, a limited liability company may do all of the 188
following: 189

(1) Purchase or otherwise acquire, lease as lessee or lessor, 190
invest in, hold, use, encumber, sell, exchange, transfer, and 191
dispose of property of any description or any interest in property 192
of any description; 193

(2) Make contracts; 194

(3) Form or acquire the control of other domestic or foreign 195
limited liability companies; 196

(4) Be a shareholder, partner, member, associate, or 197
participant in other profit or nonprofit enterprises or ventures; 198

(5) Conduct its affairs in this state and elsewhere; 199

(6) Render in this state and elsewhere a professional 200
service, the kinds of professional services authorized under 201
Chapters 4703. and 4733. of the Revised Code, or a combination of 202
the professional services of optometrists authorized under Chapter 203
4725. of the Revised Code, chiropractors authorized under Chapter 204
4734. of the Revised Code, psychologists authorized under Chapter 205
4732. of the Revised Code, registered or licensed practical nurses 206
authorized under Chapter 4723. of the Revised Code, pharmacists 207
authorized under Chapter 4729. of the Revised Code, physical 208
therapists authorized under sections 4755.40 to 4755.53 of the 209
Revised Code, mechanotherapists authorized under section 4731.151 210

<u>Of the Revised Code,</u> and doctors of medicine and surgery,	211
osteopathic medicine and surgery, or podiatric medicine and	212
surgery authorized under Chapter 4731. of the Revised Code;	213
(7) Borrow money;	214
(8) Issue, sell, and pledge its notes, bonds, and other	215
evidences of indebtedness;	216
(9) Secure any of its obligations by mortgage, pledge, or	217
deed of trust of all or any of its property;	218
(10) Guarantee or secure obligations of any person;	219
(11) Do all things permitted by law and exercise all	220
authority within or incidental to the purposes stated in its	221
articles of organization.	222
(D) In addition to the authority conferred by division (C) of	223
this section and irrespective of the purposes stated in its	224
articles of organization or operating agreement but subject to any	225
limitations stated in those articles or its operating agreement, a	226
limited liability company may invest funds not currently needed in	227
its business in any securities if the investment does not cause	228
the company to acquire control of another enterprise whose	229
activities and operations are not incidental to the purposes	230
stated in the articles of organization of the company.	231
(E)(1) No lack of authority or limitation upon the authority	232
of a limited liability company shall be asserted in any action	233
except as follows:	234
(a) By the state in an action by it against the company;	235
(b) By or on behalf of the company in an action against a	236
manager, an officer, or any member as a member;	237
(c) By a member as a member in an action against the company,	238
a manager, an officer, or any member as a member;	239
(d) In an action involving an alleged improper issue of a	240

membership interest in the company.	241
(2) Division (E)(1) of this section applies to any action commenced in this state upon any contract made in this state by a foreign limited liability company.	242 243 244
Sec. 1705.04. (A) One or more persons, without regard to residence, domicile, or state of organization, may form a limited liability company. The company is formed when one or more persons or their authorized representative signs and files with the secretary of state articles of organization that set forth all of the following:	245 246 247 248 249 250
(1) The name of the company;	251
(2) Except as provided in division (B) of this section, the period of its duration, which may be perpetual;	252 253
(3) The address to which interested persons may direct requests for copies of any operating agreement and any bylaws of the company;	254 255 256
(4) Any other provisions that are from the operating agreement or that are not inconsistent with applicable law and that the members elect to set out in the articles for the regulation of the affairs of the company.	257 258 259 260
(B) If the articles of organization or operating agreement do not set forth the period of the duration of the limited liability company, its duration shall be perpetual.	261 262 263
(C) If a limited liability company is formed under this chapter for the purpose of rendering a professional service, the kinds of professional services authorized under Chapters 4703. and 4733. of the Revised Code, or a combination of the professional services of optometrists authorized under Chapter 4725. of the Revised Code, chiropractors authorized under Chapter 4734. of the Revised Code, psychologists authorized under Chapter 4732. of the	264 265 266 267 268 269 270

Revised Code, registered or licensed practical nurses authorized 271
under Chapter 4723. of the Revised Code, pharmacists authorized 272
under Chapter 4729. of the Revised Code, physical therapists 273
authorized under sections 4755.40 to 4755.53 of the Revised Code, 274
mechanotherapists authorized under section 4731.151 Of the Revised 275
Code, and doctors of medicine and surgery, osteopathic medicine 276
and surgery, or podiatric medicine and surgery authorized under 277
Chapter 4731. of the Revised Code, the following apply: 278

(1) Each member, employee, or other agent of the company who 279
renders a professional service in this state and, if the 280
management of the company is not reserved to its members, each 281
manager of the company who renders a professional service in this 282
state shall be licensed, certificated, or otherwise legally 283
authorized to render in this state the same kind of professional 284
service; if applicable, the kinds of professional services 285
authorized under Chapters 4703. and 4733. of the Revised Code; or, 286
if applicable, any of the kinds of professional services of 287
optometrists authorized under Chapter 4725. of the Revised Code, 288
chiropractors authorized under Chapter 4734. of the Revised Code, 289
psychologists authorized under Chapter 4732. of the Revised Code, 290
registered or licensed practical nurses authorized under Chapter 291
4723. of the Revised Code, pharmacists authorized under Chapter 292
4729. of the Revised Code, physical therapists authorized under 293
sections 4755.40 to 4755.53 of the Revised Code, mechanotherapists 294
authorized under section 4731.151 Of the Revised Code, or doctors 295
of medicine and surgery, osteopathic medicine and surgery, or 296
podiatric medicine and surgery authorized under Chapter 4731. of 297
the Revised Code. 298

(2) Each member, employee, or other agent of the company who 299
renders a professional service in another state and, if the 300
management of the company is not reserved to its members, each 301
manager of the company who renders a professional service in 302

another state shall be licensed, certificated, or otherwise
legally authorized to render that professional service in the
other state.

(D) Except for the provisions of this chapter pertaining to
the personal liability of members, employees, or other agents of a
limited liability company and, if the management of the company is
not reserved to its members, the personal liability of managers of
the company, this chapter does not restrict, limit, or otherwise
affect the authority or responsibilities of any agency, board,
commission, department, office, or other entity to license,
certificate, register, and otherwise regulate the professional
conduct of individuals or organizations of any kind rendering
professional services in this state or to regulate the practice of
any profession that is within the jurisdiction of the agency,
board, commission, department, office, or other entity,
notwithstanding that the individual is a member or manager of a
limited liability company and is rendering the professional
services or engaging in the practice of the profession through the
limited liability company or that the organization is a limited
liability company.

(E) No limited liability company formed for the purpose of
providing a combination of the professional services, as defined
in section 1785.01 of the Revised Code, of optometrists authorized
under Chapter 4725. of the Revised Code, chiropractors authorized
under Chapter 4734. of the Revised Code, psychologists authorized
under Chapter 4732. of the Revised Code, registered or licensed
practical nurses authorized under Chapter 4723. of the Revised
Code, pharmacists authorized under Chapter 4729. of the Revised
Code, physical therapists authorized under sections 4755.40 to
4755.53 of the Revised Code, mechanotherapists authorized under
section 4731.151 Of the Revised Code, and doctors of medicine and
surgery, osteopathic medicine and surgery, or podiatric medicine

and surgery authorized under Chapter 4731. of the Revised Code 335
shall control the professional clinical judgment exercised within 336
accepted and prevailing standards of practice of a licensed, 337
certificated, or otherwise legally authorized optometrist, 338
chiropractor, psychologist, nurse, pharmacist, physical therapist, 339
mechanotherapist, or doctor of medicine and surgery, osteopathic 340
medicine and surgery, or podiatric medicine and surgery in 341
rendering care, treatment, or professional advice to an individual 342
patient. 343

This division does not prevent a hospital, as defined in 344
section 3727.01 of the Revised Code, insurer, as defined in 345
section 3999.36 of the Revised Code, or intermediary organization, 346
as defined in section 1751.01 of the Revised Code, from entering 347
into a contract with a limited liability company described in this 348
division that includes a provision requiring utilization review, 349
quality assurance, peer review, or other performance or quality 350
standards. Those activities shall not be construed as controlling 351
the professional clinical judgment of an individual practitioner 352
listed in this division. 353

Sec. 1705.53. Subject to any contrary provisions of the Ohio 354
Constitution, the laws of the state under which a foreign limited 355
liability company is organized govern its organization and 356
internal affairs and the liability of its members. A foreign 357
limited liability company may not be denied a certificate of 358
registration as a foreign limited liability company in this state 359
because of any difference between the laws of the state under 360
which it is organized and the laws of this state. However, a 361
foreign limited liability company that applies for registration 362
under this chapter to render a professional service in this state, 363
as a condition to obtaining and maintaining a certificate of 364
registration, shall comply with the requirements of division (C) 365
of section 1705.04 of the Revised Code and shall comply with the 366

requirements of Chapters 4703. and 4733. of the Revised Code if 367
the kinds of professional services authorized under those chapters 368
are to be rendered or with the requirements of Chapters 4723., 369
4725., 4729., 4731., 4732., 4734., and 4755. of the Revised Code 370
if a combination of the professional services of optometrists 371
authorized under Chapter 4725. of the Revised Code, chiropractors 372
authorized under Chapter 4734. of the Revised Code, psychologists 373
authorized under Chapter 4732. of the Revised Code, registered or 374
licensed practical nurses authorized under Chapter 4723. of the 375
Revised Code, pharmacists authorized under Chapter 4729. of the 376
Revised Code, physical therapists authorized under sections 377
4755.40 to 4755.53 of the Revised Code, mechanotherapists 378
authorized under section 4731.151 Of the Revised Code, and doctors 379
of medicine and surgery, osteopathic medicine and surgery, or 380
podiatric medicine and surgery authorized under Chapter 4731. of 381
the Revised Code are to be rendered. 382

Sec. 1739.01. As used in sections 1739.01 to 1739.22 of the 383
Revised Code: 384

(A) "Agreement" means a written agreement executed by members 385
of a multiple employer welfare arrangement that establishes an 386
arrangement, provides for its operation, and through which each 387
member agrees to assume and discharge all liability under sections 388
1739.01 to 1739.22 of the Revised Code relating to or arising out 389
of the operation of the arrangement in proportion to the ratio of 390
the total number of covered employees employed by the member at 391
the time the liability arose to the total number of covered 392
employees employed by all members of the arrangement at the time 393
the liability arose. 394

(B) "Excess insurance" or "stop-loss insurance" means an 395
insurance policy purchased by a multiple employer welfare 396
arrangement under which it receives reimbursement for benefits it 397

pays in excess of a preset deductible or limit. 398

(C) "~~Fully insured~~ Fully insured program" means a program by 399
which benefits are provided to members, employees of members, or 400
the dependents of such members or employees, through the purchase 401
of sickness and accident insurance from an insurance company 402
licensed to do business in this state or health services purchased 403
from a health ~~maintenance organization~~ insuring corporation 404
authorized to do business in this state. 405

(D) "Group self-insurance program" means a program by which 406
benefits are provided to members, employees of members, or the 407
dependents of such members or employees, other than through 408
sickness and accident insurance purchased from an insurance 409
company licensed to do business in this state or health care 410
services purchased from a health ~~maintenance organization~~ insuring 411
corporation authorized to do business in this state. 412

(E) "Member" means an individual or an employer that is a 413
member of an organization sponsoring a multiple employer welfare 414
arrangement. 415

(F) "Multiple employer welfare arrangement" means an employee 416
welfare benefit plan, trust, or any other arrangement, whether 417
such plan, trust, or arrangement is subject to the "Employee 418
Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 419
1001, as amended, that is established or maintained for the 420
purpose of offering or providing, through group insurance or group 421
self-insurance programs, medical, surgical, or hospital care or 422
benefits, or benefits in the event of sickness, accident, 423
disability, or death, to the employees, and their dependents, of 424
two or more employers, or to two or more self-employed individuals 425
and their dependents. 426

(G) "Premium" means any type of consideration paid to a 427
multiple employer welfare arrangement by a member for coverage 428

under the arrangement.	429
(H) "Surplus" means the total assets of the multiple employer welfare arrangement less its liabilities and reserves as determined in accordance with the requirements of sections 1739.01 to 1739.21 of the Revised Code.	430 431 432 433
(I) "Third-party administrator" has the same meaning as "administrator" in section 3959.01 of the Revised Code.	434 435
Sec. 1751.01. As used in this chapter:	436
(A) "Basic health care services" means the following services when medically necessary:	437 438
(1) Physician's services, except when such services are supplemental under division (B) of this section;	439 440
(2) Inpatient hospital services;	441
(3) Outpatient medical services;	442
(4) Emergency health services;	443
(5) Urgent care services;	444
(6) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;	445 446
(7) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care.	447 448 449 450
"Basic health care services" does not include experimental procedures.	451 452
A health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all listed basic health care services. However, this requirement does not apply to	453 454 455 456

the coverage of beneficiaries enrolled in Title XVIII of the 457
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as 458
amended, pursuant to a medicare ~~risk contract or medicare cost~~ 459
contract, or to the coverage of beneficiaries enrolled in the 460
federal employee health benefits program pursuant to 5 U.S.C.A. 461
8905, or to the coverage of beneficiaries enrolled in Title XIX of 462
the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, 463
as amended, known as the medical assistance program or medicaid, 464
provided by the Ohio department of human services under Chapter 465
5111. of the Revised Code, or to the coverage of beneficiaries 466
under any federal health care program regulated by a federal 467
regulatory body, or to the coverage of beneficiaries under any 468
contract covering officers or employees of the state that has been 469
entered into by the department of administrative services. 470

(B) "Supplemental health care services" means any health care 471
services other than basic health care services that a health 472
insuring corporation may offer, alone or in combination with 473
either basic health care services or other supplemental health 474
care services, and includes: 475

(1) Services of facilities for intermediate or long-term 476
care, or both; 477

(2) Dental care services; 478

(3) Vision care and optometric services including lenses and 479
frames; 480

(4) Podiatric care or foot care services; 481

(5) Mental health services including psychological services; 482

(6) Short-term outpatient evaluative and crisis-intervention 483
mental health services; 484

(7) Medical or psychological treatment and referral services 485
for alcohol and drug abuse or addiction; 486

(8) Home health services;	487
(9) Prescription drug services;	488
(10) Nursing services;	489
(11) Services of a dietitian licensed under Chapter 4759. of the Revised Code;	490 491
(12) Physical therapy services;	492
(13) Chiropractic services;	493
(14) Any other category of services approved by the superintendent of insurance.	494 495
(C) "Specialty health care services" means one of the supplemental health care services listed in division (B)(1) to (13) of this section, when provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services.	496 497 498 499 500
(D) "Closed panel plan" means a health care plan that requires enrollees to use participating providers.	501 502
(E) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.	503 504 505
(F) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.	506 507 508
(G) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state.	509 510 511
(H) "Emergency health services" means those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were	512 513 514 515

not received as soon as possible, and includes, where appropriate, 516
provisions for transportation and indemnity payments or service 517
agreements for out-of-area coverage. 518

(I) "Enrollee" means any natural person who is entitled to 519
receive health care benefits provided by a health insuring 520
corporation. 521

(J) "Evidence of coverage" means any certificate, agreement, 522
policy, or contract issued to a subscriber that sets out the 523
coverage and other rights to which such person is entitled under a 524
health care plan. 525

(K) "Health care facility" means any facility, except a 526
health care practitioner's office, that provides preventive, 527
diagnostic, therapeutic, acute convalescent, rehabilitation, 528
mental health, mental retardation, intermediate care, or skilled 529
nursing services. 530

(L) "Health care services" means any basic, supplemental, and 531
specialty health care services involved in or incident to the 532
furnishing of preventive, diagnostic, therapeutic, or 533
rehabilitative care. 534

(M) "Health delivery network" means any group of providers or 535
health care facilities, or both, or any representative thereof, 536
that have entered into an agreement to offer health care services 537
in a panel rather than on an individual basis. 538

(N) "Health insuring corporation" means a corporation, as 539
defined in division (G) of this section, that, pursuant to a 540
policy, contract, certificate, or agreement, pays for, reimburses, 541
or provides, delivers, arranges for, or otherwise makes available, 542
basic health care services, supplemental health care services, or 543
specialty health care services, or a combination of basic health 544
care services and either supplemental health care services or 545
specialty health care services, through either an open panel plan 546

or a closed panel plan.

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"Health insuring corporation" does not include a limited
liability company formed pursuant to Chapter 1705. of the Revised
Code, an insurer licensed under Title XXXIX of the Revised Code if
that insurer offers only open panel plans under which all
providers and health care facilities participating receive their
compensation directly from the insurer, a corporation formed by or
on behalf of a political subdivision or a department, office, or
institution of the state, or a public entity formed by or on
behalf of a board of county commissioners, a county board of
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, as
those terms are used in Chapters 340. and 5126. of the Revised
Code. Except as provided by division (D) of section 1751.02 of the
Revised Code, or as otherwise provided by law, no board,
commission, agency, or other entity under the control of a
political subdivision may accept insurance risk in providing for
health care services. However, nothing in this division shall be
construed as prohibiting such entities from purchasing the
services of a health insuring corporation or a third-party
administrator licensed under Chapter 3959. of the Revised Code.

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

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

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skilled nursing care.

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

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

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

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

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

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~~(T)~~(U) "Premium rate" means any set fee regularly paid by a subscriber to a health insuring corporation. A "premium rate" does not include a one-time membership fee, an annual administrative

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fee, or a nominal access fee, paid to a managed health care system 610
under which the recipient of health care services remains solely 611
responsible for any charges accessed for those services by the 612
provider or health care facility. 613

~~(U)~~(V) "Primary care provider" means a provider that is 614
designated by a health insuring corporation to supervise, 615
coordinate, or provide initial care or continuing care to an 616
enrollee, and that may be required by the health insuring 617
corporation to initiate a referral for specialty care and to 618
maintain supervision of the health care services rendered to the 619
enrollee. 620

~~(V)~~(W) "Provider" means any natural person or partnership of 621
natural persons who are licensed, certified, accredited, or 622
otherwise authorized in this state to furnish health care 623
services, or any professional association organized under Chapter 624
1785. of the Revised Code, provided that nothing in this chapter 625
or other provisions of law shall be construed to preclude a health 626
insuring corporation, health care practitioner, or organized 627
health care group associated with a health insuring corporation 628
from employing CERTIFIED nurse practitioners, CERTIFIED NURSE 629
ANESTHETISTS, CLINICAL NURSE SPECIALISTS, CERTIFIED NURSE 630
MIDWIVES, dietitians, physicians' assistants, dental assistants, 631
dental hygienists, optometric technicians, or other allied health 632
personnel who are licensed, certified, accredited, or otherwise 633
authorized in this state to furnish health care services. 634

~~(W)~~(X) "Provider sponsored organization" means a corporation, 635
as defined in division (G) of this section, that is at least 636
eighty per cent owned or controlled by one or more hospitals, as 637
defined in section 3727.01 of the Revised Code, or one or more 638
physicians licensed to practice medicine or surgery or osteopathic 639
medicine and surgery under Chapter 4731. of the Revised Code, or 640
any combination of such physicians and hospitals. Such control is 641

presumed to exist if at least eighty per cent of the voting rights 642
or governance rights of a provider sponsored organization are 643
directly or indirectly owned, controlled, or otherwise held by any 644
combination of the physicians and hospitals described in this 645
division. 646

~~(X)~~(Y) "Solicitation document" means the written materials 647
provided to prospective subscribers or enrollees, or both, and 648
used for advertising and marketing to induce enrollment in the 649
health care plans of a health insuring corporation. 650

~~(Y)~~(Z) "Subscriber" means a person who is responsible for 651
making payments to a health insuring corporation for participation 652
in a health care plan, or an enrollee whose employment or other 653
status is the basis of eligibility for enrollment in a health 654
insuring corporation. 655

~~(Z)~~(AA) "Urgent care services" means those health care 656
services that are appropriately provided for an unforeseen 657
condition of a kind that usually requires medical attention 658
without delay but that does not pose a threat to the life, limb, 659
or permanent health of the injured or ill person, and may include 660
such health care services provided out of the health insuring 661
corporation's approved service area pursuant to indemnity payments 662
or service agreements. 663

Sec. 1751.02. (A) Notwithstanding any law in this state to 664
the contrary, any corporation, as defined in section 1751.01 of 665
the Revised Code, may apply to the superintendent of insurance for 666
a certificate of authority to establish and operate a health 667
insuring corporation. If the corporation applying for a 668
certificate of authority is a foreign corporation domiciled in a 669
state without laws similar to those of this chapter, the 670
corporation must form a domestic corporation to apply for, obtain, 671
and maintain a certificate of authority under this chapter. 672

(B) No person shall establish, operate, or perform the 673
services of a health insuring corporation in this state without 674
obtaining a certificate of authority under this chapter. 675

(C) Except as provided by division (D) of this section, no 676
political subdivision or department, office, or institution of 677
this state, or corporation formed by or on behalf of any political 678
subdivision or department, office, or institution of this state, 679
shall establish, operate, or perform the services of a health 680
insuring corporation. Nothing in this section shall be construed 681
to preclude a board of county commissioners, a county board of 682
mental retardation and developmental disabilities, an alcohol and 683
drug addiction services board, a board of alcohol, drug addiction, 684
and mental health services, or a community mental health board, or 685
a public entity formed by or on behalf of any of these boards, 686
from using managed care techniques in carrying out the board's or 687
public entity's duties pursuant to the requirements of Chapters 688
307., 329., 340., and 5126. of the Revised Code. However, no such 689
board or public entity may operate so as to compete in the private 690
sector with health insuring corporations holding certificates of 691
authority under this chapter. 692

(D) A corporation formed by or on behalf of a publicly owned, 693
operated, or funded hospital or health care facility may apply to 694
the superintendent for a certificate of authority under division 695
(A) of this section to establish and operate a health insuring 696
corporation. 697

(E) A health insuring corporation shall operate in this state 698
in compliance with this chapter and Chapter 1753. of the Revised 699
Code, and with sections 3702.51 to 3702.62 of the Revised Code, 700
and shall operate in conformity with its filings with the 701
superintendent under this chapter, including filings made pursuant 702
to sections 1751.03, 1751.11, 1751.12, and 1751.31 of the Revised 703
Code. 704

(F) An insurer licensed under Title XXXIX of the Revised Code 705
need not obtain a certificate of authority as a health insuring 706
corporation to offer an open panel plan as long as the providers 707
and health care facilities participating in the open panel plan 708
receive their compensation directly from the insurer. If the 709
providers and health care facilities participating in the open 710
panel plan receive their compensation from any person other than 711
the insurer, or if the insurer offers a closed panel plan, the 712
insurer must obtain a certificate of authority as a health 713
insuring corporation. 714

(G) An intermediary organization need not obtain a 715
certificate of authority as a health insuring corporation, 716
regardless of the method of reimbursement to the intermediary 717
organization, as long as a health insuring corporation or a 718
self-insured employer maintains the ultimate responsibility to 719
assure delivery of all health care services required by the 720
contract between the health insuring corporation and the 721
subscriber and the laws of this state or between the self-insured 722
employer and its employees. 723

Nothing in this section shall be construed to require any 724
health care facility, provider, health delivery network, or 725
intermediary organization that contracts with a health insuring 726
corporation or self-insured employer, regardless of the method of 727
reimbursement to the health care facility, provider, health 728
delivery network, or intermediary organization, to obtain a 729
certificate of authority as a health insuring corporation under 730
this chapter, unless otherwise provided, in the case of contracts 731
with a self-insured employer, by operation of the "Employee 732
Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 733
1001, as amended. 734

(H) Any health delivery network doing business in this state, 735
including any health delivery network that is functioning as an 736

intermediary organization doing business in this state, that is 737
not required to obtain a certificate of authority under this 738
chapter shall certify to the superintendent annually, not later 739
than the first day of July, and shall provide a statement signed 740
by the highest ranking official which includes the following 741
information: 742

(1) The health delivery network's full name and the address 743
of its principal place of business; 744

(2) A statement that the health delivery network is not 745
required to obtain a certificate of authority under this chapter 746
to conduct its business. 747

(I) The superintendent shall not issue a certificate of 748
authority to a health insuring corporation that is a provider 749
sponsored organization unless all health care plans to be offered 750
by the health insuring corporation provide basic health care 751
services. Substantially all of the physicians and hospitals with 752
ownership or control of the provider sponsored organization, as 753
defined in division ~~(W)~~(X) of section 1751.01 of the Revised Code, 754
shall also be participating providers for the provision of basic 755
health care services for health care plans offered by the provider 756
sponsored organization. If a health insuring corporation that is a 757
provider sponsored organization offers health care plans that do 758
not provide basic health care services, the health insuring 759
corporation shall be deemed, for purposes of section 1751.35 of 760
the Revised Code, to have failed to substantially comply with this 761
chapter. 762

Except as specifically provided in this division and in 763
division (C) of section 1751.28 of the Revised Code, the 764
provisions of this chapter shall apply to all health insuring 765
corporations that are provider sponsored organizations in the same 766
manner that these provisions apply to all health insuring 767
corporations that are not provider sponsored organizations. 768

(J) Nothing in this section shall be construed to apply to 769
any multiple employer welfare arrangement operating pursuant to 770
Chapter 1739. of the Revised Code. 771

(K) Any person who violates division (B) of this section, and 772
any health delivery network that fails to comply with division (H) 773
of this section, is subject to the penalties set forth in section 774
1751.45 of the Revised Code. 775

Sec. 1751.03. (A) Each application for a certificate of 776
authority under this chapter shall be verified by an officer or 777
authorized representative of the applicant, shall be in a format 778
prescribed by the superintendent of insurance, and shall set forth 779
or be accompanied by the following: 780

(1) A certified copy of the applicant's articles of 781
incorporation and all amendments to the articles of incorporation; 782

(2) A copy of any regulations adopted for the government of 783
the corporation, any bylaws, and any similar documents, and a copy 784
of all amendments to these regulations, bylaws, and documents. The 785
corporate secretary shall certify that these regulations, bylaws, 786
documents, and amendments have been properly adopted or approved. 787
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(3) A list of the names, addresses, and official positions of 789
the persons responsible for the conduct of the applicant, 790
including all members of the board, the principal officers, and 791
the person responsible for completing or filing financial 792
statements with the department of insurance, accompanied by a 793
completed original biographical affidavit and release of 794
information for each of these persons on forms acceptable to the 795
department; 796

(4) A full and complete disclosure of the extent and nature 797
of any contractual or other financial arrangement between the 798

applicant and any provider or a person listed in division (A)(3) 799
of this section, including, but not limited to, a full and 800
complete disclosure of the financial interest held by any such 801
provider or person in any health care facility, provider, or 802
insurer that has entered into a financial relationship with the 803
health insuring corporation; 804

(5) A description of the applicant, its facilities, and its 805
personnel, including, but not limited to, the location, hours of 806
operation, and telephone numbers of all contracted facilities; 807

(6) The applicant's projected annual enrollee population over 808
a three-year period; 809

(7) A clear and specific description of the health care plan 810
or plans to be used by the applicant, including a description of 811
the proposed providers, procedures for accessing care, and the 812
form of all proposed and existing contracts relating to the 813
administration, delivery, or financing of health care services; 814

(8) A copy of each type of evidence of coverage and 815
identification card or similar document to be issued to 816
subscribers; 817

(9) A copy of each type of individual or group policy, 818
contract, or agreement to be used; 819

(10) The schedule of the proposed contractual periodic 820
prepayments or premium rates, or both, accompanied by appropriate 821
supporting data; 822

(11) A financial plan which provides a three-year projection 823
of operating results, including the projected expenses, income, 824
and sources of working capital; 825

(12) The enrollee complaint procedure to be utilized as 826
required under section 1751.19 of the Revised Code; 827

(13) A description of the procedures and programs to be 828

implemented on an ongoing basis to assure the quality of health 829
care services delivered to enrollees, including, if applicable, a 830
description of a quality assurance program complying with the 831
requirements of sections 1751.73 to 1751.75 of the Revised Code; 832

(14) A statement describing the geographic area or areas to 833
be served, by county; 834

(15) A copy of all solicitation documents; 835

(16) A balance sheet and other financial statements showing 836
the applicant's assets, liabilities, income, and other sources of 837
financial support; 838

(17) A description of the nature and extent of any 839
reinsurance program to be implemented, and a demonstration that 840
errors and omission insurance and, if appropriate, fidelity 841
insurance, will be in place upon the applicant's receipt of a 842
certificate of authority; 843

(18) Copies of all proposed or in force related-party or 844
intercompany agreements with an explanation of the financial 845
impact of these agreements on the applicant. If the applicant 846
intends to enter into a contract for managerial or administrative 847
services, with either an affiliated or an unaffiliated person, the 848
applicant shall provide a copy of the contract and a detailed 849
description of the person to provide these services. The 850
description shall include that person's experience in managing or 851
administering health care plans, a copy of that person's most 852
recent audited financial statement, and a completed biographical 853
affidavit on a form acceptable to the superintendent for each of 854
that person's principal officers and board members and for any 855
additional employee to be directly involved in providing 856
managerial or administrative services to the health insuring 857
corporation. If the person to provide managerial or administrative 858
services is affiliated with the health insuring corporation, the 859

contract must provide for payment for services based on actual	860
costs.	861
(19) A statement from the applicant's board that the admitted	862
assets of the applicant have not been and will not be pledged or	863
hypothecated;	864
(20) A statement from the applicant's board that the	865
applicant will submit monthly financial statements during the	866
first year of operations;	867
(21) The name and address of the applicant's Ohio statutory	868
agent for service of process, notice, or demand;	869
(22) Copies of all documents the applicant filed with the	870
secretary of state;	871
(23) The location of those books and records of the applicant	872
that must be maintained, <u>which books and records shall be</u>	873
<u>maintained in Ohio if the applicant is a domestic corporation, and</u>	874
<u>which may be maintained either in the applicant's state of</u>	875
<u>domicile or in Ohio if the applicant is a foreign corporation;</u>	876
(24) The applicant's federal identification number, corporate	877
address, and mailing address;	878
(25) An internal and external organizational chart;	879
(26) A list of the assets representing the initial net worth	880
of the applicant;	881
(27) If the applicant has a parent company, the parent	882
company's guaranty, on a form acceptable to the superintendent,	883
that the applicant will maintain Ohio's minimum net worth. If no	884
parent company exists, a statement regarding the availability of	885
future funds if needed.	886
(28) The names and addresses of the applicant's actuary and	887
external auditors;	888

(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 or in section 3901.321 of the Revised Code, 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.

(3) The filing of a notice pursuant to division (B)(1) or (2) of this section shall also serve as the submission of a notice

when required for the Superintendent's review for purposes of 919
section 3901.341 of the Revised Code, if the notice contains all 920
of the information that section 3901.341 of the Revised Code 921
requires for such submissions and a copy of any written agreement. 922
The filing of such a notice, for the purpose of satisfying this 923
division and section 3901.341 of the Revised Code, shall be 924
subject to the sixty-day review period of division (B)(2) of this 925
section. 926

(C)(1) No health insuring corporation shall expand its 927
approved service area until a copy of the request for expansion, 928
accompanied by documentation of the network of providers, forms of 929
all proposed or existing provider contracts relating to the 930
delivery of health care services, a schedule of proposed 931
contractual periodic prepayments and premium rates for group 932
contracts accompanied by appropriate supporting data, enrollment 933
projections, plan of operation, and any other changes have been 934
filed with the superintendent. 935

(2) Within ten calendar days after receipt of a complete 936
filing under division (C)(1) of this section, the superintendent 937
shall refer the appropriate jurisdictional issues to the director 938
of health pursuant to section 1751.04 of the Revised Code. 939

(3) Within seventy-five days after the superintendent's 940
receipt of a complete filing under division (C)(1) of this 941
section, the superintendent shall determine whether the plan for 942
expansion is lawful, fair, and reasonable. The superintendent may 943
not make a determination until the superintendent has received the 944
director's certification of compliance, which the director shall 945
furnish within forty-five days after referral under division 946
(C)(2) of this section. The director shall not certify that the 947
requirements of section 1751.04 of the Revised Code are not met, 948
unless the applicant has been given an opportunity for a hearing 949
as provided in division (D) of section 1751.04 of the Revised 950

Code. The forty-five-day and seventy-five-day review periods 951
provided for in division (C)(3) of this section shall cease to run 952
as of the date on which the notice of the applicant's right to 953
request a hearing is mailed and shall remain suspended until the 954
director issues a final certification. 955

(4) If the superintendent has not approved or disapproved all 956
or a portion of a service area expansion within the 957
seventy-five-day period provided for in division (C)(3) of this 958
section, the filing shall be deemed approved. 959

(5) Disapproval of all or a portion of the filing shall be 960
effected by written notice, which shall state the grounds for the 961
order of disapproval and shall be given in accordance with Chapter 962
119. of the Revised Code. 963

Sec. 1751.05. (A) The superintendent of insurance shall issue 964
or deny a certificate of authority to establish or operate a 965
health insuring corporation to any corporation filing an 966
application pursuant to section 1751.03 of the Revised Code within 967
forty-five days of the superintendent's receipt of the 968
certification from the director of health under division (C) of 969
section 1751.04 of the Revised Code. A certificate of authority 970
shall be issued upon payment of the application fee prescribed in 971
section 1751.44 of the Revised Code if the superintendent is 972
satisfied that the following conditions are met: 973

(1) The persons responsible for the conduct of the affairs of 974
the applicant are competent, trustworthy, and possess good 975
reputations. 976

(2) The director certifies, in accordance with division (C) 977
of section 1751.04 of the Revised Code, that the organization's 978
proposed plan of operation meets the requirements of division (B) 979
of that section and sections 3702.51 to 3702.62 of the Revised 980

Code. If, after the director has certified compliance, the 981
application is amended in a manner that affects its approval under 982
section 1751.04 of the Revised Code, the superintendent shall 983
request the director to review and recertify the amended plan of 984
operation. Within forty-five days of receipt of the amended plan 985
from the superintendent, the director shall certify to the 986
superintendent, pursuant to section 1751.04 of the Revised Code, 987
whether or not the amended plan meets the requirements of section 988
1751.04 of the Revised Code. The superintendent's forty-five-day 989
review period shall cease to run as of the date on which the 990
amended plan is transmitted to the director and shall remain 991
suspended until the superintendent receives a new certification 992
from the director. 993

(3) The applicant constitutes an appropriate mechanism to 994
effectively provide or arrange for the provision of the basic 995
health care services, supplemental health care services, or 996
specialty health care services to be provided to enrollees. 997

(4) The applicant is financially responsible, complies with 998
section 1751.28 of the Revised Code, and may reasonably be 999
expected to meet its obligations to enrollees and prospective 1000
enrollees. In making this determination, the superintendent may 1001
consider: 1002

(a) The financial soundness of the applicant's arrangements 1003
for health care services, including the applicant's proposed 1004
contractual periodic prepayments or premiums and the use of 1005
copayments ~~or deductibles~~; 1006

(b) The adequacy of working capital; 1007

(c) Any agreement with an insurer, a government, or any other 1008
person for insuring the payment of the cost of health care 1009
services or providing for automatic applicability of an 1010
alternative coverage in the event of discontinuance of the health 1011

insuring corporation's operations;	1012
(d) Any agreement with providers or health care facilities	1013
for the provision of health care services;	1014
(e) Any deposit of securities submitted in accordance with	1015
section 1751.27 of the Revised Code as a guarantee that the	1016
obligations will be performed.	1017
(5) The applicant has submitted documentation of an	1018
arrangement to provide health care services to its enrollees until	1019
the expiration of the enrollees' contracts with the applicant if a	1020
health care plan or the operations of the health insuring	1021
corporation are discontinued prior to the expiration of the	1022
enrollees' contracts. An arrangement to provide health care	1023
services may be made by using any one, or any combination, of the	1024
following methods:	1025
(a) The maintenance of insolvency insurance;	1026
(b) A provision in contracts with providers and health care	1027
facilities, but no health insuring corporation shall rely solely	1028
on such a provision for more than thirty days;	1029
(c) An agreement with other health insuring corporations or	1030
insurers, providing enrollees with automatic conversion rights	1031
upon the discontinuation of a health care plan or the health	1032
insuring corporation's operations;	1033
(d) Such other methods as approved by the superintendent.	1034
(6) Nothing in the applicant's proposed method of operation,	1035
as shown by the information submitted pursuant to section 1751.03	1036
of the Revised Code or by independent investigation, will cause	1037
harm to an enrollee or to the public at large, as determined by	1038
the superintendent.	1039
(7) Any deficiencies certified by the director have been	1040
corrected.	1041

(8) The applicant has deposited securities as set forth in 1042
section 1751.27 of the Revised Code. 1043

(B) If an applicant elects to fulfill the requirements of 1044
division (A)(5) of this section through an agreement with other 1045
health insuring corporations or insurers, the agreement shall 1046
require those health insuring corporations or insurers to give 1047
thirty days' notice to the superintendent prior to cancellation or 1048
discontinuation of the agreement for any reason. 1049

(C) A certificate of authority shall be denied only after 1050
compliance with the requirements of section 1751.36 of the Revised 1051
Code. 1052

Sec. 1751.06. Upon obtaining a certificate of authority as 1053
required under this chapter, a health insuring corporation may do 1054
all of the following: 1055

(A) Enroll individuals and their dependents in either of the 1056
following circumstances: 1057

(1) The individual resides or lives in the approved service 1058
area. 1059

(2) The individual's place of employment is located in the 1060
approved service area. 1061

(B) Contract with providers and health care facilities for 1062
the health care services to which enrollees are entitled under the 1063
terms of the health insuring corporation's health care contracts; 1064

(C) Contract with insurance companies authorized to do 1065
business in this state for insurance, indemnity, or reimbursement 1066
against the cost of providing emergency and nonemergency health 1067
care services for enrollees, subject to the provisions set forth 1068
in this chapter and the limitations set forth in the Revised Code; 1069

(D) Contract with any person pursuant to the requirements of 1070

division (A)(18) of section 1751.03 of the Revised Code for 1071
managerial or administrative services, or for data processing, 1072
actuarial analysis, billing services, or any other services 1073
authorized by the superintendent of insurance. However, a health 1074
insuring corporation shall not enter into a contract for any of 1075
the services listed in this division with an insurance company 1076
that is not authorized to engage in the business of insurance in 1077
this state. 1078

(E) Accept from governmental agencies, private agencies, 1079
corporations, associations, groups, individuals, or other persons, 1080
payments covering all or part of the costs of planning, 1081
development, construction, and the provision of health care 1082
services; 1083

(F) Purchase, lease, construct, renovate, operate, or 1084
maintain health care facilities, and their ancillary equipment, 1085
and any property necessary in the transaction of the business of 1086
the health insuring corporation; 1087

(G) In the employer group market, impose an affiliation 1088
period of not more than sixty days, or for late enrollees an 1089
affiliation period of not more than ninety days, which period 1090
begins on the individual's date of enrollment and runs 1091
concurrently with any waiting period imposed under the coverage. 1092
For purposes of this division, "affiliation period" means a period 1093
of time which, under the terms of the coverage offered, must 1094
expire before the coverage becomes effective. No health care 1095
services or benefits need to be provided during an affiliation 1096
period, and no periodic prepayments can be charged for any 1097
coverage during that period. 1098

(H) If a health insuring corporation offers coverage in the 1099
small employer group market through a network plan, limit or deny 1100
the coverage in accordance with section 3924.031 of the Revised 1101

Code;	1102
(I) Refuse to issue coverage in the small employer group market pursuant to section 3924.032 of the Revised Code;	1103 1104
(J) Establish employer contribution rules or group participation rules for the offering of coverage in connection with a group contract in the small employer group market, as provided in division (E)(1) of section 3924.03 of the Revised Code.	1105 1106 1107 1108 1109
Nothing in this section shall be construed as prohibiting a health insuring corporation without other commercial enrollment from contracting solely with federal health care programs regulated by federal regulatory bodies.	1110 1111 1112 1113
Nothing in this section shall be construed to limit the authority of a health insuring corporation to perform those functions not otherwise prohibited by law.	1114 1115 1116
Sec. 1751.11. (A) Every subscriber of a health insuring corporation is entitled to an evidence of coverage for the health care plan under which health care benefits are provided.	1117 1118 1119
(B) Every subscriber of a health insuring corporation that offers basic health care services is entitled to an identification card or similar document that specifies the health insuring corporation's name as stated in its articles of incorporation, and any trade or fictitious names used by the health insuring corporation. The identification card or document shall list at least one telephone number that provides the subscriber with access to health care on a twenty-four-hour-per-day <u>twenty-four-hours-per-day, seven-day-per-week seven-days-per-week</u> basis.	1120 1121 1122 1123 1124 1125 1126 1127 1128 1129
(C) No evidence of coverage, or amendment to the evidence of coverage, shall be delivered, issued for delivery, renewed, or	1130 1131

used, until the form of the evidence of coverage or amendment has
been filed by the health insuring corporation with the
superintendent of insurance. If the superintendent does not
disapprove the evidence of coverage or amendment within sixty days
after it is filed it shall be deemed approved, unless the
superintendent sooner gives approval for the evidence of coverage
or amendment. With respect to an amendment to an approved evidence
of coverage, the superintendent only may disapprove provisions
amended or added to the evidence of coverage. If the
superintendent determines within the sixty-day period that any
evidence of coverage or amendment fails to meet the requirements
of this section, the superintendent shall so notify the health
insuring corporation and it shall be unlawful for the health
insuring corporation to use such evidence of coverage or
amendment. At any time, the superintendent, upon at least thirty
days' written notice to a health insuring corporation, may
withdraw an approval, deemed or actual, of any evidence of
coverage or amendment on any of the grounds stated in this
section. Such disapproval shall be effected by a written order,
which shall state the grounds for disapproval and shall be issued
in accordance with Chapter 119. of the Revised Code.

(D) No evidence of coverage or amendment shall be delivered,
issued for delivery, renewed, or used:

(1) If it contains provisions or statements that are
inequitable, untrue, misleading, or deceptive;

(2) Unless it contains a clear, concise, and complete
statement of the following:

(a) The health care services and insurance or other benefits,
if any, to which the enrollee is entitled under the health care
plan;

(b) Any exclusions or limitations on the health care

services, type of health care services, benefits, or type of	1163
benefits to be provided, including copayments or deductibles ;	1164
(c) The enrollee's personal financial obligation for	1165
noncovered services;	1166
(d) Where and in what manner general information and	1167
information as to how services may be obtained is available,	1168
including the telephone number;	1169
(e) The premium rate with respect to individual and	1170
conversion contracts, and relevant copayment provisions with	1171
respect to all contracts. The statement of the premium rate,	1172
however, may be contained in a separate insert.	1173
(f) The method utilized by the health insuring corporation	1174
for resolving enrollee complaints.	1175
(3) Unless it provides for the continuation of an enrollee's	1176
coverage, in the event that the enrollee's coverage under the	1177
GROUP policy, contract, certificate, or agreement terminates while	1178
the enrollee is receiving inpatient care in a hospital. This	1179
continuation of coverage shall terminate at the earliest	1180
occurrence of any of the following:	1181
(a) The enrollee's discharge from the hospital;	1182
(b) The determination by the enrollee's attending physician	1183
that inpatient care is no longer medically indicated for the	1184
enrollee; <u>however, nothing in division (D)(3)(b) of this section</u>	1185
<u>precludes a health insuring corporation from engaging in</u>	1186
<u>utilization review as described in the evidence of coverage.</u>	1187
(c) The enrollee's reaching the limit for contractual	1188
benefits;	1189
(d) <u>The effective date of any new coverage.</u>	1190
(4) Unless it contains a provision that states, in substance,	1191
that the health insuring corporation is not a member of any	1192

guaranty fund, and that in the event of the health insuring 1193
corporation's insolvency, the enrollee is protected only to the 1194
extent that the hold harmless provision required by section 1195
1751.13 of the Revised Code applies to the health care services 1196
rendered; 1197

(5) Unless it contains a provision that states, in substance, 1198
that in the event of the insolvency of the health insuring 1199
corporation, the enrollee may be financially responsible for 1200
health care services rendered by a provider or health care 1201
facility that is not under contract to the health insuring 1202
corporation, whether or not the health insuring corporation 1203
authorized the use of the provider or health care facility. 1204

(E) Notwithstanding ~~division~~ divisions (C) and (D) of this 1205
section, a health insuring corporation may use an evidence of 1206
coverage that provides for the coverage of beneficiaries enrolled 1207
in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 1208
42 U.S.C.A. 301, as amended, pursuant to a medicare ~~risk contract~~ 1209
~~or medicare cost~~ contract, or an evidence of coverage that 1210
provides for the coverage of beneficiaries enrolled in the federal 1211
employees health benefits program pursuant to 5 U.S.C.A. 8905, or 1212
an evidence of coverage that provides for the coverage of 1213
beneficiaries enrolled in Title XIX of the "Social Security Act," 1214
49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the 1215
medical assistance program or medicaid, provided by the Ohio 1216
department of human services under Chapter 5111. of the Revised 1217
Code, or an evidence of coverage that provides for the coverage of 1218
beneficiaries under any other federal health care program 1219
regulated by a federal regulatory body, or an evidence of coverage 1220
that provides for the coverage of beneficiaries under any contract 1221
covering officers or employees of the state that has been entered 1222
into by the department of administrative services, if both of the 1223
following apply: 1224

(1) The evidence of coverage 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, or the department of administrative services.

(2) The evidence of coverage is filed with the superintendent of insurance 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, or the department of administrative services.

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 filing shall be accompanied by an actuarial certification in the form prescribed by the Superintendent. 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 filing shall be accompanied by an actuarial certification in the form prescribed by 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, or for policies used for the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services, 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, or the department of administrative 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, or the department of administrative 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 1319
not be a barrier to the necessary utilization of services by 1320
enrollees. 1321

(2) A health insuring corporation may not impose copayment 1322
charges on basic health care services that exceed thirty per cent 1323
of the total cost of providing any single covered health care 1324
service, except for physician office visits, emergency health 1325
services, and urgent care services. The total cost of providing a 1326
health care service is the cost to the health insuring corporation 1327
of providing the health care service to its enrollees as reduced 1328
by any applicable provider discount. An open panel plan may not 1329
impose copayments on out-of-network benefits that exceed fifty per 1330
cent of the total cost of providing any single covered health care 1331
service. 1332

(3) To ensure that copayments are not a barrier to the 1333
utilization of basic health care services, a health insuring 1334
corporation may not impose, in any contract year, on any 1335
subscriber or enrollee, copayments that exceed two hundred per 1336
cent of the total annual premium rate to the subscriber or 1337
enrollees. This limitation of two hundred per cent does not 1338
include any reasonable copayments that are not a barrier to the 1339
necessary utilization of health care services by enrollees and 1340
that are imposed on physician office visits, emergency health 1341
services, urgent care services, supplemental health care services, 1342
or specialty health care services. 1343

(E) A health insuring corporation shall not impose lifetime 1344
maximums on basic health care services. However, a health insuring 1345
corporation may establish a benefit limit for inpatient hospital 1346
services that are provided pursuant to a policy, contract, 1347
certificate, or agreement for supplemental health care services. 1348

1349

Sec. 1751.13. (A)(1)(a) A health insuring corporation shall, 1350
either directly or indirectly, enter into contracts for the 1351
provision of health care services with a sufficient number and 1352
types of providers and health care facilities to ensure that all 1353
covered health care services will be accessible to enrollees from 1354
a contracted provider or health care facility. 1355

(b) A health insuring corporation shall not refuse to 1356
contract with a physician for the provision of health care 1357
services or refuse to recognize a physician as a specialist on the 1358
basis that the physician attended an educational program or a 1359
residency program approved or certified by the American 1360
Osteopathic Association. A health insuring corporation shall not 1361
refuse to contract with a health care facility for the provision 1362
of health care services on the basis that the health care facility 1363
is certified or accredited by the American Osteopathic Association 1364
or that the health care facility is an osteopathic hospital as 1365
defined in section 3702.51 of the Revised Code. 1366

(c) Nothing in division (A)(1)(b) of this section shall be 1367
construed to require a health insuring corporation to make a 1368
benefit payment under a closed panel plan to a physician or health 1369
care facility with which the health insuring corporation does not 1370
have a contract, provided that none of the bases set forth in that 1371
division are used as a reason for failing to make a benefit 1372
payment. 1373

(2) When a health insuring corporation is unable to provide a 1374
covered health care service from a contracted provider or health 1375
care facility, the health insuring corporation must provide that 1376
health care service from a noncontracted provider or health care 1377
facility consistent with the terms of the enrollee's policy, 1378
contract, certificate, or agreement. The health insuring 1379
corporation shall either ensure that the health care service be 1380

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 [~~Provide~~ Provider/Health Care

Facility] bill, charge, collect a deposit from, seek remuneration 1411
or reimbursement from, or have any recourse against, a subscriber, 1412
enrollee, person to whom health care services have been provided, 1413
or person acting on behalf of the covered enrollee, for health 1414
care services provided pursuant to this agreement. This does not 1415
prohibit [Provider/Health Care Facility] from collecting 1416
co-insurance, ~~deductibles,~~ or copayments as specifically provided 1417
in the evidence of coverage, or fees for uncovered health care 1418
services delivered on a fee-for-service basis to persons 1419
referenced above, nor from any recourse against the health 1420
insuring corporation or its successor." 1421

(3) Provisions requiring the provider or health care facility 1422
to continue to provide covered health care services to enrollees 1423
in the event of the health insuring corporation's insolvency or 1424
discontinuance of operations. The provisions shall require the 1425
provider or health care facility to continue to provide covered 1426
health care services to enrollees as needed to complete any 1427
medically necessary procedures commenced but unfinished at the 1428
time of the health insuring corporation's insolvency or 1429
discontinuance of operations. The completion of a medically 1430
necessary procedure shall include the rendering of all covered 1431
health care services that constitute medically necessary follow-up 1432
care for that procedure. If an enrollee is receiving necessary 1433
inpatient care at a hospital, the provisions may limit the 1434
required provision of covered health care services relating to 1435
that inpatient care in accordance with division (D)(3) of section 1436
1751.11 of the Revised Code, and may also limit such required 1437
provision of covered health care services to the period ending 1438
thirty days after the health insuring corporation's insolvency or 1439
discontinuance of operations. 1440

The provisions required by division (C)(3) of this section 1441
shall not require any provider or health care facility to continue 1442

to provide any covered health care service after the occurrence of 1443
any of the following: 1444

(a) The end of the thirty-day period following the entry of a 1445
liquidation order under Chapter 3903. of the Revised Code; 1446

(b) The end of the enrollee's period of coverage for a 1447
contractual prepayment or premium; 1448

(c) The enrollee obtains equivalent coverage with another 1449
health insuring corporation or insurer, or the enrollee's employer 1450
obtains such coverage for the enrollee; 1451

(d) The enrollee or the enrollee's employer terminates 1452
coverage under the contract; 1453

(e) A liquidator effects a transfer of the health insuring 1454
corporation's obligations under the contract under division (A)(8) 1455
of section 3903.21 of the Revised Code. 1456

(4) A provision clearly stating the rights and 1457
responsibilities of the health insuring corporation, and of the 1458
contracted providers and health care facilities, with respect to 1459
administrative policies and programs, including, but not limited 1460
to, payments systems, utilization review, quality assurance, 1461
assessment, and improvement programs, credentialing, 1462
confidentiality requirements, and any applicable federal or state 1463
programs; 1464

(5) A provision regarding the availability and 1465
confidentiality of those health records maintained by providers 1466
and health care facilities to monitor and evaluate the quality of 1467
care, to conduct evaluations and audits, and to determine on a 1468
concurrent or retrospective basis the necessity of and 1469
appropriateness of health care services provided to enrollees. The 1470
provision shall include terms requiring the provider or health 1471
care facility to make these health records available to 1472

appropriate state and federal authorities involved in assessing 1473
the quality of care or in investigating the grievances or 1474
complaints of enrollees, and requiring the provider or health care 1475
facility to comply with applicable state and federal laws related 1476
to the confidentiality of medical or health records. 1477

(6) A provision that states that contractual rights and 1478
responsibilities may not be assigned or delegated by the provider 1479
or health care facility without the prior written consent of the 1480
health insuring corporation; 1481

(7) A provision requiring the provider or health care 1482
facility to maintain adequate professional liability and 1483
malpractice insurance. The provision shall also require the 1484
provider or health care facility to notify the health insuring 1485
corporation not more than ten days after the provider's or health 1486
care facility's receipt of notice of any reduction or cancellation 1487
of such coverage. 1488

(8) A provision requiring the provider or health care 1489
facility to observe, protect, and promote the rights of enrollees 1490
as patients; 1491

(9) A provision requiring the provider or health care 1492
facility to provide health care services without discrimination on 1493
the basis of a patient's participation in the health care plan, 1494
age, sex, ethnicity, religion, sexual preference, health status, 1495
or disability, and without regard to the source of payments made 1496
for health care services rendered to a patient. This requirement 1497
shall not apply to circumstances when the provider or health care 1498
facility appropriately does not render services due to limitations 1499
arising from the provider's or health care facility's lack of 1500
training, experience, or skill, or due to licensing restrictions. 1501

(10) A provision containing the specifics of any obligation 1502
on the primary care provider ~~or health care facility~~ to provide, 1503

or to arrange for the provision of, covered health care services 1504
twenty-four hours per day, seven days per week; 1505

(11) A provision setting forth procedures for the resolution 1506
of disputes arising out of the contract; 1507

(12) A provision stating that the hold harmless provision 1508
required by division (C)(2) of this section shall survive the 1509
termination of the contract with respect to services covered and 1510
provided under the contract during the time the contract was in 1511
effect, regardless of the reason for the termination, including 1512
the insolvency of the health insuring corporation; 1513

(13) A provision requiring those terms that are used in the 1514
contract and that are defined by this chapter, be used in the 1515
contract in a manner consistent with those definitions. 1516

this division does not apply to the coverage of beneficiaries 1517
enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 1518
(1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare risk 1519
contract or medicare cost contract, or to the coverage of 1520
beneficiaries enrolled in the federal employee health benefits 1521
program pursuant to 5 U.S.C.A. 8905, or to the coverage of 1522
beneficiaries enrolled in Title XIX of the "Social Security Act," 1523
49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the 1524
medical assistance program or medicaid, provided by the Ohio 1525
department of human services under Chapter 5111. of the Revised 1526
Code, or to the coverage of beneficiaries under any federal health 1527
care program regulated by a federal regulatory body, or to the 1528
coverage of beneficiaries under any contract covering officers or 1529
employees of the state that has been entered into by the 1530
department of administrative services. 1531

(D)(1) No health insuring corporation contract with a 1532
provider or health care facility shall contain any of the 1533
following: 1534

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

(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 that accepts compensation shall include provisions requiring the

intermediary organization to provide the superintendent with 1595
regulatory access to all books, records, financial information, 1596
and documents related to the provision of health care services to 1597
subscribers and enrollees under the contract. The contract shall 1598
require the intermediary organization to maintain such books, 1599
records, financial information, and documents at its principal 1600
place of business in this state and to preserve them for at least 1601
three years in a manner that facilitates regulatory review. 1602

(I)(1) A health insuring corporation shall ~~provide notice~~ 1603
notify its affected enrollees of the termination of ~~any a~~ contract 1604
with for the provision of health care services between the health 1605
insuring corporation and a primary care physician or hospital, by 1606
mail, within thirty days after the termination of the contract. 1607

(a) Notice shall be given to subscribers of the termination 1608
of a contract with a primary care physician if the subscriber, or 1609
a dependent covered under the subscriber's health care coverage, 1610
has received health care services from the primary care physician 1611
within the previous twelve months or if the subscriber or 1612
dependent has selected the physician as the subscriber's or 1613
dependent's primary care physician within the previous twelve 1614
months. 1615

(b) Notice shall be given to subscribers of the termination 1616
of a contract with a hospital if the subscriber, or a dependent 1617
covered under the subscriber's health care coverage, has received 1618
health care services from that hospital within the previous twelve 1619
months. 1620

(2) The health insuring corporation shall pay, in accordance 1621
with the terms of the contract, for all covered health care 1622
services rendered to an enrollee by a primary care physician or 1623
hospital between the date of the termination of the contract and 1624
five days after the notification of the contract termination is 1625
mailed to a subscriber at the subscriber's last known address. 1626

(J) Divisions (A) and (B) of this section do not apply to any health insuring corporation that, on 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. 1751.14. (A) Any policy, contract, or agreement for health care services authorized by this chapter that is issued, delivered, or renewed in this state and that provides that coverage of an unmarried dependent child will terminate upon attainment of the limiting age for dependent children specified in the policy, contract, or agreement, shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if the child is and continues to be both:

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

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

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

~~(C) Nothing in this section shall be construed to require a health insuring corporation to cover a dependent child who is mentally retarded or physically handicapped if the policy,~~

~~contract, or agreement is underwritten on evidence of insurability 1657
based on health factors set forth in the application, or if the 1658
dependent child does not satisfy the conditions of the policy, 1659
contract, or agreement as to any requirement for evidence of 1660
insurability or any other provision of the policy, contract, or 1661
agreement, satisfaction of which is required for coverage 1662
thereunder to take effect. In any such case, the terms of the 1663
policy, contract, or agreement shall apply with regard to the 1664
coverage or exclusion of the dependent from such coverage. 1665~~

~~(D) This section does not apply to any health insuring 1666
corporation, policy, contract, or agreement offering only 1667
supplemental health care services or specialty health care 1668
services. 1669~~

Sec. 1751.141. A health insuring corporation shall provide 1670
coverage, in accordance with the terms of the contract, for a 1671
subscriber's dependent children living outside the health insuring 1672
corporation's approved service area if a court order requires the 1673
subscriber to provide health care coverage to the dependent 1674
children. 1675

Sec. 1751.15. (A) After a health insuring corporation has 1676
furnished, directly or indirectly, basic health care services for 1677
a period of twenty-four months, and if it currently meets the 1678
financial requirements set forth in section 1751.28 of the Revised 1679
Code and had net income as reported to the superintendent of 1680
insurance for at least one of the preceding four calendar 1681
quarters, it shall hold an annual open enrollment period of not 1682
less than thirty days during its month of licensure for 1683
individuals who are not federally eligible individuals at the time 1684
they apply for enrollment. 1685

(B) During the open enrollment period described in division 1686
(A) of this section, the health insuring corporation shall accept 1687

applicants and their dependents in the order in which they apply 1688
for enrollment and in accordance with any of the following: 1689

(1) Up to its capacity, as determined by the health insuring 1690
corporation subject to review by the superintendent; 1691

(2) If less than its capacity, one per cent of the health 1692
insuring corporation's total number of subscribers residing in 1693
this state as of the immediately preceding thirty-first day of 1694
December. 1695

(C) Where a health insuring corporation demonstrates to the 1696
satisfaction of the superintendent that such open enrollment would 1697
jeopardize its economic viability, the superintendent may do any 1698
of the following: 1699

(1) Waive the requirement for open enrollment; 1700

(2) Impose a limit on the number of applicants and their 1701
dependents that must be enrolled; 1702

(3) Authorize such underwriting restrictions upon open 1703
enrollment as are necessary to do any of the following: 1704

(a) Preserve its financial stability; 1705

(b) Prevent excessive adverse selection; 1706

(c) Avoid unreasonably high or unmarketable charges for 1707
coverage of health care services. 1708

(D)(1) A request to the superintendent under division (C) of 1709
this section for any restriction, limit, or waiver during an open 1710
enrollment period must be accompanied by supporting documentation, 1711
including financial data. In reviewing the request, the 1712
superintendent may consider various factors, including the size of 1713
the health insuring corporation, the health insuring corporation's 1714
net worth and profitability, the health insuring corporation's 1715
delivery system structure, and the effect on profitability of 1716
prior open enrollments. 1717

(2) Any action taken by the superintendent under division (C) 1718
of this section shall be effective for a period of not more than 1719
one year. At the expiration of such time, a new demonstration of 1720
the health insuring corporation's need for the restriction, limit, 1721
or waiver shall be made before a new restriction, limit, or waiver 1722
is granted by the superintendent. 1723

(3) Irrespective of the granting of any restriction, limit, 1724
or waiver by the superintendent, a health insuring corporation may 1725
reject an applicant or a dependent of the applicant during its 1726
open enrollment period if the applicant or dependent: 1727

(a) Was eligible for and was covered under any 1728
employer-sponsored health care coverage, or if employer-sponsored 1729
health care coverage was available at the time of open enrollment; 1730

(b) Is eligible for continuation coverage under state or 1731
federal law; 1732

(c) Is eligible for medicare, and the health insuring 1733
corporation does not have an agreement on appropriate payment 1734
mechanisms with the governmental agency administering the medicare 1735
program. 1736

(E) A health insuring corporation shall not be required 1737
either to enroll applicants or their dependents who are confined 1738
to a health care facility because of chronic illness, permanent 1739
injury, or other infirmity that would cause economic impairment to 1740
the health insuring corporation if such applicants or their 1741
dependents were enrolled or to make the effective date of benefits 1742
for applicants or their dependents enrolled under this section 1743
earlier than ninety days after the date of enrollment. 1744

(F) A health insuring corporation shall not be required to 1745
cover the fees or costs, or both, for any basic health care 1746
service related to a transplant of a body organ if the transplant 1747
occurs within one year after the effective date of an enrollee's 1748

coverage under this section. This limitation on coverage does not
apply to a newly born child who meets the requirements for
coverage under section 1751.61 of the Revised Code.

(G) Each health insuring corporation required to hold an open
enrollment pursuant to division (A) of this section shall file
with the superintendent, not later than sixty days prior to the
commencement of the proposed open enrollment period, the following
documents:

(1) The proposed public notice of open enrollment;

(2) The evidence of coverage approved pursuant to section
1751.11 of the Revised Code that will be used during open
enrollment;

(3) The contractual periodic prepayment and premium rate
approved pursuant to section 1751.12 of the Revised Code that will
be applicable during open enrollment;

(4) Any solicitation document approved pursuant to section
1751.31 of the Revised Code to be sent to applicants, including
the application form that will be used during open enrollment;

(5) A list of the proposed dates of publication of the public
notice, and the names of the newspapers in which the notice will
appear;

(6) Any request for a restriction, limit, or waiver with
respect to the open enrollment period, along with any supporting
documentation.

(H)(1) An open enrollment period shall not satisfy the
requirements of this section unless the health insuring
corporation provides adequate public notice in accordance with
divisions (H)(2) and (3) of this section. No public notice shall
be used until the form of the public notice has been filed by the
health insuring corporation with the superintendent. If the

superintendent does not disapprove the public notice within sixty
days after it is filed, it shall be deemed approved, unless the
superintendent sooner gives approval for the public notice. If the
superintendent determines within this sixty-day period that the
public notice fails to meet the requirements of this section, the
superintendent shall so notify the health insuring corporation and
it shall be unlawful for the health insuring corporation to use
the public notice. Such disapproval shall be effected by a written
order, which shall state the grounds for disapproval and shall be
issued in accordance with Chapter 119. of the Revised Code.

(2) A public notice pursuant to division (H)(1) of this
section shall be published in at least one newspaper of general
circulation in each county in the health insuring corporation's
service area, at least once in each of the two weeks immediately
preceding the month in which the open enrollment is to occur and
in each week of that month, or until the enrollment limitation is
reached, whichever occurs first. The notice published during the
last week of open enrollment shall appear not less than five days
before the end of the open enrollment period. It shall be at least
two newspaper columns wide or two and one-half inches wide,
whichever is larger. The first two lines of the text shall be
published in not less than twelve-point, boldface type. The
remainder of the text of the notice shall be published in not less
than eight-point type. The entire public notice shall be
surrounded by a continuous black line not less than one-eighth of
an inch wide.

(3) The following information shall be included in the public
notice provided under division (H)(2) of this section:

(a) The dates that open enrollment will be held and the date
coverage obtained under the open enrollment will become effective;

(b) Notice that an applicant or the applicant's dependents

will not be denied coverage during open enrollment because of a	1811
preexisting health condition, but that some limitations and	1812
restrictions may apply;	1813
(c) The address where a person may obtain an application;	1814
(d) The telephone number that a person may call to request an	1815
application or to ask questions;	1816
(e) The date the first payment will be due;	1817
(f) The actual rates or range of rates that will be	1818
applicable for applicants;	1819
(g) Any limitation granted by the superintendent on the	1820
number of applications that will be accepted by the health	1821
insuring corporation.	1822
(4) Within thirty days after the end of an open enrollment	1823
period, the health insuring corporation shall submit to the	1824
superintendent proof of publication for the public notices, and	1825
shall report the total number of applicants and their dependents	1826
enrolled during the open enrollment period.	1827
(I)(1) No health insuring corporation may employ any scheme,	1828
plan, or device that restricts the ability of any person to enroll	1829
during open enrollment.	1830
(2) No health insuring corporation may require enrollment to	1831
be made in person. Every health insuring corporation shall permit	1832
application for coverage by mail. A representative of the health	1833
insuring corporation may visit an applicant who has submitted an	1834
application by mail, in order to explain the operations of the	1835
health insuring corporation and to answer any questions the	1836
applicant may have. Every health insuring corporation shall make	1837
open enrollment applications and solicitation documents readily	1838
available to any potential applicant who requests such material.	1839
(J) An application postmarked on the last day of an open	1840

enrollment period shall qualify as a valid application, regardless
of the date on which it is received by the health insuring
corporation.

(K) This section does not apply to any health insuring
corporation that offers only supplemental health care services or
specialty health care services, or to any health insuring
corporation that offers plans only through Title XVIII or Title
XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A.
301, as amended, and that has no other commercial enrollment, or
to any health insuring corporation that offers plans only through
other federal health care programs regulated by federal regulatory
bodies and that has no other commercial enrollment, or to any
health insuring corporation that offers plans only through
contracts covering officers or employees of the state that have
been entered into by the department of administrative services and
that has no other commercial enrollment.

(L) Each health insuring corporation shall accept federally
eligible individuals for open enrollment coverage as provided in
section 3923.581 of the Revised Code. A health insuring
corporation may reinsure coverage of any federally eligible
individual acquired under that section with the open enrollment
reinsurance program in accordance with division (G) of section
3924.11 of the Revised Code. Fixed periodic prepayment rates
charged for coverage reinsured by the program shall be established
in accordance with section 3924.12 of the Revised Code.

(M) As used in this section, "federally eligible individual"
means an eligible individual as defined in 45 C.F.R. 148.103.

Sec. 1751.16. (A) Except as provided in division (F) of this
section, every group contract issued by a health insuring
corporation shall provide an option for conversion to an
individual contract issued on a direct-payment basis to any

subscriber covered by the group contract who terminates employment	1872
or membership in the group, unless:	1873
(1) Termination of the conversion option or contract is based	1874
upon nonpayment of premium after reasonable notice in writing has	1875
been given by the health insuring corporation to the subscriber.	1876
	1877
(2) The subscriber is, or is eligible to be, covered for	1878
benefits at least comparable to the group contract under any of	1879
the following:	1880
(a) Title XVIII of the "Social Security Act," 49 Stat. 620	1881
(1935), 42 U.S.C.A. 301, as amended;	1882
(b) Any act of congress or law under this or any other state	1883
of the United States providing coverage at least comparable to the	1884
benefits under division (A)(2)(a) of this section;	1885
(c) Any policy of insurance or health care plan providing	1886
coverage at least comparable to the benefits under division	1887
(A)(2)(a) of this section.	1888
(B)(1) The direct-payment contract offered by the health	1889
insuring corporation pursuant to division (A) of this section	1890
shall provide the following:	1891
(a) In the case of an individual who is not a federally	1892
eligible individual, benefits comparable to benefits in any of the	1893
individual contracts then being issued to individual subscribers	1894
by the health insuring corporation;	1895
(b) In the case of a federally eligible individual, a basic	1896
and standard plan established by the board of directors of the	1897
Ohio health reinsurance program or plans substantially similar to	1898
the basic and standard plan in benefit design and scope of covered	1899
services. For purposes of division (B)(1)(b) of this section, the	1900
superintendent of insurance shall determine whether a plan is	1901

substantially similar to the basic or standard plan in benefit 1902
design and scope of covered services. The contractual periodic 1903
prepayments charged for such plans may not exceed an amount that 1904
is two times the midpoint of the standard rate charged any other 1905
individual of a group to which the organization is currently 1906
accepting new business and for which similar copayments ~~and~~ 1907
~~deductibles~~ are applied. 1908

(2) The direct payment contract offered pursuant to division 1909
(A) of this section may include a coordination of benefits 1910
provision as approved by the superintendent. 1911

(3) For purposes of division (B) of this section "federally 1912
eligible individual" means an eligible individual as defined in 45 1913
C.F.R. 148.103. 1914

(C) The option for conversion shall be available: 1915

(1) Upon the death of the subscriber, to the surviving spouse 1916
with respect to such of the spouse and dependents as are then 1917
covered by the group contract; 1918

(2) To a child solely with respect to the child upon the 1919
child's attaining the limiting age of coverage under the group 1920
contract while covered as a dependent under the contract; 1921

(3) Upon the divorce, dissolution, or annulment of the 1922
marriage of the subscriber, to the divorced spouse, or, in the 1923
event of annulment, to the former spouse of the subscriber. 1924

(D) No health insuring corporation shall use age as the basis 1925
for refusing to renew a converted contract. 1926

(E) Written notice of the conversion option provided by this 1927
section shall be given to the subscriber by the health insuring 1928
corporation by mail. The notice shall be sent to the subscriber's 1929
address in the records of the employer upon receipt of notice from 1930
the employer of the event giving rise to the conversion option. If 1931

the subscriber has not received notice of the conversion privilege 1932
at least fifteen days prior to the expiration of the thirty-day 1933
conversion period, then the subscriber shall have an additional 1934
period within which to exercise the privilege. This additional 1935
period shall expire fifteen days after the subscriber receives 1936
notice, but in no event shall the period extend beyond sixty days 1937
after the expiration of the thirty-day conversion period. 1938

1939

(F) This section does not apply to any group contract 1940
offering only supplemental health care services or specialty 1941
health care services. 1942

Sec. 1751.20. (A) No health insuring corporation, or agent, 1943
employee, or representative of a health insuring corporation, 1944
shall use any advertisement or solicitation document, or shall 1945
engage in any activity, that is unfair, untrue, misleading, or 1946
deceptive. 1947

(B) No health insuring corporation shall use a name that is 1948
deceptively similar to the name or description of any insurance or 1949
surety corporation doing business in this state. 1950

(C) All solicitation documents, advertisements, evidences of 1951
coverage, and enrollee identification cards used by a health 1952
insuring corporation shall contain the health insuring 1953
corporation's name. The use of a trade name, an insurance group 1954
designation, the name of a parent company, the name of a division 1955
of an affiliated insurance company, a service mark, a slogan, a 1956
symbol, or other device, without the name of the health insuring 1957
corporation as stated in its articles of incorporation, shall not 1958
satisfy this requirement if the usage would have the capacity and 1959
tendency to mislead or deceive persons as to the true identity of 1960
the health insuring corporation. 1961

(D) No solicitation document or advertisement used by a 1962

health insuring corporation shall contain any words, symbols, or
physical materials that are so similar in content, phraseology,
shape, color, or other characteristic to those used by an agency
of the federal government or this state, that prospective
enrollees may be led to believe that the solicitation document or
advertisement is connected with an agency of the federal
government or this state.

(E) A health insuring corporation that provides basic health
care services may use the phrase "health maintenance organization"
or the abbreviation "HMO" in its marketing name, advertising,
solicitation documents, or marketing literature, or in reference
to the phrase "doing business as" or the abbreviation "DBA."

(F) This section does not apply to 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 to the
coverage of beneficiaries enrolled in the federal employee health
benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage
of 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 to the coverage of beneficiaries under any federal health
care program regulated by a federal regulatory body, or to the
coverage of beneficiaries under any contract covering officers or
employees of the state that has been entered into by the
department of administrative services.

Sec. 1751.31. (A) Any changes in a health insuring
corporation's solicitation document shall be filed with the
superintendent of insurance. The superintendent, within sixty days
of filing, may disapprove any solicitation document or amendment

to it on any of the grounds stated in this section. Such 1994
disapproval shall be effected by written notice to the health 1995
insuring corporation. The notice shall state the grounds for 1996
disapproval and shall be issued in accordance with Chapter 119. of 1997
the Revised Code. 1998

(B) The solicitation document shall contain all information 1999
necessary to enable a consumer to make an informed choice as to 2000
whether or not to enroll in the health insuring corporation. The 2001
information shall include a specific description of the health 2002
care services to be available and the approximate number and type 2003
of full-time equivalent medical practitioners. The information 2004
shall be presented in the solicitation document in a manner that 2005
is clear, concise, and intelligible to prospective applicants in 2006
the proposed service area. 2007

(C) Every potential applicant whose subscription to a health 2008
care plan is solicited shall receive, at or before the time of 2009
solicitation, a solicitation document approved by the 2010
superintendent. 2011

(D) Notwithstanding division (A) of this section, a health 2012
insuring corporation may use a solicitation document that the 2013
corporation uses in connection with policies for beneficiaries of 2014
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 2015
U.S.C.A. 301, as amended, pursuant to a medicare risk contract or 2016
medicare cost contract, or for policies for beneficiaries of the 2017
federal employees health benefits program pursuant to 5 U.S.C.A. 2018
8905, or for policies for beneficiaries of Title XIX of the 2019
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as 2020
amended, known as the medical assistance program or medicaid, 2021
provided by the Ohio department of human services under Chapter 2022
5111. of the Revised Code, or for policies for beneficiaries of 2023
any other federal health care program regulated by a federal 2024

regulatory body, or for policies for beneficiaries of contracts 2025
covering officers or employees of the state entered into by the 2026
department of administrative services, if both of the following 2027
apply: 2028

(1) The solicitation document has been approved by the United 2029
States department of health and human services, the United States 2030
office of personnel management, ~~or~~ the Ohio department of human 2031
services, or the department of administrative services. 2032

(2) The solicitation document is filed with the 2033
superintendent of insurance prior to use and is accompanied by 2034
documentation of approval from the United States department of 2035
health and human services, the United States office of personnel 2036
management, ~~or~~ the Ohio department of human services, or the 2037
department of administrative services. 2038

(E) No health insuring corporation, or its agents or 2039
representatives, shall use monetary or other valuable 2040
consideration, engage in misleading or deceptive practices, or 2041
make untrue, misleading, or deceptive representations to induce 2042
enrollment. Nothing in this division shall prohibit incentive 2043
forms of remuneration such as commission sales programs for the 2044
health insuring corporation's employees and agents. 2045

(F) Any person obligated for any part of a premium rate in 2046
connection with an enrollment agreement, in addition to any right 2047
otherwise available to revoke an offer, may cancel such agreement 2048
within seventy-two hours after having signed the agreement or 2049
offer to enroll. Cancellation occurs when written notice of the 2050
cancellation is given to the health insuring corporation or its 2051
agents or other representatives. A notice of cancellation mailed 2052
to the health insuring corporation shall be considered to have 2053
been filed on its postmark date. 2054

(G) Nothing in this section shall prohibit healthy lifestyle 2055

programs. 2056

Sec. 1751.32. Each health insuring corporation, annually, on 2057
or before the first day of March, shall file a report with the 2058
superintendent of insurance and the director of health, covering 2059
the preceding calendar year. 2060

The report shall be verified by an officer of the health 2061
insuring corporation, shall be in the form the superintendent 2062
prescribes, and shall include: 2063

(A) A financial statement of the health insuring corporation, 2064
including its balance sheet and receipts and disbursements for the 2065
preceding year, which reflect, at a minimum: 2066

(1) All premium rate and other payments received for health 2067
care services rendered; 2068

(2) Expenditures with respect to all categories of providers, 2069
facilities, insurance companies, and other persons engaged to 2070
fulfill obligations of the health insuring corporation arising out 2071
of its health care policies, contracts, certificates, and 2072
agreements; 2073

(3) Expenditures for capital improvements or additions 2074
thereto, including, but not limited to, construction, renovation, 2075
or purchase of facilities and equipment. 2076

(B) A description of the enrollee population and composition, 2077
group and nongroup; 2078

(C) A summary of enrollee written complaints and their 2079
disposition; 2080

(D) A statement of the number of subscriber policies, 2081
contracts, certificates, and agreements that have been terminated 2082
by action of the health insuring corporation, including the number 2083
of enrollees affected; 2084

(E) A summary of the information compiled pursuant to 2085
division (B)(5) of section 1751.04 of the Revised Code; 2086

(F) A current report of the names and addresses of the 2087
persons responsible for the conduct of the affairs of the health 2088
insuring corporation as required by section 1751.03 of the Revised 2089
Code. Additionally, the report shall include the amount of wages, 2090
expense reimbursements, and other payments to these persons for 2091
services to the health insuring corporation, and shall include a 2092
full disclosure of the financial interests related to the 2093
operations of the health insuring corporation acquired by these 2094
persons during the preceding year. 2095

~~(G) An audit report certified by an independent certified 2096
public accountant in the form prescribed by the superintendent by 2097
rule; 2098~~

~~(H) An actuarial opinion in the form prescribed by the 2099
superintendent by rule; 2100~~

~~(I)~~(H) Any other information relating to the performance of 2101
the health insuring corporation that is necessary to enable the 2102
superintendent to carry out the superintendent's duties under this 2103
chapter. 2104

Sec. 1751.321. Each health insuring corporation, annually, on 2105
or before the first day of June, shall file with the 2106
superintendent of insurance and the director of health an audit 2107
report certified by an independent certified public accountant 2108
covering the preceding calendar year. The report shall be verified 2109
by an officer of the health insuring corporation and shall be in 2110
the form prescribed by the superintendent by rule. 2111

Sec. 1751.46. (A) The superintendent of insurance and the 2112
director of health may contract with qualified persons to make 2113
recommendations concerning the determinations required to be made 2114

by the superintendent or the director relative to an expansion of 2115
a service area pursuant to division (C) of section 1751.03 of the 2116
Revised Code, an application for a certificate of authority 2117
pursuant to sections 1751.04 and 1751.05 of the Revised Code, a 2118
contractual periodic prepayment or premium rate pursuant to 2119
section 1751.12 of the Revised Code, and an examination pursuant 2120
to division (B) of section 1751.34 of the Revised Code. The 2121
recommendations may be accepted in full or in part, or may be 2122
rejected, by the superintendent or director. 2123

The total cost of a contract with a qualified person pursuant 2124
to this division shall represent the fair market value of the 2125
services provided and shall be borne by the health insuring 2126
corporation that is the subject of the determination required to 2127
be made by the superintendent or the director. 2128

(B) No qualified person placed on contract by the 2129
superintendent or the director pursuant to division (A) of this 2130
section shall have a conflict of interest with the department of 2131
insurance, the department of health, or the health insuring 2132
corporation. 2133

Sec. 1751.55. A health insuring corporation policy, contract, 2134
or agreement shall not be construed to exclude illness or injury 2135
upon the ground that the subscriber might have elected to have 2136
such illness or injury covered by workers' compensation under 2137
~~division (A)(3) of section 4123.01~~ Chapter 4123. of the Revised 2138
Code unless the policy, contract, or agreement clearly excludes 2139
work or occupational related illness or injury, or the policy, 2140
contract, or agreement, or a separate writing signed by the 2141
subscriber, informs the subscriber that such coverage is excluded 2142
and may be available to the subscriber under workers' compensation 2143
as the sole proprietor of a business, a member of a partnership, 2144
or an officer of a family farm corporation. 2145

Sec. 1751.58. Except as otherwise provided in section 2721 of 2146
the "Health Insurance Portability and Accountability Act of 1996," 2147
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as 2148
amended, the following conditions apply to all group health 2149
insuring corporation contracts that are sold in connection with an 2150
employment-related group health care plan and that are not subject 2151
to section 3924.03 of the Revised Code: 2152

(A)(1) Except as provided in section 2712(b) to (e) of the 2153
"Health Insurance Portability and Accountability Act of 1996," if 2154
a health insuring corporation offers coverage in the small or 2155
large group market in connection with a group contract, the 2156
~~organization~~ corporation shall renew or continue in force such 2157
coverage at the option of the contract holder. 2158

(2) A health insuring corporation may cancel or decide not to 2159
renew the coverage of any eligible employee or of a dependent of 2160
an eligible employee under the group contract in accordance with 2161
division (B) of section 1751.18 Of the Revised Code. 2162

(B) Such group contracts are subject to division ~~(E)(1)~~(A)(3) 2163
of section 3924.03 and sections 3924.033 and 3924.27 of the 2164
Revised Code. 2165

(C) Such group contracts shall provide for the special 2166
enrollment periods described in section 2701(f) of the "Health 2167
Insurance Portability and Accountability Act of 1996." 2168

(D) At least once in every twelve-month period, a health 2169
insuring corporation shall provide to all late enrollees, as 2170
defined in section 3924.01 of the Revised Code, who are identified 2171
by the contract holder, the option to enroll in the group 2172
contract. The enrollment option shall be provided for a minimum 2173
period of thirty consecutive days. All delays of coverage imposed 2174
under the group contract, including any affiliation period, shall 2175

begin on the date the health insuring corporation receives notice 2176
of the late enrollee's application or request for coverage, and 2177
shall run concurrently with each other. 2178

Sec. 1751.59. ~~(A)~~ No individual or group health insuring 2179
corporation policy, contract, or agreement that makes family 2180
coverage available may be delivered, issued for delivery, or 2181
renewed in this state, unless the policy, contract, or agreement 2182
covers adopted children of the subscriber on the same basis as 2183
other dependents. 2184

~~(B)~~ The coverage required by this section is subject to the 2185
requirements and restrictions set forth in section 3924.51 of the 2186
Revised Code. ~~Coverage for dependent children living outside the~~ 2187
~~health insuring corporation's approved service area must be~~ 2188
~~provided if a court order requires the subscriber to provide~~ 2189
~~health care coverage.~~ 2190

Sec. 1751.60. (A) Except as provided for in divisions (E) and 2191
(F) of this section, every provider or health care facility that 2192
contracts with a health insuring corporation to provide health 2193
care services to the health insuring corporation's enrollees or 2194
subscribers shall seek compensation for covered services solely 2195
from the health insuring corporation and not, under any 2196
circumstances, from the enrollees or subscribers, except for 2197
approved ~~deductibles and~~ copayments. 2198

(B) No subscriber or enrollee of a health insuring 2199
corporation is liable to any contracting provider or health care 2200
facility for the cost of any covered health care services, if the 2201
subscriber or enrollee has acted in accordance with the evidence 2202
of coverage. 2203

(C) Except as provided for in divisions (E) and (F) of this 2204
section, every contract between a health insuring corporation and 2205

provider or health care facility shall contain a provision 2206
approved by the superintendent of insurance requiring the provider 2207
or health care facility to seek compensation solely from the 2208
health insuring corporation and not, under any circumstances, from 2209
the subscriber or enrollee, except for approved ~~deductibles and~~ 2210
copayments. 2211

(D) Nothing in this section shall be construed as preventing 2212
a provider or health care facility from billing the enrollee or 2213
subscriber of a health insuring corporation for noncovered 2214
services. 2215

(E) Upon application by a health insuring corporation and a 2216
provider or health care facility, the superintendent may waive the 2217
requirements of divisions (A) and (C) of this section when, in 2218
addition to the reserve requirements contained in section 1751.28 2219
of the Revised Code, the health insuring corporation provides 2220
sufficient assurances to the superintendent that the provider or 2221
health care facility has been provided with financial guarantees. 2222
No waiver of the requirements of divisions (A) and (C) of this 2223
section is effective as to enrollees or subscribers for whom the 2224
health insuring corporation is compensated under a provider 2225
agreement or risk contract entered into pursuant to Chapter 5111. 2226
or 5115. of the Revised Code. 2227

(F) The requirements of divisions (A) to (C) of this section 2228
apply only to health care services provided to an enrollee or 2229
subscriber prior to the effective date of a termination of a 2230
contract between the health insuring corporation and the provider 2231
or health care facility. 2232

Sec. 1751.62. (A) As used in this section, "screening 2233
mammography" means a radiologic examination utilized to detect 2234
unsuspected breast cancer at an early stage in an asymptomatic 2235
woman and includes the x-ray examination of the breast using 2236

equipment that is dedicated specifically for mammography, 2237
including the x-ray tube, filter, compression device, screens, 2238
film, and cassettes, and that has an average radiation exposure 2239
delivery of less than one rad mid-breast. "Screening mammography" 2240
includes two views for each breast. The term also includes the 2241
professional interpretation of the film. 2242

"Screening mammography" does not include diagnostic 2243
mammography. 2244

(B) Every individual or group health insuring corporation 2245
policy, contract, or agreement providing basic health care 2246
services that is delivered, issued for delivery, or renewed in 2247
this state shall provide benefits for the expenses of both of the 2248
following: 2249

(1) Screening mammography to detect the presence of breast 2250
cancer in adult women; 2251

(2) Cytologic screening for the presence of cervical cancer. 2252

(C) The benefits provided under division (B)(1) of this 2253
section shall cover expenses in accordance with all of the 2254
following: 2255

(1) If a woman is at least thirty-five years of age but under 2256
forty years of age, one screening mammography; 2257

(2) If a woman is at least forty years of age but under fifty 2258
years of age, either of the following: 2259

(a) One screening mammography every two years; 2260

(b) If a licensed physician has determined that the woman has 2261
risk factors to breast cancer, one screening mammography every 2262
year. 2263

(3) If a woman is at least fifty years of age but under 2264
sixty-five years of age, one screening mammography every year. 2265

(D)(1) The benefits provided under division (B)(1) of this section shall not exceed eighty-five dollars per year unless a lower amount is established pursuant to a provider contract.

(2) The benefit paid in accordance with division (D)(1) of this section shall constitute full payment. No institutional or professional health care provider shall seek or receive remuneration in excess of the payment made in accordance with division (D)(1) of this section, except for approved ~~deductibles~~ and copayments.

(E) The benefits provided under division (B)(1) of this section shall be provided only for screening mammographies that are performed in a health care facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a hospital as defined in section 3727.01 of the Revised Code.

(F) The benefits provided under divisions (B)(1) and (2) of this section shall be provided according to the terms of the subscriber contract.

(G) The benefits provided under division (B)(2) of this section shall be provided only for cytologic screenings that are processed and interpreted in a laboratory certified by the college of American pathologists or in a hospital as defined in section 3727.01 of the Revised Code.

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. 2296
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(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. 2298
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(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 or facsimile 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.~~ 2303
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(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. 2312
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(D) For concurrent review determinations, a health insuring corporation shall make the determination within one business day after obtaining all necessary information. 2320
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(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 or facsimile within 2323
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~~one business day after making the certification, and shall provide 2327
written or electronic confirmation to the enrollee and the 2328
provider or health care facility within one business day after the 2329
telephone notification. The written notification shall include the 2330
number of extended days or next review date, the new total number 2331
of days of health care services approved, and the date of 2332
admission or initiation of health care services. 2333~~

(2) In the case of an adverse determination, the health 2334
insuring corporation shall notify the provider or health care 2335
facility rendering the health care service by telephone within one 2336
business day after making the adverse determination, and shall 2337
provide written or electronic confirmation to the enrollee and the 2338
provider or health care facility within one business day after the 2339
telephone notification. The health care service to the enrollee 2340
shall be continued, with standard copayments and deductibles, if 2341
applicable, until the enrollee has been notified of the 2342
determination. 2343

(E) For retrospective review determinations, a health 2344
insuring corporation shall make the determination within thirty 2345
business days after receiving all necessary information. 2346

(1) In the case of a certification, the health insuring 2347
corporation may notify the enrollee and the provider or health 2348
care facility rendering the health care service in writing. 2349

(2) In the case of an adverse determination, the health 2350
insuring corporation shall notify the enrollee and the provider or 2351
health care facility rendering the health care service, in 2352
writing, within five business days after making the adverse 2353
determination. 2354

(F) The time frames set forth in divisions (C), (D), and (E) 2355
of this section for determinations and notifications shall prevail 2356
unless the seriousness of the medical condition of the enrollee 2357

otherwise requires a more timely response from the health insuring 2358
corporation. The health insuring corporation shall maintain 2359
written procedures for making expedited utilization review 2360
determinations and notifications of enrollees and providers or 2361
health care facilities when warranted by the medical condition of 2362
the enrollee. 2363

(G) A written notification of an adverse determination shall 2364
include the principal reason or reasons for the determination, 2365
instructions for initiating an appeal or reconsideration of the 2366
determination, and instructions for requesting a written statement 2367
of the clinical rationale used to make the determination. A health 2368
insuring corporation shall provide the clinical rationale for an 2369
adverse determination in writing to any party who received notice 2370
of the adverse determination and who follows the instructions for 2371
a request. 2372

(H) A health insuring corporation shall have written 2373
procedures to address the failure or inability of a health care 2374
facility, provider, or enrollee to provide all necessary 2375
information for review. If the health care facility, provider, or 2376
enrollee will not release necessary information, the health 2377
insuring corporation may deny certification. 2378

Sec. 1785.01. As used in this chapter: 2379

(A) "Professional service" means any type of professional 2380
service that may be performed only pursuant to a license, 2381
certificate, or other legal authorization issued pursuant to 2382
Chapter 4701., 4703., 4705., 4715., 4723., 4725., 4729., 4731., 2383
4732., 4733., 4734., or 4741., sections 4755.01 to 4755.12, or 2384
4755.40 to 4755.56 of the Revised Code to certified public 2385
accountants, licensed public accountants, architects, attorneys, 2386
dentists, nurses, optometrists, pharmacists, doctors of medicine 2387
and surgery, doctors of osteopathic medicine and surgery, doctors 2388

of podiatric medicine and surgery, practitioners of the limited 2389
branches of medicine or surgery specified in section 4731.15 of 2390
the Revised Code, mechanotherapists, psychologists, professional 2391
engineers, chiropractors, veterinarians, occupational therapists, 2392
and physical therapists. 2393

(B) "Professional association" means an association organized 2394
under this chapter for the sole purpose of rendering one of the 2395
professional services authorized under Chapter 4701., 4703., 2396
4705., 4715., 4723., 4725., 4729., 4731., 4732., 4733., 4734., or 2397
4741., sections 4755.01 to 4755.12, or 4755.40 to 4755.56 of the 2398
Revised Code, a combination of the professional services 2399
authorized under Chapters 4703. and 4733. of the Revised Code, or 2400
a combination of the professional services of optometrists 2401
authorized under Chapter 4725. of the Revised Code, chiropractors 2402
authorized under Chapter 4734. of the Revised Code, psychologists 2403
authorized under Chapter 4732. of the Revised Code, registered or 2404
licensed practical nurses authorized under Chapter 4723. of the 2405
Revised Code, pharmacists authorized under Chapter 4729. of the 2406
Revised Code, physical therapists authorized under sections 2407
4755.40 to 4755.53 of the Revised Code, mechanotherapists 2408
authorized under section 4731.151 Of the Revised Code, and doctors 2409
of medicine and surgery, osteopathic medicine and surgery, or 2410
podiatric medicine and surgery authorized under Chapter 4731. of 2411
the Revised Code. 2412

Sec. 1785.02. An individual or group of individuals each of 2413
whom is licensed, certificated, or otherwise legally authorized to 2414
render within this state the same kind of professional service, a 2415
group of individuals each of whom is licensed, certificated, or 2416
otherwise legally authorized to render within this state the 2417
professional service authorized under Chapter 4703. or 4733. of 2418
the Revised Code, or a group of individuals each of whom is 2419

licensed, certificated, or otherwise legally authorized to render 2420
within this state the professional service of optometrists 2421
authorized under Chapter 4725. of the Revised Code, chiropractors 2422
authorized under Chapter 4734. of the Revised Code, psychologists 2423
authorized under Chapter 4732. of the Revised Code, registered or 2424
licensed practical nurses authorized under Chapter 4723. of the 2425
Revised Code, pharmacists authorized under Chapter 4729. of the 2426
Revised Code, physical therapists authorized under sections 2427
4755.40 to 4755.53 of the Revised Code, mechanotherapists 2428
authorized under section 4731.151 Of the Revised Code. or doctors 2429
of medicine and surgery, osteopathic medicine and surgery, or 2430
podiatric medicine and surgery authorized under Chapter 4731. of 2431
the Revised Code may organize and become a shareholder or 2432
shareholders of a professional association. Any group of 2433
individuals described in this section who may be rendering one of 2434
the professional services as an organization created otherwise 2435
than pursuant to this chapter may incorporate under and pursuant 2436
to this chapter by amending the agreement establishing the 2437
organization in a manner that the agreement as amended constitutes 2438
articles of incorporation prepared and filed in the manner 2439
prescribed in section 1785.08 of the Revised Code and by otherwise 2440
complying with the applicable requirements of this chapter. 2441

Sec. 1785.03. A professional association may render a 2442
particular professional service only through officers, employees, 2443
and agents who are themselves duly licensed, certificated, or 2444
otherwise legally authorized to render the professional service 2445
within this state. As used in this section, "employee" does not 2446
include clerks, bookkeepers, technicians, or other individuals who 2447
are not usually and ordinarily considered by custom and practice 2448
to be rendering a particular professional service for which a 2449
license, certificate, or other legal authorization is required and 2450

does not include any other person who performs all of that 2451
person's employment under the direct supervision and control of an 2452
officer, agent, or employee who renders a particular professional 2453
service to the public on behalf of the professional association. 2454

No professional association formed for the purpose of 2455
providing a combination of the professional services, as defined 2456
in section 1785.01 of the Revised Code, of optometrists authorized 2457
under Chapter 4725. of the Revised Code, chiropractors authorized 2458
under Chapter 4734. of the Revised Code, psychologists authorized 2459
under Chapter 4732. of the Revised Code, registered or licensed 2460
practical nurses authorized under Chapter 4723. of the Revised 2461
Code, pharmacists authorized under Chapter 4729. of the Revised 2462
Code, physical therapists authorized under sections 4755.40 to 2463
4755.53 of the Revised Code, mechanotherapists authorized under 2464
section 4731.151 Of the Revised Code, and doctors of medicine and 2465
surgery, osteopathic medicine and surgery, or podiatric medicine 2466
and surgery authorized under Chapter 4731. of the Revised Code 2467
shall control the professional clinical judgment exercised within 2468
accepted and prevailing standards of practice of a licensed, 2469
certificated, or otherwise legally authorized optometrist, 2470
chiropractor, psychologist, nurse, pharmacist, physical therapist, 2471
mechanotherapist, or doctor of medicine and surgery, osteopathic 2472
medicine and surgery, or podiatric medicine and surgery in 2473
rendering care, treatment, or professional advice to an individual 2474
patient. 2475

This division does not prevent a hospital, as defined in 2476
section 3727.01 of the Revised Code, insurer, as defined in 2477
section 3999.36 of the Revised Code, or intermediary organization, 2478
as defined in section 1751.01 of the Revised Code, from entering 2479
into a contract with a professional association described in this 2480
division that includes a provision requiring utilization review, 2481
quality assurance, peer review, or other performance or quality 2482

standards. Those activities shall not be construed as controlling 2483
the professional clinical judgment of an individual practitioner 2484
listed in this division. 2485

Sec. 1785.08. Chapter 1701. of the Revised Code applies to 2486
professional associations, including their organization and the 2487
manner of filing articles of incorporation, except that the 2488
requirements of division (A) of section 1701.06 of the Revised 2489
Code do not apply to professional associations. If any provision 2490
of this chapter conflicts with any provision of Chapter 1701. of 2491
the Revised Code, the provisions of this chapter shall take 2492
precedence. A professional association for the practice of 2493
medicine and surgery, osteopathic medicine and surgery, or 2494
podiatric medicine and surgery or for the combined practice of 2495
optometry, chiropractic, psychology, nursing, pharmacy, physical 2496
therapy, mechanotherapy, medicine and surgery, osteopathic 2497
medicine and surgery, or podiatric medicine and surgery may 2498
provide in its articles of incorporation or bylaws that its 2499
directors may have terms of office not exceeding six years. 2500

Sec. 1907.161. (A) As used in this section, "health care 2501
coverage" means sickness and accident insurance or other coverage 2502
of hospitalization, surgical care, major medical care, disability, 2503
dental care, eye care, medical care, hearing aids, and 2504
prescription drugs or any combination of those benefits or 2505
services. 2506

(B) The board of county commissioners, after consultation 2507
with the judges of the county court, shall negotiate and contract 2508
for, purchase, or otherwise procure group health care coverage for 2509
the judges and their spouses and dependents from insurance 2510
companies authorized to engage in the business of insurance in 2511
this state under Title ~~XXXIA~~ XXXIX of the Revised Code, ~~medical~~ 2512

~~care corporations organized under Chapter 1737. of the Revised~~ 2513
~~Code, health care corporations organized under Chapter 1738. of~~ 2514
~~the Revised Code, or health maintenance organizations insuring~~ 2515
~~corporations organized under Chapter ~~1742.~~ 1751. of the Revised~~ 2516
Code, except that, if the county provides group health care 2517
coverage for its employees, the group health care coverage 2518
required by this section shall be provided, if possible, through 2519
the policy or plan under which the group health care coverage is 2520
provided for the county employees. 2521

(C) The portion of the costs, premiums, or charges for the 2522
group health care coverage procured pursuant to division (B) of 2523
this section that is not paid by the judges of the county court, 2524
or all of the costs, premiums, or charges for the group health 2525
care coverage if the judges will not be paying any portion of 2526
those costs, premiums, or charges, shall be paid out of the county 2527
treasury. 2528

Sec. 2305.252. (A) As used in this section: 2529

(1) "Review board, committee, risk management personnel, or 2530
corporation" means any of the following: 2531

(a) A peer review committee of a hospital, a nonprofit health 2532
care corporation that is a member of the hospital or of which the 2533
hospital is a member, or a community mental health center; 2534
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(b) A board or committee of a hospital or of a nonprofit 2536
health care corporation that is a member of the hospital or of 2537
which the hospital is a member reviewing professional 2538
qualifications or activities of the hospital medical staff or 2539
applicants for admission to the medical staff; 2540

(c) A utilization committee of a state or local society 2541
composed of doctors of medicine or doctors of osteopathic medicine 2542

and surgery or doctors of podiatric medicine; 2543

(d) A peer review committee of nursing home providers or 2544
administrators, including a corporation engaged in performing the 2545
functions of a peer review committee of nursing home providers or 2546
administrators, or a corporation engaged in performing the 2547
functions of another type of peer review or professional standards 2548
review committee; 2549

(e) A peer review committee, professional standards review 2550
committee, or arbitration committee of a state or local society 2551
composed of doctors of medicine, doctors of osteopathic medicine 2552
and surgery, doctors of dentistry, doctors of optometry, doctors 2553
of podiatric medicine, psychologists, or registered pharmacists; 2554

(f) A peer review committee of a health ~~maintenance~~ 2555
~~organization~~ insuring corporation that has at least a two-thirds 2556
majority of member physicians in active practice and that conducts 2557
professional credentialing and quality review activities involving 2558
the competence or professional conduct of health care providers, 2559
which conduct adversely affects, or could adversely affect, the 2560
health or welfare of any patient. For purposes of this division, 2561
"health ~~maintenance organization~~ insuring corporation" includes 2562
~~wholly owned~~ wholly owned subsidiaries of a health ~~maintenance~~ 2563
~~organization~~ insuring corporation. 2564

(g) A peer review committee of any insurer authorized under 2565
Title XXXIX of the Revised Code to do the business of sickness and 2566
accident insurance in this state that has at least a two-thirds 2567
majority of physicians in active practice and that conducts 2568
professional credentialing and quality review activities involving 2569
the competence or professional conduct of health care providers, 2570
which conduct adversely affects, or could adversely affect, the 2571
health or welfare of any patient; 2572

(h) A peer review committee of any insurer authorized under 2573

Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state that has at least a two-thirds majority of physicians in active practice and that conducts professional credentialing and quality review activities involving the competence or professional conduct of a health care facility that has contracted with the insurer to provide health care services to insureds, which conduct adversely affects, or could adversely affect, the health or welfare of any patient; 2574
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(i) A peer review committee of an insurer authorized under Title XXXIX of the Revised Code to do the business of medical professional liability insurance in this state and that conducts professional quality review activities involving the competence or professional conduct of health care providers, which conduct adversely affects, or could affect, the health or welfare of any patient; 2582
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(j) A peer review committee of a health care entity. 2589

(2) "Peer review committee" means a utilization review committee, quality assurance committee, quality improvement committee, tissue committee, credentialing committee, and any other committee that conducts professional credentialing and quality review activities involving the competence or professional conduct of health care practitioners. 2590
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(3) "Health care entity" means a government entity, a for-profit or nonprofit corporation, a limited liability company, a partnership, a professional corporation, a state or local society as described in division (A)(1)(c) of this section, or other health care organization, including, but not limited to, health care entities described in division (A)(1) of this section, whether acting on its own behalf or on behalf of or in affiliation with other health care entities, that conducts, as part of its purpose, professional credentialing and quality review activities 2596
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involving the competence or professional conduct of health care
practitioners.

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(4) "Incident report or risk management report" means a
report of an incident involving injury or potential injury to a
patient as a result of patient care by a health care entity that
is prepared by or for the use of a review board, committee, risk
management personnel, or corporation and is within the scope of
the functions of that review board, committee, risk management
personnel, or corporation.

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(5) "Tort action" means a civil action for damages for
injury, death, or loss to a patient of a health care entity. "Tort
action" includes a product liability claim but does not include a
civil action for a breach of contract or another agreement between
persons.

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(B) Notwithstanding any contrary provision of section 149.43,
~~1742.141~~ 1751.21, 2305.24, 2305.25, 2305.251, or 2305.28 of the
Revised Code, an incident report or risk management report and the
contents of an incident report or risk management report are not
subject to discovery in, and are not admissible in evidence in the
trial of, a tort action. An individual who prepares or has
knowledge of the contents of an incident report or risk management
report shall not testify and shall not be required to testify in a
tort action as to the contents of the report. This division does
not prohibit or limit the discovery or admissibility of testimony
or evidence relating to patient care that is within a person's
personal knowledge.

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(C) Except as specified in division (B) of this section, this
section does not affect any provision of section ~~1742.141~~ 1751.21,
2305.24, 2305.25, 2305.251, or 2305.28 of the Revised Code that
describes, imposes, or confers an immunity from tort or other
civil liability, a forfeiture of an immunity from tort or other

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civil liability, a requirement of confidentiality, a limitation upon the use of information, data, reports, or records, tort or other civil liability, or a limitation upon discovery of matter, introduction into evidence of matter, or testimony pertaining to matter in a tort or other civil action. This section does not affect a privileged communication between an attorney and the attorney's client under section 2317.02 of the Revised Code.

(D) This section shall be considered to be purely remedial in operation and shall be applied in a remedial manner in any civil action in which this section is relevant, whether the civil action is pending in court or commenced on or after ~~the effective date of this section~~ January 27, 1997, regardless of when the cause of action accrued and notwithstanding any other section of the Revised Code or prior rule of law of this state.

Sec. 3701.18. (A) As used in this section:

(1) "Amblyopia" means reduced vision in an eye that has not received adequate use during early childhood.

(2) "501(c) organization" means an organization exempt from federal income taxation pursuant to 26 U.S.C.A. 501(a) and (c).

(B) There is hereby created in the state treasury the save our sight fund. The fund shall consist of voluntary contributions deposited as provided in section 4503.104 of the Revised Code. All investment earnings from the fund shall be credited to the fund.

(C) The director of health shall use the money in the save our sight fund as follows:

(1) To provide support to 501(c) organizations that offer vision services in all counties of the state and have demonstrated experience in the delivery of vision services to do one or more of the following:

<u>(a) Implement a voluntary children's vision screening</u>	2667
<u>training and certification program for volunteers, child day-care</u>	2668
<u>providers, nurses, teachers, health care professionals practicing</u>	2669
<u>in primary care settings, and others serving children;</u>	2670
<u>(b) Provide materials for the program implemented under</u>	2671
<u>division (C)(1)(a) of this section;</u>	2672
<u>(c) Develop and implement a registry and targeted voluntary</u>	2673
<u>case management system to determine whether children with</u>	2674
<u>amblyopia are receiving professional eye care and to provide their</u>	2675
<u>parents with information and support regarding their child's</u>	2676
<u>vision care;</u>	2677
<u>(d) Establish a matching grant program for the purchase and</u>	2678
<u>distribution of protective eyewear to children;</u>	2679
<u>(e) Provide vision health and safety programs and materials</u>	2680
<u>for classrooms.</u>	2681
<u>(2) For the purpose of section 4503.104 Of the Revised Code,</u>	2682
<u>to develop and distribute informational materials on the</u>	2683
<u>importance of eye care and safety to the registrar of motor</u>	2684
<u>vehicles and each deputy registrar;</u>	2685
<u>(3) To pay costs incurred by the director in administering</u>	2686
<u>the fund;</u>	2687
<u>(4) To reimburse the bureau of motor vehicles for the</u>	2688
<u>administrative costs incurred in performing its duties under</u>	2689
<u>section 4503.104 Of the Revised Code.</u>	2690
<u>(D) A 501(c) organization seeking funding from the save our</u>	2691
<u>sight fund for any of the projects specified in division (C) of</u>	2692
<u>this section shall submit a request for the funding to the</u>	2693
<u>director in accordance with rules adopted under division (E) of</u>	2694
<u>this section. The director shall determine the appropriateness of</u>	2695
<u>and approve or disapprove projects for funding and approve or</u>	2696

disapprove the disbursement of money from the save our sight fund. 2697

(E) The public health council shall adopt rules in accordance 2698
with Chapter 119. of the Revised Code to implement this section. 2699
The rules shall include the parameters of the projects specified 2700
in division (C)(1) of this section that may be funded with money 2701
in the save our sight fund and procedures for 501(c) organizations 2702
to request funding from the fund. 2703

Sec. 3701.75. (A) As used in this section: 2704

(1) "Electronic record" means a record communicated, 2705
received, or stored by electronic, magnetic, optical, or similar 2706
means for storage in an information system or transmission from 2707
one information system to another. "Electronic record" includes a 2708
record that is communicated, received, or stored by electronic 2709
data interchange, electronic mail, facsimile, telex, or similar 2710
methods of communication. 2711

(2) "Electronic signature" means any of the following 2712
attached to or associated with an electronic record by an 2713
individual to authenticate the record: 2714

(a) A code consisting of a combination of letters, numbers, 2715
characters, or symbols that is adopted or executed by an 2716
individual as that individual's electronic signature; 2717

(b) A computer-generated signature code created for an 2718
individual; 2719

(c) An electronic image of an individual's handwritten 2720
signature created by using a pen computer. 2721

(3) "Health care record" means any document or combination of 2722
documents pertaining to a patient's medical history, diagnosis, 2723
prognosis, or medical condition that is generated and maintained 2724
in the process of the patient's treatment. 2725

(B) Any All notes, orders, and observations entered into a 2726

health care record, including any interpretive reports of 2727
diagnostic tests or specific treatments, such as radiologic or 2728
electrocardiographic reports, operative reports, reports of 2729
pathologic examination of tissue, and similar reports, shall be 2730
authenticated by the individual who made or authorized the entry. 2731
An entry into a health care record may be authenticated by 2732
executing handwritten signatures or handwritten initials directly 2733
on the entry or by executing an electronic signature. An entry 2734
that is an electronic signature executed in accordance with an 2735
electronic signature system that is certified by the department of 2736
health under division (C) of this section shall be considered for 2737
all legal purposes to be the same as having executed a handwritten 2738
signature or handwritten initials, except when any federal law 2739
governing state participation in a federal program requires that 2740
entries into health care records record may be authenticated only 2741
by handwritten signatures or handwritten initials. The An 2742
electronic signature generated by a certified system shall be 2743
presumed to be the signature of the individual to whom it is 2744
assigned and to be affixed for the purpose of authenticating an 2745
entry into a health care record. 2746

~~(C)(1) The department of health shall administer a program~~ 2747
~~under which entities that create and maintain health care records~~ 2748
~~may receive certification from the department of their electronic~~ 2749
~~signature systems. The department shall determine the types of~~ 2750
~~entities that are eligible to have their electronic signature~~ 2751
~~systems certified under this section.~~ 2752

~~The department shall certify an eligible entity's electronic~~ 2753
~~signature system if all of the following apply:~~ 2754

~~(a)(1) The entity responsible for creating and maintaining~~ 2755
~~the health care record adopts a policy that permits the use of~~ 2756
~~electronic signatures on electronic records.~~ 2757

~~(b)(2) The entity's electronic signature system utilizes~~ 2758

either a two-level access control mechanism that assigns a unique
identifier to each user or a biometric access control device.

~~(e)(3)~~ The entity takes steps to safeguard against
unauthorized access to the system and forgery of electronic
signatures.

~~(d)(4)~~ The system includes a process to verify that the
individual affixing the electronic signature has reviewed the
contents of the entry and determined that the entry contains what
that individual intended.

~~(e)(5)~~ The policy adopted by the entity pursuant to division
~~(C)(B)(1)(a)~~ of this section prescribes all of the following:

~~(i)(a)~~ A procedure by which each user of the system must
certify in writing that the user will follow the confidentiality
and security policies maintained by the entity for the system;

~~(ii)(b)~~ Penalties for misusing the system;

~~(iii)(c)~~ Training for all users of the system that includes
an explanation of the appropriate use of the system and the
consequences for not complying with the entity's confidentiality
and security policies.

~~(2) In lieu of making a direct determination of compliance
under division (C)(1) of this section, the department may accept
the approval of any private or public organization that has
reviewed the entity's system, if the department determines that
the organization has standards at least as stringent as those
specified in division (C)(1) of this section. Organizations with
standards for approval of electronic signature systems that the
department may accept include the joint commission on
accreditation of healthcare organizations, the American
osteopathic association, the United States food and drug
administration, and the United States health care financing
administration. If an entity receives approval of its electronic~~

~~signature system in this manner, and is subsequently cited by the
private or public organization for a violation that involves the
entity's system, the entity shall immediately notify the
department of the citation and the department shall withdraw its
certification.~~

~~(3) The public health council shall adopt rules in accordance
with Chapter 119. of the Revised Code as necessary for the
department's administration of the program for certifying the
electronic signature systems of entities that create and maintain
health care records.~~

Sec. 3702.141. (A) As used in this section, "existing health
care facility" has the same meaning as in section 3702.51 of the
Revised Code.

(B) Section 3702.14 of the Revised Code shall not be
construed to require any existing health care facility that is
conducting an activity specified in section 3702.11 of the Revised
Code, which activity was initiated on or before March 20, 1997, to
alter, upgrade, or otherwise improve the structure or fixtures of
the facility in order to comply with any rule adopted under
section 3702.11 of the Revised Code relating to that activity,
unless one of the following applies:

(1) The facility initiates a construction, renovation, or
reconstruction project that involves a capital expenditure of at
least fifty thousand dollars, not including expenditures for
equipment or staffing or operational costs, and that directly
involves the area in which the existing service is conducted.

(2) The facility initiates another activity specified in
section 3702.11 of the Revised Code.

(3) The facility initiates a service level designation change
for obstetric and newborn care.

(4) <u>The facility proposes to add a cardiac catheterization laboratory to an existing cardiac catheterization service.</u>	2820 2821
(5) <u>The facility proposes to add an open-heart operating room to an existing open-heart surgery service.</u>	2822 2823
(6) <u>The director of health determines, by clear and convincing evidence, that failure to comply with the rule would create an imminent risk to the health and welfare of any patient.</u>	2824 2825 2826
(C) <u>If division (B)(4) or (5) of this section applies, any alteration, upgrade, or other improvement required shall apply only to the proposed addition to the existing service if the cost of the addition is less than the capital expenditure threshold set forth in division (B)(1) of this section.</u>	2827 2828 2829 2830 2831
(D) <u>No person or government entity shall divide or otherwise segment a construction, renovation, or reconstruction project in order to evade application of the capital expenditure threshold set forth in division (B)(1) of this section.</u>	2832 2833 2834 2835
Sec. 3901.21. The following are hereby defined as unfair and deceptive acts or practices in the business of insurance:	2836 2837
(A) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer as shown by the last preceding verified statement made by it to the insurance department of this state, or as to the legal reserve system upon which any life insurer	2838 2839 2840 2841 2842 2843 2844 2845 2846 2847 2848 2849

operates, or using any name or title of any policy or class of 2850
policies misrepresenting the true nature thereof, or making any 2851
misrepresentation or incomplete comparison to any person for the 2852
purpose of inducing or tending to induce such person to purchase, 2853
amend, lapse, forfeit, change, or surrender insurance. 2854

Any written statement concerning the premiums for a policy 2855
which refers to the net cost after credit for an assumed dividend, 2856
without an accurate written statement of the gross premiums, cash 2857
values, and dividends based on the insurer's current dividend 2858
scale, which are used to compute the net cost for such policy, and 2859
a prominent warning that the rate of dividend is not guaranteed, 2860
is a misrepresentation for the purposes of this division. 2861

(B) Making, publishing, disseminating, circulating, or 2862
placing before the public or causing, directly or indirectly, to 2863
be made, published, disseminated, circulated, or placed before the 2864
public, in a newspaper, magazine, or other publication, or in the 2865
form of a notice, circular, pamphlet, letter, or poster, or over 2866
any radio station, or in any other way, or preparing with intent 2867
to so use, an advertisement, announcement, or statement containing 2868
any assertion, representation, or statement, with respect to the 2869
business of insurance or with respect to any person in the conduct 2870
of the person's insurance business, which is untrue, deceptive, or 2871
misleading. 2872

(C) Making, publishing, disseminating, or circulating, 2873
directly or indirectly, or aiding, abetting, or encouraging the 2874
making, publishing, disseminating, or circulating, or preparing 2875
with intent to so use, any statement, pamphlet, circular, article, 2876
or literature, which is false as to the financial condition of an 2877
insurer and which is calculated to injure any person engaged in 2878
the business of insurance. 2879

(D) Filing with any supervisory or other public official, or 2880

making, publishing, disseminating, circulating, or delivering to 2881
any person, or placing before the public, or causing directly or 2882
indirectly to be made, published, disseminated, circulated, 2883
delivered to any person, or placed before the public, any false 2884
statement of financial condition of an insurer. 2885

Making any false entry in any book, report, or statement of 2886
any insurer with intent to deceive any agent or examiner lawfully 2887
appointed to examine into its condition or into any of its 2888
affairs, or any public official to whom such insurer is required 2889
by law to report, or who has authority by law to examine into its 2890
condition or into any of its affairs, or, with like intent, 2891
willfully omitting to make a true entry of any material fact 2892
pertaining to the business of such insurer in any book, report, or 2893
statement of such insurer, or mutilating, destroying, suppressing, 2894
withholding, or concealing any of its records. 2895

(E) Issuing or delivering or permitting agents, officers, or 2896
employees to issue or deliver agency company stock or other 2897
capital stock or benefit certificates or shares in any common-law 2898
corporation or securities or any special or advisory board 2899
contracts or other contracts of any kind promising returns and 2900
profits as an inducement to insurance. 2901

(F) Making or permitting any unfair discrimination among 2902
individuals of the same class and equal expectation of life in the 2903
rates charged for any contract of life insurance or of life 2904
annuity or in the dividends or other benefits payable thereon, or 2905
in any other of the terms and conditions of such contract. 2906

(G)(1) Except as otherwise expressly provided by law, 2907
knowingly permitting or offering to make or making any contract of 2908
life insurance, life annuity or accident and health insurance, or 2909
agreement as to such contract other than as plainly expressed in 2910
the contract issued thereon, or paying or allowing, or giving or 2911

offering to pay, allow, or give, directly or indirectly, as 2912
inducement to such insurance, or annuity, any rebate of premiums 2913
payable on the contract, or any special favor or advantage in the 2914
dividends or other benefits thereon, or any valuable consideration 2915
or inducement whatever not specified in the contract; or giving, 2916
or selling, or purchasing, or offering to give, sell, or purchase, 2917
as inducement to such insurance or annuity or in connection 2918
therewith, any stocks, bonds, or other securities, or other 2919
obligations of any insurance company or other corporation, 2920
association, or partnership, or any dividends or profits accrued 2921
thereon, or anything of value whatsoever not specified in the 2922
contract. 2923

(2) Nothing in division (F) or division (G)(1) of this 2924
section shall be construed as prohibiting any of the following 2925
practices: (a) in the case of any contract of life insurance or 2926
life annuity, paying bonuses to policyholders or otherwise abating 2927
their premiums in whole or in part out of surplus accumulated from 2928
nonparticipating insurance, provided that any such bonuses or 2929
abatement of premiums shall be fair and equitable to policyholders 2930
and for the best interests of the company and its policyholders; 2931
(b) in the case of life insurance policies issued on the 2932
industrial debit plan, making allowance to policyholders who have 2933
continuously for a specified period made premium payments directly 2934
to an office of the insurer in an amount which fairly represents 2935
the saving in collection expenses; (c) readjustment of the rate of 2936
premium for a group insurance policy based on the loss or expense 2937
experience thereunder, at the end of the first or any subsequent 2938
policy year of insurance thereunder, which may be made retroactive 2939
only for such policy year. 2940

(H) Making, issuing, circulating, or causing or permitting to 2941
be made, issued, or circulated, or preparing with intent to so 2942
use, any statement to the effect that a policy of life insurance 2943

is, is the equivalent of, or represents shares of capital stock or 2944
any rights or options to subscribe for or otherwise acquire any 2945
such shares in the life insurance company issuing that policy or 2946
any other company. 2947

(I) Making, issuing, circulating, or causing or permitting to 2948
be made, issued or circulated, or preparing with intent to so 2949
issue, any statement to the effect that payments to a policyholder 2950
of the principal amounts of a pure endowment are other than 2951
payments of a specific benefit for which specific premiums have 2952
been paid. 2953

(J) Making, issuing, circulating, or causing or permitting to 2954
be made, issued, or circulated, or preparing with intent to so 2955
use, any statement to the effect that any insurance company was 2956
required to change a policy form or related material to comply 2957
with Title XXXIX of the Revised Code or any regulation of the 2958
superintendent of insurance, for the purpose of inducing or 2959
intending to induce any policyholder or prospective policyholder 2960
to purchase, amend, lapse, forfeit, change, or surrender 2961
insurance. 2962

(K) Aiding or abetting another to violate this section. 2963

(L) Refusing to issue any policy of insurance, or canceling 2964
or declining to renew such policy because of the sex or marital 2965
status of the applicant, prospective insured, insured, or 2966
policyholder. 2967

(M) Making or permitting any unfair discrimination between 2968
individuals of the same class and of essentially the same hazard 2969
in the amount of premium, policy fees, or rates charged for any 2970
policy or contract of insurance, other than life insurance, or in 2971
the benefits payable thereunder, or in underwriting standards and 2972
practices or eligibility requirements, or in any of the terms or 2973
conditions of such contract, or in any other manner whatever. 2974

(N) Refusing to make available disability income insurance 2975
solely because the applicant's principal occupation is that of 2976
managing a household. 2977

(O) Refusing, when offering maternity benefits under any 2978
individual or group sickness and accident insurance policy, to 2979
make maternity benefits available to the policyholder for the 2980
individual or individuals to be covered under any comparable 2981
policy to be issued for delivery in this state, including family 2982
members if the policy otherwise provides coverage for family 2983
members. Nothing in this division shall be construed to prohibit 2984
an insurer from imposing a reasonable waiting period for such 2985
benefits under an individual sickness and accident insurance 2986
policy issued to an individual who is not a federally eligible 2987
individual or a nonemployer-related group sickness and accident 2988
insurance policy, but in no event shall such waiting period exceed 2989
two hundred seventy days. 2990

For purposes of division (O) of this section, "federally 2991
eligible individual" means an eligible individual as defined in 45 2992
C.F.R. 148.103. 2993

(P) Using, or permitting to be used, a pattern settlement as 2994
the basis of any offer of settlement. As used in this division, 2995
"pattern settlement" means a method by which liability is 2996
routinely imputed to a claimant without an investigation of the 2997
particular occurrence upon which the claim is based and by using a 2998
predetermined formula for the assignment of liability arising out 2999
of occurrences of a similar nature. Nothing in this division shall 3000
be construed to prohibit an insurer from determining a claimant's 3001
liability by applying formulas or guidelines to the facts and 3002
circumstances disclosed by the insurer's investigation of the 3003
particular occurrence upon which a claim is based. 3004

(Q) Refusing to insure, or refusing to continue to insure, or 3005

limiting the amount, extent, or kind of life or sickness and 3006
accident insurance or annuity coverage available to an individual, 3007
or charging an individual a different rate for the same coverage 3008
solely because of blindness or partial blindness. With respect to 3009
all other conditions, including the underlying cause of blindness 3010
or partial blindness, persons who are blind or partially blind 3011
shall be subject to the same standards of sound actuarial 3012
principles or actual or reasonably anticipated actuarial 3013
experience as are sighted persons. Refusal to insure includes, but 3014
is not limited to, denial by an insurer of disability insurance 3015
coverage on the grounds that the policy defines "disability" as 3016
being presumed in the event that the eyesight of the insured is 3017
lost. However, an insurer may exclude from coverage disabilities 3018
consisting solely of blindness or partial blindness when such 3019
conditions existed at the time the policy was issued. To the 3020
extent that the provisions of this division may appear to conflict 3021
with any provision of section 3999.16 of the Revised Code, this 3022
division applies. 3023

(R)(1) Directly or indirectly offering to sell, selling, or 3024
delivering, issuing for delivery, renewing, or using or otherwise 3025
marketing any policy of insurance or insurance product in 3026
connection with or in any way related to the grant of a student 3027
loan guaranteed in whole or in part by an agency or commission of 3028
this state or the United States, except insurance that is required 3029
under federal or state law as a condition for obtaining such a 3030
loan and the premium for which is included in the fees and charges 3031
applicable to the loan; or, in the case of an insurer or insurance 3032
agent, knowingly permitting any lender making such loans to engage 3033
in such acts or practices in connection with the insurer's or 3034
agent's insurance business. 3035

(2) Except in the case of a violation of division (G) of this 3036
section, division (R)(1) of this section does not apply to either 3037

of the following: 3038

(a) Acts or practices of an insurer, its agents, 3039
representatives, or employees in connection with the grant of a 3040
guaranteed student loan to its insured or the insured's spouse or 3041
dependent children where such acts or practices take place more 3042
than ninety days after the effective date of the insurance; 3043

(b) Acts or practices of an insurer, its agents, 3044
representatives, or employees in connection with the solicitation, 3045
processing, or issuance of an insurance policy or product covering 3046
the student loan borrower or the borrower's spouse or dependent 3047
children, where such acts or practices take place more than one 3048
hundred eighty days after the date on which the borrower is 3049
notified that the student loan was approved. 3050

(S) Denying coverage, under any health insurance or health 3051
care policy, contract, or plan providing family coverage, to any 3052
natural or adopted child of the named insured or subscriber solely 3053
on the basis that the child does not reside in the household of 3054
the named insured or subscriber. 3055

(T)(1) Using any underwriting standard or engaging in any 3056
other act or practice that, directly or indirectly, due solely to 3057
any health status-related factor in relation to one or more 3058
individuals, does either of the following: 3059

(a) Terminates or fails to renew an existing individual 3060
policy, contract, or plan of health benefits, or a health benefit 3061
plan issued to an employer, for which an individual would 3062
otherwise be eligible; 3063

(b) With respect to a health benefit plan issued to an 3064
employer, excludes or causes the exclusion of an individual from 3065
coverage under an existing employer-provided policy, contract, or 3066
plan of health benefits. 3067

(2) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code for purposes of implementing division (T)(1) of this section.	3068 3069 3070
(3) For purposes of division (T)(1) of this section, "health status-related factor" means any of the following:	3071 3072
(a) Health status;	3073
(b) Medical condition, including both physical and mental illnesses;	3074 3075
(c) Claims experience;	3076
(d) Receipt of health care;	3077
(e) Medical history;	3078
(f) Genetic information;	3079
(g) Evidence of insurability, including conditions arising out of acts of domestic violence;	3080 3081
(h) Disability.	3082
(U) With respect to a health benefit plan issued to a small employer, as those terms are defined in section 3924.01 of the Revised Code, negligently or willfully placing coverage for adverse risks with a certain carrier, as defined in section 3924.01 of the Revised Code.	3083 3084 3085 3086 3087
(V) Using any program, scheme, device, or other unfair act or practice that, directly or indirectly, causes or results in the placing of coverage for adverse risks with another carrier, as defined in section 3924.01 of the Revised Code.	3088 3089 3090 3091
(W) Failing to comply with section 3923.23, 3923.231, 3923.232, 3923.233, or 3923.234 of the Revised Code by engaging in any unfair, discriminatory reimbursement practice.	3092 3093 3094
(X) Intentionally establishing an unfair premium for, or misrepresenting the cost of, any insurance policy financed under a	3095 3096

premium finance agreement of an insurance premium finance company. 3097

(Y)(1)(a) Limiting coverage under, refusing to issue, 3098
canceling, or refusing to renew, any individual policy or contract 3099
of life insurance, or limiting coverage under or refusing to issue 3100
any individual policy or contract of health insurance, for the 3101
reason that the insured or applicant for insurance is or has been 3102
a victim of domestic violence; 3103

(b) Adding a surcharge or rating factor to a premium of any 3104
individual policy or contract of life or health insurance for the 3105
reason that the insured or applicant for insurance is or has been 3106
a victim of domestic violence; 3107

(c) Denying coverage under, or limiting coverage under, any 3108
policy or contract of life or health insurance, for the reason 3109
that a claim under the policy or contract arises from an incident 3110
of domestic violence; 3111

(d) Inquiring, directly or indirectly, of an insured under, 3112
or of an applicant for, a policy or contract of life or health 3113
insurance, as to whether the insured or applicant is or has been a 3114
victim of domestic violence, or inquiring as to whether the 3115
insured or applicant has sought shelter or protection from 3116
domestic violence or has sought medical or psychological treatment 3117
as a victim of domestic violence. 3118

(2) Nothing in division (Y)(1) of this section shall be 3119
construed to prohibit an insurer from inquiring as to, or from 3120
underwriting or rating a risk on the basis of, a person's physical 3121
or mental condition, even if the condition has been caused by 3122
domestic violence, provided that all of the following apply: 3123

(a) The insurer routinely considers the condition in 3124
underwriting or in rating risks, and does so in the same manner 3125
for a victim of domestic violence as for an insured or applicant 3126
who is not a victim of domestic violence; 3127

(b) The insurer does not refuse to issue any policy or 3128
contract of life or health insurance or cancel or refuse to renew 3129
any policy or contract of life insurance, solely on the basis of 3130
the condition, except where such refusal to issue, cancellation, 3131
or refusal to renew is based on sound actuarial principles or is 3132
related to actual or reasonably anticipated experience; 3133

(c) The insurer does not consider a person's status as being 3134
or as having been a victim of domestic violence, in itself, to be 3135
a physical or mental condition; 3136

(d) The underwriting or rating of a risk on the basis of the 3137
condition is not used to evade the intent of division (Y)(1) of 3138
this section, or of any other provision of the Revised Code. 3139

(3)(a) Nothing in division (Y)(1) of this section shall be 3140
construed to prohibit an insurer from refusing to issue a policy 3141
or contract of life insurance insuring the life of a person who is 3142
or has been a victim of domestic violence if the person who 3143
committed the act of domestic violence is the applicant for the 3144
insurance or would be the owner of the insurance policy or 3145
contract. 3146

(b) Nothing in division (Y)(2) of this section shall be 3147
construed to permit an insurer to cancel or refuse to renew any 3148
policy or contract of health insurance in violation of the "Health 3149
Insurance Portability and Accountability Act of 1996," 110 Stat. 3150
1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a manner that 3151
violates or is inconsistent with any provision of the Revised Code 3152
that implements the "Health Insurance Portability and 3153
Accountability Act of 1996." 3154

(4) An insurer is immune from any civil or criminal liability 3155
that otherwise might be incurred or imposed as a result of any 3156
action taken by the insurer to comply with division (Y) of this 3157
section. 3158

(5) As used in division (Y) of this section, "domestic violence" means any of the following acts:	3159
	3160
(a) Knowingly causing or attempting to cause physical harm to a family or household member;	3161
	3162
(b) Recklessly causing serious physical harm to a family or household member;	3163
	3164
(c) Knowingly causing, by threat of force, a family or household member to believe that the person will cause imminent physical harm to the family or household member.	3165
	3166
	3167
For the purpose of division (Y)(5) of this section, "family or household member" has the same meaning as in section 2919.25 of the Revised Code.	3168
	3169
	3170
Nothing in division (Y)(5) of this section shall be construed to require, as a condition to the application of division (Y) of this section, that the act described in division (Y)(5) of this section be the basis of a criminal prosecution.	3171
	3172
	3173
	3174
With respect to private passenger automobile insurance, no insurer shall charge different premium rates to persons residing within the limits of any municipal corporation based solely on the location of the residence of the insured within those limits.	3175
	3176
	3177
	3178
The enumeration in sections 3901.19 to 3901.26 of the Revised Code of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement this section, or to take action under other sections of the Revised Code.	3179
	3180
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	3184
This section does not prohibit the sale of shares of any investment company registered under the "Investment Company Act of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any policies, annuities, or other contracts described in section	3185
	3186
	3187
	3188

3907.15 of the Revised Code.	3189
As used in this section, "estimate," "statement,"	3190
"representation," "misrepresentation," "advertisement," or	3191
"announcement" includes oral or written occurrences.	3192
Sec. 3901.38. (A) As used in this section and section	3193
3901.381 of the Revised Code:	3194
(1) "Beneficiary" means any policyholder, subscriber, member,	3195
employee, or other person who is eligible for benefits under a	3196
benefits contract.	3197
(2) "Benefits contract" means a sickness and accident	3198
insurance policy providing hospital, surgical, or medical expense	3199
coverage, or a health insuring corporation contract or other	3200
policy or agreement under which a third-party payer agrees to	3201
reimburse for covered health care or dental services rendered to	3202
beneficiaries, up to the limits and exclusions contained in the	3203
benefits contract.	3204
(3) "Completed claim" means a proof of loss or a claim for	3205
payment for health care services which has been submitted to the	3206
appropriate claims processing office of the third-party payer	3207
accompanied by sufficient documentation for the third-party payer	3208
to determine proof of loss and reasonably required by the	3209
third-party payer to accept or reject the claim.	3210
(4) "Hospital" has the same meaning set forth in section	3211
3727.01 of the Revised Code.	3212
(5) "Proof of loss" means a claim for payment for health care	3213
services which has been submitted to the appropriate claims	3214
processing office of the third-party payer accompanied by	3215
sufficient documentation for the third-party payer to determine	3216
benefits payable under the benefits contract and reasonably	3217
required by the third-party payer to accept or reject the claim.	3218

(6) "Provider" means a hospital, nursing home, physician, 3219
podiatrist, dentist, pharmacist, chiropractor, or other licensed 3220
health care provider entitled to reimbursement by a third-party 3221
payer for services rendered to a beneficiary under a benefits 3222
contract. 3223

(7) "Reimburse" means indemnify, make payment, or otherwise 3224
accept responsibility for payment for health care services 3225
rendered to a beneficiary, or arrange for the provision of health 3226
care services to a beneficiary. 3227

(8) "Third-party payer" means any of the following: 3228

(a) An insurance company; 3229

(b) A health insuring corporation; 3230

(c) A ~~preferred provider organization;~~ 3231

~~(d)~~ A labor organization; 3232

~~(e)~~(d) An employer; 3233

~~(f)~~(e) An intermediary organization, as defined in section 3234
1751.01 of the Revised Code, that is not a health delivery network 3235
contracting solely with self-insured employers; 3236

~~(g)~~(f) An administrator subject to sections 3959.01 to 3237
3959.16 of the Revised Code; 3238

~~(h)~~(g) A health delivery network, as defined in section 3239
1751.01 of the Revised Code; 3240

~~(i)~~(h) Any other person that is obligated pursuant to a 3241
benefits contract to reimburse for covered health care services 3242
rendered to beneficiaries under such contract. 3243

(B)(1) Except as provided in division (B)(2) of this section 3244
and in section 3901.381 of the Revised Code, within twenty-four 3245
days of the receipt of a completed claim from a provider or a 3246
beneficiary for reimbursement for health care services rendered by 3247

the provider to a beneficiary, a third-party payer shall, in 3248
accordance with division (D) of this section, make payment of any 3249
amount due on such claim. 3250

(2) A third-party payer and a provider may, in negotiating a 3251
reimbursement contract, agree to any time period by which a 3252
third-party payer shall, subject to division (D) of this section, 3253
make payment of any amount due on a completed claim. Nothing in 3254
this division shall be construed as limiting in any manner the 3255
application of the requirements of this section to any benefits or 3256
reimbursement contract. 3257

(3) Any provider or beneficiary aggrieved with respect to any 3258
act of a third-party payer that such provider or beneficiary 3259
believes to be a violation of division (B)(1) or (2) of this 3260
section may file a written complaint with the superintendent of 3261
insurance. If a series of such complaints is received by the 3262
superintendent with respect to a particular third-party payer and 3263
if, after investigation, the superintendent finds that such 3264
third-party payer has engaged in a series of such violations 3265
which, taken together, constitute a consistent pattern or a 3266
practice of such third-party payer to violate division (B)(1) or 3267
(2) of this section, the superintendent shall issue an order 3268
requiring such third-party payer to cease and desist from engaging 3269
in such violations and to pay a late payment penalty as specified 3270
in divisions (B)(4) and (5) of this section with respect to the 3271
claims the superintendent finds were not timely paid. In the 3272
order, the superintendent shall specify the reasons for the 3273
superintendent's finding and order and state that a hearing 3274
conducted pursuant to Chapter 119. of the Revised Code shall be 3275
held within fifteen days after requested in writing by the 3276
third-party payer. The provisions of ~~this~~ division (B)(3) of this 3277
section are in addition to, and not in lieu of, such other 3278
remedies as providers and beneficiaries may otherwise have by law. 3279

(4)(a) The late payment penalty shall be computed based upon 3280
the number of days that have elapsed between the date payment is 3281
due in accordance with division (B)(1) or (2) of this section and 3282
the date payment is actually sent. 3283

(b) The interest rate for determining the amount of the late 3284
payment penalty shall be the rate agreed to by the provider and 3285
the third-party payer or the rate specified by and determined in 3286
accordance with division (A) of section 1343.01 of the Revised 3287
Code. 3288

(5) A provider and a third-party payer may enter into a 3289
contractual agreement in which the timing of payments by the 3290
third-party payer is not directly related to the receipt of a 3291
completed claim. Such contractual arrangement may include periodic 3292
interim payment arrangements, capitation payment arrangements, or 3293
other payment arrangements acceptable to the provider and the 3294
third-party payer. Except as agreed to under such contract, this 3295
section does not apply to such payment arrangements. 3296

(6) Any late payment penalty due and payable by a third-party 3298
payer in accordance with this section shall not be used to reduce 3299
benefits or payments otherwise payable under a benefits contract. 3300

(C) No third-party payer shall refuse to process or pay 3302
within the time period required under division (B)(1) or (2) of 3303
this section a completed claim submitted by a provider on the 3304
ground the beneficiary has not been discharged from the hospital 3305
or the treatment has not been completed, if the submitted claim 3306
covers services actually rendered and charges actually incurred 3307
over at least a thirty-day period. 3308

(D)(1) Notwithstanding section ~~1742.10~~ 1751.13 or division 3309
(I)(2) of section 3923.04 of the Revised Code, a reimbursement 3310

contract entered into or renewed on or after June 29, 1988, 3311
between a third-party payer and a hospital shall provide that 3312
reimbursement for any service provided by a hospital pursuant to a 3313
reimbursement contract and covered under a benefits contract shall 3314
be made directly to the hospital. 3315

(2) If the third-party payer and the hospital have not 3316
entered into a contract regarding the provision and reimbursement 3317
for covered services, the third-party payer shall accept and honor 3318
a completed and validly executed assignment of benefits with a 3319
hospital by a beneficiary, except when the third-party payer has 3320
notified the hospital in writing of the conditions under which the 3321
third-party payer will not accept and honor an assignment of 3322
benefits. Such notice shall be made annually. 3323

(3) A third-party payer may not refuse to accept and honor a 3324
validly executed assignment of benefits with a hospital pursuant 3325
to division (D)(2) of this section for medically necessary 3326
hospital services provided on an emergency basis. 3327

(E) A series of violations which taken together, constitute a 3328
consistent pattern or a practice of violation of any of the 3329
provisions of this section is an unfair and deceptive act pursuant 3330
to sections 3901.19 to 3901.23 of the Revised Code and is subject 3331
to proceedings pursuant to those sections. 3332

Sec. 3917.01. (A) Group life insurance is that form of life 3333
insurance covering not less than ten employees with or without 3334
medical examination, written under a policy issued to the 3335
employer, or to a trustee of a trust created by such employer, the 3336
premium on which is to be paid by the employer, by the employer 3337
and employees jointly, or by such trustee out of funds contributed 3338
by the employer or by the employer and employees jointly, and 3339
insuring only all of the employer's employees or all of any 3340
classes thereof, determined by sex, age, or conditions pertaining 3341

to the employment, for amounts of insurance based upon some plan 3342
which will preclude individual selection, for the benefit of 3343
persons other than the employer; but when the premium is to be 3344
paid by the employer and employee jointly and the benefits of the 3345
policy are offered to all eligible employees, not less than 3346
seventy-five per cent of such employees may be so insured. Such 3347
group policy may provide that "employees" includes retired 3348
employees of the employer and the officers, managers, employees, 3349
and retired employees of subsidiary or affiliated corporations and 3350
the individual proprietors, partners, employees, and retired 3351
employees of affiliated individuals and firms, when the business 3352
of such subsidiary or affiliated corporations, firms, or 3353
individuals is controlled by the common employer through stock 3354
ownership, contract, or otherwise. This section does not define as 3355
a group the lives covered by a policy issued on more than one life 3356
which provides for payments upon the death of any one or more or 3357
upon the death of each of the lives so insured, and upon which the 3358
premium rates charged are computed on the same basis as used by 3359
the issuing company on single life policies and upon its regular 3360
forms of insurance. 3361

(B) As used in sections 3917.01 to 3917.06 of the Revised 3362
Code, the following forms of life insurance are group life 3363
insurance: 3364

(1) Life insurance covering the members of one or more 3365
companies, batteries, troops, battalions, divisions, or other 3366
units of the national guard or naval militia of any state, written 3367
under a policy issued to the commanding general of the national 3368
guard or commanding officer of the naval militia, who is the 3369
employer for the purposes of such sections, the premium on which 3370
is to be paid by the members of such units for the benefit of 3371
persons other than the employer; provided that when the benefits 3372
of the policy are offered to all eligible members of a unit of the 3373

national guard or naval militia, not less than seventy-five per 3374
cent of the members of such a unit may be insured; 3375

(2) Life insurance covering the members of one or more troops 3376
or other units of the state troopers or state police of any state, 3377
written under a policy issued to the commanding officer of the 3378
state troopers or state police who is the employer for the 3379
purposes of such sections, the premium on which is to be paid by 3380
the members of such units for the benefit of persons other than 3381
the employer; provided that when the benefits of the policy are 3382
offered to all eligible members of a unit of the state troopers or 3383
state police, not less than seventy-five per cent of the members 3384
of such a unit may be insured; 3385

(3) Life insurance covering the members of any labor union, 3386
written under a policy issued to such union which is the employer 3387
for the purposes of such sections, the premium on which is to be 3388
paid by the union or by the union and its members jointly, and 3389
insuring only all of its members, who are actively engaged in the 3390
same occupation, for amounts of insurance based upon some plan 3391
which will preclude individual selection, for the benefit of 3392
persons other than the union or its officials; provided that in 3393
case the insurance policy is cancellable at the end of any policy 3394
year at the option of the insurance company and that the basis of 3395
premium rates may be changed by the insurance company at the 3396
beginning of any policy year, all members of a labor union may be 3397
insured; and provided that when the premium is to be paid by the 3398
union and its members jointly and the benefits are offered to all 3399
eligible members, not less than seventy-five per cent of such 3400
members may be insured; and provided that when members apply and 3401
pay for additional amounts of insurance, a smaller percentage of 3402
members may be insured for such additional amounts if they pass 3403
satisfactory medical examinations or submit satisfactory evidence 3404
of insurability; 3405

(4) Life insurance written under a policy issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements:

(a) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor, excepting that no debtor is eligible unless the indebtedness constitutes an obligation to repay that is binding upon the debtor during the debtor's lifetime at and from the date the insurance becomes effective upon the debtor's life. The policy may provide that "debtors" includes the debtors of one or more subsidiary corporations and the debtors of one or more affiliated corporations, proprietors, or partnerships if the business of the policyholder and of such affiliated corporations, proprietors, or partnerships is under common control through stock ownership, contract, or otherwise.

(b) The premium for the policy shall be paid by the policyholder, either from the creditor's funds, or from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors shall not include debtors under obligations outstanding at its date of issue without evidence of individual insurability unless at least seventy-five per cent of the then eligible debtors elect to pay the required charges. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(c) The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least one hundred persons yearly, or may reasonably be expected to receive at least one hundred new entrants during the first policy year,

and continues to receive not less than one hundred new entrants to 3438
the group yearly, and only if the policy reserves to the insurer 3439
the right to require evidence of individual insurability if less 3440
than seventy-five per cent of the new entrants become insured. The 3441
policy may exclude from the classes eligible for insurance classes 3442
of debtors determined by age. 3443

(d) The amount of insurance on the life of any debtor may be 3444
determined by the age of the debtor based upon a plan which will 3445
preclude individual selection and shall at no time exceed the 3446
amount owed by the debtor that is repayable in installments to the 3447
creditor. 3448

(e) The insurance shall be payable to the policyholder. Such 3449
payment shall reduce or extinguish the unpaid indebtedness of the 3450
debtor to the extent of such payment. 3451

(5) Life insurance covering the members of any duly organized 3452
corporation or association of veterans or veteran society or 3453
association of the World War veterans, written under a policy 3454
issued to such corporation, association, or society which is the 3455
employer for the purpose of such sections, the premium on which is 3456
to be paid by the corporation, association, society, and its 3457
members jointly, and insuring all of its members who are actively 3458
engaged in any occupation for amounts of insurance based upon some 3459
plan which will preclude individual selection for the benefit of 3460
persons other than the corporation, association, or society or its 3461
officials; provided that when the premium is to be paid by the 3462
corporation, association, or society and its members jointly and 3463
the benefits are offered to all eligible members, not less than 3464
seventy-five per cent of such members may be insured; and provided 3465
that when members apply and pay for additional amounts of 3466
insurance, a smaller percentage of members may be insured for such 3467
additional amounts if they pass satisfactory medical examinations 3468
or submit satisfactory evidence of insurability; 3469

3470

(6) Life insurance covering the members of any organization 3471
of agriculturists or horticulturists organized under the 3472
co-operative laws of this state, written under a policy issued to 3473
such co-operative association which is the employer for the 3474
purpose of such sections, the premium on which is to be paid by 3475
the association or by the association and its members jointly, and 3476
insuring all of its members who are actively engaged in 3477
agricultural or horticultural pursuits, for an amount of insurance 3478
based upon some plan which will preclude individual selection, and 3479
for the benefit of persons other than the association or its 3480
officials; provided that when the premium is to be paid by the 3481
corporation, association, or society and its members jointly and 3482
the benefits are offered to all eligible members, not less than 3483
seventy-five per cent of such members may be insured; provided 3484
that when members apply and pay for additional amounts of 3485
insurance, a smaller percentage of members may be insured for such 3486
additional amounts if they pass satisfactory medical examinations 3487
or submit satisfactory evidence of insurability; 3488

(7) Life insurance covering employees of a political 3489
subdivision or district of this state, or of an educational or 3490
other institution supported in whole or in part by public funds, 3491
or of any classes thereof, determined by conditions pertaining to 3492
employment, or of this state or any department or division 3493
thereof, written under a policy issued to such political 3494
subdivision, district, or institution, or the proper official or 3495
board of this state or of such state department or division 3496
thereof, which is the employer for the purpose of such sections, 3497
the premium on which is to be paid by such employees, unless 3498
otherwise provided by law, charter, or ordinance, for the benefit 3499
of persons other than the employer; provided that when the 3500
benefits of the policy are offered to all eligible employees of a 3501

political subdivision or district of the state or of an 3502
educational or other institution supported in whole, or in part by 3503
public funds, or of this state or a state department or division 3504
thereof, not less than seventy-five per cent of such employees may 3505
be insured; and provided that when employees apply and pay for 3506
additional amounts of insurance, a smaller percentage of employees 3507
may be insured for such additional amounts if they pass 3508
satisfactory medical examinations or submit satisfactory evidence 3509
of insurability; and provided that upon acquisition by a political 3510
subdivision of any privately owned property or enterprise, the 3511
employees of which have been covered by a group policy of life or 3512
other insurance as employees of such private employer, such 3513
political subdivision and insurance company may continue such 3514
contract in force upon similar conditions as the last preceding 3515
private employer; 3516

(8) Life insurance covering the members, or the members and 3517
the employees of members of any duly organized association, other 3518
than an association subject to any other provision of this 3519
division, written under a policy issued to such association, which 3520
association is the employer for the purpose of such sections, the 3521
premium on which is to be paid by the insured members or their 3522
employees, insuring members and their employees for amounts of 3523
insurance based upon some plan which will preclude individual 3524
selection except as provided in this section, for the benefit of 3525
persons other than the association; provided the association has 3526
been in existence for at least two years immediately preceding the 3527
purchase of the insurance; provided that there must be at least 3528
fifty insured members in any group; and provided that the 3529
association has been organized and is maintained in good faith for 3530
purposes other than that of obtaining insurance; 3531

(9) Life insurance issued to trustees of a trust fund 3532
established jointly by one or more employers in the same industry, 3533

on the one hand, and one or more labor unions representing as 3534
bargaining agents employees of such employers, on the other hand, 3535
or by two or more employers in the same industry, or by two or 3536
more labor unions, which trustees shall be deemed the policyholder 3537
to insure employees of the employers or members of unions for the 3538
benefit of persons other than the employers or the unions or the 3539
trustees, subject to the following requirements: 3540

(a) The persons eligible for such insurance shall be all of 3541
the employees of the employers, or all of the members of the 3542
unions, or all of any class of such employees determined by sex, 3543
age, or conditions pertaining to their employment, or to 3544
membership in the unions, or to any or all of them. The policy may 3545
provide that "employees" includes the retired employees of the 3546
employer and the officers, managers, employees, and retired 3547
employees of subsidiary or affiliated corporations and the 3548
individual proprietors, partners, employees, and retired employees 3549
of affiliated individuals and firms, when the business of such 3550
subsidiary or affiliated corporations, firms, or individuals is 3551
controlled by the common employer through stock ownership, 3552
contract, or otherwise. The policy may provide that "employees" 3553
includes the individual proprietor or partners if the employer is 3554
an individual proprietor or a partnership. The policy may provide 3555
that "employees" includes the trustees or their employees, or 3556
both, if their duties are principally connected with such 3557
trusteeship. 3558

(b) The premium for the policy shall be paid by the trustees, 3559
either wholly from funds contributed by the employers of the 3560
insured persons, or partly from such funds and partly from funds 3561
contributed by the insured employees. If part of the premium is to 3562
be derived from funds contributed by the insured employees, then 3563
such policy may be placed in force only if it covers at least 3564
seventy-five per cent of the then eligible employees. A policy on 3565

which no part of the premium is derived from funds contributed by 3566
the insured employees must insure all eligible employees. 3567

3568

(c) Any policy must insure at least ten persons at date of 3569
issue. 3570

(d) The amounts of insurance under the policy must be based 3571
upon some plan precluding individual selection by the insured 3572
persons or the policyholder or the employers or the unions or the 3573
trustees. 3574

(10) Life insurance covering the members of a credit union, 3575
which shall be deemed to be the employer for the purposes of this 3576
section, the premium on which is to be paid by the credit union or 3577
by the credit union and its members jointly, and insuring all of 3578
its eligible members for amounts of insurance not in excess of the 3579
share balance as to each member, and for the benefit of persons 3580
other than the credit union or its officers; provided that in the 3581
determination of the eligibility of members there may be 3582
classifications and limitations based upon age; provided also that 3583
when the premium is to be paid by the credit union and its members 3584
jointly and the benefits are offered to all eligible members, not 3585
less than seventy-five per cent of such members may be so insured; 3586
provided also that in obtaining such insurance, the officers of 3587
the credit union shall consider proposals from any licensed 3588
insurer; provided also that members may be required to provide 3589
evidence of insurability satisfactory to the insurer. 3590

(11) Life insurance covering the members of any duly 3591
organized corporation or association of members of the Ohio 3592
national guard, the Ohio naval militia, and the Ohio military 3593
reserve, which shall have been in existence for at least two years 3594
immediately preceding the purchase of such insurance, written 3595
under a policy issued to such corporation or association, which 3596
corporation or association is the employer for the purpose of such 3597

sections, the premium on which is to be paid by the insured 3598
members, insuring members for amounts of insurance based upon some 3599
plan which will preclude individual selection, except as provided 3600
in this section, for the benefit of persons other than the 3601
corporation or association, provided that there must be at least 3602
fifty insured members in any group, and provided further that 3603
unless seventy-five per cent of all members or one thousand 3604
members, whichever is the lesser number, are insured, each member 3605
must pass a satisfactory medical examination in order to be 3606
insured; and provided that, when members apply and pay for 3607
additional amounts of insurance, they may be insured for such 3608
additional amounts if they pass satisfactory medical examinations 3609
or submit satisfactory evidence of insurability. 3610

(12) Life insurance that is written under a policy issued to 3611
a trustee under a trust established by an insurer for the purpose 3612
of providing continued group life insurance coverage to those 3613
former employees, former members, or former members and the 3614
employees of such members, and their spouses and dependent 3615
children, previously covered under policies of group life 3616
insurance issued by the insurer to employers or trustees pursuant 3617
to division (A) of this section, to associations pursuant to 3618
division (B)(8) of this section, or to trustees pursuant to 3619
division (B)(9) of this section, and that is evidenced by the 3620
issuance of a certificate of insurance to such former employees or 3621
members; provided that The amount of the continued life insurance 3622
coverage made available to a former employee or member and to the 3623
employee's or member's spouse and dependents shall not exceed the 3624
amount of the group life insurance coverage previously provided to 3625
the employee or member and the employee's or member's eligible 3626
dependents at the time of the employee's separation from 3627
employment or the member's termination of membership. 3628

(C) Any policy issued pursuant to this section, except a 3629

policy issued to a creditor pursuant to division (B) (4) of this section, may be extended, in the form of group term life insurance only, to insure the spouse and dependent children of an insured employee or member, or any class or classes thereof, subject to the following requirements:

(1) The premiums for the group term life insurance shall be paid by the policyholder, either from the employer, union or association funds, or from funds contributed by the employer, union, or association, or from funds contributed by the insured employee or member, or from both.

(2) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the insured employee or member or by the policyholder, ~~provided that group term life insurance upon the life of a spouse or dependent child shall not exceed the lesser of (a) ten thousand dollars, or (b) one half of the amount of insurance on the life of the insured employee or member under the group policy.~~

(3) Upon termination of the group term life insurance with respect to the spouse of any insured employee or member by reason of such person's termination of employment or membership or death, the spouse insured pursuant to this section shall have the same conversion rights as to the group term life insurance on the spouse's life as is provided for the insured employee or member.

(4) Only one certificate need be issued for delivery to an insured employee or member if a statement concerning any dependent's coverage is included in such certificate.

Sec. 3917.06. No policy of group life insurance shall be issued or delivered in this state until a copy of its form has been filed with the superintendent of insurance and formally approved by ~~him~~ the superintendent; nor shall such policy be so

issued or delivered unless it contains in substance the following 3660
provisions: 3661

(A) A provision that the policyholder is entitled to a grace 3662
period of thirty-one days for the payment of any premiums due 3663
except the first during which grace period the death benefit 3664
coverage shall continue in force, unless the policyholder has 3665
given the insurer written notice of discontinuance in advance of 3666
the date of discontinuance and in accordance with the terms of the 3667
policy; the policy may provide that the policyholder is liable to 3668
the insurer for the payment of a pro rata premium for the time the 3669
policy was in force during such grace period; 3670

(B) A provision that the policy is incontestable after two 3671
years from its date of issue, except for nonpayment of premiums 3672
and except for violation of the conditions of the policy relating 3673
to military or naval service in time of war; 3674

(C) A provision that the policy and the application submitted 3675
in connection therewith constitute the entire contract between the 3676
parties, and that all statements contained in such application are 3677
deemed, in the absence of fraud, representations and not 3678
warranties, and that no such statement shall be used in defense to 3679
a claim under the policy, unless it is contained in a written 3680
application; 3681

(D) A provision for the equitable adjustment of the premium 3682
or the amount of insurance payable in the event of a misstatement 3683
of the age of an employee or other person whose life is insured 3684
under a group life policy; 3685

(E) Except in the case of a policy described in division 3686
(B)(4) of section 3917.01 of the Revised Code, a provision that 3687
the company will issue to the policyholder for delivery to each 3688
person whose life is insured under such policy, an individual 3689
certificate setting forth a statement as to the insurance 3690

protection to which ~~he~~ the person is entitled, to whom payable, 3691
together with provision to the effect that in case of the 3692
termination of the employment for any reason or of membership in 3693
the classes eligible for insurance under the policy, such person 3694
is entitled to have issued to ~~him~~ the person by the company, 3695
without evidence of insurability, and upon application made to the 3696
company within thirty-one days after such termination, and upon 3697
the payment of the premium applicable to the class of risk to 3698
which ~~he~~ the person belongs and to the form and amount of the 3699
policy at ~~his~~ the person's then attained age, either a policy of 3700
life insurance in any one of the forms customarily issued by the 3701
company, except term insurance, in any amount not in excess of the 3702
amount of ~~his~~ the person's protection under ~~such~~ the group 3703
insurance policy at the time of ~~such~~ the termination, as ~~he~~ the 3704
person elects or, if applicable, the coverage described in 3705
division (B)(12) of section 3917.01 Of the Revised Code; 3706

(F) A provision that if the group policy terminates or is 3707
amended so as to terminate the insurance of any class of insured 3708
persons, every person insured thereunder at the date of such 3709
termination whose insurance terminates and who has been so insured 3710
for at least five years prior to such termination date is entitled 3711
to have issued to ~~him~~ the person by the insurer an individual 3712
policy of life insurance, subject to the same conditions as are 3713
provided by division (E) of this section, except that the group 3714
policy may provide that the amount of such individual policy shall 3715
not exceed the smaller of (1) the amount of the person's life 3716
insurance protection ceasing because of the termination ~~of~~ or 3717
amendment of the group policy, less the amount of any life 3718
insurance for which ~~he~~ the person is or becomes eligible under any 3719
group policy issued or reinstated by the same or another insurer 3720
within thirty-one days after such termination, and (2) two 3721
thousand dollars; 3722

(G) A provision that if a person insured under the group 3723
policy dies during the period within which ~~he~~ the person would 3724
have been entitled to have an individual policy issued to ~~him~~ the 3725
person in accordance with division (E) or (F) of this section, and 3726
before such an individual policy has become effective, the amount 3727
of life insurance which ~~he~~ the person would have been entitled to 3728
have issued to ~~him~~ the person under such individual policy shall 3729
be payable as a claim under the group policy, whether or not 3730
application for the individual policy or the payment of the first 3731
premium therefor has been made; 3732

(H) A provision that to the group or class of persons 3733
originally insured there shall be added from time to time all new 3734
employees of the employer or other persons eligible to insurance 3735
in such group or class; 3736

(I) In the case of a policy issued to a labor union covering 3737
all members of the union, a notice that the annual renewable term 3738
premium depends upon the attained ages of the members in the group 3739
and increases with advancing ages. 3740

Policies of group life insurance, when issued in this state 3741
by any company not organized under the laws of this state, may 3742
contain, when issued, any provision required by the law of the 3743
state, territory, or district of the United States under which the 3744
company is organized; and policies issued in other states or 3745
countries by companies organized in this state, may contain any 3746
provision required or permitted by the laws of the state, 3747
territory, district, or country in which the same are issued. Any 3748
such policy may be issued or delivered in this state which in the 3749
opinion of the superintendent contains provisions on any one or 3750
more of the requirements of this section more favorable to the 3751
policyholder or to the person whose life is insured under such 3752
policy than such requirements. 3753

The group life insurance policy together with any application 3754
in connection therewith shall be available for inspection during 3755
regular business hours at the office of the policyholder where 3756
such policy is on file, by any beneficiary thereunder or by an 3757
authorized representative of such beneficiary. 3758

Except as provided in sections 3917.01 to 3917.06, ~~inclusive,~~ 3759
of the Revised Code, no contract of life insurance shall be made 3760
covering a group in this state. 3761

Sec. 3923.021. (A) As used in this section, "benefits 3762
provided are not unreasonable in relation to the premium charged" 3763
means the rates were calculated in accordance with sound actuarial 3764
principles. 3765

(B) With respect to any filing, made pursuant to section 3766
3923.02 of the Revised Code, of any premium rates for any 3767
individual policy of sickness and accident insurance or for any 3768
indorsement or rider pertaining thereto, the superintendent of 3769
insurance may, within thirty days after filing: 3770

(1) Disapprove such filing after finding that the benefits 3771
provided are unreasonable in relation to the premium charged. Such 3772
disapproval shall be effected by written order of the 3773
superintendent, a copy of which shall be mailed to the insurer 3774
that has made the filing. In the order, the superintendent shall 3775
specify the reasons for the disapproval and state that a hearing 3776
will be held within fifteen days after requested in writing by the 3777
insurer. If a hearing is so requested, the superintendent shall 3778
also give such public notice as the superintendent considers 3779
appropriate. The superintendent, within fifteen days after the 3780
commencement of any hearing, shall issue a written order, a copy 3781
of which shall be mailed to the insurer that has made the filing, 3782
either affirming the prior disapproval or approving such filing 3783
after finding that the benefits provided are not unreasonable in 3784

relation to the premium charged.

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(2) Set a date for a public hearing to commence no later than
forty days after the filing. The superintendent shall give the
insurer making the filing twenty days' written notice of the
hearing and shall give such public notice as the superintendent
considers appropriate. The superintendent, within twenty days
after the commencement of a hearing, shall issue a written order,
a copy of which shall be mailed to the insurer that has made the
filing, either approving such filing if the superintendent finds
that the benefits provided are not unreasonable in relation to the
premium charged, or disapproving such filing if the superintendent
finds that the benefits provided are unreasonable in relation to
the premium charged. This division does not apply to any insurer
organized or transacting the business of insurance under Chapter
3907. or 3909. of the Revised Code.

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(3) Take no action, in which case such filing shall be deemed
to be approved and shall become effective upon the thirty-first
day after such filing, unless the superintendent has previously
given to the insurer a written approval.

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(C) At any time after any filing has been approved pursuant
to this section, the superintendent may, after a hearing of which
at least twenty days' written notice has been given to the insurer
that has made such filing and for which such public notice as the
superintendent considers appropriate has been given, withdraw
approval of such filing after finding that the benefits provided
are unreasonable in relation to the premium charged. Such
withdrawal of approval shall be effected by written order of the
superintendent, a copy of which shall be mailed to the insurer
that has made the filing, which shall state the ground for such
withdrawal and the date, not less than forty days after the date
of such order, when the withdrawal or approval shall become
effective.

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(D) The superintendent may retain at the insurer's expense 3817
such attorneys, actuaries, accountants, and other experts not 3818
otherwise a part of the superintendent's staff as shall be 3819
reasonably necessary to assist in the preparation for and conduct 3820
of any public hearing under this section. The expense for 3821
retaining such experts and the expenses of the department of 3822
insurance incurred in connection with such public hearing shall be 3823
assessed against the insurer in an amount not to exceed one 3824
one-hundredth of one per cent of the sum of premiums earned plus 3825
net realized investment gain or loss of such insurer as reflected 3826
in the most current annual statement on file with the 3827
superintendent. Any person retained shall be under the direction 3828
and control of the superintendent and shall act in a purely 3829
advisory capacity. 3830

~~(E) This section does not apply to any filing of any premium 3831
rate or rating formula for individual sickness and accident 3832
insurance policies offered in accordance with division (L) of 3833
section 3923.58 of the Revised Code, or for any amendment thereto. 3834~~

Sec. 3923.122. (A) Every policy of group sickness and 3835
accident insurance providing hospital, surgical, or medical 3836
expense coverage for other than specific diseases or accidents 3837
only, and delivered, issued for delivery, or renewed in this state 3838
on or after January 1, 1976, shall include a provision giving each 3839
insured the option to convert to the following: 3840

(1) In the case of an individual who is not a federally 3841
eligible individual, any of the individual policies of hospital, 3842
surgical, or medical expense insurance then being issued by the 3843
insurer with benefit limits not to exceed those in effect under 3844
the group policy; 3845

(2) In the case of a federally eligible individual, a basic 3846
or standard plan established by the board of directors of the Ohio 3847

health reinsurance program or plans substantially similar to the 3848
basic and standard plan in benefit design and scope of covered 3849
services. For purposes of division (A)(2) of this section, the 3850
superintendent of insurance shall determine whether a plan is 3851
substantially similar to the basic or standard plan in benefit 3852
design and scope of covered services. 3853

(B) An option for conversion to an individual policy shall be 3854
available without evidence of insurability to every insured, 3855
including any person eligible under division (D) of this section, 3856
who terminates employment or membership in the group holding the 3857
policy after having been continuously insured thereunder for at 3858
least one year. 3859

Upon receipt of the insured's written application and upon 3860
payment of at least the first quarterly premium not later than 3861
thirty-one days after the termination of coverage under the group 3862
policy, the insurer shall issue a converted policy on a form then 3863
available for conversion. The premium shall be in accordance with 3864
the insurer's table of premium rates in effect on the later of the 3865
following dates: 3866

(1) The effective date of the converted policy; 3867

(2) The date of application therefor; and shall be applicable 3868
to the class of risk to which each person covered belongs and to 3869
the form and amount of the policy at the person's then attained 3870
age. However, premiums charged federally eligible individuals may 3871
not exceed an amount that is two times the midpoint of the 3872
standard rate charged any other individual of a group to which the 3873
insurer is currently accepting new business and for which similar 3874
copayments and deductibles are applied. 3875

At the election of the insurer, a separate converted policy 3876
may be issued to cover any dependent of an employee or member of 3877
the group. 3878

Except as provided in division (H) of this section, any 3879
converted policy shall become effective as of the day following 3880
the date of termination of insurance under the group policy. 3881

Any probationary or waiting period set forth in the converted 3882
policy is deemed to commence on the effective date of the 3883
insured's coverage under the group policy. 3884

(C) No insurer shall be required to issue a converted policy 3885
to any person who is, or is eligible to be, covered for benefits 3886
at least comparable to the group policy under: 3887

(1) Title XVIII of the Social Security Act, as amended or 3888
superseded; 3889

(2) Any act of congress or law under this or any other state 3890
of the United States that duplicates coverage offered under 3891
division (C)(1) of this section; 3892

(3) Any policy that duplicates coverage offered under 3893
division (C)(1) of this section; 3894

(4) Any other group sickness and accident insurance providing 3895
hospital, surgical, or medical expense coverage for other than 3896
specific diseases or accidents only. 3897

(D) The option for conversion shall be available: 3898

(1) Upon the death of the employee or member, to the 3899
surviving spouse with respect to such of the spouse and dependents 3900
as are then covered by the group policy; 3901

(2) To a child solely with respect to the child upon 3902
attaining the limiting age of coverage under the group policy 3903
while covered as a dependent thereunder; 3904

(3) Upon the divorce, dissolution, or annulment of the 3905
marriage of the employee or member, to the divorced spouse, or 3906
former spouse in the event of annulment, of such employee or 3907
member, or upon the legal separation of the spouse from such 3908

employee or member, to the spouse. 3909

Persons possessing the option for conversion pursuant to this 3910
division shall be considered members for the purposes of division 3911
(H) of this section. 3912

(E) If coverage is continued under a group policy on an 3913
employee following retirement prior to the time the employee is, 3914
or is eligible to be, covered by Title XVIII of the Social 3915
Security Act, the employee may elect, in lieu of the continuance 3916
of group insurance, to have the same conversion rights as would 3917
apply had the employee's insurance terminated at retirement by 3918
reason of termination of employment. 3919

(F) If the insurer and the group policyholder agree upon one 3920
or more additional plans of benefits to be available for converted 3921
policies, the applicant for the converted policy may elect such a 3922
plan in lieu of a converted policy. 3923

(G) The converted policy may contain provisions for avoiding 3924
duplication of benefits provided pursuant to divisions (C)(1), 3925
(2), (3), and (4) of this section or provided under any other 3926
insured or noninsured plan or program. 3927

(H) If an employee or member becomes entitled to obtain a 3928
converted policy pursuant to this section, and if the employee or 3929
member has not received notice of the conversion privilege at 3930
least fifteen days prior to the expiration of the thirty-one-day 3931
conversion period provided in division (B) of this section, then 3932
the employee or member has an additional period within which to 3933
exercise the privilege. This additional period shall expire 3934
fifteen days after the employee or member receives notice, but in 3935
no event shall the period extend beyond sixty days after the 3936
expiration of the thirty-one-day conversion period. 3937

Written notice presented to the employee or member, or mailed 3938
by the policyholder to the last known address of the employee or 3939

member as indicated on its records, constitutes notice for the
purpose of this division. In the case of a person who is eligible
for a converted policy under division (D)(2) or (D)(3) of this
section, a policyholder shall not be responsible for presenting or
mailing such notice, unless such policyholder has actual knowledge
of the person's eligibility for a converted policy.

If an additional period is allowed by an employee or member
for the exercise of a conversion privilege, and if written
application for the converted policy, accompanied by at least the
first quarterly premium, is made after the expiration of the
thirty-one-day conversion period, but within the additional period
allowed an employee or member in accordance with this division,
the effective date of the converted policy shall be the date of
application.

(I) The converted policy may provide:

~~(1) That that any hospital, surgical, or medical expense
benefits otherwise payable with respect to any person may be
reduced by the amount of any such benefits payable under the group
policy for the same loss after termination of coverage.~~

~~(2) For termination of coverage on any person who is, or is
eligible to be, covered pursuant to division (C) of this section.~~

~~(3) That the insurer may request information in advance of
any premium due date of the policy as to whether the insured is,
or is eligible to be, covered pursuant to division (C) of this
section. If the insured is, or is eligible to be, covered, and the
insured fails to furnish the details of the insured's coverage or
eligibility to the insurer within thirty one days after the date
of the request, the benefits payable under the converted policy
may be based on the hospital, surgical, or medical expenses
actually incurred after excluding expenses to the extent of the
amount of benefits for which the insured is, or is eligible to be,~~

covered pursuant to division (C) of this section.	3971
(J) The converted policy may contain:	3972
(1) Any exclusion, reduction, or limitation contained in the group policy or customarily used in individual policies issued by the insurer;	3973 3974 3975
(2) Any provision permitted in this section;	3976
(3) Any other provision not prohibited by law.	3977
Any provision required or permitted in this section may be made a part of any converted policy by means of an endorsement or rider.	3978 3979 3980
(K) The time limit specified in a converted policy for certain defenses with respect to any person who was covered by a group policy shall commence on the effective date of such person's coverage under the group policy.	3981 3982 3983 3984
(L) No insurer shall use deterioration of health as the basis for refusing to renew a converted policy.	3985 3986
(M) No insurer shall use age as the basis for refusing to renew a converted policy.	3987 3988
(N) A converted policy made available pursuant to this section shall, if delivery of the policy is to be made in this state, comply with this section. If delivery of a converted policy is to be made in another state, it may be on a form offered by the insurer in the jurisdiction where the delivery is to be made and which provides benefits substantially in compliance with those required in a policy delivered in this state.	3989 3990 3991 3992 3993 3994 3995
(O) As used in this section, "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.	3996 3997
Sec. 3923.57. Notwithstanding any provision of this chapter, every individual policy of sickness and accident insurance that is	3998 3999

delivered, issued for delivery, or renewed in this state is 4000
subject to the following conditions, as applicable: 4001

(A) Pre-existing conditions provisions shall not exclude or 4002
limit coverage for a period beyond twelve months following the 4003
policyholder's effective date of coverage and may only relate to 4004
conditions during the six months immediately preceding the 4005
effective date of coverage. 4006

(B) In determining whether a pre-existing conditions 4007
provision applies to a policyholder or dependent, each policy 4008
shall credit the time the policyholder or dependent was covered 4009
under a previous policy, contract, or plan if the previous 4010
coverage was continuous to a date not more than thirty days prior 4011
to the effective date of the new coverage, exclusive of any 4012
applicable service waiting period under the policy. 4013

(C)(1) Except as otherwise provided in division (C) of this 4014
section, an insurer that provides an individual sickness and 4015
accident insurance policy to an individual shall renew or continue 4016
in force such coverage at the option of the individual. 4017

(2) An insurer may nonrenew or discontinue coverage of an 4018
individual in the individual market based only on one or more of 4019
the following reasons: 4020

(a) The individual failed to pay premiums or contributions in 4021
accordance with the terms of the policy or the insurer has not 4022
received timely premium payments. 4023

(b) The individual performed an act or practice that 4024
constitutes fraud or made an intentional misrepresentation of 4025
material fact under the terms of the policy. 4026

(c) The insurer is ceasing to offer coverage in the 4027
individual market in accordance with division (D) of this section 4028
and the applicable laws of this state. 4029

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

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

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

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

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

the insurer if the insurer does all of the following: 4061

(a) Provides notice to each individual provided coverage of 4062
this type in such market of the discontinuation at least ninety 4063
days prior to the date of the discontinuation of the coverage; 4064

(b) Offers to each individual provided coverage of this type 4065
in such market, the option to purchase any other individual health 4066
insurance coverage currently being offered by the insurer for 4067
individuals in that market; 4068

(c) In exercising the option to discontinue coverage of this 4069
type and in offering the option of coverage under division 4070
(D)(1)(b) of this section, acts uniformly without regard to any 4071
health status-related factor of covered individuals or of 4072
individuals who may become eligible for such coverage. 4073

(2) If an insurer elects to discontinue offering all health 4074
insurance coverage in the individual market in this state, health 4075
insurance coverage may be discontinued by the insurer only if both 4076
of the following apply: 4077

(a) The insurer provides notice to the department of 4078
insurance and to each individual of the discontinuation at least 4079
one hundred eighty days prior to the date of the expiration of the 4080
coverage. 4081

(b) All health insurance delivered or issued for delivery in 4082
this state in such market is discontinued and coverage under that 4083
health insurance in that market is not renewed. 4084

(3) In the event of a discontinuation under division (D)(2) 4085
of this section in the individual market, the insurer shall not 4086
provide for the issuance of any health insurance coverage in the 4087
market and this state during the five-year period beginning on the 4088
date of the discontinuation of the last health insurance coverage 4089
not so renewed. 4090

(E) ~~Notwithstanding~~ Notwithstanding divisions (C) and (D) of 4091
this section, an insurer may, at the time of coverage renewal, 4092
modify the health insurance coverage for a policy form offered to 4093
individuals in the individual market if the modification is 4094
consistent with the law of this state and effective on a uniform 4095
basis among all individuals with that policy form. 4096

(F) Such policies are subject to sections 2743 and 2747 of 4097
the "Health Insurance Portability and Accountability Act of 1996," 4098
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-43 and 4099
300gg-47, as amended. 4100

(G) Sections 3924.031 and 3924.032 of the Revised Code shall 4101
apply to sickness and accident insurance policies offered in the 4102
individual market in the same manner as they apply to health 4103
benefit plans offered in the small employer market. 4104

In accordance with 45 C.F.R. 148.102, divisions (C) to (G) of 4105
this section also apply to all group sickness and accident 4106
insurance policies that are not sold in connection with an 4107
employment-related group health plan and that provide more than 4108
short-term, limited duration coverage. 4109

In applying divisions (C) to (G) of this section with respect 4110
to health insurance coverage that is made available by an insurer 4111
in the individual market to individuals only through one or more 4112
associations, the term "individual" includes the association of 4113
which the individual is a member. 4114

For purposes of this section, any policy issued pursuant to 4115
division (C) of section 3923.13 of the Revised Code in connection 4116
with a public or private college or university student health 4117
insurance program is considered to be issued to a bona fide 4118
association ~~and is not subject to divisions (C) to (G) of this~~ 4119
~~section.~~ 4120

As used in this section, "bona fide association" has the same 4121

meaning as in section 3924.03 of the Revised Code, and "health
status-related factor" and "network plan" have the same meanings
as in section 3924.031 of the Revised Code.

This section does not apply to any policy that provides
coverage for specific diseases or accidents only, or to any
hospital indemnity, medicare supplement, long-term care,
disability income, one-time-limited-duration policy of no longer
than six months, or other policy that offers only supplemental
benefits.

Sec. 3923.571. Except as otherwise provided in section 2721
of the "Health Insurance Portability and Accountability Act of
1996," Pub. L. No. 104-191, 110 Stat. 1995, 42 U.S.C.A. 300gg-21,
as amended, the following conditions apply to all group policies
of sickness and accident insurance that are sold in connection
with an employment-related group health plan and that are not
subject to section 3924.03 of the Revised Code:

(A) Any such policy shall comply with the requirements of
division (A) of section 3924.03 and section 3924.033 of the
Revised Code.

(B)(1) Except as provided in section 2712(b) to (e) of the
"Health Insurance Portability and Accountability Act of 1996," if
an insurer offers coverage in the small or large group market in
connection with a group policy, the insurer shall renew or
continue in force such coverage at the option of the policyholder.

(2) An insurer may cancel or decide not to renew the coverage
of an employee or of a dependent of an employee if the employee or
dependent, as applicable, has performed an act or practice that
constitutes fraud or made an intentional misrepresentation of
material fact under the terms of the coverage and if the
cancellation or nonrenewal is not based, either directly or

indirectly, on any health status-related factor in relation to the 4152
employee or dependent. 4153

As used in division (B)(2) of this section, "health 4154
status-related factor" has the same meaning as in section 3924.031 4155
of the Revised Code. 4156

(C)(1) No such policy, or insurer offering health insurance 4157
coverage in connection with such a policy, shall require any 4158
individual, as a condition of coverage or continued coverage under 4159
the policy, to pay a premium or contribution that is greater than 4160
the premium or contribution for a similarly situated individual 4161
covered under the policy on the basis of any health status-related 4162
factor in relation to the individual or to an individual covered 4163
under the policy as a dependent of the individual. 4164

(2) Nothing in division (C)(1) of this section shall be 4165
construed to restrict the amount that an employer may be charged 4166
for coverage under a group policy, or to prevent a group policy, 4167
and an insurer offering group health insurance coverage, from 4168
establishing premium discounts or rebates or modifying otherwise 4169
applicable copayments or deductibles in return for adherence to 4170
programs of health promotion and disease prevention. 4171

(D) Such policies shall provide for the special enrollment 4172
periods described in section 2701(f) of the "Health Insurance 4173
Portability and Accountability Act of 1996." 4174

(E) At least once in every twelve-month period, an insurer 4175
shall provide to all late enrollees, as defined in section 3924.01 4176
of the Revised Code, who are identified by the policyholder, the 4177
option to enroll in the group policy. The enrollment option shall 4178
be provided for a minimum period of thirty consecutive days. All 4179
delays of coverage imposed under the group policy, including any 4180
pre-existing condition exclusion period or service waiting period, 4181
shall begin on the date the insurer receives notice of the late 4182

enrollee's application or request for coverage, and shall run 4183
concurrently with each other. 4184

Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of 4185
the Revised Code: 4186

(1) "Health benefit plan" and "MEWA" have the same meanings 4187
as in section 3924.01 of the Revised Code. 4188

(2) "Insurer" means any sickness and accident insurance 4189
company authorized to do business in this state, or MEWA 4190
authorized to issue insured health benefit plans in this state. 4191
"Insurer" does not include any health insuring corporation that is 4192
owned or operated by an insurer. 4193

(3) "Pre-existing conditions provision" means a policy 4194
provision that excludes or limits coverage for charges or expenses 4195
incurred during a specified period following the insured's 4196
effective date of coverage as to a condition which, during a 4197
specified period immediately preceding the effective date of 4198
coverage, had manifested itself in such a manner as would cause an 4199
ordinarily prudent person to seek medical advice, diagnosis, care, 4200
or treatment or for which medical advice, diagnosis, care, or 4201
treatment was recommended or received, or a pregnancy existing on 4202
the effective date of coverage. 4203

(B) Beginning in January of each year, insurers in the 4204
business of issuing individual policies of sickness and accident 4205
insurance as contemplated by section 3923.021 of the Revised Code, 4206
except individual policies issued pursuant to section 3923.122 of 4207
the Revised Code, shall accept applicants for open enrollment 4208
coverage, as set forth in this division, in the order in which 4209
they apply for coverage and subject to the limitation set forth in 4210
division (G) of this section. Insurers shall accept for coverage 4211
pursuant to this section individuals to whom both of the following 4212
conditions apply: 4213

(1) The individual is not applying for coverage as an 4214
employee of an employer, as a member of an association, or as a 4215
member of any other group. 4216

(2) The individual is not covered, and is not eligible for 4217
coverage, under any other private or public health benefits 4218
arrangement, including the medicare program established under 4219
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 4220
U.S.C.A. 301, as amended, or any other act of congress or law of 4221
this or any other state of the United States that provides 4222
benefits comparable to the benefits provided under this section, 4223
any medicare supplement policy, or any continuation of coverage 4224
policy under state or federal law. 4225

(C) An insurer shall offer to any individual accepted under 4226
this section the ~~small-employer Ohio health care plan~~ basic and 4227
standard plans established by the board of directors of the Ohio 4228
health reinsurance program under division (A) of section 3924.10 4229
of the Revised Code or a health benefit ~~plan~~ plans that ~~is~~ are 4230
substantially similar to the ~~small-employer Ohio health care plan~~ 4231
basic and standard plans in benefit plan design and scope of 4232
covered services. 4233

An insurer may offer other health benefit plans in addition 4234
to, but not in lieu of, the ~~plan~~ plans required to be offered 4235
under this division. ~~These additional~~ A basic health benefit ~~plans~~ 4236
plan shall provide, at a minimum, the coverage provided by the 4237
~~small-employer Ohio health care~~ basic plan or any health benefit 4238
plan that is substantially similar to the ~~small-employer Ohio~~ 4239
health care basic plan in benefit plan design and scope of covered 4240
services. A standard health benefit plan shall provide, at a 4241
minimum, the coverage provided by the Ohio health care standard 4242
plan or any health benefit plan that is substantially similar to 4243
the Ohio health care standard plan in benefit plan design and 4244
scope of covered services. 4245

For purposes of this division, the superintendent of insurance shall determine whether a health benefit plan is substantially similar to the ~~small-employer~~ Ohio health care plan BASIC AND STANDARD PLANS in benefit plan design and scope of covered services.

(D) Health benefit plans issued under this section may establish pre-existing conditions provisions that exclude or limit coverage for a period of up to twelve months following the individual's effective date of coverage and that may relate only to conditions during the six months immediately preceding the effective date of coverage.

(E) Premiums charged to individuals under this section may not exceed an amount that is two and one-half times the highest rate charged any other individual to which the insurer is currently accepting new business, and for which similar copayments and deductibles are applied.

(F) In offering health benefit plans under this section, an insurer may require the purchase of health benefit plans that condition the reimbursement of health services upon the use of a specific network of providers.

(G)(1) In no event shall an insurer be required to accept annually under this section individuals who, in the aggregate, would cause the insurer to have a total number of new insureds that is more than one-half per cent of its total number of insured individuals in this state per year, as contemplated by section 3923.021 of the Revised Code, calculated as of the immediately preceding thirty-first day of December and excluding the insurer's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division ~~(M)~~(L) of this section.

(2) An officer of the insurer shall certify to the department

of insurance when it has met the enrollment limit set forth in 4277
division (G)(1) of this section. Upon providing such 4278
certification, the insurer shall be relieved of its open 4279
enrollment requirement under this section for the remainder of the 4280
calendar year. 4281

(H) An insurer shall not be required to accept under this 4282
section applicants who, at the time of enrollment, are confined to 4283
a health care facility because of chronic illness, permanent 4284
injury, or other infirmity that would cause economic impairment to 4285
the insurer if the applicants were accepted, or to make the 4286
effective date of benefits for individuals accepted under this 4287
section earlier than ninety days after the date of acceptance. 4288

(I) The requirements of this section do not apply to any 4289
insurer that is currently in a state of supervision, insolvency, 4290
or liquidation. If an insurer demonstrates to the satisfaction of 4291
the superintendent that the requirements of this section would 4292
place the insurer in a state of supervision, insolvency, or 4293
liquidation, the superintendent may waive or modify the 4294
requirements of division (B) or (G) of this section. The actions 4295
of the superintendent under this division shall be effective for a 4296
period of not more than one year. At the expiration of such time, 4297
a new showing of need for a waiver or modification by the insurer 4298
shall be made before a new waiver or modification is issued or 4299
imposed. 4300

(J) No hospital, health care facility, or health care 4301
practitioner, and no person who employs any health care 4302
practitioner, shall balance bill any individual or dependent of an 4303
individual for any health care supplies or services provided to 4304
the individual or dependent who is insured under a policy issued 4305
under this section. The hospital, health care facility, or health 4306
care practitioner, or any person that employs the health care 4307
practitioner, shall accept payments made to it by the insurer 4308

under the terms of the policy or contract insuring or covering 4309
such individual as payment in full for such health care supplies 4310
or services. 4311

As used in this division, "hospital" has the same meaning as 4312
in section 3727.01 of the Revised Code; "health care practitioner" 4313
has the same meaning as in section 4769.01 of the Revised Code; 4314
and "balance bill" means charging or collecting an amount in 4315
excess of the amount reimbursable or payable under the policy or 4316
health care service contract issued to an individual under this 4317
section for such health care supply or service. "Balance bill" 4318
does not include charging for or collecting copayments or 4319
deductibles required by the policy or contract. 4320

(K) An insurer shall pay an agent a commission in the amount 4321
of five per cent of the premium charged for initial placement or 4322
for otherwise securing the issuance of a policy or contract issued 4323
to an individual under this section, and four per cent of the 4324
premium charged for the renewal of such a policy or contract. The 4325
superintendent may adopt, in accordance with Chapter 119. of the 4326
Revised Code, such rules as are necessary to enforce this 4327
division. 4328

~~(L) Individuals accepted for coverage under this section may 4329
be issued contracts and certificates subject to the requirements 4330
of section 3923.12 of the Revised Code. The coverage issued to 4331
such individuals is not subject to the requirements of section 4332
3923.021 of the Revised Code. 4333~~

~~(M)~~ This section does not apply to any policy that provides 4334
coverage for specific diseases or accidents only, or to any 4335
hospital indemnity, medicare supplement, long-term care, 4336
disability income, one-time-limited-duration policy of no longer 4337
than six months, or other policy that offers only supplemental 4338
benefits. 4339

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

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

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

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

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

health insuring corporation for purposes of sections 3924.01 to 4371
3924.14 of the Revised Code. 4372

(E) "Case characteristics" means, with respect to a small 4373
employer, the geographic area in which the employees work; the age 4374
and sex of the individual employees and their dependents; the 4375
appropriate industry classification as determined by the carrier; 4376
the number of employees and dependents; and such other objective 4377
criteria as may be established by the carrier. "Case 4378
characteristics" does not include claims experience, health 4379
status, or duration of coverage from the date of issue. 4380

(F) "Dependent" means the spouse or child of an eligible 4381
employee, subject to applicable terms of the health benefits plan 4382
covering the employee. 4383

(G) "Eligible employee" means an employee who works a normal 4384
work week of twenty-five or more hours. "Eligible employee" does 4385
not include a temporary or substitute employee, or a seasonal 4386
employee who works only part of the calendar year on the basis of 4387
natural or suitable times or circumstances. 4388

(H) "Health benefit plan" means any hospital or medical 4389
expense policy or certificate or any health plan provided by a 4390
carrier, that is delivered, issued for delivery, renewed, or used 4391
in this state on or after the date occurring six months after 4392
November 24, 1995. "Health benefit plan" does not include policies 4393
covering only accident, credit, dental, disability income, 4394
long-term care, hospital indemnity, medicare supplement, specified 4395
disease, or vision care; coverage under a 4396
one-time-limited-duration policy of no longer than six months; 4397
coverage issued as a supplement to liability insurance; insurance 4398
arising out of a workers' compensation or similar law; automobile 4399
medical-payment insurance; or insurance under which benefits are 4400
payable with or without regard to fault and which is statutorily 4401

required to be contained in any liability insurance policy or 4402
equivalent self-insurance. 4403

(I) "Late enrollee" means an eligible employee or dependent 4404
who enrolls in a small employer's health benefit plan other than 4405
during the first period in which the employee or dependent is 4406
eligible to enroll under the plan or during a special enrollment 4407
period described in section 2701(f) of the "Health Insurance 4408
Portability and Accountability Act of 1996," Pub. L. No. 104-191, 4409
110 Stat. 1955, 42 U.S.C.A. 300gg, as amended. 4410

(J) "MEWA" means any "multiple employer welfare arrangement" 4411
as defined in section 3 of the "Federal Employee Retirement Income 4412
Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended, 4413
except for any arrangement which is fully insured as defined in 4414
division (b)(6)(D) of section 514 of that act. 4415

(K) "Midpoint rate" means, for small employers with similar 4416
case characteristics and plan designs and as determined by the 4417
applicable carrier for a rating period, the arithmetic average of 4418
the applicable base premium rate and the corresponding highest 4419
premium rate. 4420

(L) "Pre-existing conditions provision" means a policy 4421
provision that excludes or limits coverage for charges or expenses 4422
incurred during a specified period following the insured's 4423
enrollment date as to a condition for which medical advice, 4424
diagnosis, care, or treatment was recommended or received during a 4425
specified period immediately preceding the enrollment date. 4426
Genetic information shall not be treated as such a condition in 4427
the absence of a diagnosis of the condition related to such 4428
information. 4429

For purposes of this division, "enrollment date" means, with 4430
respect to an individual covered under a group health benefit 4431
plan, the date of enrollment of the individual in the plan or, if 4432

earlier, the first day of the waiting period for such enrollment. 4433

(M) "Service waiting period" means the period of time after 4434
employment begins before an employee is eligible to be covered for 4435
benefits under the terms of any applicable health benefit plan 4436
offered by the small employer. 4437

(N)(1) "Small employer" means, in connection with a group 4438
health benefit plan and with respect to a calendar year and a plan 4439
year, an employer who employed an average of at least two but no 4440
more than fifty eligible employees on business days during the 4441
preceding calendar year and who employs at least two employees on 4442
the first day of the plan year. 4443

(2) For purposes of division (N)(1) of this section, all 4444
persons treated as a single employer under subsection (b), (c), 4445
(m), or (o) of section 414 of the "Internal Revenue Code of 1986," 4446
100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one 4447
employer. In the case of an employer that was not in existence 4448
throughout the preceding calendar year, the determination of 4449
whether the employer is a small or large employer shall be based 4450
on the average number of eligible employees that it is reasonably 4451
expected the employer will employ on business days in the current 4452
calendar year. Any reference in division (N) of this section to an 4453
"employer" includes any predecessor of the employer. Except as 4454
otherwise specifically provided, provisions of sections 3924.01 to 4455
3924.14 of the Revised Code that apply to a small employer that 4456
has a health benefit plan shall continue to apply until the plan 4457
anniversary following the date the employer no longer meets the 4458
requirements of this division. 4459

(O) "~~SEHC~~ OHC plan" means an Ohio ~~small employer~~ health care 4460
plan, which is ~~a health benefit~~ the basic, standard, or carrier 4461
reimbursement plan for small ~~individuals and~~ employers and 4462
individuals established by the board in accordance with section 4463

3924.10 of the Revised Code. 4464

Sec. 3924.03. Except as otherwise provided in section 2721 of 4465
the "Health Insurance Portability and Accountability Act of 1996," 4466
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as 4467
amended, health benefit plans covering small employers are subject 4468
to the following conditions, as applicable: 4469

(A)(1) Pre-existing conditions provisions shall not exclude 4470
or limit coverage for a period beyond twelve months, or eighteen 4471
months in the case of a late enrollee, following the individual's 4472
enrollment date and may only relate to a physical or mental 4473
condition, regardless of the cause of the condition, for which 4474
medical advice, diagnosis, care, or treatment was recommended or 4475
received within the six months immediately preceding the 4476
enrollment date. 4477

Division (A)(1) of this section is subject to the exceptions 4478
set forth in section 2701(d) of the "Health Insurance Portability 4479
and Accountability Act of 1996." 4480

(2) The period of any such pre-existing condition exclusion 4481
shall be reduced by the aggregate of the periods of creditable 4482
coverage, if any, applicable to the employee or dependent as of 4483
the enrollment date. 4484

(3) A period of creditable coverage shall not be counted, 4485
with respect to enrollment of an individual under a group health 4486
benefit plan, if, after that period and before the enrollment 4487
date, there was a sixty-three-day period during all of which the 4488
individual was not covered under any creditable coverage. 4489

Subsections (c)(2) to (4) and (e) of section 2701 of the "Health 4490
Insurance Portability and Accountability Act of 1996" apply with 4491
respect to crediting previous coverage. 4492

(4) As used in division (A) of this section: 4493

(a) "Creditable coverage" has the same meaning as in section 4494
2701(c)(1) of the "Health Insurance Portability and Accountability 4495
Act of 1996." 4496

(b) "Enrollment date" means, with respect to an individual 4497
covered under a group health benefit plan, the date of enrollment 4498
of the individual in the plan or, if earlier, the first day of the 4499
waiting period for such enrollment. 4500

(B)(1) Except as provided in section 2712(b) to (e) of the 4501
"Health Insurance Portability and Accountability Act of 1996," if 4502
a carrier offers coverage in the small employer market in 4503
connection with a group health benefit plan, the carrier shall 4504
renew or continue in force such coverage at the option of the plan 4505
sponsor of the plan. 4506

(2) A carrier may cancel or decide not to renew the coverage 4507
of any eligible employee or of a dependent of an eligible employee 4508
if the employee or dependent, as applicable, has performed an act 4509
or practice that constitutes fraud or made an intentional 4510
misrepresentation of material fact under the terms of the coverage 4511
and if the cancellation or nonrenewal is not based, either 4512
directly or indirectly, on any health status-related factor in 4513
relation to the employee or dependent. 4514

As used in division (B)(2) of this section, "health 4515
status-related factor" has the same meaning as in section 3924.031 4516
of the Revised Code. 4517

(C) A carrier shall not exclude any eligible employee or 4518
dependent, who would otherwise be covered under a health benefit 4519
plan, on the basis of any actual or expected health condition of 4520
the employee or dependent. 4521

If, prior to November 24, 1995, a carrier excluded an 4522
eligible employee or dependent, other than a late enrollee, on the 4523
basis of an actual or expected health condition, the carrier 4524

shall, upon the initial renewal of the coverage on or after that 4525
date, extend coverage to the employee or dependent if all other 4526
eligibility requirements are met. 4527

(D) No health benefit plan issued by a carrier shall limit or 4528
exclude, by use of a rider or amendment applicable to a specific 4529
individual, coverage by type of illness, treatment, medical 4530
condition, or accident, except for pre-existing conditions as 4531
permitted under division (A) of this section. If a health benefit 4532
plan that is delivered or issued for delivery prior to April 14, 4533
1993, contains such limitations or exclusions, by use of a rider 4534
or amendment applicable to a specific individual, the plan shall 4535
eliminate the use of such riders or amendments within eighteen 4536
months after April 14, 1993. 4537

(E)(1) Except as provided in sections 3924.031 and 3924.032 4538
of the Revised Code, and subject to such rules as may be adopted 4539
by the superintendent of insurance in accordance with Chapter 119. 4540
of the Revised Code, a carrier shall offer and make available 4541
every health benefit plan that it is actively marketing to every 4542
small employer that applies to the carrier for such coverage. 4543

Division (E)(1) of this section does not apply to a health 4544
benefit plan that a carrier makes available in the small employer 4545
market only through one or more bona fide associations. 4546

Division (E)(1) of this section shall not be construed to 4547
preclude a carrier from establishing employer contribution rules 4548
or group participation rules for the offering of coverage in 4549
connection with a group health benefit plan in the small employer 4550
market, as allowed under the law of this state. As used in 4551
division (E)(1) of this section, "employer contribution rule" 4552
means a requirement relating to the minimum level or amount of 4553
employer contribution toward the premium for enrollment of 4554
employees and dependents and "group participation rule" means a 4555

requirement relating to the minimum number of employees or dependents that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(2) Each health benefit plan, at the time of initial group enrollment, shall make coverage available to all the eligible employees of a small employer without a service waiting period. The decision of whether to impose a service waiting period shall be made by the small employer. Such waiting periods shall not be greater than ninety days.

(3) Each health benefit plan shall provide for the special enrollment periods described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996."

(4) At least once in every twelve-month period, a carrier shall provide to all late enrollees who are identified by the small employer, the option to enroll in the health benefit plan. The enrollment option shall be provided for a minimum period of thirty consecutive days. All delays of coverage imposed under the health benefit plan, including any pre-existing condition exclusion period, affiliation period, or service waiting period, shall begin on the date the carrier receives notice of the late enrollee's application or request for coverage, and shall run concurrently with each other.

(F) The benefit structure of any health benefit plan may, at the time of coverage renewal, be changed by the carrier to make it consistent with the benefit structure contained in health benefit plans being marketed to new small employer groups. If the health benefit plan is available in the small employer market other than only through one or more bona fide associations, the modification must be consistent with the law of this state and effective on a uniform basis among small employer group plans.

(G) A carrier may obtain any facts and information necessary 4587
to apply this section, or supply those facts and information to 4588
any other third-party payer, without the consent of the 4589
beneficiary. Each person claiming benefits under a health benefit 4590
plan shall provide any facts and information necessary to apply 4591
this section. 4592

For purposes of this section, "bona fide association" means 4593
an association that has been actively in existence for at least 4594
five years; has been formed and maintained in good faith for 4595
purposes other than obtaining insurance; does not condition 4596
membership in the association on any health status-related factor, 4597
as defined in section 3924.031 of the Revised Code, relating to an 4598
individual, including an employee or dependent; makes health 4599
insurance coverage offered through the association available to 4600
all members regardless of any health status-related factor, as 4601
defined in section 3924.031 of the Revised Code, relating to such 4602
members or to individuals eligible for coverage through a member; 4603
does not make health insurance coverage offered through the 4604
association available other than in connection with a member of 4605
the association; and meets any other requirement imposed by the 4606
superintendent. To maintain its status as a "bona fide 4607
association," each association shall annually certify to the 4608
superintendent that it meets the requirements of this paragraph. 4609

Sec. 3924.033. (A) Each carrier, in connection with the 4610
offering of a health benefit plan to a small employer, shall 4611
disclose to the employer, as part of its solicitation and sales 4612
materials, ~~that the information described in division (B) of this~~ 4613
~~section is available upon request.~~ 4614

~~(B) A carrier shall provide the following information to a~~ 4615
~~small employer upon request:~~ 4616

(1) The provisions of the plan concerning the carrier's right 4617

to change premium rates and the factors that may affect changes in premium rates; 4618
4619

(2) The provisions of the plan relating to renewability of coverage; 4620
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(3) The provisions of the plan relating to any pre-existing condition exclusion; 4622
4623

(4) The benefits and premiums available under all health benefit plans for which the employer is qualified. 4624
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~~(C)~~(B) The information described in division ~~(B)~~(A) of this section shall be provided in a manner determined to be understandable by the average small employer, and in a manner sufficient to reasonably inform a small employer regarding the employer's rights and obligations under the health benefit plan. 4626
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~~(D)~~(C) Nothing in this section requires a carrier to disclose any information that is by law proprietary and trade secret information. 4631
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Sec. 3924.08. (A) The board of directors of the Ohio health reinsurance program shall consist of nine appointed members who shall serve staggered terms as determined by the initial board for its members and by the plan of operation of the program for members of subsequent boards. Within thirty days after April 14, 1993, the members of the board shall be appointed, as follows: 4634
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(1) The chairperson of the senate committee having jurisdiction over insurance shall appoint the following members: 4640
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(a) Two member carriers that are small employer carriers; 4642

(b) One member carrier that is a health insuring corporation predominantly in the small employer market; 4643
4644

(c) One representative of providers of health care. 4645

(2) The chairperson of the committee in the house of 4646

representatives having jurisdiction over insurance shall appoint 4647
the following members: 4648

(a) One member carrier that is a small employer carrier; 4649

(b) One member carrier whose principal health insurance 4650
business is in the large employer market; 4651

(c) One representative of an employer with fifty or fewer 4652
employees; 4653

(d) One representative of consumers in this state. 4654

(3) The superintendent of insurance shall appoint a 4655
representative of a member carrier operating in the small employer 4656
market who is a fellow of the society of actuaries. 4657

The superintendent, a member of the house of representatives 4658
appointed by the speaker of the house of representatives, and a 4659
member of the senate appointed by the president of the senate, 4660
shall be ex-officio members of the board. The membership of all 4661
boards subsequent to the initial board shall reflect the 4662
distribution described in division (A) of this section. 4663

The chairperson of the initial board and each subsequent 4664
board shall represent a small employer member carrier and shall be 4665
elected by a majority of the voting members of the board. Each 4666
chairperson shall serve for the maximum duration established in 4667
the plan of operation. 4668

(B) Within one hundred eighty days after the appointment of 4669
the initial board, the board shall establish a plan of operation 4670
and, thereafter, any amendments to the plan that are necessary or 4671
suitable, to assure the fair, reasonable, and equitable 4672
administration of the program. The board shall, immediately upon 4673
adoption, provide to the superintendent copies of the plan of 4674
operation and all subsequent amendments to it. 4675

(C) The plan of operation shall establish rules, conditions, 4676

- and procedures for all of the following: 4677
- (1) The handling and accounting of assets and moneys of the program and for an annual fiscal reporting to the superintendent; 4678
4679
 - (2) Filling vacancies on the board; 4680
 - (3) Selecting an ~~administering insurer, which shall be a carrier as defined in section 3924.01 of the Revised Code~~ administrator of the program, and setting forth the powers and duties of the ~~administering insurer;~~ administrator. The administrator may be a carrier as defined in section 3924.01 of the Revised Code or a person licensed as an administrator under Chapter 3959. of the Revised Code, or the board may, in its sole discretion, choose to serve as administrator of the program. 4681
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 - (4) Reinsuring risks in accordance with sections 3924.07 to 3924.14 of the Revised Code; 4689
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 - (5) Collecting assessments subject to section 3924.13 of the Revised Code from all members to provide for claims reinsured by the program and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made; 4691
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 - (6) Providing protection for carriers from the financial risk associated with small employers that present poor credit risks; 4695
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 - (7) Establishing standards for the coverage of small employers that have a high turnover of employees; 4698
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 - (8) Establishing an appeals process for carriers to seek relief when a carrier has experienced an unfair share of administrative and credit risks; 4700
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 - (9) Establishing the adjusted average market premium prices for use by the ~~SEHC plan~~ OHC plans for individuals, for groups of two to twenty-five employees, and for groups of twenty-six to fifty employees that are offered in the state; 4703
4704
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4706

(10) Establishing participation standards at issue and renewal for reinsured cases;	4707 4708
(11) Reinsuring risks and collecting assessments in accordance with division (G) of section 3924.11 of the Revised Code;	4709 4710 4711
(12) Any additional matters as determined by the board.	4712
Sec. 3924.09. The Ohio health reinsurance program shall have the general powers and authority granted under the laws of the state to insurance companies licensed to transact sickness and accident insurance, except the power to issue insurance. The board of directors of the program also shall have the specific authority to do all of the following:	4713 4714 4715 4716 4717 4718
(A) Enter into contracts as are necessary or proper to carry out the provisions and purposes of sections 3924.07 to 3924.14 of the Revised Code, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions;	4719 4720 4721 4722 4723 4724
(B) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against any program or board member;	4725 4726 4727
(C) Take such legal action as is necessary to avoid the payment of improper claims against the program;	4728 4729
(D) Design the SEHC plan <u>OHC plans</u> which, when offered by a carrier, is <u>are</u> eligible for reinsurance and issue reinsurance policies in accordance with the requirements of sections 3924.07 to 3924.14 of the Revised Code;	4730 4731 4732 4733
(E) Establish rules, conditions, and procedures pertaining to the reinsurance of members' risks by the program;	4734 4735

(F) Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the operation of the program;

(G) Assess members in accordance with division (G) of section 3924.11 and the provisions of section 3924.13 of the Revised Code, and make such advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.

(H) Appoint members to appropriate legal, actuarial, and other committees if necessary to provide technical assistance with respect to the operation of the program, policy and other contract design, and any other function within the authority of the program;

(I) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

(J) Reinsure risks, collect assessments, and otherwise carry out its duties under division (G) of section 3924.11 of the Revised Code;

(K) Study the operation of the Ohio health reinsurance program and the open enrollment reinsurance program and, based on its findings, make legislative recommendations to the general assembly for improvements in the effectiveness, operation, and integrity of the programs;

(L) Design a basic and standard plan for purposes of sections 1751.16, 3923.122, and 3923.581 of the Revised Code.

Sec. 3924.10. (A) The board of directors of the Ohio health

reinsurance program shall design the ~~SEHC plan~~ OHC basic, 4766
standard, and carrier reimbursement plans which, when offered by a 4767
carrier, ~~is~~ are eligible for reinsurance under the program. The 4768
board shall establish the form and level of coverage to be made 4769
available by carriers in their ~~SEHC plan~~ OHC plans. In designing 4770
the ~~plan~~ plans the board shall also establish benefit levels, 4771
deductibles, coinsurance factors, exclusions, and limitations for 4772
the ~~plan~~ plans. The forms and levels of coverage established by 4773
the board shall specify which components of a health benefit ~~plan~~ 4774
plans offered by a carrier may be reinsured. The ~~SEHC plan is~~ OHC 4775
plans are subject to division (C) of section 3924.02 of the 4776
Revised Code and to the provisions in Chapters 1751., 1753., 4777
3923., and any other chapter of the Revised Code that require 4778
coverage or the offer of coverage of a health care service or 4779
benefit. 4780

(B) The board shall adopt the ~~SEHC plan~~ OHC plans within one 4781
hundred eighty days after ~~its appointment~~ the effective date of 4782
this amendment. The ~~plan~~ plans may include cost containment 4783
features including any of the following: 4784

(1) Utilization review of health care services, including 4785
review of the medical necessity of hospital and physician 4786
services; 4787

(2) Case management benefit alternatives; 4788

(3) Selective contracting with hospitals, physicians, and 4789
other health care providers; 4790

(4) Reasonable benefit differentials applicable to 4791
participating and nonparticipating providers; 4792

(5) Employee assistance program options that provide 4793
preventive and early intervention mental health and substance 4794
abuse services; 4795

(6) Other provisions for the cost-effective management of the ~~plan plans.~~ 4796
4797

(C) ~~An SEHC plan~~ OHC plans established for use by health 4798
insuring corporations shall be consistent with the basic method of 4799
operation of such corporations. 4800

(D) Each carrier shall certify to the superintendent of 4801
insurance, in the form and manner prescribed by the 4802
superintendent, that the ~~SEHC plan~~ OHC plans filed by the carrier 4803
~~is~~ are in substantial compliance with the provisions of the board 4804
~~SEHC plan~~ OHC plans. Upon receipt by the superintendent of the 4805
certification, the carrier may use the certified ~~plan plans.~~ 4806

(E) Each carrier shall, on and after sixty days after the 4807
date that the program becomes operational and as a condition of 4808
transacting business in this state, renew coverage provided to any 4809
individual or group under its ~~SEHC plan~~ OHC plans. 4810

Sec. 3924.11. Any member of the Ohio health reinsurance 4811
program may reinsure small employer groups or individuals in 4812
accordance with the following conditions and limitations: 4813

(A) ~~With respect to eligible employees and their dependents 4814
who are hired subsequent to the commencement of the employer's 4815
coverage by a carrier and who are not late enrollees, and with 4816
respect to employees of an employer who are otherwise eligible for 4817
insurance but were excluded by the carrier's underwriting and who 4818
are not late enrollees, coverage may be reinsured in any of the 4819
following ways:~~ 4820

~~(1) Except in the case of late enrollees, within sixty days 4821
after the commencement of their coverage under the plan;~~ 4822

~~(2) In the case of late enrollees who were not eligible to 4823
enroll during a special enrollment period described in section 4824
2701(f) of the "Health Insurance Portability and Accountability 4825~~

Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 4826
300gg 42, as amended, eighteen months after the date the late 4827
enrollee becomes a member of the small employer's plan; 4828

~~(3) In the case of late enrollees who were eligible to enroll 4829
during a special enrollment period described in section 2701(f) of 4830
the "Health Insurance Portability and Accountability Act of 1996," 4831
as amended, within sixty days after the commencement of their 4832
coverage under the plan A small employer group or individual may 4833
be reinsured within sixty days after the commencement of the 4834
group's or individual's coverage under the plan. 4835~~

(B)(1) The carrier may reinsure either the entire eligible 4837
group or any eligible individual, in accordance with the premium 4838
rates established in section 3924.12 of the Revised Code, upon 4839
commencement of the coverage. 4840

(2) The carrier may reinsure an eligible employee, or the 4841
dependents of an eligible employee, who were previously excluded 4842
from group coverage for medical reasons, and shall reinsure such 4843
employees or dependents within sixty days after the carrier is 4844
required to include them in the group coverage. 4845

(C) With respect to an ~~SEHC~~ OHC plan, the program shall 4846
reinsure the level of coverage provided. 4847

(D) With respect to other plans issued to small employers, 4848
the program shall reinsure the level of coverage provided up to, 4849
but not exceeding, the level of coverage provided in an ~~SEHC~~ OHC 4850
carrier reimbursement plan. In the coverage provided to small 4851
employers, carriers shall be required to use high-cost care 4852
management, hospital precertification techniques, and other cost 4853
containment mechanisms established by the program. 4854

(E) A carrier may not reinsure existing business, except 4855
pursuant to division (A) of this section. 4856

(F) If an employer group is covered under a plan other than an ~~SEHC~~ OHC carrier reimbursement plan and the carrier chooses to reinsure the group subsequent to the initial coverage period, or if a new individual joins the group and the carrier wants to reinsure that individual, the carrier shall not force the employer to change to an ~~SEHC~~ OHC carrier reimbursement plan. The carrier shall allow the employer to maintain the same benefit plan and reinsure only that portion of the plan that is consistent with an ~~SEHC~~ OHC carrier reimbursement plan.

(G) With respect to coverage provided to an individual acquired under section 3923.58 or a federally eligible individual acquired under section 3923.581 of the Revised Code, the following conditions and limitations apply:

(1) Within sixty days after the commencement of the initial coverage, any carrier may reinsure coverage of such an individual with the open enrollment reinsurance program in accordance with division (G) of this section. Premium rates charged for coverage reinsured by the program shall be established in accordance with section 3924.12 of the Revised Code.

(2) The board of directors of the Ohio health reinsurance program shall establish the open enrollment reinsurance fund for coverage provided under section 3923.58 of the Revised Code and, with respect to federally eligible individuals, coverage provided under section 3923.581 of the Revised Code. The fund shall be maintained separately from any reinsurance fund established for ~~small employer~~ Ohio health care plans issued pursuant to sections 3924.07 to 3924.14 of the Revised Code. The board shall calculate, on a retrospective basis, the amount needed for maintenance of the open enrollment reinsurance fund and, on the basis of that calculation, shall determine the amount to be assessed each carrier that is required to provide open enrollment coverage.

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Assessments shall be apportioned by the board among all 4889
carriers participating in the open enrollment reinsurance program 4890
in proportion to their respective shares of the total premiums, 4891
net of reinsurance premiums paid by a carrier for open enrollment 4892
coverage and net of reinsurance premiums paid by the carrier for 4893
all other individual health benefit plans, earned in this state 4894
from all health benefit plans covering individuals that are issued 4895
by all such carriers during the calendar year coinciding with or 4896
ending during the fiscal year of the open enrollment program, or 4897
on any other equitable basis reflecting coverage of individuals in 4898
this state as may be provided in the plan of operation adopted by 4899
the board. In no event shall the assessment of any carrier under 4900
this section exceed, on an annual basis, three per cent of its 4901
Ohio premiums for health benefit plans covering individuals as 4902
reported on its most recent annual statement filed with the 4903
superintendent of insurance. 4904

The board shall submit its determination of the amount of the 4905
assessment to the superintendent for review of the accuracy of the 4906
calculation of the assessment. Upon approval by the 4907
superintendent, each carrier shall, within thirty days after 4908
receipt of the notice of assessment, submit the assessment to the 4909
board for purposes of the open enrollment reinsurance fund. 4910

(3) If the assessments made and collected pursuant to 4911
division (G)(2) of this section are not sufficient to pay the 4912
claims reinsured under division (G) of this section and the 4913
allocated administrative expenses, incurred or estimated to be 4914
incurred during the period for which the assessment was made, the 4915
secretary of the board shall immediately notify the 4916
superintendent, and the superintendent shall suspend the operation 4917
of open enrollment under section 3923.58 of the Revised Code and, 4918
with respect to federally eligible individuals, under section 4919
3923.581 of the Revised Code until the board has collected in 4920

subsequent years through assessments made pursuant to division 4921
(G)(2) of this section an amount sufficient to pay such claims and 4922
administrative expenses. 4923

(4)(a) Any carrier that is subject to open enrollment under 4924
section 3923.58 of the Revised Code may elect not to participate 4925
in the open enrollment reinsurance program under division (G) of 4926
this section by filing an application with the superintendent and 4927
obtaining the superintendent's approval. In determining whether to 4928
approve an application, the superintendent shall consider whether 4929
the carrier meets all of the following standards: 4930

(i) Demonstration by the carrier of a substantial and 4931
established market presence; 4932

(ii) Demonstrated experience in the individual market and 4933
history of rating and underwriting individual plans; 4934

(iii) Commitment to comply with the requirements of section 4935
3923.58 of the Revised Code; 4936

(iv) Financial ability to assume and manage the risk of 4937
enrolling open enrollment individuals without the need for, or 4938
protection of, reinsurance. 4939

(b) A carrier whose application for nonparticipation has been 4940
rejected by the superintendent may appeal the decision in 4941
accordance with Chapter 119. of the Revised Code. A carrier that 4942
has received approval of the superintendent not to participate in 4943
the open enrollment reinsurance program shall, on or before the 4944
first day of December, annually certify to the superintendent that 4945
it continues to meet the standards described in division (G)(4)(a) 4946
of this section. 4947

(c) In any year subsequent to the year in which its 4948
application not to participate has been approved, a carrier may 4949
elect to participate in the open enrollment reinsurance program by 4950

giving notice to the superintendent and board on or before the 4951
thirty-first day of December. If, after a period of 4952
nonparticipation, a carrier elects to participate in the open 4953
enrollment reinsurance program, the carrier retains the risks it 4954
assumed during the period when it was not participating. 4955

(d) The superintendent may, at any time, authorize a carrier 4956
to modify an election not to participate if the risk from the 4957
carrier's open enrollment business jeopardizes the financial 4958
condition of the carrier. If the superintendent authorizes the 4959
carrier to again participate in the open enrollment reinsurance 4960
program, the carrier shall retain the risks it assumed during the 4961
period of nonparticipation. 4962

(5)(a) The open enrollment reinsurance program shall be 4963
operated separately from the Ohio health reinsurance program. 4964

(b) A carrier's election to participate in the open 4965
enrollment reinsurance program under division (G) of this section 4966
shall not be construed as an election to participate in the Ohio 4967
health reinsurance program under section 3924.07 of the Revised 4968
Code. 4969

Sec. 3924.13. (A) Following the close of each calendar year, 4970
the ~~administering insurer~~ administrator of the Ohio health 4971
reinsurance program shall determine the net premiums, the program 4972
expenses for administration, and the incurred losses, if any, for 4973
the year, taking into account investment income and other 4974
appropriate gains and losses. For purposes of this section, health 4975
benefit plan premiums earned by MEWAs shall be established by 4976
adding paid claim losses and administrative expenses of the MEWA. 4977
Health benefit plan premiums and benefits paid by a carrier that 4978
are less than an amount determined by the board of directors of 4979
the program to justify the cost of collection shall not be 4980
considered for purposes of determining assessments. For purposes 4981

of this division, "net premiums" means health benefit plan 4982
premiums, less administrative expense allowances. 4983

(B) Any net loss for the year shall be recouped first by 4984
assessments of carriers in accordance with this division. 4985
Assessments shall be apportioned by the board among all carriers 4986
participating in the program in proportion to their respective 4987
shares of the total premiums, net of reinsurance premiums paid for 4988
coverage under this program earned in the state from health 4989
benefit plans covering small employers that are issued by 4990
participating members during the calendar year coinciding with or 4991
ending during the fiscal year of the program, or on any other 4992
equitable basis reflecting coverage of small employers as may be 4993
provided in the plan of operation. An assessment shall be made 4994
pursuant to this division against a health insuring corporation 4995
that is approved by the secretary of health and human services as 4996
a federally qualified health maintenance organization pursuant to 4997
the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, 4998
as amended, subject to an assessment adjustment formula adopted by 4999
the board for such health insuring corporations that recognizes 5000
the restrictions imposed on the entities by federal law. The 5001
adjustment formula shall be adopted by the board prior to the 5002
first anniversary of the program's operation. In no event shall 5003
the assessment made pursuant to this division exceed, on an annual 5004
basis, one per cent of the carrier's Ohio small employer group 5005
premium as reported on its most recent annual statement filed with 5006
the superintendent of insurance. If an excess is actuarially 5007
projected, the superintendent may take any action necessary to 5008
lower the assessment to the maximum level of one per cent. 5009

(C) If assessments exceed actual losses and administrative 5010
expenses of the program, the excess shall be held at interest and 5011
used by the board to offset future losses or to reduce program 5012
premiums. As used in this division, "future losses" includes 5013

reserves for incurred but not reported claims. 5014

(D) Each carrier's proportion of participation in the program 5015
shall be determined annually by the board based on annual 5016
statements and other reports deemed necessary by the board and 5017
filed by the carrier with the board. MEWAs shall report to the 5018
board claims payments made and administrative expenses incurred in 5019
this state on an annual basis on a form prescribed by the 5020
superintendent. 5021

(E) Provision shall be made in the plan of operation for the 5022
imposition of an interest penalty for late payment of assessments. 5023

(F) A carrier may seek from the superintendent a deferment, 5024
in whole or in part, from any assessment issued by the board. The 5025
superintendent may defer, in whole or in part, the assessment of a 5026
carrier if, in the opinion of the superintendent, payment of the 5027
assessment would endanger the carrier's ability to fulfill its 5028
contractual obligations. 5029

(G) In the event an assessment against a carrier is deferred 5030
in whole or in part, the amount by which the assessment is 5031
deferred may be assessed against the other carriers in a manner 5032
consistent with the basis for assessments set forth in this 5033
section. In such event, the other carriers assessed shall have a 5034
claim in the amount of the assessment against the carrier 5035
receiving the deferment. The carrier receiving the deferment shall 5036
remain liable to the program for the amount deferred. The 5037
superintendent may attach appropriate conditions to any deferment. 5038

Sec. 3999.22. (A) As used in this section: 5039

(1) "Claim" means any attempt to cause a health care insurer 5040
to make payment of a health care benefit. 5041

(2) "Health care benefit" means the right under a contract or 5042
a certificate or policy of insurance to have a payment made by a 5043

health care insurer for a specified health care service. 5044

(3) "Health care insurer" means any person that is authorized 5045
to do the business of sickness and accident insurance~~+,~~ any 5046
~~prepaid dental plan, medical care corporation, health care~~ 5047
~~corporation, dental care corporation, or health maintenance~~ 5048
~~organization;~~ insuring corporation, and any legal entity that is 5049
self-insured and provides health care benefits to its employees or 5050
members. 5051

(B) No person shall knowingly solicit, offer, pay, or receive 5052
any kickback, bribe, or rebate, directly or indirectly, overtly or 5053
covertly, in cash or in kind, in return for referring an 5054
individual for the furnishing of health care services or goods for 5055
which whole or partial reimbursement is or may be made by a health 5056
care insurer, except as authorized by the health care or health 5057
insurance contract, policy, or plan. This division does not apply 5058
to any of the following: 5059

(1) Deductibles, copayments, or similar amounts owed by the 5060
person covered by the health care or health insurance contract, 5061
policy, or plan; 5062

(2) Discounts or similar reductions in prices; 5063

(3) Any amount paid within a bona fide legal entity, or 5064
within legal entities under common ownership or control, including 5065
any amount paid to an employee in a bona fide employment 5066
relationship; 5067

(4) Any amount paid as part of a bona fide lease, management, 5068
or other business contract. 5069

(C) Nothing in this section shall be construed to apply to 5070
any of the following: 5071

(1) A provider who provides goods or services requested by an 5072
individual that are not covered by the individual's health care or 5073

health insurance contract, policy, or plan;	5074
(2) A provider who, in good faith, provides goods or services ordered by another health care provider;	5075 5076
(3) A provider who, in good faith, resubmits a claim previously submitted that has not been paid or denied within thirty days of the original submission, if the provider notifies the payor or returns any duplicate payment within sixty days after receipt of the duplicate payment;	5077 5078 5079 5080 5081
(4) A provider who, in good faith, makes a diagnosis that differs from the interpretation of a diagnosis reached by a health care insurer in the payment of claims.	5082 5083 5084
(D) Whoever violates this section is guilty of a felony of the fifth degree on a first offense and a felony of the fourth degree on each subsequent offense.	5085 5086 5087
<u>Sec. 4503.104. In addition to the fees collected under sections 4503.10 and 4503.102 of the Revised Code, the registrar of motor vehicles or deputy registrar shall ask each person applying for or renewing a motor vehicle registration whether the person wishes to make a one-dollar voluntary contribution to the save our sight fund established under section 3701.18 of the Revised Code. Every application for registration or renewal notice shall state whether the owner of the motor vehicle wishes to make a one-dollar voluntary contribution to the save our sight fund established under section 3701.18 of the Revised Code. The registrar or deputy registrar shall also make available to each person applying for or renewing a motor vehicle registration informational materials on the importance of eye care and safety provided by the director of health under division (C)(2) of section 3701.18 of the Revised Code.</u>	5088 5089 5090 5091 5092 5093 5094 5095 5096 5097 5098 5099 5100 5101 5102
<u>All donations collected under this section during each calendar quarter shall be forwarded by the registrar to the</u>	5103 5104

treasurer of state, who shall deposit them into the save our sight 5105
fund. 5106

Sec. 4715.22. (A) As used in this section, "health care 5107
facility" means either of the following: 5108

(1) A HOSPITAL REGISTERED UNDER SECTION 3701.07 OF THE 5109
REVISED CODE; 5110

(2) A "HOME" AS DEFINED IN SECTION 3721.01 OF THE REVISED 5111
CODE. 5112

(B) A licensed dental hygienist ~~may~~ shall practice under the 5113
supervision, order, control, and full responsibility of a dentist 5114
licensed under this chapter. A dental hygienist may practice in a 5115
dental office, public or private school, ~~hospital~~ health care 5116
facility, dispensary, or public institution, ~~provided the service~~ 5117
~~is rendered under the supervision of a licensed dentist of this~~ 5118
~~state. Except as provided in division (C) or (D) of this section,~~ 5119
a dental hygienist may not provide dental hygiene services to a 5120
patient when the supervising dentist is not physically present at 5121
the location where the dental hygienist is practicing. 5122

(C) A dental hygienist may provide, for not more than fifteen 5123
consecutive business days, dental hygiene services to a patient 5124
when the supervising dentist is not physically present at the 5125
location at which the services are provided if all of the 5126
following requirements are met: 5127

(1) The dental hygienist has at least two years and a minimum 5128
of three thousand hours of experience in the practice of dental 5129
hygiene. 5130

(2) The dental hygienist has successfully completed a course 5131
approved by the state dental board in the identification and 5132
prevention of potential medical emergencies. 5133

(3) The dental hygienist complies with written protocols for 5134

emergencies the supervising dentist establishes. 5135

(4) The dental hygienist does not perform, while the supervising dentist is absent from the location, procedures while the patient is anesthetized, definitive root planing, definitive subgingival curettage, or other procedures identified in rules the state dental board adopts. 5136
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(5) The supervising dentist has evaluated the dental hygienist's skills. 5141
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(6) The supervising dentist examined the patient not more than seven months prior to the date the dental hygienist provides the dental hygiene services to the patient. 5143
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(7) The dental hygienist complies with written protocols or written standing orders that the supervising dentist establishes. 5146
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(8) The supervising dentist completed and evaluated a medical and dental history of the patient not more than one year prior to the date the dental hygienist provides dental hygiene services to the patient and, except when the dental hygiene services are provided in a health care facility, the supervising dentist determines that the patient is in a medically stable condition. 5148
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(9) If the dental hygiene services are provided in a health care facility, a doctor of medicine and surgery or osteopathic medicine and surgery who holds a current certificate issued under Chapter 4731. of the Revised Code or a registered nurse licensed under Chapter 4723. of the Revised Code is present in the health care facility when the services are provided. 5155
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(10) In advance of the appointment for dental hygiene services, the patient is notified that the supervising dentist will be absent from the location and that the dental hygienist cannot diagnose the patient's dental health care status. 5161
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<u>(11) The dental hygienist is employed by, or under contract with, one of the following:</u>	5165 5166
<u>(a) The supervising dentist;</u>	5167
<u>(b) A dentist licensed under this chapter who is one of the following:</u>	5168 5169
<u>(i) The employer of the supervising dentist;</u>	5170
<u>(ii) A shareholder in a professional association formed under Chapter 1785. of the Revised Code of which the supervising dentist is a shareholder;</u>	5171 5172 5173
<u>(iii) A member or manager of a limited liability company formed under Chapter 1705. of the Revised Code of which the supervising dentist is a member or manager;</u>	5174 5175 5176
<u>(iv) A shareholder in a corporation formed under division (B) of section 1701.03 of the Revised Code of which the supervising dentist is a shareholder;</u>	5177 5178 5179
<u>(v) A partner or employee of a partnership or a limited liability partnership formed under Chapter 1775. of the Revised Code of which the supervising dentist is a partner or employee.</u>	5180 5181 5182
<u>(c) A government entity that employs the dental hygienist to provide dental hygiene services in a public school or in connection with other programs the government entity administers.</u>	5183 5184 5185
<u>(D) A DENTAL HYGIENIST MAY PROVIDE DENTAL HYGIENE SERVICES TO A PATIENT WHEN THE SUPERVISING DENTIST IS NOT PHYSICALLY PRESENT AT THE LOCATION AT WHICH THE SERVICES ARE PROVIDED IF THE SERVICES ARE PROVIDED AS PART OF A DENTAL HYGIENE PROGRAM THAT IS APPROVED BY THE STATE DENTAL BOARD AND all of the following requirements are met:</u>	5186 5187 5188 5189 5190 5191
<u>(1) The program is OPERATED THROUGH A SCHOOL DISTRICT BOARD OF EDUCATION OR THE GOVERNING BOARD OF AN EDUCATIONAL SERVICE CENTER; THE BOARD OF HEALTH OF A CITY OR GENERAL HEALTH DISTRICT</u>	5192 5193 5194

OR THE AUTHORITY HAVING THE DUTIES OF A BOARD OF HEALTH UNDER 5195
SECTION 3709.05 OF THE REVISED CODE; A NATIONAL, STATE, DISTRICT, 5196
OR LOCAL DENTAL ASSOCIATION; OR ANY OTHER PUBLIC OR PRIVATE ENTITY 5197
RECOGNIZED BY THE STATE DENTAL BOARD. 5198

(2) THE SUPERVISING DENTIST IS EMPLOYED BY OR A VOLUNTEER 5199
FOR, AND THE PATIENTS ARE REFERRED BY, THE ENTITY THROUGH WHICH 5200
THE PROGRAM IS OPERATED. 5201

(3) THE SERVICES ARE PERFORMED AFTER EXAMINATION AND 5202
DIAGNOSIS BY THE DENTIST AND IN ACCORDANCE WITH THE DENTIST'S 5203
WRITTEN TREATMENT PLAN. 5204

(E) No person shall do either of the following: 5205

(1) Practice dental hygiene in a manner that is separate or 5206
otherwise independent from the dental practice of a supervising 5207
dentist; 5208

(2) Establish or maintain an office or practice that is 5209
primarily devoted to the provision of dental hygiene services. 5210

(F) The state dental board shall adopt rules under division 5211
(C) of section 4715.03 of the Revised Code identifying procedures 5212
a dental hygienist may not perform when practicing in the absence 5213
of the supervising dentist pursuant to division (C) or (D) of this 5214
section. 5215

Sec. 4715.39. (A) The state dental board may adopt rules, in 5216
accordance with Chapter 119. of the Revised Code, defining define 5217
the duties which that may be performed by dental assistants and 5218
other individuals designated by the board as qualified personnel, 5219
and may adopt rules establishing. If defined, the duties shall be 5220
defined in rules adopted in accordance with Chapter 119. of the 5221
Revised Code. The rules may include training and practice 5222
standards for dental assistants and other qualified personnel; 5223
such. The standards may include examination and issuance of a 5224

certificate. If the board issues a certificate, the recipient 5225
shall display the certificate in a conspicuous location in any 5226
office in which the recipient is employed to perform the duties 5227
authorized by the certificate. 5228

The board's rules may allow a dental assistant to polish the 5229
clinical crowns of teeth IF all of the following requirements are 5230
met: 5231

(1) The dental assistant's polishing activities are limited 5232
to the use of a rubber cup attached to a slow-speed rotary dental 5233
hand piece. 5234

(2) The dentist supervising the assistant supervises not more 5235
than two dental assistants engaging in polishing activities at any 5236
given time. 5237

(3) The dental assistant is certified by the dental assisting 5238
national board or the Ohio commission on dental assistant 5239
certification. 5240

(4) The dental assistant receives a certificate from the 5241
board authorizing the assistant to engage in the polishing 5242
activities. The board may issue the certificate only if the 5243
individual has SUCCESSFULLY COMPLETED TRAINING IN THE POLISHING OF 5244
CLINICAL CROWNS through A PROGRAM ACCREDITED BY THE COMMISSION ON 5245
DENTAL ACCREDITATION OR EQUIVALENT TRAINING APPROVED BY THE BOARD. 5246
THE TRAINING SHALL INCLUDE COURSES IN BASIC DENTAL ANATOMY AND 5247
INFECTION CONTROL, FOLLOWED BY A COURSE IN CORONAL POLISHING THAT 5248
INCLUDES didactic, preclinical, and CLINICAL TRAINING; ANY OTHER 5249
training REQUIRED BY THE BOARD; and a skills assessment that 5250
includes successful completion of standardized testing. 5251

(B) Subject to the rules of the board, licensed dentists may 5252
assign to dental assistants and other qualified personnel dental 5253
procedures that do not require the professional competence or 5254

skill of the licensed dentist or dental hygienist as the board by 5255
rule authorizes ~~such~~ dental assistants and other qualified 5256
personnel to perform. The performance of dental procedures by 5257
dental assistants and other qualified personnel shall be under 5258
direct supervision and full responsibility of the licensed 5259
dentist. 5260

(C) Nothing in this section shall be construed by rule of the 5261
state dental board or otherwise to ~~authorize~~ do the following: 5262
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(1) Authorize dental assistants or other qualified personnel ~~as~~ 5264
~~as that term is used in this section~~ to engage in the practice of 5265
dental hygiene as defined by sections 4715.22 and 4715.23 of the 5266
Revised Code or to perform the duties of a dental hygienist, 5267
including the removal of calcarious deposits or accretions on the 5268
crowns and roots of teeth, ~~or as authorizing;~~ 5269

(2) Authorize the assignment of ~~diagnosis, treatment~~ any of 5270
the following: 5271

(a) Diagnosis; 5272

(b) Treatment planning and prescription ~~(, including~~ 5273
prescription for drugs and medicaments or authorization for 5274
restorative, prosthodontic, ~~or~~ orthodontic appliances), ~~or~~ 5275
surgical; 5276

(c) Surgical procedures on hard or soft tissue of the oral 5277
cavity, or any other intraoral procedure that contributes to or 5278
results in an irremediable alteration of the oral anatomy ~~or the;~~ 5279

(d) The making of final impressions from which casts are made 5280
to construct any dental restoration. 5281

(D) No dentist shall assign any dental assistant or other 5282
individual acting in the capacity of qualified personnel to 5283
perform any dental procedure ~~such personnel are~~ that the assistant 5284

or other individual is not authorized by board rule to perform. No 5285
dental assistant or other individual acting in the capacity of 5286
qualified personnel shall perform any dental procedure other than 5287
in accordance with board rule or any dental procedure that ~~such~~ 5288
~~personnel are~~ the assistant or other individual is not authorized 5289
by board rule to perform. 5290

Sec. 4723.16. (A) An individual whom the board of nursing 5291
licenses, certificates, or otherwise legally authorizes to engage 5292
in the practice of nursing as a registered nurse or as a licensed 5293
practical nurse may render the professional services of a 5294
registered or licensed practical nurse within this state through a 5295
corporation formed under division (B) of section 1701.03 of the 5296
Revised Code, a limited liability company formed under Chapter 5297
1705. of the Revised Code, a partnership, or a professional 5298
association formed under Chapter 1785. of the Revised Code. This 5299
division does not preclude an individual of that nature from 5300
rendering professional services as a registered or licensed 5301
practical nurse through another form of business entity, 5302
including, but not limited to, a nonprofit corporation or 5303
foundation, or in another manner that is authorized by or in 5304
accordance with this chapter, another chapter of the Revised Code, 5305
or rules of the board of nursing adopted pursuant to this chapter. 5306

(B) A corporation, limited liability company, partnership, or 5307
professional association described in division (A) of this section 5308
may be formed for the purpose of providing a combination of the 5309
professional services of the following individuals who are 5310
licensed, certificated, or otherwise legally authorized to 5311
practice their respective professions: 5312

(1) Optometrists who are authorized to practice optometry 5313
under Chapter 4725. of the Revised Code; 5314

(2) Chiropractors who are authorized to practice chiropractic 5315

under Chapter 4734. of the Revised Code;	5316
(3) Psychologists who are authorized to practice psychology under Chapter 4732. of the Revised Code;	5317 5318
(4) Registered or licensed practical nurses who are authorized to practice nursing as registered nurses or as licensed practical nurses under this chapter;	5319 5320 5321
(5) Pharmacists who are authorized to practice pharmacy under Chapter 4729. of the Revised Code;	5322 5323
(6) Physical therapists who are authorized to practice physical therapy under sections 4755.40 to 4755.53 of the Revised Code;	5324 5325 5326
(7) <u>Mechanotherapists who are authorized to practice mechanotherapy under section 4731.151 of the Revised Code;</u>	5327 5328
<u>(8)</u> Doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are licensed, certificated, or otherwise legally authorized for their respective practices under Chapter 4731. of the Revised Code.	5329 5330 5331 5332
This division shall apply notwithstanding a provision of a code of ethics applicable to a nurse that prohibits a registered or licensed practical nurse from engaging in the practice of nursing as a registered nurse or as a licensed practical nurse in combination with a person who is licensed, certificated, or otherwise legally authorized to practice optometry, chiropractic, psychology, pharmacy, physical therapy, <u>mechanotherapy</u> , medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, but who is not also licensed, certificated, or otherwise legally authorized to engage in the practice of nursing as a registered nurse or as a licensed practical nurse.	5333 5334 5335 5336 5337 5338 5339 5340 5341 5342 5343
Sec. 4725.114. (A) An individual whom the state board of optometry licenses, certificates, or otherwise legally authorizes	5344 5345

to engage in the practice of optometry may render the professional 5346
services of an optometrist within this state through a corporation 5347
formed under division (B) of section 1701.03 of the Revised Code, 5348
a limited liability company formed under Chapter 1705. of the 5349
Revised Code, a partnership, or a professional association formed 5350
under Chapter 1785. of the Revised Code. This division does not 5351
preclude an individual of that nature from rendering professional 5352
services as an optometrist through another form of business 5353
entity, including, but not limited to, a nonprofit corporation or 5354
foundation, or in another manner that is authorized by or in 5355
accordance with this chapter, another chapter of the Revised Code, 5356
or rules of the state board of optometry adopted pursuant to this 5357
chapter. 5358

(B) A corporation, limited liability company, partnership, or 5359
professional association described in division (A) of this section 5360
may be formed for the purpose of providing a combination of the 5361
professional services of the following individuals who are 5362
licensed, certificated, or otherwise legally authorized to 5363
practice their respective professions: 5364

(1) Optometrists who are authorized to practice optometry 5365
under Chapter 4725. of the Revised Code; 5366

(2) Chiropractors who are authorized to practice chiropractic 5367
under Chapter 4734. of the Revised Code; 5368

(3) Psychologists who are authorized to practice psychology 5369
under Chapter 4732. of the Revised Code; 5370

(4) Registered or licensed practical nurses who are 5371
authorized to practice nursing as registered nurses or as licensed 5372
practical nurses under Chapter 4723. of the Revised Code; 5373

(5) Pharmacists who are authorized to practice pharmacy under 5374
Chapter 4729. of the Revised Code; 5375

(6) Physical therapists who are authorized to practice 5376
physical therapy under sections 4755.40 to 4755.53 of the Revised 5377
Code; 5378

(7) Mechanotherapists who are authorized to practice 5379
mechanotherapy under section 4731.151 of the Revised Code; 5380

(8) Doctors of medicine and surgery, osteopathic medicine and 5381
surgery, or podiatric medicine and surgery who are authorized for 5382
their respective practices under Chapter 4731. of the Revised 5383
Code. 5384

This division shall apply notwithstanding a provision of a 5385
code of ethics applicable to an optometrist that prohibits an 5386
optometrist from engaging in the practice of optometry in 5387
combination with a person who is licensed, certificated, or 5388
otherwise legally authorized to practice chiropractic, psychology, 5389
nursing, pharmacy, physical therapy, mechanotherapy, medicine and 5390
surgery, osteopathic medicine and surgery, or podiatric medicine 5391
and surgery, but who is not also licensed, certificated, or 5392
otherwise legally authorized to engage in the practice of 5393
optometry. 5394

Sec. 4729.161. (A) An individual registered with the state 5395
board of pharmacy to engage in the practice of pharmacy may render 5396
the professional services of a pharmacist within this state 5397
through a corporation formed under division (B) of section 1701.03 5398
of the Revised Code, a limited liability company formed under 5399
Chapter 1705. of the Revised Code, a partnership, or a 5400
professional association formed under Chapter 1785. of the Revised 5401
Code. This division does not preclude an individual of that nature 5402
from rendering professional services as a pharmacist through 5403
another form of business entity, including, but not limited to, a 5404
nonprofit corporation or foundation, or in another manner that is 5405
authorized by or in accordance with this chapter, another chapter 5406

of the Revised Code, or rules of the state board of pharmacy	5407
adopted pursuant to this chapter.	5408
(B) A corporation, limited liability company, partnership, or	5409
professional association described in division (A) of this section	5410
may be formed for the purpose of providing a combination of the	5411
professional services of the following individuals who are	5412
licensed, certificated, or otherwise legally authorized to	5413
practice their respective professions:	5414
(1) Optometrists who are authorized to practice optometry	5415
under Chapter 4725. of the Revised Code;	5416
(2) Chiropractors who are authorized to practice chiropractic	5417
under Chapter 4734. of the Revised Code;	5418
(3) Psychologists who are authorized to practice psychology	5419
under Chapter 4732. of the Revised Code;	5420
(4) Registered or licensed practical nurses who are	5421
authorized to practice nursing as registered nurses or as licensed	5422
practical nurses under Chapter 4723. of the Revised Code;	5423
(5) Pharmacists who are authorized to practice pharmacy under	5424
Chapter 4729. of the Revised Code;	5425
(6) Physical therapists who are authorized to practice	5426
physical therapy under sections 4755.40 to 4755.53 of the Revised	5427
Code;	5428
(7) <u>Mechanotherapists who are authorized to practice</u>	5429
<u>mechanotherapy under section 4731.151 of the Revised Code;</u>	5430
<u>(8)</u> Doctors of medicine and surgery, osteopathic medicine and	5431
surgery, or podiatric medicine and surgery who are authorized for	5432
their respective practices under Chapter 4731. of the Revised	5433
Code.	5434
This division shall apply notwithstanding a provision of a	5435

code of ethics applicable to a pharmacist that prohibits a 5436
pharmacist from engaging in the practice of pharmacy in 5437
combination with a person who is licensed, certificated, or 5438
otherwise legally authorized to practice optometry, chiropractic, 5439
psychology, nursing, physical therapy, mechanotherapy, medicine 5440
and surgery, osteopathic medicine and surgery, or podiatric 5441
medicine and surgery, but who is not also licensed, certificated, 5442
or otherwise legally authorized to engage in the practice of 5443
pharmacy. 5444

Sec. 4731.226. (A)(1) An individual whom the state medical 5445
board licenses, certificates, or otherwise legally authorizes to 5446
engage in the practice of medicine and surgery, osteopathic 5447
medicine and surgery, or podiatric medicine and surgery may render 5448
the professional services of a doctor of medicine and surgery, 5449
osteopathic medicine and surgery, or podiatric medicine and 5450
surgery within this state through a corporation formed under 5451
division (B) of section 1701.03 of the Revised Code, a limited 5452
liability company formed under Chapter 1705. of the Revised Code, 5453
a partnership, or a professional association formed under Chapter 5454
1785. of the Revised Code. ~~This division~~ Division (A)(1) of this 5455
section does not preclude an individual of that nature from 5456
rendering professional services as a doctor of medicine and 5457
surgery, osteopathic medicine and surgery, or podiatric medicine 5458
and surgery through another form of business entity, including, 5459
but not limited to, a nonprofit corporation or foundation, or in 5460
another manner that is authorized by or in accordance with this 5461
chapter, another chapter of the Revised Code, or rules of the 5462
state medical board adopted pursuant to this chapter. 5463

(2) An individual whom the state medical board authorizes to 5464
engage in the practice of mechanotherapy may render the 5465
professional services of a mechanotherapist within this state 5466

through a corporation formed under division (B) of section 1701.03 5467
of the Revised Code, a limited liability company formed under 5468
Chapter 1705. of the Revised Code, a partnership, or a 5469
professional association formed under Chapter 1785. of the Revised 5470
Code. Division (A)(2) of this section does not preclude an 5471
individual of that nature from rendering professional services as 5472
a mechanotherapist through another form of business entity, 5473
including, but not limited to, a nonprofit corporation or 5474
foundation, or in another manner that is authorized by or in 5475
accordance with this chapter, another chapter of the Revised Code, 5476
or rules of the state medical board adopted pursuant to this 5477
chapter. 5478

(B) A corporation, limited liability company, partnership, or 5479
professional association described in division (A) of this section 5480
may be formed for the purpose of providing a combination of the 5481
professional services of the following individuals who are 5482
licensed, certificated, or otherwise legally authorized to 5483
practice their respective professions: 5484

(1) Optometrists who are authorized to practice optometry 5485
under Chapter 4725. of the Revised Code; 5486

(2) Chiropractors who are authorized to practice chiropractic 5487
under Chapter 4734. of the Revised Code; 5488

(3) Psychologists who are authorized to practice psychology 5489
under Chapter 4732. of the Revised Code; 5490

(4) Registered or licensed practical nurses who are 5491
authorized to practice nursing as registered nurses or as licensed 5492
practical nurses under Chapter 4723. of the Revised Code; 5493

(5) Pharmacists who are authorized to practice pharmacy under 5494
Chapter 4729. of the Revised Code; 5495

(6) Physical therapists who are authorized to practice 5496
physical therapy under sections 4755.40 to 4755.53 of the Revised 5497

Code;	5498
(7) <u>Mechanotherapists who are authorized to practice</u>	5499
<u>mechanotherapy under section 4731.151 of the Revised Code;</u>	5500
(8) Doctors of medicine and surgery, osteopathic medicine and	5501
surgery, or podiatric medicine and surgery who are authorized for	5502
their respective practices under this chapter.	5503
This division <u>(C) Division (B) of this section</u> shall apply	5504
notwithstanding a provision of a code of ethics described in	5505
division (B)(18) of section 4731.22 of the Revised Code that	5506
prohibits a <u>either of the following:</u>	5507
(1) A doctor of medicine and surgery, osteopathic medicine	5508
and surgery, or podiatric medicine and surgery from engaging in	5509
the doctor's authorized practice in combination with a person who	5510
is licensed, certificated, or otherwise legally authorized to	5511
engage in the practice of optometry, chiropractic, psychology,	5512
nursing, pharmacy, or physical therapy, <u>or mechanotherapy,</u> but who	5513
is not also licensed, certificated, or otherwise legally	5514
authorized to practice medicine and surgery, osteopathic medicine	5515
and surgery, or podiatric medicine and surgery.	5516
(2) <u>A mechanotherapist from engaging in the practice of</u>	5517
<u>mechanotherapy in combination with a person who is licensed,</u>	5518
<u>certificated, or otherwise legally authorized to engage in the</u>	5519
<u>practice of optometry, chiropractic, psychology, nursing,</u>	5520
<u>pharmacy, physical therapy, medicine and surgery, osteopathic</u>	5521
<u>medicine and surgery, or podiatric medicine and surgery, but who</u>	5522
<u>is not also licensed, certificated, or otherwise legally</u>	5523
<u>authorized to engage in the practice of mechanotherapy.</u>	5524
Sec. 4731.65. As used in sections 4731.65 to 4731.71 of the	5525
Revised Code:	5526
(A)(1) "Clinical laboratory services" means either of the	5527

following:	5528
(a) Any examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment or for the assessment of health;	5529 5530 5531 5532
(b) Procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.	5533 5534 5535
(2) "Clinical laboratory services" does not include the mere collection or preparation of specimens.	5536 5537
(B) "Designated health services" means any of the following:	5538
(1) Clinical laboratory services;	5539
(2) Home health care services;	5540
(3) Outpatient prescription drugs.	5541
(C) "Fair market value" means the value in arms-length transactions, consistent with general market value and:	5542 5543
(1) With respect to rentals or leases, the value of rental property for general commercial purposes, not taking into account its intended use;	5544 5545 5546
(2) With respect to a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor if the lessor is a potential source of referrals to the lessee.	5547 5548 5549 5550
(D) "Governmental health care program" means any program providing health care benefits that is administered by the federal government, this state, or a political subdivision of this state, including the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, health care coverage for public employees, health care	5551 5552 5553 5554 5555 5556

benefits administered by the bureau of workers' compensation, the 5557
medical assistance program established under Chapter 5111. of the 5558
Revised Code, and disability assistance medical assistance 5559
established under Chapter 5115. of the Revised Code. 5560

(E)(1) "Group practice" means a group of two or more holders 5561
of certificates under this chapter legally organized as a 5562
partnership, professional corporation or association, limited 5563
liability company, foundation, nonprofit corporation, faculty 5564
practice plan, or similar group practice entity, including an 5565
organization comprised of a nonprofit medical clinic that 5566
contracts with a professional corporation or association of 5567
physicians to provide medical services exclusively to patients of 5568
the clinic in order to comply with section 1701.03 of the Revised 5569
Code and including a corporation, limited liability company, 5570
partnership, or professional association described in division (B) 5571
of section 4731.226 of the Revised Code formed for the purpose of 5572
providing a combination of the professional services of 5573
optometrists who are licensed, certificated, or otherwise legally 5574
authorized to practice optometry under Chapter 4725. of the 5575
Revised Code, chiropractors who are licensed, certificated, or 5576
otherwise legally authorized to practice chiropractic under 5577
Chapter 4734. of the Revised Code, psychologists who are licensed, 5578
certificated, or otherwise legally authorized to practice 5579
psychology under Chapter 4732. of the Revised Code, registered or 5580
licensed practical nurses who are licensed, certificated, or 5581
otherwise legally authorized to practice nursing under Chapter 5582
4723. of the Revised Code, pharmacists who are licensed, 5583
certificated, or otherwise legally authorized to practice pharmacy 5584
under Chapter 4729. of the Revised Code, physical therapists who 5585
are licensed, certificated, or otherwise legally authorized to 5586
practice physical therapy under sections 4755.40 to 4755.53 of the 5587
Revised Code, mechanotherapists who are licensed, certificated, or 5588

otherwise legally authorized to practice mechanotherapy under 5589
section 4731.151 of the Revised Code, and of doctors of medicine 5590
and surgery, osteopathic medicine and surgery, or podiatric 5591
medicine and surgery who are licensed, certificated, or otherwise 5592
legally authorized for their respective practices under this 5593
chapter, to which all of the following apply: 5594

(a) Each physician who is a member of the group practice 5595
provides substantially the full range of services that the 5596
physician routinely provides, including medical care, 5597
consultation, diagnosis, or treatment, through the joint use of 5598
shared office space, facilities, equipment, and personnel. 5599

(b) Substantially all of the services of the members of the 5600
group are provided through the group and are billed in the name of 5601
the group and amounts so received are treated as receipts of the 5602
group. 5603

(c) The overhead expenses of and the income from the practice 5604
are distributed in accordance with methods previously determined 5605
by members of the group. 5606

(d) The group practice meets any other requirements that the 5607
state medical board applies in rules adopted under section 4731.70 5608
of the Revised Code. 5609

(2) In the case of a faculty practice plan associated with a 5610
hospital with a medical residency training program in which 5611
physician members may provide a variety of specialty services and 5612
provide professional services both within and outside the group, 5613
as well as perform other tasks such as research, the criteria in 5614
division (E)(1) of this section apply only with respect to 5615
services rendered within the faculty practice plan. 5616

(F) "Home health care services" and "immediate family" have 5617
the same meanings as in the rules adopted under section 4731.70 of 5618
the Revised Code. 5619

(G) "Hospital" has the same meaning as in section 3727.01 of the Revised Code. 5620
5621

(H) A "referral" includes both of the following: 5622

(1) A request by a holder of a certificate under this chapter for an item or service, including a request for a consultation with another physician and any test or procedure ordered by or to be performed by or under the supervision of the other physician; 5623
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(2) A request for or establishment of a plan of care by a certificate holder that includes the provision of designated health services. 5628
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5630

(I) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code. 5631
5632

Sec. 4732.28. (A) An individual whom the state board of psychology licenses, certificates, or otherwise legally authorizes to engage in the practice of psychology may render the professional services of a psychologist within this state through a corporation formed under division (B) of section 1701.03 of the Revised Code, a limited liability company formed under Chapter 1705. of the Revised Code, a partnership, or a professional association formed under Chapter 1785. of the Revised Code. This division does not preclude an individual of that nature from rendering professional services as a psychologist through another form of business entity, including, but not limited to, a nonprofit corporation or foundation, or in another manner that is authorized by or in accordance with this chapter, another chapter of the Revised Code, or rules of the state board of psychology adopted pursuant to this chapter. 5633
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(B) A corporation, limited liability company, partnership, or professional association described in division (A) of this section 5648
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may be formed for the purpose of providing a combination of the professional services of the following individuals who are licensed, certificated, or otherwise legally authorized to practice their respective professions:

(1) Optometrists who are authorized to practice optometry under Chapter 4725. of the Revised Code;

(2) Chiropractors who are authorized to practice chiropractic under Chapter 4734. of the Revised Code;

(3) Psychologists who are authorized to practice psychology under this chapter;

(4) Registered or licensed practical nurses who are authorized to practice nursing as registered nurses or as licensed practical nurses under Chapter 4723. of the Revised Code;

(5) Pharmacists who are authorized to practice pharmacy under Chapter 4729. of the Revised Code;

(6) Physical therapists who are authorized to practice physical therapy under sections 4755.40 to 4755.53 of the Revised Code;

(7) Mechanotherapists who are authorized to practice mechanotherapy under section 4731.151 of the Revised Code;

(8) Doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are authorized for their respective practices under Chapter 4731. of the Revised Code.

This division shall apply notwithstanding a provision of a code of ethics applicable to a psychologist that prohibits a psychologist from engaging in the practice of psychology in combination with a person who is licensed, certificated, or otherwise legally authorized to practice optometry, chiropractic, nursing, pharmacy, physical therapy, mechanotherapy, medicine and

surgery, osteopathic medicine and surgery, or podiatric medicine 5680
and surgery, but who is not also licensed, certificated, or 5681
otherwise legally authorized to engage in the practice of 5682
psychology. 5683

Sec. 4734.091. (A) An individual whom the chiropractic 5684
examining board licenses, certificates, or otherwise legally 5685
authorizes to engage in the practice of chiropractic may render 5686
the professional services of a chiropractor within this state 5687
through a corporation formed under division (B) of section 1701.03 5688
of the Revised Code, a limited liability company formed under 5689
Chapter 1705. of the Revised Code, a partnership, or a 5690
professional association formed under Chapter 1785. of the Revised 5691
Code. This division does not preclude an individual of that nature 5692
from rendering professional services as a chiropractor through 5693
another form of business entity, including, but not limited to, a 5694
nonprofit corporation or foundation, or in another manner that is 5695
authorized by or in accordance with this chapter, another chapter 5696
of the Revised Code, or rules of the chiropractic examining board 5697
adopted pursuant to this chapter. 5698

(B) A corporation, limited liability company, partnership, or 5699
professional association described in division (A) of this section 5700
may be formed for the purpose of providing a combination of the 5701
professional services of the following individuals who are 5702
licensed, certificated, or otherwise legally authorized to 5703
practice their respective professions: 5704

(1) Optometrists who are authorized to practice optometry, 5705
under Chapter 4725. of the Revised Code; 5706

(2) Chiropractors who are authorized to practice chiropractic 5707
under this chapter; 5708

(3) Psychologists who are authorized to practice psychology 5709
under Chapter 4732. of the Revised Code; 5710

(4) Registered or licensed practical nurses who are authorized to practice nursing as registered nurses or as licensed practical nurses under Chapter 4723. of the Revised Code;	5711 5712 5713
(5) Pharmacists who are authorized to practice pharmacy under Chapter 4729. of the Revised Code;	5714 5715
(6) Physical therapists who are authorized to practice physical therapy under sections 4755.40 to 4755.53 of the Revised Code;	5716 5717 5718
(7) <u>Mechanotherapists who are authorized to practice mechanotherapy under section 4731.151 of the Revised Code;</u>	5719 5720
<u>(8)</u> Doctors of medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery who are authorized for their respective practices under Chapter 4731. of the Revised Code.	5721 5722 5723 5724
This division shall apply notwithstanding a provision of a code of ethics described in division (A)(9) of section 4734.10 of the Revised Code that prohibits an individual from engaging in the practice of chiropractic in combination with a person who is licensed, certificated, or otherwise authorized for the practice of optometry, psychology, nursing, pharmacy, physical therapy, <u>mechanotherapy</u> , medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery, but who is not also licensed, certificated, or otherwise legally authorized to engage in the practice of chiropractic.	5725 5726 5727 5728 5729 5730 5731 5732 5733 5734
Sec. 4755.471. (A) An individual whom the physical therapy section of the Ohio occupational therapy, physical therapy, and athletic trainers board licenses, certificates, or otherwise legally authorizes to engage in the practice of physical therapy may render the professional services of a physical therapist within this state through a corporation formed under division (B)	5735 5736 5737 5738 5739 5740

of section 1701.03 of the Revised Code, a limited liability 5741
company formed under Chapter 1705. of the Revised Code, a 5742
partnership, or a professional association formed under Chapter 5743
1785. of the Revised Code. This division does not preclude an 5744
individual of that nature from rendering professional services as 5745
a physical therapist through another form of business entity, 5746
including, but not limited to, a nonprofit corporation or 5747
foundation, or in another manner that is authorized by or in 5748
accordance with sections 4755.40 to 4755.53 of the Revised Code, 5749
another chapter of the Revised Code, or rules of the Ohio 5750
occupational therapy, physical therapy, and athletic trainers 5751
board adopted pursuant to sections 4755.40 to 4755.53 of the 5752
Revised Code. 5753

(B) A corporation, limited liability company, partnership, or 5754
professional association described in division (A) of this section 5755
may be formed for the purpose of providing a combination of the 5756
professional services of the following individuals who are 5757
licensed, certificated, or otherwise legally authorized to 5758
practice their respective professions: 5759

(1) Optometrists who are authorized to practice optometry 5760
under Chapter 4725. of the Revised Code; 5761

(2) Chiropractors who are authorized to practice chiropractic 5762
under Chapter 4734. of the Revised Code; 5763

(3) Psychologists who are authorized to practice psychology 5764
under Chapter 4732. of the Revised Code; 5765

(4) Registered or licensed practical nurses who are 5766
authorized to practice nursing as registered nurses or as licensed 5767
practical nurses under Chapter 4723. of the Revised Code; 5768

(5) Pharmacists who are authorized to practice pharmacy under 5769
Chapter 4729. of the Revised Code; 5770

(6) Physical therapists who are authorized to practice 5771
physical therapy under sections 4755.40 to 4755.53 of the Revised 5772
Code; 5773

(7) Mechanotherapists who are authorized to practice 5774
mechanotherapy under section 4731.151 of the Revised Code; 5775

(8) Doctors of medicine and surgery, osteopathic medicine and 5776
surgery, or podiatric medicine and surgery who are authorized for 5777
their respective practices under Chapter 4731. of the Revised 5778
Code. 5779

This division shall apply notwithstanding a provision of a 5780
code of ethics applicable to a physical therapist that prohibits a 5781
physical therapist from engaging in the practice of physical 5782
therapy in combination with a person who is licensed, 5783
certificated, or otherwise legally authorized to practice 5784
optometry, chiropractic, psychology, nursing, pharmacy, 5785
mechanotherapy, medicine and surgery, osteopathic medicine and 5786
surgery, or podiatric medicine and surgery, but who is not also 5787
licensed, certificated, or otherwise legally authorized to engage 5788
in the practice of physical therapy. 5789

Sec. 5111.25. (A) The department of human services shall pay 5790
each eligible nursing facility a per resident per day rate for its 5791
reasonable capital costs established prospectively each fiscal 5792
year for each facility. Except as otherwise provided in sections 5793
5111.20 to 5111.32 of the Revised Code, the rate shall be based on 5794
the facility's capital costs for the calendar year preceding the 5795
fiscal year in which the rate will be paid. The rate shall equal 5796
the sum of divisions (A)(1) to (3) of this section: 5797

(1) The lesser of the following: 5798

(a) Eighty-eight and sixty-five one_hundredths per cent of 5799
the facility's desk-reviewed, actual, allowable, per diem cost of 5800

ownership and eighty-five per cent of the facility's actual, 5801
allowable, per diem cost of nonextensive renovation determined 5802
under division (F) of this section; 5803

(b) Eighty-eight and sixty-five one-hundredths per cent of 5804
the following limitation: 5805

(i) For the fiscal year beginning July 1, 1993, sixteen 5806
dollars per resident day; 5807

(ii) For the fiscal year beginning July 1, 1994, sixteen 5808
dollars per resident day, adjusted to reflect the rate of 5809
inflation for the twelve-month period beginning July 1, 1992, and 5810
ending June 30, 1993, using the consumer price index for shelter 5811
costs for all urban consumers for the north central region, 5812
published by the United States bureau of labor statistics; 5813

(iii) For subsequent fiscal years, the limitation in effect 5814
during the previous fiscal year, adjusted to reflect the rate of 5815
inflation for the twelve-month period beginning on the first day 5816
of July for the calendar year preceding the calendar year that 5817
precedes the fiscal year and ending on the following thirtieth day 5818
of June, using the consumer price index for shelter costs for all 5819
urban consumers for the north central region, published by the 5820
United States bureau of labor statistics. 5821

(2) Any efficiency incentive determined under division (D) of 5822
this section; 5823

(3) Any amounts for return on equity determined under 5824
division (H) of this section. 5825

Buildings shall be depreciated using the straight line method 5826
over forty years or over a different period approved by the 5827
department. Components and equipment shall be depreciated using 5828
the straight-line method over a period designated in rules adopted 5829
by the department in accordance with Chapter 119. of the Revised 5830
Code, consistent with the guidelines of the American hospital 5831

association, or over a different period approved by the 5832
department. Any rules adopted under this division that specify 5833
useful lives of buildings, components, or equipment apply only to 5834
assets acquired on or after July 1, 1993. Depreciation for costs 5835
paid or reimbursed by any government agency shall not be included 5836
in cost of ownership or renovation unless that part of the payment 5837
under sections 5111.20 to 5111.32 of the Revised Code is used to 5838
reimburse the government agency. 5839

(B) The capital cost basis of nursing facility assets shall 5840
be determined in the following manner: 5841

(1) For purposes of calculating the rate to be paid for the 5842
fiscal year beginning July 1, 1993, for facilities with dates of 5843
licensure on or before June 30, 1993, the capital cost basis shall 5844
be equal to the following: 5845

(a) For facilities that have not had a change of ownership 5846
during the period beginning January 1, 1993 and ending June 30, 5847
1993, the desk-reviewed, actual, allowable capital cost basis that 5848
is listed on the facility's cost report for the cost reporting 5849
period ending December 31, 1992, plus the actual, allowable 5850
capital cost basis of any assets constructed or acquired after 5851
December 31, 1992, but before July 1, 1993, if the aggregate 5852
capital costs of those assets would increase the facility's rate 5853
for capital costs by twenty or more cents per resident per day. 5854

(b) For facilities that have a date of licensure or had a 5855
change of ownership during the period beginning January 1, 1993, 5856
and ending June 30, 1993, the actual, allowable capital cost basis 5857
of the person or government entity that owns the facility on June 5858
30, 1993. 5859

Capital cost basis shall be calculated as provided in 5860
division (B)(1) of this section subject to approval by the United 5861
States health care financing administration of any necessary 5862

amendment to the state plan for providing medical assistance. 5863

The department shall include the actual, allowable capital 5864
cost basis of assets constructed or acquired during the period 5865
beginning January 1, 1993, and ending June 30, 1993, in the 5866
calculation for the facility's rate effective July 1, 1993, if the 5867
aggregate capital costs of the assets would increase the 5868
facility's rate by twenty or more cents per resident per day and 5869
the facility provides the department with sufficient documentation 5870
of the costs before June 1, 1993. If the facility provides the 5871
documentation after that date, the department shall adjust the 5872
facility's rate to reflect the costs of the assets one month after 5873
the first day of the month after the department receives the 5874
documentation. 5875

(2) Except as provided in division (B)(4) of this section, 5876
for purposes of calculating the rates to be paid for fiscal years 5877
beginning after June 30, 1994, for facilities with dates of 5878
licensure on or before June 30, 1993, the capital cost basis of 5879
each asset shall be equal to the desk-reviewed, actual, allowable, 5880
capital cost basis that is listed on the facility's cost report 5881
for the calendar year preceding the fiscal year during which the 5882
rate will be paid. 5883

(3) For facilities with dates of licensure after June 30, 5884
1993, the capital cost basis shall be determined in accordance 5885
with the principles of the medicare program established under 5886
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 5887
U.S.C.A. 301, as amended, except as otherwise provided in sections 5888
5111.20 to 5111.32 of the Revised Code. 5889

(4) ~~If~~ Except as provided in division (B)(5) of this section, 5890
if a provider transfers an interest in a facility to another 5891
provider after June 30, 1993, there shall be no increase in the 5892
capital cost basis of the asset if the providers are related 5893

parties. If the providers are not related parties or if they are 5894
related parties and division (B)(5) of this section requires the 5895
adjustment of the capital cost basis under this division, the 5896
basis of the asset shall be adjusted by the lesser of the 5897
following: 5898

(a) One-half of the change in construction costs during the 5899
time that the transferor held the asset, as calculated by the 5900
department of human services using the "Dodge building cost 5901
indexes, northeastern and north central states," published by 5902
Marshall and Swift; 5903

(b) One-half of the change in the consumer price index for 5904
all items for all urban consumers, as published by the United 5905
States bureau of labor statistics, during the time that the 5906
transferor held the asset. 5907

(5) If a provider transfers an interest in a facility to 5908
another provider who is a related party, the capital cost basis of 5909
the asset shall be adjusted as specified in division (B)(4) of 5910
this section for a transfer to a provider that is not a related 5911
party if all of the following conditions are met: 5912

(a) The related party is a relative of owner; 5913

(b) The provider making the transfer retains no ownership 5914
interest in the facility; 5915

(c) The United States internal revenue service has issued a 5916
ruling that the transfer is an arm's length transaction for 5917
purposes of federal income taxation; 5918

(d) Except in the case of hardship caused by a catastrophic 5919
event, as determined by the department, or in the case of a 5920
provider making the transfer who is at least sixty-five years of 5921
age, not less than twenty years have elapsed since, for the same 5922
facility, the capital cost basis was adjusted most recently under 5923
division (B)(5) of this section or actual, allowable cost of 5924

ownership was determined most recently under division (C)(9) of 5925
this section. 5926

(C) As used in this division, "lease expense" means lease 5927
payments in the case of an operating lease and depreciation 5928
expense and interest expense in the case of a capital lease. As 5929
used in this division, "new lease" means a lease, to a different 5930
lessee, of a nursing facility that previously was operated under a 5931
lease. 5932

(1) Subject to the limitation specified in division (A)(1) of 5933
this section, for a lease of a facility that was effective on May 5934
27, 1992, the entire lease expense is an actual, allowable cost of 5935
ownership during the term of the existing lease. The entire lease 5936
expense also is an actual, allowable cost of ownership if a lease 5937
in existence on May 27, 1992, is renewed under either of the 5938
following circumstances: 5939

(a) The renewal is pursuant to a renewal option that was in 5940
existence on May 27, 1992; 5941

(b) The renewal is for the same lease payment amount and 5942
between the same parties as the lease in existence on May 27, 5943
1992. 5944

(2) Subject to the limitation specified in division (A)(1) of 5945
this section, for a lease of a facility that was in existence but 5946
not operated under a lease on May 27, 1992, actual, allowable cost 5947
of ownership shall include the lesser of the annual lease expense 5948
or the annual depreciation expense and imputed interest expense 5949
that would be calculated at the inception of the lease using the 5950
lessor's entire historical capital asset cost basis, adjusted by 5951
the lesser of the following amounts: 5952

(a) One-half of the change in construction costs during the 5953
time the lessor held each asset until the beginning of the lease, 5954
as calculated by the department using the "Dodge building cost 5955

indexes, northeastern and north central states," published by 5956
Marshall and Swift; 5957

(b) One-half of the change in the consumer price index for 5958
all items for all urban consumers, as published by the United 5959
States bureau of labor statistics, during the time the lessor held 5960
each asset until the beginning of the lease. 5961

(3) Subject to the limitation specified in division (A)(1) of 5962
this section, for a lease of a facility with a date of licensure 5963
on or after May 27, 1992, that is initially operated under a 5964
lease, actual, allowable cost of ownership shall include the 5965
annual lease expense if there was a substantial commitment of 5966
money for construction of the facility after December 22, 1992, 5967
and before July 1, 1993. If there was not a substantial commitment 5968
of money after December 22, 1992, and before July 1, 1993, actual, 5969
allowable cost of ownership shall include the lesser of the annual 5970
lease expense or the sum of the following: 5971

(a) The annual depreciation expense that would be calculated 5972
at the inception of the lease using the lessor's entire historical 5973
capital asset cost basis; 5974

(b) The greater of the lessor's actual annual amortization of 5975
financing costs and interest expense at the inception of the lease 5976
or the imputed interest expense calculated at the inception of the 5977
lease using seventy per cent of the lessor's historical capital 5978
asset cost basis. 5979

(4) Subject to the limitation specified in division (A)(1) of 5980
this section, for a lease of a facility with a date of licensure 5981
on or after May 27, 1992, that was not initially operated under a 5982
lease and has been in existence for ten years, actual, allowable 5983
cost of ownership shall include the lesser of the annual lease 5984
expense or the annual depreciation expense and imputed interest 5985
expense that would be calculated at the inception of the lease 5986

using the entire historical capital asset cost basis of the 5987
lessor, adjusted by the lesser of the following: 5988

(a) One-half of the change in construction costs during the 5989
time the lessor held each asset until the beginning of the lease, 5990
as calculated by the department using the "Dodge building cost 5991
indexes, northeastern and north central states," published by 5992
Marshall and Swift; 5993

(b) One-half of the change in the consumer price index for 5994
all items for all urban consumers, as published by the United 5995
States bureau of labor statistics, during the time the lessor held 5996
each asset until the beginning of the lease. 5997

(5) Subject to the limitation specified in division (A)(1) of 5998
this section, for a new lease of a facility that was operated 5999
under a lease on May 27, 1992, actual, allowable cost of ownership 6000
shall include the lesser of the annual new lease expense or the 6001
annual old lease payment. If the old lease was in effect for ten 6002
years or longer, the old lease payment from the beginning of the 6003
old lease shall be adjusted by the lesser of the following: 6004

(a) One-half of the change in construction costs from the 6005
beginning of the old lease to the beginning of the new lease, as 6006
calculated by the department using the "Dodge building cost 6007
indexes, northeastern and north central states," published by 6008
Marshall and Swift; 6009

(b) One-half of the change in the consumer price index for 6010
all items for all urban consumers, as published by the United 6011
States bureau of labor statistics, from the beginning of the old 6012
lease to the beginning of the new lease. 6013

(6) Subject to the limitation specified in division (A)(1) of 6014
this section, for a new lease of a facility that was not in 6015
existence or that was in existence but not operated under a lease 6016
on May 27, 1992, actual, allowable cost of ownership shall include 6017

the lesser of annual new lease expense or the annual amount
calculated for the old lease under division (C)(2), (3), (4), or
(6) of this section, as applicable. If the old lease was in effect
for ten years or longer, the lessor's historical capital asset
cost basis shall be adjusted by the lesser of the following for
purposes of calculating the annual amount under division (C)(2),
(3), (4), or (6) of this section:

(a) One-half of the change in construction costs from the
beginning of the old lease to the beginning of the new lease, as
calculated by the department using the "Dodge building cost
indexes, northeastern and north central states," published by
Marshall and Swift;

(b) One-half of the change in the consumer price index for
all items for all urban consumers, as published by the United
States bureau of labor statistics, from the beginning of the old
lease to the beginning of the new lease.

In the case of a lease under division (C)(3) of this section
of a facility for which a substantial commitment of money was made
after December 22, 1992, and before July 1, 1993, the old lease
payment shall be adjusted for the purpose of determining the
annual amount.

(7) For any revision of a lease described in division (C)(1),
(2), (3), (4), (5), or (6) of this section, or for any subsequent
lease of a facility operated under such a lease, other than
execution of a new lease, the portion of actual, allowable cost of
ownership attributable to the lease shall be the same as before
the revision or subsequent lease.

(8) Except as provided in division (C)(9) of this section, if
a provider leases an interest in a facility to another provider
who is a related party, the related party's actual, allowable cost
of ownership shall include the lesser of the annual lease expense

or the reasonable cost to the lessor. 6049

(9) If a provider leases an interest in a facility to another provider who is a related party, regardless of the date of the lease, the related party's actual, allowable cost of ownership shall include the annual lease expense, subject to the limitations specified in divisions (C)(1) to (7) of this section, if all of the following conditions are met: 6050
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(a) The related party is a relative of owner; 6056

(b) If the lessor retains an ownership interest, it is in only the real property and any improvements on the real property; 6057
6058

(c) The United States internal revenue service has issued a ruling that the lease is an arm's length transaction for purposes of federal income taxation; 6059
6060
6061

(d) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was adjusted most recently under division (B)(5) of this section or actual, allowable cost of ownership was determined most recently under division (C)(9) of this section. 6062
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(10) This division does not apply to leases of specific items of equipment. 6069
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(D)(1) Subject to division (D)(2) of this section, the department shall pay each nursing facility an efficiency incentive that is equal to fifty per cent of the difference between the following: 6071
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(a) Eighty-eight and sixty-five one-hundredths per cent of the facility's desk-reviewed, actual, allowable, per diem cost of ownership; 6075
6076
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(b) The applicable amount specified in division (E) of this 6078

section. 6079

(2) The efficiency incentive paid to a nursing facility shall 6080
not exceed the greater of the following: 6081

(a) The efficiency incentive the facility was paid during the 6082
fiscal year ending June 30, 1994; 6083

(b) Three dollars per resident per day, adjusted annually for 6084
rates paid beginning July 1, 1994, for the inflation rate for the 6085
twelve-month period beginning on the first day of July of the 6086
calendar year preceding the calendar year that precedes the fiscal 6087
year for which the efficiency incentive is determined and ending 6088
on the thirtieth day of the following June, using the consumer 6089
price index for shelter costs for all urban consumers for the 6090
north central region, as published by the United States bureau of 6091
labor statistics. 6092

(3) For purposes of calculating the efficiency incentive, 6093
depreciation for costs that are paid or reimbursed by any 6094
government agency shall be considered as costs of ownership, and 6095
renovation costs that are paid under division (F) of this section 6096
shall not be considered costs of ownership. 6097

(E) The following amounts shall be used to calculate 6098
efficiency incentives for nursing facilities under this section: 6099

(1) For facilities with dates of licensure prior to January 6100
1, 1958, four dollars and twenty-four cents per patient day; 6101

(2) For facilities with dates of licensure after December 31, 6102
1957, but prior to January 1, 1968: 6103

(a) Five dollars and twenty-four cents per patient day if the 6104
cost of construction was three thousand five hundred dollars or 6105
more per bed; 6106

(b) Four dollars and twenty-four cents per patient day if the 6107
cost of construction was less than three thousand five hundred 6108

dollars per bed.	6109
(3) For facilities with dates of licensure after December 31, 1967, but prior to January 1, 1976:	6110
(a) Six dollars and twenty-four cents per patient day if the cost of construction was five thousand one hundred fifty dollars or more per bed;	6111
(b) Five dollars and twenty-four cents per patient day if the cost of construction was less than five thousand one hundred fifty dollars per bed, but exceeded three thousand five hundred dollars per bed;	6112
(c) Four dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.	6113
(4) For facilities with dates of licensure after December 31, 1975, but prior to January 1, 1979:	6114
(a) Seven dollars and twenty-four cents per patient day if the cost of construction was six thousand eight hundred dollars or more per bed;	6115
(b) Six dollars and twenty-four cents per patient day if the cost of construction was less than six thousand eight hundred dollars per bed but exceeded five thousand one hundred fifty dollars per bed;	6116
(c) Five dollars and twenty-four cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less per bed, but exceeded three thousand five hundred dollars per bed;	6117
(d) Four dollars and twenty-four cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.	6118
(5) For facilities with dates of licensure after December 31,	6119
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1978, but prior to January 1, 1981:	6139
(a) Seven dollars and seventy-four cents per patient day if	6140
the cost of construction was seven thousand six hundred	6141
twenty-five dollars or more per bed;	6142
(b) Seven dollars and twenty-four cents per patient day if	6143
the cost of construction was less than seven thousand six hundred	6144
twenty-five dollars per bed but exceeded six thousand eight	6145
hundred dollars per bed;	6146
(c) Six dollars and twenty-four cents per patient day if the	6147
cost of construction was six thousand eight hundred dollars or	6148
less per bed but exceeded five thousand one hundred fifty dollars	6149
per bed;	6150
(d) Five dollars and twenty-four cents per patient day if the	6151
cost of construction was five thousand one hundred fifty dollars	6152
or less but exceeded three thousand five hundred dollars per bed;	6153
	6154
(e) Four dollars and twenty-four cents per patient day if the	6155
cost of construction was three thousand five hundred dollars or	6156
less per bed.	6157
(6) For facilities with dates of licensure in 1981 or any	6158
year thereafter prior to December 22, 1992, the following amount:	6159
(a) For facilities with construction costs less than seven	6160
thousand six hundred twenty-five dollars per bed, the applicable	6161
amounts for the construction costs specified in divisions	6162
(E)(5)(b) to (e) of this section;	6163
(b) For facilities with construction costs of seven thousand	6164
six hundred twenty-five dollars or more per bed, six dollars per	6165
patient day, provided that for 1981 and annually thereafter prior	6166
to December 22, 1992, department shall do both of the following to	6167
the six-dollar amount:	6168

(i) Adjust the amount for fluctuations in construction costs 6169
calculated by the department using the "Dodge building cost 6170
indexes, northeastern and north central states," published by 6171
Marshall and Swift, using 1980 as the base year; 6172

(ii) Increase the amount, as adjusted for inflation under 6173
division (E)(6)(b)(i) of this section, by one dollar and 6174
seventy-four cents. 6175

(7) For facilities with dates of licensure on or after 6176
January 1, 1992, seven dollars and ninety-seven cents, adjusted 6177
for fluctuations in construction costs between 1991 and 1993 as 6178
calculated by the department using the "Dodge building cost 6179
indexes, northeastern and north central states," published by 6180
Marshall and Swift, and then increased by one dollar and 6181
seventy-four cents. 6182

For the fiscal year that begins July 1, 1994, each of the 6183
amounts listed in divisions (E)(1) to (7) of this section shall be 6184
increased by twenty-five cents. For the fiscal year that begins 6185
July 1, 1995, each of those amounts shall be increased by an 6186
additional twenty-five cents. For subsequent fiscal years, each of 6187
those amounts, as increased for the prior fiscal year, shall be 6188
adjusted to reflect the rate of inflation for the twelve-month 6189
period beginning on the first day of July of the calendar year 6190
preceding the calendar year that precedes the fiscal year and 6191
ending on the following thirtieth day of June, using the consumer 6192
price index for shelter costs for all urban consumers for the 6193
north central region, as published by the United States bureau of 6194
labor statistics. 6195

If the amount established for a nursing facility under this 6196
division is less than the amount that applied to the facility 6197
under division (B) of former section 5111.25 of the Revised Code, 6198
as the former section existed immediately prior to December 22, 6199

1992, the amount used to calculate the efficiency incentive for
the facility under division (D)(2) of this section shall be the
amount that was calculated under division (B) of the former
section.

(F) Beginning July 1, 1993, regardless of the facility's date
of licensure or the date of the nonextensive renovations, the rate
for the costs of nonextensive renovations for nursing facilities
shall be eighty-five per cent of the desk-reviewed, actual,
allowable, per diem, nonextensive renovation costs. This division
applies to nonextensive renovations regardless of whether they are
made by an owner or a lessee. If the tenancy of a lessee that has
made nonextensive renovations ends before the depreciation expense
for the renovation costs has been fully reported, the former
lessee shall not report the undepreciated balance as an expense.

(1) For a nonextensive renovation made after July 1, 1993, to
qualify for payment under this division, both of the following
conditions must be met:

(a) At least five years have elapsed since the date of
licensure of the portion of the facility that is proposed to be
renovated, except that this condition does not apply if the
renovation is necessary to meet the requirements of federal,
state, or local statutes, ordinances, rules, or policies.

(b) The provider has obtained prior approval from the
department of human services, and if required the director of
health has granted a certificate of need for the renovation under
section 3702.52 of the Revised Code. The provider shall submit a
plan that describes in detail the changes in capital assets to be
accomplished by means of the renovation and the timetable for
completing the project. The time for completion of the project
shall be no more than eighteen months after the renovation begins.

The department of human services shall adopt rules in accordance with Chapter 119. of the Revised Code that specify criteria and procedures for prior approval of renovation projects. No provider shall separate a project with the intent to evade the characterization of the project as a renovation or as an extensive renovation. No provider shall increase the scope of a project after it is approved by the department of human services unless the increase in scope is approved by the department.

(2) The payment provided for in this division is the only payment that shall be made for the costs of a nonextensive renovation. Nonextensive renovation costs shall not be included in costs of ownership, and a nonextensive renovation shall not affect the date of licensure for purposes of calculating the efficiency incentive under divisions (D) and (E) of this section.

(G) The owner of a nursing facility operating under a provider agreement shall provide written notice to the department of human services at least forty-five days prior to entering into any contract of sale for the facility or voluntarily terminating participation in the medical assistance program. After the date on which a transaction of sale is closed, the owner shall refund to the department the amount of excess depreciation paid to the facility by the department for each year the owner has operated the facility under a provider agreement and prorated according to the number of medicaid patient days for which the facility has received payment. If a nursing facility is sold after five or fewer years of operation under a provider agreement, the refund to the department shall be equal to the excess depreciation paid to the facility. If a nursing facility is sold after more than five years but less than ten years of operation under a provider agreement, the refund to the department shall equal the excess depreciation paid to the facility multiplied by twenty per cent, multiplied by the difference between ten and the number of years

that the facility was operated under a provider agreement. If a 6263
nursing facility is sold after ten or more years of operation 6264
under a provider agreement, the owner shall not refund any excess 6265
depreciation to the department. The owner of a facility that is 6266
sold or that voluntarily terminates participation in the medical 6267
assistance program also shall refund any other amount that the 6268
department properly finds to be due after the audit conducted 6269
under this division. For the purposes of this division, 6270
"depreciation paid to the facility" means the amount paid to the 6271
nursing facility for cost of ownership pursuant to this section 6272
less any amount paid for interest costs, amortization of financing 6273
costs, and lease expenses. For the purposes of this division, 6274
"excess depreciation" is the nursing facility's depreciated basis, 6275
which is the owner's cost less accumulated depreciation, 6276
subtracted from the purchase price net of selling costs but not 6277
exceeding the amount of depreciation paid to the facility. 6278

A cost report shall be filed with the department within 6279
ninety days after the date on which the transaction of sale is 6280
closed or participation is voluntarily terminated. The report 6281
shall show the accumulated depreciation, the sales price, and 6282
other information required by the department. The amount of the 6283
last two monthly payments to a nursing facility made pursuant to 6284
division (A)(1) of section 5111.22 of the Revised Code before a 6285
sale or termination of participation shall be held in escrow by a 6286
bank, trust company, or savings and loan association, except that 6287
if the amount the owner will be required to refund under this 6288
section is likely to be less than the amount of the last two 6289
monthly payments, the department shall take one of the following 6290
actions instead of withholding the amount of the last two monthly 6291
payments: 6292

(1) In the case of an owner that owns other facilities that 6293
participate in the medical assistance program, obtain a promissory 6294

note in an amount sufficient to cover the amount likely to be 6295
refunded; 6296

(2) In the case of all other owners, withhold the amount of 6297
the last monthly payment to the nursing facility. 6298

The department shall, within ninety days following the filing 6299
of the cost report, audit the cost report and issue an audit 6300
report to the owner. The department also may audit any other cost 6301
report that the facility has filed during the previous three 6302
years. In the audit report, the department shall state its 6303
findings and the amount of any money owed to the department by the 6304
nursing facility. The findings shall be subject to adjudication 6305
conducted in accordance with Chapter 119. of the Revised Code. No 6306
later than fifteen days after the owner agrees to a settlement, 6307
any funds held in escrow less any amounts due to the department 6308
shall be released to the owner and amounts due to the department 6309
shall be paid to the department. If the amounts in escrow are less 6310
than the amounts due to the department, the balance shall be paid 6311
to the department within fifteen days after the owner agrees to a 6312
settlement. If the department does not issue its audit report 6313
within the ninety-day period, the department shall release any 6314
money held in escrow to the owner. For the purposes of this 6315
section, a transfer of corporate stock, the merger of one 6316
corporation into another, or a consolidation does not constitute a 6317
sale. 6318

If a nursing facility is not sold or its participation is not 6319
terminated after notice is provided to the department under this 6320
division, the department shall order any payments held in escrow 6321
released to the facility upon receiving written notice from the 6322
owner that there will be no sale or termination. After written 6323
notice is received from a nursing facility that a sale or 6324
termination will not take place, the facility shall provide notice 6325
to the department at least forty-five days prior to entering into 6326

any contract of sale or terminating participation at any future
time. 6327
6328

(H) The department shall pay each eligible proprietary 6329
nursing facility a return on the facility's net equity computed at 6330
the rate of one and one-half times the average interest rate on 6331
special issues of public debt obligations issued to the federal 6332
hospital insurance trust fund for the cost reporting period, 6333
except that no facility's return on net equity shall exceed one 6334
dollar per patient day. 6335

When calculating the rate for return on net equity, the 6336
department shall use the greater of the facility's inpatient days 6337
during the applicable cost reporting period or the number of 6338
inpatient days the facility would have had during that period if 6339
its occupancy rate had been ninety-five per cent. 6340

(I) If a nursing facility would receive a lower rate for 6341
capital costs for assets in the facility's possession on July 1, 6342
1993, under this section than it would receive under former 6343
section 5111.25 of the Revised Code, as the former section existed 6344
immediately prior to December 22, 1992, the facility shall receive 6345
for those assets the rate it would have received under the former 6346
section for each fiscal year beginning on or after July 1, 1993, 6347
until the rate it would receive under this section exceeds the 6348
rate it would have received under the former section. Any facility 6349
that receives a rate calculated under the former section 5111.25 6350
of the Revised Code for assets in the facility's possession on 6351
July 1, 1993, also shall receive a rate calculated under this 6352
section for costs of any assets it constructs or acquires after 6353
July 1, 1993. 6354

Sec. 5111.251. (A) The department of human services shall pay 6355
each eligible intermediate care facility for the mentally retarded 6356
for its reasonable capital costs, a per resident per day rate 6357

established prospectively each fiscal year for each intermediate 6358
care facility for the mentally retarded. Except as otherwise 6359
provided in sections 5111.20 to 5111.32 of the Revised Code, the 6360
rate shall be based on the facility's capital costs for the 6361
calendar year preceding the fiscal year in which the rate will be 6362
paid. The rate shall equal the sum of the following: 6363

(1) The facility's desk-reviewed, actual, allowable, per diem 6364
cost of ownership for the preceding cost reporting period, limited 6365
as provided in divisions (C) and (F) of this section; 6366

(2) Any efficiency incentive determined under division (B) of 6367
this section; 6368

(3) Any amounts for renovations determined under division (D) 6369
of this section; 6370

(4) Any amounts for return on equity determined under 6371
division (I) of this section. 6372

Buildings shall be depreciated using the straight line method 6373
over forty years or over a different period approved by the 6374
department. Components and equipment shall be depreciated using 6375
the straight line method over a period designated by the 6376
department in rules adopted in accordance with Chapter 119. of the 6377
Revised Code, consistent with the guidelines of the American 6378
hospital association, or over a different period approved by the 6379
department of human services. Any rules adopted under this 6380
division that specify useful lives of buildings, components, or 6381
equipment apply only to assets acquired on or after July 1, 1993. 6382
Depreciation for costs paid or reimbursed by any government agency 6383
shall not be included in costs of ownership or renovation unless 6384
that part of the payment under sections 5111.20 to 5111.32 of the 6385
Revised Code is used to reimburse the government agency. 6386

(B) The department of human services shall pay to each 6387

intermediate care facility for the mentally retarded an efficiency 6388
incentive equal to fifty per cent of the difference between any 6389
desk-reviewed, actual, allowable cost of ownership and the 6390
applicable limit on cost of ownership payments under division (C) 6391
of this section. For purposes of computing the efficiency 6392
incentive, depreciation for costs paid or reimbursed by any 6393
government agency shall be considered as a cost of ownership, and 6394
the applicable limit under division (C) of this section shall 6395
apply both to facilities with more than eight beds and facilities 6396
with eight or fewer beds. The efficiency incentive paid to a 6397
facility with eight or fewer beds shall not exceed three dollars 6398
per patient day, adjusted annually for the inflation rate for the 6399
twelve-month period beginning on the first day of July of the 6400
calendar year preceding the calendar year that precedes the fiscal 6401
year for which the efficiency incentive is determined and ending 6402
on the thirtieth day of the following June, using the consumer 6403
price index for shelter costs for all urban consumers for the 6404
north central region, as published by the United States bureau of 6405
labor statistics. 6406

(C) Cost of ownership payments to intermediate care 6407
facilities for the mentally retarded with more than eight beds 6408
shall not exceed the following limits: 6409

(1) For facilities with dates of licensure prior to January 6410
1, 1958, not exceeding two dollars and fifty cents per patient 6411
day; 6412

(2) For facilities with dates of licensure after December 31, 6413
1957, but prior to January 1, 1968, not exceeding: 6414

(a) Three dollars and fifty cents per patient day if the cost 6415
of construction was three thousand five hundred dollars or more 6416
per bed; 6417

(b) Two dollars and fifty cents per patient day if the cost 6418

of construction was less than three thousand five hundred dollars
per bed. 6419
6420

(3) For facilities with dates of licensure after December 31,
1967, but prior to January 1, 1976, not exceeding: 6421
6422

(a) Four dollars and fifty cents per patient day if the cost
of construction was five thousand one hundred fifty dollars or
more per bed; 6423
6424
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(b) Three dollars and fifty cents per patient day if the cost
of construction was less than five thousand one hundred fifty
dollars per bed, but exceeds three thousand five hundred dollars
per bed; 6426
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(c) Two dollars and fifty cents per patient day if the cost
of construction was three thousand five hundred dollars or less
per bed. 6430
6431
6432

(4) For facilities with dates of licensure after December 31,
1975, but prior to January 1, 1979, not exceeding: 6433
6434

(a) Five dollars and fifty cents per patient day if the cost
of construction was six thousand eight hundred dollars or more per
bed; 6435
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(b) Four dollars and fifty cents per patient day if the cost
of construction was less than six thousand eight hundred dollars
per bed but exceeds five thousand one hundred fifty dollars per
bed; 6438
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(c) Three dollars and fifty cents per patient day if the cost
of construction was five thousand one hundred fifty dollars or
less per bed, but exceeds three thousand five hundred dollars per
bed; 6442
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(d) Two dollars and fifty cents per patient day if the cost
of construction was three thousand five hundred dollars or less
per bed. 6446
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(5) For facilities with dates of licensure after December 31, 1978, but prior to January 1, 1980, not exceeding:	6449
	6450
(a) Six dollars per patient day if the cost of construction was seven thousand six hundred twenty-five dollars or more per bed;	6451
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	6453
(b) Five dollars and fifty cents per patient day if the cost of construction was less than seven thousand six hundred twenty-five dollars per bed but exceeds six thousand eight hundred dollars per bed;	6454
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(c) Four dollars and fifty cents per patient day if the cost of construction was six thousand eight hundred dollars or less per bed but exceeds five thousand one hundred fifty dollars per bed;	6458
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	6460
(d) Three dollars and fifty cents per patient day if the cost of construction was five thousand one hundred fifty dollars or less but exceeds three thousand five hundred dollars per bed;	6461
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	6463
(e) Two dollars and fifty cents per patient day if the cost of construction was three thousand five hundred dollars or less per bed.	6464
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	6466
(6) For facilities with dates of licensure after December 31, 1979, but prior to January 1, 1981, not exceeding:	6467
	6468
(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;	6469
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	6471
(b) Six dollars per patient day if the beds were originally licensed as nursing home beds by the department of health.	6472
	6473
(7) For facilities with dates of licensure after December 31, 1980, but prior to January 1, 1982, not exceeding:	6474
	6475
(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;	6476
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(b) Six dollars and forty-five cents per patient day if the beds were originally licensed as nursing home beds by the department of health.	6479 6480 6481
(8) For facilities with dates of licensure after December 31, 1981, but prior to January 1, 1983, not exceeding:	6482 6483
(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;	6484 6485 6486
(b) Six dollars and seventy-nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.	6487 6488 6489
(9) For facilities with dates of licensure after December 31, 1982, but prior to January 1, 1984, not exceeding:	6490 6491
(a) Twelve dollars per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;	6492 6493 6494
(b) Seven dollars and nine cents per patient day if the beds were originally licensed as nursing home beds by the department of health.	6495 6496 6497
(10) For facilities with dates of licensure after December 31, 1983, but prior to January 1, 1985, not exceeding:	6498 6499
(a) Twelve dollars and twenty-four cents per patient day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;	6500 6501 6502 6503
(b) Seven dollars and twenty-three cents per patient day if the beds were originally licensed as nursing home beds by the department of health.	6504 6505 6506
(11) For facilities with dates of licensure after December 31, 1984, but prior to January 1, 1986, not exceeding:	6507 6508

(a) Twelve dollars and fifty-three cents per patient day if 6509
the beds were originally licensed as residential facility beds by 6510
the department of mental retardation and developmental 6511
disabilities; 6512

(b) Seven dollars and forty cents per patient day if the beds 6513
were originally licensed as nursing home beds by the department of 6514
health. 6515

(12) For facilities with dates of licensure after December 6516
31, 1985, but prior to January 1, 1987, not exceeding: 6517

(a) Twelve dollars and seventy cents per patient day if the 6518
beds were originally licensed as residential facility beds by the 6519
department of mental retardation and developmental disabilities; 6520

(b) Seven dollars and fifty cents per patient day if the beds 6521
were originally licensed as nursing home beds by the department of 6522
health. 6523

(13) For facilities with dates of licensure after December 6524
31, 1986, but prior to January 1, 1988, not exceeding: 6525

(a) Twelve dollars and ninety-nine cents per patient day if 6526
the beds were originally licensed as residential facility beds by 6527
the department of mental retardation and developmental 6528
disabilities; 6529

(b) Seven dollars and sixty-seven cents per patient day if 6530
the beds were originally licensed as nursing home beds by the 6531
department of health. 6532

(14) For facilities with dates of licensure after December 6533
31, 1987, but prior to January 1, 1989, not exceeding thirteen 6534
dollars and twenty-six cents per patient day; 6535

(15) For facilities with dates of licensure after December 6536
31, 1988, but prior to January 1, 1990, not exceeding thirteen 6537
dollars and forty-six cents per patient day; 6538

(16) For facilities with dates of licensure after December 6539
31, 1989, but prior to January 1, 1991, not exceeding thirteen 6540
dollars and sixty cents per patient day; 6541

(17) For facilities with dates of licensure after December 6542
31, 1990, but prior to January 1, 1992, not exceeding thirteen 6543
dollars and forty-nine cents per patient day; 6544

(18) For facilities with dates of licensure after December 6545
31, 1991, but prior to January 1, 1993, not exceeding thirteen 6546
dollars and sixty-seven cents per patient day; 6547

(19) For facilities with dates of licensure after December 6548
31, 1992, not exceeding fourteen dollars and twenty-eight cents 6549
per patient day. 6550

(D) Beginning January 1, 1981, regardless of the original 6551
date of licensure, the department of human services shall pay a 6552
rate for the per diem capitalized costs of renovations to 6553
intermediate care facilities for the mentally retarded made after 6554
January 1, 1981, not exceeding six dollars per patient day using 6555
1980 as the base year and adjusting the amount annually until June 6556
30, 1993, for fluctuations in construction costs calculated by the 6557
department using the "Dodge building cost indexes, northeastern 6558
and north central states," published by Marshall and Swift. The 6559
payment provided for in this division is the only payment that 6560
shall be made for the capitalized costs of a nonextensive 6561
renovation of an intermediate care facility for the mentally 6562
retarded. Nonextensive renovation costs shall not be included in 6563
cost of ownership, and a nonextensive renovation shall not affect 6564
the date of licensure for purposes of division (C) of this 6565
section. This division applies to nonextensive renovations 6566
regardless of whether they are made by an owner or a lessee. If 6567
the tenancy of a lessee that has made renovations ends before the 6568
depreciation expense for the renovation costs has been fully 6569

reported, the former lessee shall not report the undepreciated
balance as an expense. 6570
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For a nonextensive renovation to qualify for payment under
this division, both of the following conditions must be met: 6572
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(1) At least five years have elapsed since the date of
licensure or date of an extensive renovation of the portion of the
facility that is proposed to be renovated, except that this
condition does not apply if the renovation is necessary to meet
the requirements of federal, state, or local statutes, ordinances,
rules, or policies. 6574
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(2) The provider has obtained prior approval from the
department of human services. The provider shall submit a plan
that describes in detail the changes in capital assets to be
accomplished by means of the renovation and the timetable for
completing the project. The time for completion of the project
shall be no more than eighteen months after the renovation begins.
The department of human services shall adopt rules in accordance
with Chapter 119. of the Revised Code that specify criteria and
procedures for prior approval of renovation projects. No provider
shall separate a project with the intent to evade the
characterization of the project as a renovation or as an extensive
renovation. No provider shall increase the scope of a project
after it is approved by the department of human services unless
the increase in scope is approved by the department. 6580
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(E) The amounts specified in divisions (C) and (D) of this
section shall be adjusted beginning July 1, 1993, for the
estimated inflation for the twelve-month period beginning on the
first day of July of the calendar year preceding the calendar year
that precedes the fiscal year for which rate will be paid and
ending on the thirtieth day of the following June, using the
consumer price index for shelter costs for all urban consumers for
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the north central region, as published by the United States bureau
of labor statistics. 6601
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(F)(1) For facilities of eight or fewer beds that have dates
of licensure or have been granted project authorization by the
department of mental retardation and developmental disabilities
before July 1, 1993, and for facilities of eight or fewer beds
that have dates of licensure or have been granted project
authorization after that date if the facilities demonstrate that
they made substantial commitments of funds on or before that date,
cost of ownership shall not exceed eighteen dollars and thirty
cents per resident per day. The eighteen-dollar and thirty-cent
amount shall be increased by the change in the "Dodge building
cost indexes, northeastern and north central states," published by
Marshall and Swift, during the period beginning June 30, 1990, and
ending July 1, 1993, and by the change in the consumer price index
for shelter costs for all urban consumers for the north central
region, as published by the United States bureau of labor
statistics, annually thereafter. 6603
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(2) For facilities with eight or fewer beds that have dates
of licensure or have been granted project authorization by the
department of mental retardation and developmental disabilities on
or after July 1, 1993, for which substantial commitments of funds
were not made before that date, cost of ownership payments shall
not exceed the applicable amount calculated under division (F)(1)
of this section, if the department of human services gives prior
approval for construction of the facility. If the department does
not give prior approval, cost of ownership payments shall not
exceed the amount specified in division (C) of this section. 6619
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(3) Notwithstanding divisions (D) and (F)(1) and (2) of this
section, the total payment for cost of ownership, cost of
ownership efficiency incentive, and capitalized costs of
renovations for an intermediate care facility for the mentally 6629
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retarded with eight or fewer beds shall not exceed the sum of the 6633
limitations specified in divisions (C) and (D) of this section. 6634

(G) Notwithstanding any provision of this section or section 6635
5111.24 of the Revised Code, the department of human services may 6636
adopt rules in accordance with Chapter 119. of the Revised Code 6637
that provide for a calculation of a combined maximum payment limit 6638
for indirect care costs and cost of ownership for intermediate 6639
care facilities for the mentally retarded with eight or fewer 6640
beds. 6641

(H) After June 30, 1980, the owner of an intermediate care 6642
facility for the mentally retarded operating under a provider 6643
agreement shall provide written notice to the department of human 6644
services at least forty-five days prior to entering into any 6645
contract of sale for the facility or voluntarily terminating 6646
participation in the medical assistance program. After the date on 6647
which a transaction of sale is closed, the owner shall refund to 6648
the department the amount of excess depreciation paid to the 6649
facility by the department for each year the owner has operated 6650
the facility under a provider agreement and prorated according to 6651
the number of medicaid patient days for which the facility has 6652
received payment. If an intermediate care facility for the 6653
mentally retarded is sold after five or fewer years of operation 6654
under a provider agreement, the refund to the department shall be 6655
equal to the excess depreciation paid to the facility. If an 6656
intermediate care facility for the mentally retarded is sold after 6657
more than five years but less than ten years of operation under a 6658
provider agreement, the refund to the department shall equal the 6659
excess depreciation paid to the facility multiplied by twenty per 6660
cent, multiplied by the number of years less than ten that a 6661
facility was operated under a provider agreement. If an 6662
intermediate care facility for the mentally retarded is sold after 6663
ten or more years of operation under a provider agreement, the 6664

owner shall not refund any excess depreciation to the department. 6665
For the purposes of this division, "depreciation paid to the 6666
facility" means the amount paid to the intermediate care facility 6667
for the mentally retarded for cost of ownership pursuant to this 6668
section less any amount paid for interest costs. For the purposes 6669
of this division, "excess depreciation" is the intermediate care 6670
facility for the mentally retarded's depreciated basis, which is 6671
the owner's cost less accumulated depreciation, subtracted from 6672
the purchase price but not exceeding the amount of depreciation 6673
paid to the facility. 6674

A cost report shall be filed with the department within 6675
ninety days after the date on which the transaction of sale is 6676
closed or participation is voluntarily terminated for an 6677
intermediate care facility for the mentally retarded subject to 6678
this division. The report shall show the accumulated depreciation, 6679
the sales price, and other information required by the department. 6680
The amount of the last two monthly payments to an intermediate 6681
care facility for the mentally retarded made pursuant to division 6682
(A)(1) of section 5111.22 of the Revised Code before a sale or 6683
voluntary termination of participation shall be held in escrow by 6684
a bank, trust company, or savings and loan association, except 6685
that if the amount the owner will be required to refund under this 6686
section is likely to be less than the amount of the last two 6687
monthly payments, the department shall take one of the following 6688
actions instead of withholding the amount of the last two monthly 6689
payments: 6690

(1) In the case of an owner that owns other facilities that 6691
participate in the medical assistance program, obtain a promissory 6692
note in an amount sufficient to cover the amount likely to be 6693
refunded; 6694

(2) In the case of all other owners, withhold the amount of 6695
the last monthly payment to the intermediate care facility for the 6696

mentally retarded. 6697

The department shall, within ninety days following the filing 6698
of the cost report, audit the report and issue an audit report to 6699
the owner. The department also may audit any other cost reports 6700
for the facility that have been filed during the previous three 6701
years. In the audit report, the department shall state its 6702
findings and the amount of any money owed to the department by the 6703
intermediate care facility for the mentally retarded. The findings 6704
shall be subject to an adjudication conducted in accordance with 6705
Chapter 119. of the Revised Code. No later than fifteen days after 6706
the owner agrees to a settlement, any funds held in escrow less 6707
any amounts due to the department shall be released to the owner 6708
and amounts due to the department shall be paid to the department. 6709
If the amounts in escrow are less than the amounts due to the 6710
department, the balance shall be paid to the department within 6711
fifteen days after the owner agrees to a settlement. If the 6712
department does not issue its audit report within the ninety-day 6713
period, the department shall release any money held in escrow to 6714
the owner. For the purposes of this section, a transfer of 6715
corporate stock, the merger of one corporation into another, or a 6716
consolidation does not constitute a sale. 6717

If an intermediate care facility for the mentally retarded is 6719
not sold or its participation is not terminated after notice is 6720
provided to the department under this division, the department 6721
shall order any payments held in escrow released to the facility 6722
upon receiving written notice from the owner that there will be no 6723
sale or termination of participation. After written notice is 6724
received from an intermediate care facility for the mentally 6725
retarded that a sale or termination of participation will not take 6726
place, the facility shall provide notice to the department at 6727
least forty-five days prior to entering into any contract of sale 6728

or terminating participation at any future time.

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(I) The department of human services shall pay each eligible proprietary intermediate care facility for the mentally retarded a return on the facility's net equity computed at the rate of one and one-half times the average of interest rates on special issues of public debt obligations issued to the federal hospital insurance trust fund for the cost reporting period. No facility's return on net equity paid under this division shall exceed one dollar per patient day.

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In calculating the rate for return on net equity, the department shall use the greater of the facility's inpatient days during the applicable cost reporting period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.

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(J)(1) Except as provided in division (J)(2) of this section, if a provider leases or transfers an interest in a facility to another provider who is a related party, the related party's allowable cost of ownership shall include the lesser of the following:

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(a) The annual lease expense or actual cost of ownership, whichever is applicable;

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(b) The reasonable cost to the lessor or provider making the transfer.

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(2) If a provider leases or transfers an interest in a facility to another provider who is a related party, regardless of the date of the lease or transfer, the related party's allowable cost of ownership shall include the annual lease expense or actual cost of ownership, whichever is applicable, subject to the limitations specified in divisions (B) to (I) of this section, if all of the following conditions are met:

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- (a) The related party is a relative of owner; 6759
- (b) In the case of a lease, if the lessor retains any ownership interest, it is in only the real property and any improvements on the real property; 6760
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- (c) In the case of a transfer, the provider making the transfer retains no ownership interest in the facility; 6763
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- (d) The United States internal revenue service has issued a ruling that the lease or transfer is an arm's length transaction for purposes of federal income taxation; 6765
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- (e) Except in the case of hardship caused by a catastrophic event, as determined by the department, or in the case of a lessor or provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, allowable cost of ownership was determined most recently under this division. 6768
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- Sec. 5111.264.** The Except as provided in section 5111.25 or 5111.251 Of the Revised Code, the costs of goods, services, and facilities, furnished to a provider by a related party are includable in the allowable costs of the provider at the reasonable cost to the related party. 6774
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- Sec. 5111.81.** (A) There is hereby established the pharmacy and therapeutics committee of the department of human services. 6779
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The committee shall consist of eight members and shall be 6781
appointed by the director of human services. The membership of the 6782
committee shall include: two pharmacists licensed under Chapter 6783
4729. of the Revised Code; two doctors of medicine and two doctors 6784
of osteopathy licensed under Chapter 4731. of the Revised Code; a 6785
registered nurse licensed under Chapter 4723. of the Revised Code; 6786
and a pharmacologist who has a doctoral degree. The committee 6787
shall elect one of its members as chairperson. 6788

(B) In the absence of fraud or bad faith, neither the 6789
pharmacy and therapeutics committee nor a current or former 6790
member, agent, representative, employee, or independent contractor 6791
of the committee shall be held liable in damages to a person as 6792
the result of an act, omission, proceeding, conduct, or decision 6793
relating to the official duties undertaken or performed pursuant 6794
to this section, ~~section 5111.811 of the Revised Code~~, or rules 6795
promulgated pursuant to section 111.15 or Chapter 119. of the 6796
Revised Code. If a current or former member, agent, 6797
representative, employee, or independent contractor of the 6798
committee requests the state to defend the current or former 6799
member, agent, representative, employee, or independent contractor 6800
against a claim or in an action arising out of an act, omission, 6801
proceeding, conduct, or decision relating to official duties 6802
undertaken or performed, if the request is made in writing at a 6803
reasonable time before the trial of the claim or in the action, 6804
and if the person requesting the defense cooperates in good faith 6805
in the defense of the claim or action, the state shall provide and 6806
pay for the defense of the claim or action and shall pay any 6807
resulting judgment, compromise, or settlement. The state shall not 6808
pay that part of a claim or judgment that is for punitive or 6809
exemplary damages. 6810

Sec. 5112.01. As used in sections 5112.02 to 5112.21 of the 6811
Revised Code: 6812

(A)(1) "Hospital" means a nonfederal hospital to which either 6813
of the following applies: 6814

(a) The hospital is registered under section 3701.07 of the 6815
Revised Code as a general medical and surgical hospital or a 6816
pediatric general hospital, and provides inpatient hospital 6817
services, as defined in 42 C.F.R. 440.10; 6818

(b) The hospital is recognized under the medicare program 6819

established by Title XVIII of the "Social Security Act," 49 Stat. 6820
620 (1935), 42 U.S.C.A. 301, as amended, as a cancer hospital and 6821
is exempt from the medicare prospective payment system. 6822

"Hospital" does not include a hospital operated by a health 6823
~~maintenance organization~~ insuring corporation that has been issued 6824
a certificate of authority under section ~~1742.05~~ 1751.05 of the 6825
Revised Code or a hospital that does not charge patients for 6826
services. 6827

(2) "Disproportionate share hospital" means a hospital that 6828
meets the definition of a disproportionate share hospital in rules 6829
adopted under section 5112.03 of the Revised Code. 6830

(B) "Bad debt," "charity care," "courtesy care," and 6831
"contractual allowances" have the same meanings given these terms 6832
in regulations adopted under Title XVIII of the "Social Security 6833
Act." 6834

(C) "Cost reporting period" means the twelve-month period 6835
used by a hospital in reporting costs for purposes of Title XVIII 6836
of the "Social Security Act." 6837

(D) "Governmental hospital" means a county hospital with more 6838
than five hundred registered beds or a state-owned and -operated 6839
hospital with more than five hundred registered beds. 6840

(E) "Indigent care pool" means the sum of the following: 6841

(1) The total of assessments to be paid in a program year by 6842
all hospitals under section 5112.06 of the Revised Code, less the 6843
assessments deposited into the legislative budget services fund 6844
under section 5112.19 of the Revised Code; 6845

(2) The total amount of intergovernmental transfers required 6846
to be made in the same program year by governmental hospitals 6847
under section 5112.07 of the Revised Code, less the amount of 6848
transfers deposited into the legislative budget services fund 6849

under section 5112.19 of the Revised Code; 6850

(3) The total amount of federal matching funds that will be 6851
made available in the same program year as a result of payments 6852
the department of human services makes to hospitals under section 6853
5112.08 of the Revised Code. 6854

(F) "Intergovernmental transfer" means any transfer of money 6855
by a governmental hospital under section 5112.07 of the Revised 6856
Code. 6857

(G) "Medical assistance program" means the program of medical 6858
assistance established under section 5111.01 of the Revised Code 6859
and Title XIX of the "Social Security Act." 6860

(H) "Program year" means a period beginning the first day of 6861
October, or a later date designated in rules adopted under section 6862
5112.03 of the Revised Code, and ending the thirtieth day of 6863
September, or an earlier date designated in rules adopted under 6864
that section. 6865

(I) "Registered beds" means the total number of hospital beds 6866
registered with the department of health, as reported in the most 6867
recent "directory of registered hospitals" published by the 6868
department of health. 6869

(J) "Total facility costs" means the total costs for all 6870
services rendered to all patients, including the direct, indirect, 6871
and overhead cost to the hospital of all services, supplies, 6872
equipment, and capital related to the care of patients, regardless 6873
of whether patients are enrolled in a health ~~maintenance~~ 6874
~~organization~~ insuring corporation, excluding costs associated with 6875
providing skilled nursing services in distinct-part nursing 6876
facility units, as shown on the hospital's cost report filed under 6877
section 5112.04 of the Revised Code. Effective October 1, 1993, if 6878
rules adopted under section 5112.03 of the Revised Code so 6879
provide, "total facility costs" may exclude costs associated with 6880

providing care to recipients of any of the governmental programs 6881
listed in division (B) of that section. 6882

(K) "Uncompensated care" means bad debt and charity care. 6883

Sec. 5112.08. The director of human services shall adopt 6884
rules under section 5112.03 of the Revised Code establishing a 6885
methodology to pay hospitals that is sufficient to expend all 6886
money in the indigent care pool. Under the rules: 6887

(A) The department of human services shall classify similar 6888
hospitals into groups and allocate funds for distribution within 6889
each group. 6890

(B) The department shall establish a method of allocating 6891
funds to each group of hospitals, taking into consideration the 6892
relative amount of indigent care provided by each group. The 6893
amount to be allocated to each group shall be based on any 6894
combination of the following indicators of indigent care that the 6895
director considers appropriate: 6896

(1) Total costs, volume, or proportion of services to 6897
recipients of the medical assistance program, including recipients 6898
enrolled in health ~~maintenance organizations~~ insuring
corporations; 6899
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(2) Total costs, volume, or proportion of services to 6901
low-income patients in addition to recipients of the medical 6902
assistance program, which may include recipients of Title V of the 6903
"Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as 6904
amended, general assistance established under Chapter 5113. of the 6905
Revised Code, and disability assistance established under Chapter 6906
5115. of the Revised Code; 6907

(3) The amount of uncompensated care provided by the 6908
hospitals; 6909

(4) Other factors that the director considers to be 6910

appropriate indicators of indigent care. 6911

(C) The department shall distribute funds to hospitals in 6912
each group in a manner that first may provide for an additional 6913
payment to individual hospitals that provide a high proportion of 6914
indigent care in relation to the total care provided by the 6915
hospital or in relation to other hospitals. The department shall 6916
establish a formula to distribute the remainder of the funds 6917
allocated to the group to all hospitals in the group. The formula 6918
shall be consistent with section 1923 of the "Social Security 6919
Act," 42 U.S.C.A. 1396r-4, as amended, and shall be based on any 6920
combination of the indicators of indigent care listed in division 6921
(B) of this section that the director considers appropriate. 6922

(D) The department shall make payments to each hospital in 6923
installments not later than ten working days after the deadline 6924
established in rules for each hospital to pay an installment on 6925
its assessment under section 5112.06 of the Revised Code. In the 6926
case of a governmental hospital that makes intergovernmental 6927
transfers, the department shall pay an installment under this 6928
section not later than ten working days after the earlier of that 6929
deadline or the deadline established in rules for the governmental 6930
hospital to pay an installment on its intergovernmental transfer. 6931
If the amount in the hospital care assurance program fund and the 6932
hospital care assurance match fund created under section 5112.18 6933
of the Revised Code is insufficient to make the total payments for 6934
which hospitals are eligible to receive in any period, the 6935
department shall reduce the amount of each payment by the 6936
percentage by which the amount is insufficient. The department 6937
shall pay hospitals any amounts not paid in the period in which 6938
they are due as soon as moneys are available in the funds. 6939

Sec. 5725.18. (A) An annual franchise tax on the privilege of 6940
being an insurance company is hereby levied on each domestic 6941

insurance company. In the month of May, annually, the treasurer of 6942
state shall charge for collection from each domestic insurance 6943
company a franchise tax in the amount computed in accordance with 6944
the following, as applicable: 6945

(1) With respect to a domestic insurance company that is a 6946
health insuring corporation, one per cent of all premium rate 6947
payments received, exclusive of payments received under the 6948
medicare program established under Title XVIII of the "Social 6949
Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, 6950
or pursuant to the medical assistance program established under 6951
Chapter 5111. of the Revised Code, as reflected in its annual 6952
report for the preceding calendar year; 6953

(2) With respect to a domestic insurance company that is not 6954
a health insuring corporation, one and four-tenths per cent of the 6955
gross amount of premiums received from policies covering risks 6956
within this state, exclusive of premiums received under the 6957
medicare program established under Title XVIII of the "Social 6958
Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, 6959
or pursuant to the medical assistance program established under 6960
Chapter 5111. of the Revised Code, as reflected in its annual 6961
statement for the preceding calendar year, and, if the company 6962
operates a health insuring corporation as a line of business, one 6963
per cent of all premium rate payments received from that line of 6964
business, exclusive of payments received under the medicare 6965
program established under Title XVIII of the "Social Security 6966
Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or 6967
pursuant to the medical assistance program established under 6968
Chapter 5111. of the Revised Code, as reflected in its annual 6969
statement for the preceding calendar year. 6970

(B) The gross amount of premium rate payments or premiums 6971
used to compute the applicable tax in accordance with division (A) 6972

of this section is subject to the deductions prescribed by section 6973
5729.03 of the Revised Code for foreign insurance companies. The 6974
objects of such tax are those declared in section 5725.24 of the 6975
Revised Code, to which only such tax shall be applied. 6976

(C) In no case shall such tax be less than two hundred fifty 6977
dollars. 6978

Sec. 5729.03. (A) If the superintendent of insurance finds 6979
the annual statement required by section 5729.02 of the Revised 6980
Code to be correct, the superintendent shall compute the following 6981
amount, as applicable, of the balance of such gross amount, after 6982
deducting such return premiums and considerations received for 6983
reinsurance, and charge such amount to such company as a tax upon 6984
the business done by it in this state for the period covered by 6985
such annual statement: 6986

(1) If the company is a health insuring corporation, one per 6987
cent of the balance of premium rate payments received, exclusive 6988
of payments received under the medicare program established under 6989
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 6990
U.S.C.A. 301, as amended, or pursuant to the medical assistance 6991
program established under Chapter 5111. of the Revised Code, as 6992
reflected in its annual report; 6993

(2) If the company is not a health insuring corporation, one 6994
and four-tenths per cent of the balance of premiums received, 6995
exclusive of premiums received under the medicare program 6996
established under Title XVIII of the "Social Security Act," 49 6997
Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or pursuant to the 6998
medical assistance program established under Chapter 5111. of the 6999
Revised Code, as reflected in its annual statement, and, if the 7000
company operates a health insuring corporation as a line of 7001
business, one per cent of the balance of premium rate payments 7002
received from that line of business, exclusive of payments 7003

received under the medicare program established under Title XVIII 7004
of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 7005
301, as amended, or pursuant to the medical assistance program 7006
established under Chapter 5111. of the Revised Code, as reflected 7007
in its annual statement. 7008

(B) Any insurance policies that were not issued in violation 7009
of Title XXXIX of the Revised Code and that were issued prior to 7010
April 15, 1967, by a life insurance company organized and operated 7011
without profit to any private shareholder or individual, 7012
exclusively for the purpose of aiding educational or scientific 7013
institutions organized and operated without profit to any private 7014
shareholder or individual, are not subject to the tax imposed by 7015
this section. All taxes collected pursuant to this section shall 7016
be credited to the general revenue fund. 7017

(C) In no case shall the tax imposed under this section be 7018
less than two hundred fifty dollars. 7019

Section 2. That existing sections 1701.03, 1705.03, 1705.04, 7020
1705.53, 1739.01, 1751.01, 1751.02, 1751.03, 1751.05, 1751.06, 7021
1751.11, 1751.12, 1751.13, 1751.14, 1751.15, 1751.16, 1751.20, 7022
1751.31, 1751.32, 1751.46, 1751.55, 1751.58, 1751.59, 1751.60, 7023
1751.62, 1751.81, 1785.01, 1785.02, 1785.03, 1785.08, 1907.161, 7024
2305.252, 3701.75, 3901.21, 3901.38, 3917.01, 3917.06, 3923.021, 7025
3923.122, 3923.57, 3923.571, 3923.58, 3924.01, 3924.03, 3924.033, 7026
3924.08, 3924.09, 3924.10, 3924.11, 3924.13, 3999.22, 4715.22, 7027
4715.39, 4723.16, 4725.114, 4729.161, 4731.226, 4731.65, 4732.28, 7028
4734.091, 4755.471, 5111.25, 5111.251, 5111.264, 5111.81, 5112.01, 7029
5112.08, 5725.18, and 5729.03 and sections 3924.05, 5111.75, 7030
5111.77, 5111.771, and 5111.811 of the Revised Code are hereby 7031
repealed. 7032

Section 3. That Section 3 of Am. Sub. S.B. 67 of the 122nd 7033

General Assembly be amended to read as follows: 7034

"Sec. 3. (A) The certificate of authority of every prepaid 7035
dental plan organization, health care corporation, dental care 7036
corporation, and health maintenance organization licensed to 7037
operate under Chapter 1736., 1738., 1740., or 1742. of the Revised 7038
Code, respectively, shall renew, by operation of law, on January 7039
1, 1998, as a certificate of authority to operate under Chapter 7040
1751. of the Revised Code. All assets and liabilities of the 7041
prepaid dental plan organization, health care corporation, dental 7042
care corporation, or health maintenance organization, including 7043
all obligations under subscriber contracts delivered, issued for 7044
delivery, or renewed prior to ~~the effective date of this section~~ 7045
June 4, 1997, shall be assumed by the successor entity. Except as 7046
otherwise provided in division (B) of this section, such entity 7047
shall, no later than January 1, 1998, comply with Chapter 1751. of 7048
the Revised Code. 7049

(B)(1) Each entity described in division (A) of this section 7050
shall do both of the following: 7051

(a) Comply with sections 1751.19 and 1751.26 of the Revised 7052
Code no later than six months after ~~the effective date of this~~ 7053
~~section~~ June 4, 1997. 7054

(b) Comply with section 1751.28 of the Revised Code by ~~making~~ 7055
~~annual deposits with the Superintendent of Insurance, no later~~ 7056
~~than the first day of January of each year, for up to three years,~~ 7057
~~beginning the first day of January immediately following the~~ 7058
~~effective date of this section~~ INCREASING the entity's net worth, 7059
on the first day of JANUARY IN EACH OF THE YEARS 1998, 1999, AND 7060
2000, by AN AMOUNT EQUAL TO AT LEAST ONE-THIRD OF any difference 7061
between the entity's net worth as of June 4, 1997, and the NET 7062
WORTH REQUIRED BY SECTION 1751.28 OF THE REVISED CODE. Each entity 7063
shall attain the NET WORTH REQUIRED BY SECTION 1751.28 OF THE 7064

REVISED CODE NO LATER THAN JANUARY 1, 2000. 7065

(2) Every contract delivered, issued for delivery, or renewed 7066
by an entity described in division (A) of this section prior to 7067
~~the effective date of this section~~ June 4, 1997, shall comply with 7068
section 1751.13 of the Revised Code no later than the contract's 7069
first renewal date after the first day of January immediately 7070
following ~~the effective date of this section~~ June 4, 1997. 7071

7072

(3) Every contract delivered, issued for delivery, or renewed 7073
by an entity described in division (A) of this section prior to 7074
~~the effective date of this section~~ June 4, 1997, shall comply with 7075
section 1751.31 of the Revised Code no later than three months 7076
after ~~the effective date of this section~~ June 4, 1997. 7077

7078

(4) An entity described in division (A) of this section may 7079
comply with section 1751.27 of the Revised Code by making annual 7080
deposits with the Superintendent of Insurance, not later than the 7081
first day of January of each year, for up to three years beginning 7082
the first day of January immediately following ~~the effective date~~ 7083
~~of this section~~ June 4, 1997. An equal amount shall be deposited 7084
each year until the total amount required under section 1751.27 of 7085
the Revised Code has been deposited." 7086

Section 4. That existing Section 3 of Am. Sub. S.B. 67 of the 7087
122nd General Assembly is hereby repealed. 7088

Section 5. That Section 6 of Am. Sub. S.B. 154 of the 122nd 7089
General Assembly be amended to read as follows: 7090

SECTION 6 OF AM. SUB. S.B. 154/122nd GA 7091

"Sec. 6. The Insurance Agent Education Advisory Council 7092
operating pursuant to section 3905.483 of the Revised Code shall 7093
create a temporary committee to conduct a special study of the 7094

continuing education requirements for insurance agents as set 7095
forth in the Revised Code and the Administrative Code. The 7096
committee shall be composed of the eleven members of the Insurance 7097
Agent Education Advisory Council appointed by the Superintendent 7098
of Insurance pursuant to section 3905.483 of the Revised Code; a 7099
representative, appointed by the Governor, of the Association of 7100
Fraternal Insurance Counselors; a representative, appointed by the 7101
Governor, of private entities engaged in the business of providing 7102
continuing education to agents; a representative, appointed by the 7103
Governor, of financial institutions; two members of the House of 7104
Representatives, one from each party, appointed by the Speaker of 7105
the House of Representatives; and two members of the Senate, one 7106
from each party, appointed by the President of the Senate. The 7107
Superintendent or the Superintendent's designee shall serve on the 7108
committee as a nonvoting member. 7109

The committee shall hold an organizational meeting within 7110
thirty days after ~~the effective date of this section~~ June 30, 7111
1998. At the organizational meeting, the voting members of the 7112
committee shall elect a chairperson and a vice-chairperson for the 7113
committee. The committee shall meet at the call of the 7114
chairperson. 7115

The committee shall study all aspects of the continuing 7116
education requirements for insurance agents as set forth in the 7117
Revised Code and the Administrative Code, and shall be charged 7118
with providing findings and recommendations on how any aspect of 7119
these requirements may be improved. 7120

The study shall include, but is not limited to, an 7121
examination of issues related to the following questions: 7122

(A) Will a reduction in the biennial continuing education 7123
requirement satisfy the continuing education requirements imposed 7124
by other states on nonresident agents? 7125

(B) What are the best methods for assuring the quality of continuing education courses and programs of study?

(C) Is the Superintendent of Insurance's annual approval of a continuing education course or program of study necessary if there is no change in the course's or program's curriculum, or could a course or program of study be approved for a longer period of time?

(D) Could the process of approval for continuing education courses and programs of study be streamlined, to provide for a more timely and efficient process of approval?

(E) Should an agent receive continuing education credit for completing courses or programs of study that pertain to subjects outside of the agent's area of practice or licensure?

(F) What is the optimal number of hours of instruction a statutory continuing education requirement should require agents to complete?

(G) Should continuing education requirements include a minimum number of hours of courses or programs of study on ethics?

(H) Should the completion of a correspondence course, which course requires the successful completion of a test on the course material, be an optional method for an agent's fulfillment of continuing education requirements?

(I) Should minimum requirements be established for instructors of continuing education courses, such as minimum industry experience and a current agent's license?

(J) Should an agent be limited as to the number of hours of continuing education credit that the agent may earn from private providers and associations or from insurance companies, as a percentage of the total number of hours of continuing education credit that the agent earns, or is permitted to earn, during a

single compliance period? 7156

(K) Should an agent receive continuing education credit for 7157
completing sales-related courses or programs of study? 7158

(L) Should an agent's receipt of any special designation 7159
exempt the agent from the completion of further continuing 7160
education requirements? 7161

(M) Has the continuing education requirement improved the 7162
quality of licensed insurance agents? 7163

(N) Would a system in which agents certified their compliance 7164
with continuing education requirements to the Superintendent, 7165
which system included a program of random verification of agent 7166
compliance by the Department of Insurance, be a feasible 7167
alternative to the current system of continuing education 7168
compliance verification? 7169

The committee shall hold a sufficient number of public 7170
hearings outside of Franklin County to provide interested parties 7171
throughout the state a chance to voice their opinions and make 7172
recommendations with regard to the continuing education 7173
requirements for insurance agents. 7174

The committee shall issue an interim report within nine 7175
months after ~~the effective date of this section~~ June 30, 1998. The 7176
committee shall issue its final report within eighteen months 7177
after ~~the effective date of this section~~ June 30, 1998. Copies of 7178
the interim and the final reports shall be submitted, at the time 7179
of their issuance, to the Speaker of the House of Representatives, 7180
to the President of the Senate, to the Governor, to the chair of 7181
the House committee having primary jurisdiction over insurance 7182
legislation, to the chair of the Senate committee having primary 7183
jurisdiction over insurance legislation, to the Superintendent of 7184
Insurance, and to the Insurance Agent Education Advisory Council. 7185
The committee may request staff assistance from the Legislative 7186

Service Commission as needed for the completion of the reports. 7187
Upon the issuance of its final report, the committee shall cease 7188
to exist." 7189

Section 6. That existing Section 6 of Am. Sub. S.B. 154 of 7190
the 122nd General Assembly is hereby repealed. 7191

Section 7. That Section 194 of Am. Sub. H.B. 215 of the 122nd 7192
General Assembly be amended to read as follows: 7193

"Sec. 194. Insurance Tax Phase-in Schedules 7194

Sections 1731.07, 5725.18, 5725.181, 5729.03, and 5729.031 of 7195
the Revised Code, as amended or enacted by ~~this act~~ Am. Sub. H.B. 7196
215 or Sub. H.B. 698 of the 122nd General Assembly, shall first 7197
apply to tax year 1999 and shall be implemented according to the 7198
following schedule: 7199

(A) For tax years 1999 through 2002, the tax imposed under 7200
section 5729.03 of the Revised Code on ~~the gross premiums of~~ 7201
foreign insurance companies that are not health insuring 7202
corporations shall ~~be~~ equal the sum of the amounts computed under 7203
divisions (A)(1) and (2) of this section. 7204

(1) With respect to the gross premiums of the company, 7205
exclusive of premiums received under Medicare or Medicaid, the 7206
amount computed using the following rates: 7207

<u>For Tax Year</u>	<u>The percentage of premiums is</u>
1999	2.3%
2000	2.09%
2001	1.84%
2002	1.62%

(2) With respect to premium rate payments received by the 7214
company, exclusive of payments received under Medicare or 7215
Medicaid, if the company operates a health insuring corporation as 7216

a line of business, the amount computed using the following rates: 7217

<u>For Tax Year</u>	<u>The percentage of premium rate payments is</u>
1999	.21%
2000	.42%
2001	.60%
2002	.80%

(B) For tax years 1999 through 2002, the tax imposed under 7224
 section 5725.18 of the Revised Code on domestic insurance 7225
 companies that are not health insuring ~~corporations~~ corporations 7226
 shall equal the sum of the amounts computed under ~~division~~ 7227
divisions (B)(1) and (2) of this section. 7228

(1) The tax computed according to the method prescribed in 7229
 section 5725.181 of the Revised Code, as enacted by ~~this act~~ Am. 7230
Sub. H.B. 215 of the 122nd General Assembly, multiplied by the 7231
 percentage prescribed as follows: 7232

<u>For Tax Year</u>	<u>Multiply the tax under section 5725.181 of the Revised Code by</u>	
1999	79%	7233
2000	58%	7234
2001	40%	7235
2002	20%	7236
		7237
		7238
		7239

(2) The tax computed ~~using~~ according to the ~~percentage of~~ 7240
~~gross premiums method~~ prescribed by in section 5725.18 of the 7241
 Revised Code, as amended by ~~this act~~ Sub. H.B. 698 of the 122nd 7242
General Assembly, multiplied by the percentage prescribed as 7243
 follows: 7244

<u>For Tax Year</u>	<u>Multiply the tax under amended section 5725.18 of the Revised Code by</u>
---------------------	--

1999	21%
2000	42%
2001	60%
2002	80%

(C) For tax years 1999 through 2002, the tax imposed under 7253
 sections 5725.18 and 5729.03 of the Revised Code on domestic and 7254
 foreign insurance companies that are health insuring corporations 7255
 shall be computed using the following rates: 7256

<u>For Tax Year</u>	<u>The percentage of premium rate payments is</u>
1999	.21%
2000	.42%
2001	.60%
2002	.80%

(D) For tax years 1999 through 2002, the minimum tax for 7263
 domestic insurance companies taxed under sections 5725.18 and 7264
 5725.181 of the Revised Code, the minimum tax for foreign 7265
 insurance companies taxed under section 5729.03 of the Revised 7266
 Code, and the minimum tax for companies that are health insuring 7267
 corporations taxed under those sections shall equal the amount 7268
 prescribed as follows: 7269

<u>For Tax Year</u>	<u>The minimum tax is</u>
1999	\$50
2000	\$100
2001	\$150
2002	\$200

(E) For tax years 1999 through 2002, the credit available 7275
 under section 5729.031 of the Revised Code may be claimed against 7276
 the tax imposed on foreign insurance companies as computed under 7277
 division (A) of this section, against the tax imposed on domestic 7278
 insurance companies as computed under division (B) of this 7279
 section, or against the tax imposed on companies that are health 7280

insuring corporations as computed under division (C) of this 7281
section. The credit shall equal a percentage of the amount 7282
computed under division (C) of section 5729.031 of the Revised 7283
Code according to the following schedule: 7284

<u>For Tax Year</u>	<u>Percentage of credit allowed</u>
1999	20%
2000	40%
2001	60%
2002	80%

As used in this section, "health insuring corporation" has 7291
the same meaning as in section 1751.01 of the Revised Code, and 7292
"tax year" means the calendar year in which the tax imposed on the 7293
insurance company or health insuring corporation is charged." 7294

Section 8. That existing Section 194 of Am. Sub. H.B. 215 of 7295
the 122nd General Assembly is hereby repealed. 7296

Section 9. Pursuant to the authority granted under section 7297
3905.29 of the Revised Code, the Superintendent of Insurance shall 7298
modify the forms on which annual financial statements are 7299
submitted by domestic and foreign insurance companies to include, 7300
as a separate item, the amount of premium rate payments received, 7301
exclusive of payments received under Medicare or Medicaid, by any 7302
such insurance company that operates a health insuring corporation 7303
as a line of business. 7304

Section 10. (A) Until November 1, 1999, the Director of 7305
Health shall not adopt any rule, whether by adopting, amending, or 7306
rescinding a rule or by submitting a rule for review under section 7307
119.032 of the Revised Code, that has the effect of allowing 7308
cardiac catheterization to be performed without an on-site 7309
open-heart surgery service. 7310

(B) In 1999, the Director of Health shall appear three times 7311
before the standing committee of the House of Representatives that 7312
primarily deals with health matters and the standing committee of 7313
the Senate that primarily deals with health matters to report on 7314
the progress of the Department of Health in collecting statewide 7315
and national data on the outcomes of cardiac catheterization 7316
performed without an on-site open-heart surgery service. The first 7317
appearance before each committee shall be made not later than 7318
April 1, 1999. The second appearance shall be made not sooner than 7319
30 days after the first appearance, but not later than June 1, 7320
1999. The third appearance shall be made not sooner than 30 days 7321
after the second appearance, but not later than October 1, 1999. 7322
At the third appearance, the Director shall make a final report on 7323
the Department's findings. The Director shall submit a written 7324
copy of the report to the Speaker of the House of Representatives 7325
and the President of the Senate. 7326

Section 11. For purposes of determining whether a dental 7327
hygienist has met the experience requirements specified in 7328
division (C)(1) of section 4715.22 of the Revised Code, as amended 7329
by this act, all experience that the dental hygienist obtained 7330
prior to the effective date of this act shall be counted. 7331

Section 12. Sections 3701.18 and 4503.104 of the Revised 7332
Code, as enacted by this act, shall take effect on the first day 7333
of the month that follows the month that includes the day that is 7334
the ninetieth day after the effective of this act. 7335

Section 13. The amendment of sections 5112.01 and 5112.08 of 7336
the Revised Code by this act is not intended to supersede the 7337
repeal of those sections effective July 1, 1999. 7338

Section 14. The repeal of sections 5111.75, 5111.77, 7339

5111.771, and 5111.811 of the Revised Code is intended to confirm 7340
that such repeal was the result intended by the General Assembly 7341
in enacting Am. Sub. S.B. 62 and Am. Sub. S.B. 150 of the 121st 7342
General Assembly. The earlier of the two acts, Am. Sub. S.B. 62, 7343
repealed the sections in pursuance of its specific purpose of 7344
abolishing the Legislative Committee on Medicaid Oversight. The 7345
later of the two acts, Am. Sub. S.B. 150, purportedly amended the 7346
sections as they related to its general purpose of revising the 7347
health care and insurance laws. The later act, Am. Sub. S.B. 150, 7348
did not have a purpose sufficiently independent from that of Am. 7349
Sub. S.B. 62 such as to revive the sections. 7350

Section 15. Section 3901.21 of the Revised Code is presented 7351
in this act as a composite of the section as amended by both Sub. 7352
H.B. 374 and Am. Sub. S.B. 70 of the 122nd General Assembly, with 7353
the language of neither of the acts shown in capital letters. 7354
Section 3924.08 of the Revised Code is presented in this act as a 7355
composite of the section as amended by both Sub. H.B. 374 and Am. 7356
Sub. S.B. 67 of the 122nd General Assembly, with the new language 7357
of neither of the acts shown in capital letters. This is in 7358
recognition of the principle stated in division (B) of section 7359
1.52 of the Revised Code that such amendments are to be harmonized 7360
where not substantively irreconcilable and constitutes a 7361
legislative finding that such is the resulting version in effect 7362
prior to the effective date of this act. 7363