Ohio Revised Code

Section 5168.75 Definitions for R.C. 5168.75 to 5168.86.

Effective: October 17, 2019
Legislation: House Bill 166 - 133rd General Assembly

As used in sections 5168.75 to 5168.86 of the Revised Code:

(A) "Basic health care services" means all of the services listed in division (A)(1) of section 1751.01 of the Revised Code.

(B) "Care management system" has the same meaning as in section 5167.01 of the Revised Code.

(C) "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

(D) "Franchise fee" means the fee imposed on health insuring corporation plans under section 5168.76 of the Revised Code.

(E) "Health insuring corporation" has the same meaning as in section 1751.01 of the Revised Code, except it does not mean a corporation that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, only supplemental health care services or only specialty health care services.

(F) "Health insuring corporation plan" means a policy, contract, certificate, or agreement of a health insuring corporation under which the corporation pays for, reimburses, provides, delivers, arranges for, or otherwise makes available basic health care services. "Health insuring corporation plan" does not mean any of the following:

(1) A policy, contract, certificate, or agreement under which a health insuring corporation pays for, reimburses, provides, delivers, arranges for, or otherwise makes available only supplemental health care services or only specialty health care services;

(2) An approved health benefits plan described in 5 U.S.C. 8903 or 8903a, if imposing the franchise fee on the plan would violate 5 U.S.C. 8909(f);

(3) A medicare advantage plan authorized by Part C of Title XVIII of the "Social Security Act," 42 U.S.C. 1395w-21 et seq.

(G) "Indirect guarantee percentage" means the percentage specified in section 1903(w)(4)(C)(ii) of the "Social Security Act," 42 U.S.C. 1396b(w)(4)(C)(ii), that is to be used in determining whether a health care class is indirectly held harmless for any portion of the costs of a broad-based health-care-related tax. If the indirect guarantee percentage changes during a fiscal year, the indirect guarantee percentage is the following:

(1) For the part of the fiscal year before the change takes effect, the percentage in effect before the change;

(2) For the part of the fiscal year beginning with the date the indirect guarantee percentage changes, the new percentage.

(H) "Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code.

(I) "Medicaid provider" has the same meaning as in section 5164.01 of the Revised Code.

(J) "Ohio medicaid member month" means a month in which a medicaid recipient residing in this state is enrolled in a health insuring corporation plan.

(K) "Other Ohio member month" means a month in which a resident of this state who is not a medicaid recipient is enrolled in a health insuring corporation plan.

(L) "Rate year" means the fiscal year for which a franchise fee is imposed.