As Passed by the House

131st General Assembly

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Sub. S. B. No. 129

Senators Gardner, Cafaro

Cosponsors: Senators Yuko, Skindell, Manning, Brown, Seitz, Williams, Hite, Oelslager, Lehner, Tavares, Eklund, Hughes, Jones, Obhof, Patton, Sawyer, Schiavoni, Thomas, Uecker Representatives Bishoff, DeVitis, Henne, Amstutz, Anielski, Antani, Boyd, Brown, Burkley, Conditt, Craig, Cupp, Green, Hambley, Huffman, Lepore-Hagan, McClain, Patterson, Rogers, Schaffer, Sears, Smith, R., Sprague

A BILL

То	amend sections 340.034, 1739.05, and 5119.25, to	1
	enact sections 1751.72, 3923.041, and 5160.34 of	2
	the Revised Code, and to amend Sections 110.12	3
	and 812.40 of Am. Sub. H.B. 64 of the 131st	4
	General Assembly, to amend Section 812.40 of Am.	5
	Sub. H.B. 483 of the 130th General Assembly to	6
	amend the law related to the prior authorization	7
	requirements of insurers and to delay the	8
	effective date of certain laws regarding	9
	community mental health and addiction services.	10

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

Section 1. That sections 340.034, 1739.05, and 5119.25 be	11
amended and sections 1751.72, 3923.041, and 5160.34 of the	12
Revised Code be enacted to read as follows:	13
Sec. 340.034. All of the following apply to the recovery	14
housing required by section 340.033 of the Revised Code to be	15

included in the array of treatment services and recovery support	16
for all levels of opioid and co-occurring drug addiction that	17
are part of the continuum of care established by each board of	18
alcohol, drug addiction, and mental health services pursuant to	19
division (A)(11) of section 340.03 of the Revised Code:	20
(A) The recovery housing shall not be subject to	21
residential facility licensure by the department of mental	22
health and addiction services under section 5119.34 of the	23
Revised Code. In addition, the recovery housing shall not be	24
owned and operated by a board of alcohol, drug addiction, and	25
mental health services unless any of the following applies:	26
(1) The board owns and operates the recovery housing on	27
September 15, 2016 July 1, 2017.	28
(2) The board utilizes local funds in the development,	29
purchase, or operation of the recovery housing.	30
(3) The board determines that there is a need for the	31
board to assume the ownership and operation of the recovery	32
housing such as when an existing owner and operator of the	33
recovery housing goes out of business, and the board considers	34
the assumption of ownership and operation of the recovery	35
housing to be in the best interest of the community.	36
(B) The recovery housing shall have protocols for all of	37
the following:	38
(1) Administrative oversight;	39
(2) Quality standards;	40
(3) Policies and procedures, including house rules, for	41
its residents to which the residents must agree to adhere.	42
(C) Family members of the recovery housing's residents may	43

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combination of divisions (A)(1) and (2) of this section.

(B) A multiple employer welfare arrangement that is

created pursuant to sections 1739.01 to 1739.22 of the Revised	72
Code and that operates a group self-insurance program shall	73
comply with all laws applicable to self-funded programs in this	74
state, including sections 3901.04, 3901.041, 3901.19 to 3901.26,	75
3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46,	76
3901.491, 3902.01 to 3902.14, <u>3923.041,</u> 3923.24, 3923.282,	77
3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3923.80, 3923.85,	78
3924.031, 3924.032, and 3924.27 of the Revised Code.	79
(C) A multiple employer welfare arrangement created	80
pursuant to sections 1739.01 to 1739.22 of the Revised Code	81
shall solicit enrollments only through agents or solicitors	82
licensed pursuant to Chapter 3905. of the Revised Code to sell	83
or solicit sickness and accident insurance.	84
(D) A multiple employer welfare arrangement created	85
pursuant to sections 1739.01 to 1739.22 of the Revised Code	86
shall provide benefits only to individuals who are members,	87
employees of members, or the dependents of members or employees,	88
or are eligible for continuation of coverage under section	89
1751.53 or 3923.38 of the Revised Code or under Title X of the	90
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100	91
Stat. 227, 29 U.S.C.A. 1161, as amended.	92
(E) A multiple employer welfare arrangement created	93
pursuant to sections 1739.01 to 1739.22 of the Revised Code is	94
subject to, and shall comply with, sections 3903.81 to 3903.93	95
of the Revised Code in the same manner as other life or health	96
insurers, as defined in section 3903.81 of the Revised Code.	97
Sec. 1751.72. (A) As used in this section:	98
(1) "Chronic condition" means a medical condition that has	99
persisted after reasonable efforts have been made to relieve or	100

cure its cause and has continued, either continuously or	101
episodically, for longer than six continuous months.	102
(2) "Clinical peer" means a health care practitioner in	103
the same, or in a similar, specialty that typically manages the	104
medical condition, procedure, or treatment under review.	105
(3) "Covered person" means a person receiving coverage for	106
health services under a policy, contract, or agreement issued by	107
a health insuring corporation.	108
(4) "Emergency services" has the same meaning as in	109
section 1753.28 of the Revised Code.	110
(5) "Fraudulent or materially incorrect information" means	111
any type of intentional deception or misrepresentation made by a	112
person with the knowledge that the deception could result in	113
some unauthorized benefit to the covered person in question.	114
(6) "Health care practitioner" has the same meaning as in	115
section 3701.74 of the Revised Code.	116
(7) "NCPDP SCRIPT standard" means the national council for	117
prescription drug programs SCRIPT standard version 201310 or the	118
most recent standard adopted by the the United States department	119
of health and human services.	120
(8) "Prior authorization requirement" means any practice	121
implemented by a health insuring corporation in which coverage	122
of a health care service, device, or drug is dependent upon a	123
covered person or a health care practitioner obtaining approval	124
from the health insuring corporation prior to the service,	125
device, or drug being performed, received, or prescribed, as	126
applicable. "Prior authorization" includes prospective or	127
utilization review procedures conducted prior to providing a	128
health care service, device, or drug	120

(9) "Urgent care services" means a medical care or other	130
service for a condition where application of the timeframe for	131
making routine or non-life threatening care determinations is	132
<pre>either of the following:</pre>	133
(a) Could seriously jeopardize the life, health, or safety	134
of the patient or others due to the patient's psychological	135
state;	136
(b) In the opinion of a practitioner with knowledge of the	137
patient's medical or behavioral condition, would subject the	138
patient to adverse health consequences without the care or	139
treatment that is the subject of the request.	140
(10) "Utilization review" and "utilization review	141
organization" have the same meanings as in section 1751.77 of	142
the Revised Code.	143
(B) If a policy, contract, or agreement issued by a health	144
insuring corporation contains a prior authorization requirement,	145
then all of the following apply:	146
(1) On or before January 1, 2018, the health insuring	147
corporation shall permit health care practitioners to access the	148
prior authorization form through the applicable electronic	149
software system.	150
(2) (a) For policies issued on or after January 1, 2018,	151
the health insuring corporation or other payer acting on behalf	152
of the health insuring corporation, shall accept prior	153
authorization requests through a secure electronic transmission.	154
(b) For policies issued on or after January 1, 2018, the	155
health insuring corporation, a pharmacy benefit manager	156
responsible for handling prior authorization requests, or other	157
payer acting on behalf of the health insuring corporation shall	158

accept and respond to prior prescription benefit authorization	159
requests through a secure electronic transmission using NCPDP	160
SCRIPT standard ePA transactions, and for prior medical benefit	161
authorization requests through a secure electronic transmission	162
using standards established by the council for affordable	163
quality health care on operating rules for information exchange	164
or its successor.	165
(c) For purposes of division (B)(2) of this section,	166
neither of the following shall be considered a secure electronic	167
<pre>transmission:</pre>	168
(i) A facsimile;	169
(ii) A proprietary payer portal for prescription drug	170
requests that does not use NCPDP SCRIPT standard.	171
(3) For policies issued on or after January 1, 2018, a	172
health care practitioner and health insuring corporation may	173
enter into a contractual arrangement under which the health	174
insuring corporation agrees to process prior authorization	175
requests that are not submitted electronically because of the	176
financial hardship that electronic submission of prior	177
authorization requests would create for the health care	178
practitioner or if internet connectivity is limited or	179
unavailable where the health care practitioner is located.	180
(4)(a) For policies issued on or after January 1, 2018, if	181
the health care practitioner submits the request for prior	182
authorization as described in divisions (B)(1) and (2) of this	183
section, the health insuring corporation shall respond to all	184
prior authorization requests within forty-eight hours for urgent	185
care services, or ten calendar days for any prior approval	186
request that is not for an urgent care service, of the time the	187

request is received by the health insuring corporation with all_	188
information necessary to support the prior authorization	189
request. Division (B)(4) of this section does not apply to	190
<pre>emergency services.</pre>	191
(b) (i) The response required under division (B) (4) (a) of	192
this section shall indicate whether the request is approved,	193
denied, or incomplete. If the prior authorization is denied, the	194
health insuring corporation shall provide the specific reason	195
for the denial. If the prior authorization request is	196
incomplete, the health insuring corporation shall indicate the	197
specific additional information that is required to process the	198
request.	199
(ii) For a response that is considered incomplete, the	200
health care practitioner shall provide the additional	201
information requested under division (B)(4)(b)(i) of this	202
section within seventy-two hours of the time the request is	203
received by the practitioner.	204
(5) (a) For policies issued on or after January 1, 2018, if	205
a health care practitioner submits a prior authorization request	206
as described in divisions (B)(1) and (2) of this section, the	207
health insuring corporation shall provide an electronic receipt	208
to the health care practitioner acknowledging that the prior	209
authorization request was received.	210
(b) For policies issued on or after January 1, 2018, if a	211
health insuring corporation requests additional information that	212
is required to process a prior authorization request as	213
described in division (B)(4)(b)(i) of this section, the health	214
care practitioner shall provide an electronic receipt to the	215
health insuring corporation acknowledging that the request for	216
additional information was received	217

(6)(a) For policies issued on or after January 1, 2017,	218
for a prior approval related to a chronic condition, the health	219
insuring corporation shall honor a prior authorization approval	220
for an approved drug for the lesser of the following from the	221
<pre>date of the approval:</pre>	222
(i) Twelve months;	223
(ii) The last day of the covered person's eligibility	224
under the policy, contract, or agreement.	225
(b) The duration of all other prior authorization	226
approvals shall be dictated by the policy, contract, or	227
agreement issued by the health insuring corporation.	228
(c) A health insuring corporation may, in relation to a	229
prior approval under division (B)(6)(a) of this section, require	230
a health care practitioner to submit information to the health	231
insuring corporation indicating that the patient's chronic	232
condition has not changed.	233
(i) The request for information by the health insuring	234
corporation and the response by the health care practitioner	235
shall be in an electronic format, which may be by electronic	236
mail or other electronic communication.	237
(ii) The frequency of the submission of requested	238
information shall be consistent with medical or scientific	239
evidence as defined in section 3922.01 of the Revised Code, but	240
shall not be required more frequently than quarterly.	241
(iii) If the health care practitioner does not respond	242
within five calendar days from the date the request was	243
received, the health insuring corporation may terminate the	244
twelve-month approval	245

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(d) A year long approval provided under division (B)(6)(a)	246
of this section is no longer valid and automatically terminates	247
if there are changes to federal or state laws or federal	248
regulatory guidance or compliance information prescribing that	249
the drug in question is no longer approved or safe for the	250
intended purpose.	251
(e) A twelve-month approval provided under division (B)(6)	252
(a) of this section does not apply to and is not required for	253
any of the following:	254
(i) Medications that are prescribed for a non-maintenance	255
<pre>condition;</pre>	256
(ii) Medications that have a typical treatment of less	257
than one year;	258
(iii) Medications that require an initial trial period to	259
determine effectiveness and tolerability, beyond which a one-	260
year, or greater, prior authorization period will be given;	261
(iv) Medications where there is medical or scientific	262
evidence as defined in section 3922.01 of the Revised Code that	263
do not support a twelve-month prior approval;	264
(v) Medications that are a schedule I or II controlled	265
substance or any opioid analgesic or benzodiazepine, as defined	266
in section 3719.01 of the Revised Code;	267
(vi) Medications that are not prescribed by an in-network	268
provider as part of a care management program.	269
(7) For policies issued on or after January 1, 2017, a	270
health insuring corporation may, but is not required to, provide	271
the twelve-month approval prescribed in division (B)(6)(a) of	272
this section for a prescription drug that meets either of the	273

following:	274
(a) The drug is prescribed or administered to treat a rare	275
medical condition and pursuant to medical or scientific evidence	276
as defined in section 3922.01 of the Revised Code.	277
(b) Medications that are controlled substances not	278
included in division (B)(6)(e)(v) of this section.	279
For purposes of division (B)(7) of this section, "rare	280
medical condition" means any disease or condition that affects	281
fewer than two hundred thousand individuals in the United	282
States.	283
(8) Nothing in division (B)(6) or (7) of this section	284
prohibits the substitution of any drug that has received a	285
twelve-month approval under division (B)(6)(a) of this section	286
when there is a release of a United States food and drug	287
administration approved comparable brand product or a generic	288
counterpart of a brand product that is listed as therapeutically	289
equivalent in the United States food and drug administration's	290
publication titled approved drug products with therapeutic	291
equivalence evaluations.	292
(9) (a) For policies issued on or after January 1, 2017,	293
upon written request, a health insuring corporation shall permit	294
a retrospective review for a claim that is submitted for a	295
service where prior authorization was required but not obtained	296
if the service in question meets all of the following:	297
(i) The service is directly related to another service for	298
which prior approval has already been obtained and that has	299
already been performed.	300
(ii) The new service was not known to be needed at the	301
time the original prior authorized service was performed	303

(iii) The need for the new service was revealed at the	303
time the original authorized service was performed.	304
(b) Once the written request and all necessary information	305
is received, the health insuring corporation shall review the	306
claim for coverage and medical necessity. The health insuring	307
corporation shall not deny a claim for such a new service based	308
solely on the fact that a prior authorization approval was not	309
received for the new service in question.	310
(10)(a) For policies issued on or after January 1, 2017,	311
the health insuring corporation shall disclose to all	312
participating health care practitioners any new prior	313
authorization requirement at least thirty days prior to the	314
effective date of the new requirement.	315
(b) The notice may be sent via electronic mail or standard	316
mail and shall be conspicuously entitled "Notice of Changes to	317
Prior Authorization Requirements." The notice is not required to	318
contain a complete listing of all changes made to the prior	319
authorization requirements, but shall include specific	320
information on where the health care practitioner may locate the	321
information on the health insuring corporation's web site or, if	322
applicable, the health insuring corporation's portal.	323
(c) All participating health care practitioners shall	324
promptly notify the health insuring corporation of any changes	325
to the health care practitioner's electronic mail or standard	326
mail address.	327
(11) (a) For policies issued on or after January 1, 2017,	328
the health insuring corporation shall make available to all	329
participating health care practitioners on its web site or	330
provider portal a listing of its prior authorization	331

requirements, including specific information or documentation	332
that a provider must submit in order for the prior authorization	333
request to be considered complete.	334
(b) The health insuring corporation shall make available	335
on its web site information about the policies, contracts, or	336
agreements offered by the health insuring corporation that	337
clearly identifies specific services, drugs, or devices to which	338
a prior authorization requirement exists.	339
(12) For policies issued on or after January 1, 2018, the	340
health insuring corporation shall establish a streamlined appeal	341
process relating to adverse prior authorization decision	342
determinations that shall include all of the following:	343
(a) For urgent care services, the appeal shall be	344
considered within forty-eight hours after the health insuring	345
corporation receives the appeal.	346
(b) For all other matters, the appeal shall be considered	347
within ten calendar days after the health insuring corporation	348
receives the appeal.	349
(c) The appeal shall be between the health care	350
practitioner requesting the service in question and a clinical	351
peer.	352
(d) If the appeal does not resolve the disagreement,	353
either the covered person or an authorized representative as	354
defined in section 3922.01 of the Revised Code may request an	355
external review under Chapter 3922. of the Revised Code to the	356
extent Chapter 3922. of the Revised Code is applicable.	357
(C) For policies issued on or after January 1, 2017,	358
except in cases of fraudulent or materially incorrect	359
information, a health insuring corporation shall not	360

retroactively deny a prior authorization for a health care	361
service, drug, or device when all of the following are met:	362
(1) The health care practitioner submits a prior	363
authorization request to the health insuring corporation for a	364
health care service, drug, or device.	365
(2) The health insuring corporation approves the prior	366
authorization request after determining that all of the	367
<pre>following are true:</pre>	368
(a) The patient is eligible under the health benefit plan.	369
(b) The health care service, drug, or device is covered	370
under the patient's health benefit plan.	371
(c) The health care service, drug, or device meets the	372
health insuring corporation's standards for medical necessity	373
and prior authorization.	374
(3) The health care practitioner renders the health care	375
service, drug, or device pursuant to the approved prior	376
authorization request and all of the terms and conditions of the	377
health care practitioner's contract with the health insuring	378
corporation.	379
(4) On the date the health care practitioner renders the	380
prior approved health care service, drug, or device, all of the	381
<pre>following are true:</pre>	382
(a) The patient is eligible under the health benefit plan.	383
(b) The patient's condition or circumstances related to	384
the patient's care has not changed.	385
(c) The health care practitioner submits an accurate claim	386
that matches the information submitted by the health care	387

practitioner in the approved prior authorization request.	388
(5) If the health care practitioner submits a claim that	389
includes an unintentional error and the error results in a claim	390
that does not match the information originally submitted by the	391
health care practitioner in the approved prior authorization	392
request, upon receiving a denial of services from the health	393
insuring corporation, the health care practitioner may resubmit	394
the claim pursuant to division (C) of this section with the	395
information that matches the information included in the	396
approved prior authorization.	397
(D) Any provision of a contractual arrangement entered	398
into between a health insuring corporation and a health care	399
practitioner or beneficiary that is contrary to divisions (A) to	400
(C) of this section is unenforceable.	401
(E) For policies issued on or after January 1, 2017,	402
committing a series of violations of this section that, taken	403
together, constitute a practice or pattern shall be considered	404
an unfair and deceptive practice under sections 3901.19 to	405
3901.26 of the Revised Code.	406
(F) The superintendent of insurance may adopt rules in	407
accordance with Chapter 119. of the Revised Code as necessary to	408
implement the provisions of this section.	409
(G) This section does not apply to any of the following	410
types of coverage: a policy, contract, certificate, or agreement	411
that covers only a specified accident, accident only, credit,	412
dental, disability income, long-term care, hospital indemnity,	413
supplemental coverage as described in section 3923.37 of the	414
Revised Code, specified disease, or vision care; coverage issued	415
as a supplement to liability insurance; insurance arising out of	416

workers' compensation or similar law; automobile medical payment	417
insurance; insurance under which benefits are payable with or	418
without regard to fault and which is statutorily required to be	419
contained in any liability insurance policy or equivalent self-	420
insurance; a medicare supplement policy of insurance as defined	421
by the superintendent of insurance by rule; coverage under a	422
plan through medicare or the federal employees benefit program;	423
or any coverage issued under Chapter 55 of Title 10 of the	424
United States Code and any coverage issued as a supplement to	425
that coverage.	426
Sec. 3923.041. (A) As used in this section:	427
(1) "Chronic condition" means a medical condition that has	428
persisted after reasonable efforts have been made to relieve or	429
cure its cause and has continued, either continuously or	430
episodically, for longer than six continuous months.	431
(2) "Clinical peer" means a health care practitioner in	432
the same or in a similar, specialty that typically manages the	433
medical condition, procedure, or treatment under review.	434
(3) "Covered person" means a person receiving coverage for	435
health services under a policy of sickness and accident	436
insurance or a public employee benefit plan.	437
(4) "Emergency service" has the same meaning as in section	438
1753.28 of the Revised Code.	439
(5) "Fraudulent or materially incorrect information" means	440
any type of intentional deception or misrepresentation made by a	441
person with the knowledge that the deception could result in	442
some unauthorized benefit to the covered person in question.	443
(6) "Health care practitioner" has the same meaning as in	444
section 3701.74 of the Revised Code.	445

(7) "NCPDP SCRIPT standard" means the national council for	446
prescription drug programs SCRIPT standard version 201310 or the	447
most recent standard adopted by the United States department of	448
health and human services.	449
(8) "Prior authorization requirement" means any practice	450
implemented by either a sickness and accident insurer or a	451
public employee benefit plan in which coverage of a health care	452
service, device, or drug is dependent upon a covered person or a	453
health care practitioner obtaining approval from the insurer or	454
plan prior to the service, device, or drug being performed,	455
received, or prescribed, as applicable. "Prior authorization"	456
includes prospective or utilization review procedures conducted	457
prior to providing a health care service, device, or drug.	458
(9) "Urgent care services" means a medical care or other	459
service for a condition where application of the timeframe for	460
making routine or non-life threatening care determinations is	461
<pre>either of the following:</pre>	462
(a) Could seriously jeopardize the life, health, or safety	463
of the patient or others due to the patient's psychological	464
state;	465
(b) In the opinion of a practitioner with knowledge of the	466
patient's medical or behavioral condition, would subject the	467
patient to adverse health consequences without the care or	468
treatment that is the subject of the request.	469
(10) "Utilization review" and "utilization review_	470
organization" have the same meanings as in section 1751.77 of	471
the Revised Code.	472
(B) If a policy issued by a sickness and accident insurer	473
or a public employee benefit plan contains a prior authorization	474

requirement, then all of the following apply:	475
(1) For policies issued on or after January 1, 2018, the	476
insurer or plan shall permit health care practitioners to access	477
the prior authorization form through the applicable electronic	478
software system.	479
(2) (a) For policies issued on or after January 1, 2018,	480
the insurer or plan, or other payer acting on behalf of the	481
insurer or plan, to accept prior authorization requests through	482
a secure electronic transmission.	483
(b) For policies issued on or after January 1, 2018, the	484
insurer or plan, a pharmacy benefit manager responsible for	485
handling prior authorization requests, or other payer acting on	486
behalf of the insurer or plan shall accept and respond to prior	487
prescription benefit authorization requests through a secure	488
electronic transmission using NCPDP SCRIPT standard ePA	489
transactions, and for prior medical benefit authorization	490
requests through a secure electronic transmission using	491
standards established by the council for affordable quality	492
health care on operating rules for information exchange or its	493
successor.	494
(c) For purposes of division (B)(2) of this section,	495
neither of the following shall be considered a secure electronic	496
<pre>transmission:</pre>	497
(i) A facsimile;	498
(ii) A proprietary payer portal for prescription drug	499
requests that does not use NCPDP SCRIPT standard.	500
(3) For policies issued on or after January 1, 2018, a	501
health care practitioner and an insurer or plan may enter into a	502
contractual arrangement under which the insurer or plan agrees	503

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to process prior authorization requests that are not submitted	504
electronically because of the financial hardship that electronic	505
submission of prior authorization requests would create for the	506
health care practitioner or if internet connectivity is limited_	507
or unavailable where the health care practitioner is located.	508
(4)(a) For policies issued on or after January 1, 2018, if	509
the health care practitioner submits the request for prior	510
authorization electronically as described in divisions (B)(1)	511
and (2) of this section, the insurer or plan shall respond to	512
all prior authorization requests within forty-eight hours for	513
urgent care services, or ten calendar days for any prior	514
approval request that is not for an urgent care service, of the	515
time the request is received by the insurer or plan with all_	516
information necessary to support the prior authorization	517
request. Division (B)(4) of this section does not apply to	518
emergency services.	519
(b)(i) The response required under division (B)(4)(a) of	520
this section shall indicate whether the request is approved,	521
denied, or incomplete. If the prior authorization is denied, the	522
insurer or plan shall provide the specific reason for the	523
denial. If the prior authorization request is incomplete, the	524
insurer or plan shall indicate the specific additional	525
information that is required to process the request.	526
(ii) For a response that is considered incomplete, the	527
health care practitioner shall provide the additional	528
information requested under division (B)(4)(b)(i) of this	529
section within seventy-two hours of the time the request is	530
received by the practitioner.	531
(5)(a) For policies issued on or after January 1, 2018, if	532
a health care practitioner submits a prior authorization request	533

as described in divisions (B)(1) and (2) of this section, the	534
insurer or plan shall provide an electronic receipt to the	535
health care practitioner acknowledging that the prior	536
authorization request was received.	537
(b) For policies issued on or after January 1, 2018, if an	538
issuer or plan requests additional information that is required	539
to process a prior authorization request as described in	540
division (B)(4)(b)(i) of this section, the health care	541
practitioner shall provide an electronic receipt to the issuer	542
or plan acknowledging that the request for additional	543
information was received.	544
(6)(a) For policies issued on or after January 1, 2017,	545
for a prior approval related to a chronic condition, the insurer	546
or plan shall honor a prior authorization approval for an	547
approved drug for the lesser of the following from the date of	548
the approval:	549
(i) Twelve months;	550
(ii) The last day of the covered person's eligibility	551
under the policy or plan.	552
(b) The duration of all other prior authorization	553
approvals shall be dictated by the policy or plan.	554
(c) An insurer or plan, in relation to prior approval	555
under division (B)(6)(a) of this section, may require a health	556
care practitioner to submit information to the insurer or plan	557
indicating that the patient's chronic condition has not changed.	558
(i) The request for information by the insurer or plan and	559
the response by the health care practitioner shall be in an	560
electronic format, which may be by traditional electronic mail	561
or other electronic communication.	562

(ii) The frequency of the submission of requested	563
information shall be consistent with medical or scientific	564
evidence as defined in section 3922.01 of the Revised Code, but	565
shall not be required more frequently than quarterly.	566
(iii) If the health care practitioner does not respond	567
within five calendar days from the date the request was	568
received, the insurer or plan may terminate the twelve-month	569
approval.	570
(d) A year long approval provided under division (B)(6)(a)	571
of this section is no longer valid and automatically terminates	572
if there are changes to federal or state laws or federal	573
regulatory guidance or compliance information prescribing that	574
the drug in question is no longer approved or safe for the	575
intended purpose.	576
(e) A twelve-month approval provided under division (B)(6)	577
(a) of this section does not apply to and is not required for	578
any of the following:	579
(i) Medications that are prescribed for a non-maintenance	580
<pre>condition;</pre>	581
(ii) Medications that have a typical treatment of less	582
than one year;	583
(iii) Medications that require an initial trial period to	584
determine effectiveness and tolerability, beyond which a one-	585
year, or greater, prior authorization period will be given;	586
(iv) Medications where there is medical or scientific	587
evidence as defined in section 3922.01 of the Revised Code that	588
do not support a twelve-month prior approval;	589
(v) Medications that are a schedule I or II controlled	590

<u>substance or any opioid analgesic or benzodiazepine, as defined</u>	591
in section 3719.01 of the Revised Code;	592
(vi) Medications that are not prescribed by an in-network	593
provider as part of the care management program.	594
(7) For policies issued on or after January 1, 2017, an_	595
insurer or plan may, but is not required to, provide the twelve-	596
month approval prescribed in division (B)(6)(a) of this section	597
for a prescription drug that meets either of the following:	598
(a) The drug is prescribed or administered to treat a rare	599
medical condition and pursuant to medical or scientific evidence	600
as defined in section 3922.01 of the Revised Code.	601
(b) Medications that are controlled substances not	602
included in division (B)(6)(e)(v) of this section.	603
For purposes of division (B)(7) of this section, "rare	604
medical condition" means any disease or condition that affects	605
fewer than two hundred thousand individuals in the United	606
States.	607
(8) Nothing in division (B)(6) or (7) of this section	608
prohibits the substitution of any drug that has received a	609
twelve-month approval under division (B)(6)(a) of this section	610
when there is a release of a United States food and drug	611
administration approved comparable brand product or a generic	612
counterpart of a brand product that is listed as therapeutically	613
equivalent in the United States food and drug administration's	614
publication titled approved drug products with therapeutic	615
equivalence evaluations.	616
(9)(a) For policies issued on or after January 1, 2017,	617
upon written request, an insurer or plan shall permit a	618
retrospective review for a claim that is submitted for a service	619

where prior authorization was required but not obtained if the	620
service in question meets all of the following:	621
(i) The service is directly related to another service for	622
which prior approval has already been obtained and that has	623
already been performed.	624
(ii) The new service was not known to be needed at the	625
time the original prior authorized service was performed.	626
(iii) The need for the new service was revealed at the	627
time the original authorized service was performed.	628
(b) Once the written request and all necessary information	629
is received, the insurer or plan shall review the claim for	630
coverage and medical necessity. The insurer or plan shall not	631
deny a claim for such a new service based solely on the fact	632
that a prior authorization approval was not received for the new	633
service in question.	634
(10)(a) For policies issued on or after January 1, 2017,	635
the insurer or plan shall disclose to all participating health	636
care practitioners any new prior authorization requirement at	637
least thirty days prior to the effective date of the new	638
requirement.	639
(b) The notice may be sent via electronic mail or standard	640
mail and shall be conspicuously entitled "Notice of Changes to	641
Prior Authorization Requirements." The notice is not required to	642
contain a complete listing of all changes made to the prior	643
authorization requirements, but shall include specific	644
information on where the health care practitioner may locate the	645
information on the insurer or plan's web site or, if applicable,	646
the insurer's or plan's portal.	647
(c) All participating health care practitioners shall_	648

promptly notify the insurer or plan of any changes to the health	649
care practitioner's electronic mail or standard mail address.	650
(11)(a) For policies issued on or after January 1, 2017,	651
the insurer or plan shall make available to all participating	652
health care practitioners on its web site or provider portal a	653
listing of its prior authorization requirements, including	654
specific information or documentation that a provider must	655
submit in order for the prior authorization request to be	656
considered complete.	657
(b) The insurer or plan shall make available on its web	658
site information about the policies, contracts, or agreements	659
offered by the insurer or plan that clearly identifies specific	660
services, drugs, or devices to which a prior authorization	661
requirement exists.	662
(12) For policies issued on or after January 1, 2018, the	663
insurer or plan shall establish a streamlined appeal process	664
relating to adverse prior authorization determinations that	665
shall include all of the following:	666
(a) For urgent care services, the appeal shall be	667
considered within forty-eight hours after the insurer or plan	668
receives the appeal.	669
(b) For all other matters, the appeal shall be considered	670
within ten calendar days after the insurer or plan receives the	671
appeal.	672
(c) The appeal shall be between the health care	673
practitioner requesting the service in question and a clinical	674
peer.	675
(d) If the appeal does not resolve the disagreement,	676
either the covered person or an authorized representative as	677

defined in section 3922.01 of the Revised Code may request an	678
external review under Chapter 3922. of the Revised Code to the	679
extent Chapter 3922. of the Revised Code is applicable.	680
(C) For policies issued on or after January 1, 2017,	681
except in cases of fraudulent or materially incorrect	682
information, an insurer or plan shall not retroactively deny a	683
prior authorization for a health care service, drug, or device	684
when all of the following are met:	685
(1) The health care practitioner submits a prior	686
authorization request to the insurer or plan for a health care	687
service, drug, or device;	688
(2) The insurer or plan approves the prior authorization	689
request after determining that all of the following are true:	690
(a) The patient is eligible under the health benefit plan.	691
(b) The health care service, drug, or device is covered	692
under the patient's health benefit plan.	693
(c) The health care service, drug, or device meets the	694
insurer's or plan's standards for medical necessity and prior	695
authorization.	696
(3) The health care practitioner renders the health care	697
service, drug, or device pursuant to the approved prior	698
authorization request and all of the terms and conditions of the	699
health care practitioner's contract with the insurer or plan;	700
(4) On the date the health care practitioner renders the	701
prior approved health care service, drug, or device, all of the	702
<pre>following are true:</pre>	703
(a) The patient is eligible under the health benefit plan.	704

(b) The patient's condition or circumstances related to	705
the patient's care has not changed.	706
(c) The health care practitioner submits an accurate claim	707
that matches the information submitted by the health care	708
practitioner in the approved prior authorization request.	709
(5) If the health care practitioner submits a claim that	710
includes an unintentional error and the error results in a claim	711
that does not match the information originally submitted by the	712
health care practitioner in the approved prior authorization	713
request, upon receiving a denial of services from the insurer or	714
plan, the health care practitioner may resubmit the claim	715
pursuant to division (C) of this section with the information	716
that matches the information included in the approved prior	717
authorization.	718
(D) Any provision of a contractual arrangement entered	719
into between an insurer or plan and a health care practitioner	720
or beneficiary that is contrary to divisions (A) to (C) of this	721
section is unenforceable.	722
(E) For policies issued on or after January 1, 2017,	723
committing a series of violations of this section that, taken	724
together, constitute a practice or pattern shall be considered	725
an unfair and deceptive practice under sections 3901.19 to	726
3901.26 of the Revised Code.	727
(F) The superintendent of insurance may adopt rules in	728
accordance with Chapter 119. of the Revised Code as necessary to	729
implement the provisions of this section.	730
(G) This section does not apply to any of the following	731
types of coverage: a policy, contract, certificate, or agreement	732
that covers only a specified accident, accident only, credit,	733

dental, disability income, long-term care, hospital indemnity,	734
supplemental coverage as described in section 3923.37 of the	735
Revised Code, specified disease, or vision care; coverage issued	736
as a supplement to liability insurance; insurance arising out of	737
workers' compensation or similar law; automobile medical payment	738
insurance; insurance under which benefits are payable with or	739
without regard to fault and which is statutorily required to be	740
contained in any liability insurance policy or equivalent self-	741
insurance; a medicare supplement policy of insurance as defined	742
by the superintendent of insurance by rule; coverage under a	743
plan through medicare or the federal employees benefit program;	744
or any coverage issued under Chapter 55 of Title 10 of the	745
United States Code and any coverage issued as a supplement to	746
that coverage.	747

Sec. 5119.25. (A) The director of mental health and addiction services, in whole or in part, may withhold funds otherwise to be allocated to a board of alcohol, drug addiction, and mental health services under section 5119.23 of the Revised Code if the board fails to comply with Chapter 340. or 5119. of the Revised Code or rules of the department of mental health and addiction services. However, beginning September 15, 2016July 1, 2017, the director shall withhold all such funds from the board when required to do so under division (A) (4) of section 340.08 of the Revised Code or division (G) (1) of section 5119.22 of the Revised Code.

(B) The director of mental health and addiction services may withhold funds otherwise to be allocated to a board of alcohol, drug addiction, and mental health services under section 5119.23 of the Revised Code if the board denies available service on the basis of race, color, religion, creed, sex, age, national origin, disability as defined in section

4112.01 of the Revised Code, or developmental disability.	765
(C) The director shall issue a notice identifying the	766
areas of noncompliance and the action necessary to achieve	767
compliance. The director may offer technical assistance to the	768
board to achieve compliance. The board shall have thirty days	769
from receipt of the notice of noncompliance to present its	770
position that it is in compliance or to submit to the director	771
evidence of corrective action the board took to achieve	772
compliance. Before withholding funds, the director or the	773
director's designee shall hold a hearing within thirty days of	774
receipt of the board's position or evidence to determine if	775
there are continuing violations and that either assistance is	776
rejected or the board is unable, or has failed, to achieve	777
compliance. The director may appoint a representative from	778
another board of alcohol, drug addiction, and mental health	779
services to serve as a mentor for the board in developing and	780
executing a plan of corrective action to achieve compliance. Any	781
such representative shall be from a board that is in compliance	782
with Chapter 340. of the Revised Code, this chapter, and the	783
department's rules. Subsequent to the hearing process, if it is	784
determined that compliance has not been achieved, the director	785
may allocate all or part of the withheld funds to one or more	786
community mental health services providers or community	787
addiction services providers to provide the mental health	788
service or addiction service for which the board is not in	789
compliance until the time that there is compliance. The director	790
shall adopt rules in accordance with Chapter 119. of the Revised	791
Code to implement this section.	792
Sec. 5160.34. (A) As used in this section:	793
(1) "Chronic condition" means a medical condition that has	794

persisted after reasonable efforts have been made to relieve or	795
cure its cause and has continued, either continuously or	796
episodically, for longer than six continuous months.	797
(2) "Clinical peer" means a medical provider in the same,	798
or in a similar, specialty that typically manages the medical	799
condition, procedure, or treatment under review.	800
(3) "Emergency services" has the same meaning as in	801
section 1753.28 of the Revised Code.	802
(4) "Prior authorization requirement" means any practice	803
implemented by a medical assistance program in which coverage of	804
a health care service, device, or drug is dependent upon a	805
medical assistance recipient or a health care provider,	806
receiving approval from the department of medicaid or its	807
designee, including a medicaid managed care organization, prior	808
to the service, device, or drug being performed, received, or	809
prescribed, as applicable. "Prior authorization" includes	810
prospective or utilization review procedures conducted prior to	811
providing a health care service, device, or drug.	812
(5) "Urgent care services" means a medical care or other	813
service for a condition where application of the timeframe for	814
making routine or non-life threatening care determinations is	815
either of the following:	816
(a) Could seriously jeopardize the life, health, or safety	817
of the recipient or others due to the recipient's psychological	818
state;	819
(b) In the opinion of a practitioner with knowledge of the	820
recipient's medical or behavioral condition, would subject the	821
recipient to adverse health consequences without the care or	822
treatment that is the subject of the request.	823

(6) "Utilization review" and "utilization review_	824
organization" have the same meanings as in section 1751.77 of	825
the Revised Code.	826
(B) If a medical assistance program has a prior	827
authorization requirement, the department of medicaid or its	828
designee, including a medicaid managed care organization, shall	829
do all of the following:	830
(1) On or before January 1, 2018, permit a health care	831
provider to access the prior authorization form through the	832
applicable electronic software system.	833
(2) (a) On or before January 1, 2018, permit the department	834
or its designee to accept and respond to prior prescription	835
benefit authorization requests through a secure electronic	836
transmission.	837
(b) On or before January 1, 2018, the department or its	838
designee shall accept and respond to prior prescription benefit	839
authorization requests through a secure electronic transmission	840
using NCPDP SCRIPT standard ePA transactions, and for prior	841
medical benefit authorization requests through a secure	842
electronic transmission using standards established by the	843
council for affordable quality health care on operating rules	844
for information exchange or its successor.	845
(c) For purposes of division (B)(2) of this section,	846
neither of the following shall be considered a secure electronic	847
<pre>transmission:</pre>	848
(i) A facsimile;	849
(ii) A proprietary payer portal for prescription drug	850
requests that does not use NCPDP SCRIPT standard	851

(3) On or before January 1, 2018, a health care provider	852
and the department of medicaid or its designee may enter into a	853
contractual arrangement under which the department or its	854
designee agrees to process prior authorization requests that are	855
not submitted electronically because of the financial hardship	856
that electronic submission of prior authorization requests would	857
create for the provider or if internet connectivity is limited	858
or unavailable where the provider is located.	859
(4)(a) On or before January 1, 2018, if the health care	860
provider submits the request for prior authorization	861
electronically as described in divisions (B)(1) and (2) of this	862
section, respond to all prior authorization requests within	863
forty-eight hours for urgent care services, or ten calendar days	864
for any prior approval request that is not for an urgent care	865
service, of the time the request is received by the department	866
or its designee with all information necessary to support the	867
prior authorization request. Division (B)(5) of this section	868
does not apply to emergency services.	869
(b) (i) The response required under division (B) (4) (a) of	870
this section shall indicate whether the request is approved,	871
denied, or incomplete. If the prior authorization is denied, the	872
department or its designee shall provide the specific reason for	873
the denial. If the prior authorization request is incomplete,	874
the department or its designee shall indicate the specific	875
additional information that is required to process the request.	876
(ii) For a response that is considered incomplete, the	877
health care provider shall provide the additional information	878
requested under division (B)(4)(b)(i) of this section within	879
seventy-two hours of the time the request is received by the	880
provider.	881

(5)(a) On or before January 1, 2018, if a health care	882
provider submits a prior authorization request as described in	883
divisions (B)(1) and (2) of this section, the department or its	884
designee shall provide an electronic receipt to the health care	885
provider acknowledging that the prior authorization request was	886
received.	887
(b) On or before January 1, 2018, if the department or its	888
designee requests additional information that is required to	889
process a prior authorization request as described in division	890
(B) (4) (b) (i) of this section, the health care provider shall	891
provide an electronic receipt to the department or its designee_	892
acknowledging that the request for additional information was	893
received.	894
(6)(a) On or before January 1, 2017, honor a prior	895
authorization approval for an approved drug for the lesser of	896
the following from the date of approval:	897
(i) Twelve months;	898
(ii) The last day of the medical assistance recipient's	899
eligibility for the medical assistance program.	900
(b) The duration of all other prior authorization	901
approvals shall be dictated by the medical assistance program.	902
(c) The department or its designee, in relation to prior	903
approval under division (B)(6)(a) of this section, may require a	904
health care provider to submit information to the department or	905
its designee indicating that the patient's chronic condition has	906
not changed.	907
(i) The request for information by the department or its	908
designee and the response by the health care provider shall be	909
in an electronic format, which may be by traditional electronic	910

mail or other electronic communication.	911
(ii) The frequency of the submission of requested	912
information shall be consistent with medical or scientific	913
evidence as defined in section 3922.01 of the Revised Code, but	914
shall not be required more frequently than quarterly.	915
(iii) If the health care provider does not respond within	916
five calendar days from the date the request was received, the	917
insurer or plan may terminate the twelve-month approval.	918
(d) A year long approval provided under division (B)(6)(a)	919
of this section is no longer valid and automatically terminates	920
if there are changes to federal or state laws or federal	921
regulatory guidance or compliance information prescribing that	922
the drug in question is no longer approved or safe for the	923
<pre>intended purpose.</pre>	924
(e) A twelve-month approval provided under division (B)(6)	925
(a) of this section does not apply to and is not required for	926
any of the following:	927
(i) Medications that are prescribed for a non-maintenance	928
<pre>condition;</pre>	929
(ii) Medications that have a typical treatment of less	930
than one year;	931
(iii) Medications that require an initial trial period to	932
determine effectiveness and tolerability, beyond which a one-	933
year, or greater, prior authorization period will be given;	934
(iv) Medications where there is medical or scientific	935
evidence as defined in section 3922.01 of the Revised Code that	936
do not support a twelve-month prior approval;	937
(v) Medications that are a schedule T or TI controlled	938

substance or any opioid analgesic or benzodiazepine, as defined	939
in section 3719.01 of the Revised Code;	940
(vi) Medications that are not prescribed by an in-network	941
provider as part of a care management program.	942
(7) On or before January 1, 2017, the department or its	943
designee may, but is not required to, provide the twelve-month	944
approval prescribed in division (B)(6)(a) of this section for a	945
prescription drug that meets either of the following:	946
(a) The drug is prescribed or administered to treat a rare	947
medical condition and pursuant to medical or scientific evidence	948
as defined in section 3922.01 of the Revised Code.	949
(b) Medications that are controlled substances not	950
included in division (B)(6)(e)(v) of this section.	951
For purposes of division (B)(7) of this section, "rare	952
medical condition" means any disease or condition that affects	953
fewer than two-hundred thousand individuals in the United	954
States.	955
(8) Nothing in division (B)(6) or (7) of this section	956
prohibits the substitution of any drug that has received a	957
twelve-month approval under division (B)(6)(a) of this section	958
when there is a release of a United States food and drug	959
administration approved comparable brand product or a generic	960
counterpart of a brand product that is listed as therapeutically	961
equivalent in the United States food and drug administration's	962
publication titled approved drug products with therapeutic	963
equivalence evaluations.	964
(9)(a) On or after January 1, 2017, upon written request,	965
the department or its designee shall permit a retrospective	966
review for a claim that is submitted for a service where prior	967

authorization was required, but not obtained if the service in	968
question meets all of the following:	969
(i) The service is directly related to another service for	970
which prior approval has already been obtained and that has	971
already been performed.	972
(ii) The new service was not known to be needed at the	973
time the original prior authorized service was performed.	974
(iii) The need for the new service was revealed at the	975
time the original authorized service was performed.	976
(b) Once the written request and all necessary information	977
is received, the department or its designee shall review the	978
claim for coverage and medical necessity. The department or its	979
designee shall not deny a claim for such a new service based	980
solely on the fact that a prior authorization approval was not	981
received for the new service in question.	982
(10)(a) On or before January 1, 2017, disclose to all	983
participating health care providers any new prior authorization	984
requirement at least thirty days prior to the effective date of	985
the new requirement.	986
(b) The notice may be sent via electronic mail or standard	987
mail and shall be conspicuously entitled "Notice of Changes to	988
Prior Authorization Requirements." The notice is not required to	989
contain a complete listing of all changes made to the prior	990
authorization requirements, but shall include specific	991
information on where the health care practitioner may locate the	992
information on the department's or its designee's web site or,	993
if applicable, the department's or its designee's portal.	994
(c) All participating health care providers shall promptly	995
notify the department or its designee of any changes to the	996

health care provider's electronic mail or standard mail address.	997
(11)(a) On or before January 1, 2017, make available to	998
all participating health care providers on its web site or	999
provider portal a listing of its prior authorization	1000
requirements, including specific information or documentation	1001
that a provider must submit in order for the prior authorization	1002
request to be considered complete.	1003
(b) Make available on its web site information about the	1004
medical assistance programs offered in this state that clearly	1005
identifies specific services, drugs, or devices to which a prior	1006
authorization requirement exists.	1007
(12) On or before January 1, 2018, establish a streamlined	1008
appeal process relating to adverse prior authorization	1009
determinations that shall include all of the following:	1010
(a) For urgent care services, the appeal shall be	1011
considered within forty-eight hours after the department or its	1012
designee receives the appeal.	1013
(b) For all other matters, the appeal shall be considered	1014
within ten calendar days after the department or its designee	1015
receives the appeal.	1016
(c) The appeal shall be between the health care provider	1017
requesting the service in question and a clinical peer appointed	1018
by or contracted by the department or the department's designee.	1019
(d) If the appeal does not resolve the disagreement, the	1020
appeal procedures shall permit the recipient to further appeal	1021
in accordance with section 5160.31 of the Revised Code.	1022
(C) Beginning January 1, 2017, except in cases of	1023
fraudulent or materially incorrect information, the department_	1024

or its designee shall not retroactively deny a prior	1025
authorization for a health care service, drug, or device when	1026
all of the following are met:	1027
(1) The health care provider submits a prior authorization	1028
request to the department or its designee for a health care	1029
service, drug, or device.	1030
(2) The department or its designee approves the prior	1031
authorization request after determining that all of the	1032
following are true:	1033
(a) The recipient is eligible for the health care service,	1034
drug, or device under the medical assistance program.	1035
(b) The health care service, drug, or device is covered by	1036
the medical assistance program.	1037
(c) The health care service, drug, or device meets the	1038
department's standards for medical necessity and prior	1039
authorization.	1040
(3) The health care provider renders the health care	1041
service, drug, or device pursuant to the approved prior	1042
authorization request and all of the terms and conditions of the	1043
health care provider's contract with the department or the	1044
department's designee.	1045
(4) On the date the health care provider renders the prior	1046
approved health care service, drug, or device, all of the	1047
following are true:	1048
(a) The recipient is eligible for the medical assistance	1049
program.	1050
(b) The recipient's condition or circumstances related to	1051
the recipient's care has not changed	1052

(c) The health care provider submits an accurate claim	1053
that matches the information submitted by the health care	1054
provider in the approved prior authorization request.	1055
(5) If the health care provider submits a claim that	1056
includes an unintentional error and the error results in a claim	1057
that does not match the information originally submitted by the	1058
health care provider in the approved prior authorization	1059
request, upon receiving a denial of services from the department	1060
or its designee, the health care practitioner may resubmit the	1061
claim pursuant to division (C) of this section with the	1062
information that matches the information included in the	1063
approved prior authorization.	1064
(D) Any provision of a contractual arrangement entered	1065
into between the department or its designee and a health care	1066
provider or recipient that is contrary to divisions (A) to (C)	1067
of this section is unenforceable.	1068
(E) The director of medicaid may adopt rules in accordance	1069
with Chapter 119. of the Revised Code as necessary to implement	1070
the provisions of this section.	1071
Section 2. That existing sections 340.034, 1739.05, and	1072
5119.25 of the Revised Code are hereby repealed.	1073
Section 3. That sections 110.12 and 812.40 of Am. Sub.	1074
H.B. 64 of the 131st General Assembly be amended to read as	1075
follows:	1076
Sec. 110.12. Sections 110.10 and 110.11 of this act Am.	1077
Sub. H.B. 64 of the 131st General Assembly shall take effect	1078
September 15, 2016 July 1, 2017.	1079
It is the intent of this amendment to delay the taking	1080
effect of the amendments to sections 340 01, 340 03, 340 15, and	1081

5119.21 of the Revised Code, as contemplated by the amendment,	1082
until July 1, 2017.	1083
Sec. 812.40. Section 340.034 of the Revised Code takes	1084
effect September 15, 2016 July 1, 2017.	1085
effect depended 13, 2010 outy 1, 2017.	1005
Section 4. That existing Sections 110.12 and 812.40 of Am.	1086
Sub. H.B. 64 of the 131st General Assembly are hereby repealed.	1087
Section 5. That Section 812.40 of Am. Sub. H.B. 483 of the	1088
130th General Assembly be amended to read as follows:	1089
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Sec. 812.40. (A) The following take effect two years after	1090
the effective date of this act July 1, 2017:	1091
(1) The amendments by this act Am. Sub. H.B. 483 of the	1092
130th General Assembly to sections 340.01, 340.03, 340.08,	1093
340.09, 340.15, 5119.21, and 5119.22 of the Revised Code;	1094
(2) The enactment by this act Am. Sub. H.B. 483 of the	1095
130th General Assembly of sections 340.033, 340.034, 340.20,	1096
5119.362, 5119.363, and 5119.364 of the Revised Code.	1097
(B) The amendments by this act Am. Sub. H.B. 483 of the	1098
130th General Assembly to division (A) of section 5119.25 of the	1099
Revised Code take effect two years after the effective date of	1100
this sectionJuly 1, 2017. The amendments by this act Am. Sub.	1101
H.B. 483 of the 130th General Assembly to division (C) of that	1102
section take effect at the earliest time permitted by law.	1103
Section 6. That existing Section 812.40 of Am. Sub. H.B.	1104
483 of the 130th General Assembly is hereby repealed.	1105
Section 7. Sections 340.034 and 5119.25 of the Revised	1106
Code, as amended by this act, take effect on September 15, 2016.	1107