**As Introduced**

**130th General Assembly**
**Regular Session** **H. B. No. 34**
**2013-2014**

**Representative Hackett**

**A B I L L**

To amend sections 4121.129, 4121.44, 4121.441, 4123.29, 4123.291, 4123.353, 4123.37, 4123.411, 4123.47, 4123.511, 4123.512, 4123.66, 4123.82, 4123.93, and 4729.80 of the Revised Code to allow the Administrator of Workers' Compensation to pay for specified medical benefits during an earlier time frame, to make changes to the Health Partnership Program, to eliminate the $15,000 Medical-Only Program, to make other changes to the Workers' Compensation Law, and to make appropriations for the Bureau of Workers' Compensation for the biennium beginning July 1, 2013, and ending June 30, 2015; and to provide authorization and conditions for the operation of the Bureau's programs.

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

**Section 1.** That sections 4121.129, 4121.44, 4121.441, 4123.29, 4123.291, 4123.353, 4123.37, 4123.411, 4123.47, 4123.511, 4123.512, 4123.66, 4123.82, 4123.93, and 4729.80 of the Revised Code be amended to read as follows:

**Sec. 4121.129.** (A) There is hereby created the workers'

compensation audit committee consisting of at least three members. One member shall be the member of the bureau of workers' compensation board of directors who is a certified public accountant. The board, by majority vote, shall appoint two additional members of the board to serve on the audit committee and may appoint additional members who are not board members, as the board determines necessary. Members of the audit committee serve at the pleasure of the board, and the board, by majority vote, may remove any member except the member of the committee who is the certified public accountant member of the board. The board, by majority vote, shall determine how often the audit committee shall meet and report to the board. If the audit committee meets on the same day as the board holds a meeting, no member shall be compensated for more than one meeting held on that day. The audit committee shall do all of the following:

(1) Recommend to the board an accounting firm to perform the annual ~~audits~~ analysis required under section 4123.47 of the Revised Code;

(2) Recommend an auditing firm for the board to use when conducting audits under section 4121.125 of the Revised Code;

(3) Review the results of each annual audit and management review and, if any problems exist, assess the appropriate course of action to correct those problems and develop an action plan to correct those problems;

(4) Monitor the implementation of any action plans created pursuant to division (A)(3) of this section;

(5) Review all internal audit reports on a regular basis.

(B) There is hereby created the workers' compensation actuarial committee consisting of at least three members. One member shall be the member of the board who is an actuary. The board, by majority vote, shall appoint two additional members of

the board to serve on the actuarial committee and may appoint additional members who are not board members, as the board determines necessary. Members of the actuarial committee serve at the pleasure of the board and the board, by majority vote, may remove any member except the member of the committee who is the actuary member of the board. The board, by majority vote, shall determine how often the actuarial committee shall meet and report to the board. If the actuarial committee meets on the same day as the board holds a meeting, no member shall be compensated for more than one meeting held on that day. The actuarial committee shall do both of the following:

(1) Recommend actuarial consultants for the board to use for the funds specified in this chapter and Chapters 4123., 4127., and 4131. of the Revised Code;

(2) Review calculations on rate schedules and performance prepared by the actuarial consultants with whom the board enters into a contract.

(C)(1) There is hereby created the workers' compensation investment committee consisting of at least four members. Two of the members shall be the members of the board who serve as the investment and securities experts on the board. The board, by majority vote, shall appoint two additional members of the board to serve on the investment committee and may appoint additional members who are not board members. Each additional member the board appoints shall have at least one of the following qualifications:

(a) Experience managing another state's pension funds or workers' compensation funds;

(b) Expertise that the board determines is needed to make investment decisions.

Members of the investment committee serve at the pleasure of

the board and the board, by majority vote, may remove any member except the members of the committee who are the investment and securities expert members of the board. The board, by majority vote, shall determine how often the investment committee shall meet and report to the board. If the investment committee meets on the same day as the board holds a meeting, no member shall be compensated for more than one meeting held on that day.

(2) The investment committee shall do all of the following:

(a) Develop the investment policy for the administration of the investment program for the funds specified in this chapter and Chapters 4123., 4127., and 4131. of the Revised Code in accordance with the requirements specified in section 4123.442 of the Revised Code;

(b) Submit the investment policy developed pursuant to division (C)(2)(a) of this section to the board for approval;

(c) Monitor implementation by the administrator of workers' compensation and the bureau of workers' compensation chief investment officer of the investment policy approved by the board;

(d) Recommend outside investment counsel with whom the board may contract to assist the investment committee in fulfilling its duties;

(e) Review the performance of the bureau of workers' compensation chief investment officer and any investment consultants retained by the administrator to assure that the investments of the assets of the funds specified in this chapter and Chapters 4123., 4127., and 4131. of the Revised Code are made in accordance with the investment policy approved by the board and ~~that the best possible return on~~ to assure compliance with the investment ~~is achieved~~ policy and effective management of the funds.

**Sec. 4121.44.** (A) The administrator of workers' compensation shall oversee the implementation of the Ohio workers' compensation qualified health plan system as established under section 4121.442 of the Revised Code.

(B) The administrator shall direct the implementation of the health partnership program administered by the bureau as set forth in section 4121.441 of the Revised Code. To implement the health partnership program, the bureau:

(1) Shall certify one or more external vendors, which shall be known as "managed care organizations," to provide medical management and cost containment services in the health partnership program for a period of two years beginning on the date of certification, consistent with the standards established under this section;

(2) May recertify external vendors for additional periods of two years; and

(3) May integrate the certified vendors with bureau staff and existing bureau services for purposes of operation and training to allow the bureau to assume operation of the health partnership program at the conclusion of the certification periods set forth in division (B)(1) or (2) of this section.

The bureau may enter into a contract with any vendor that is certified by the bureau to provide medical management and cost containment services in the health partnership program pursuant to division (B)(1) or (2) of this section. The contract may include incentives and penalties that may be imposed within the discretion of the administrator based upon the vendor's compliance and performance.

(C) Any vendor selected shall demonstrate all of the following:

(1) Arrangements and reimbursement agreements with a provider panel including a substantial number of ~~the~~ medical, professional, and pharmacy providers ~~currently being utilized by claimants~~ participating in the health partnership program, selected on the basis of access, quality, and cost.

(2) Ability to accept a common format of medical bill data in an electronic fashion from any provider who wishes to submit medical bill data in that form.

(3) A computer system able to handle the volume of medical bills and willingness to customize that system to the bureau's needs and to be operated by the vendor's staff, bureau staff, or some combination of both staffs.

(4) A prescription drug system where pharmacies on a statewide basis have access to the eligibility and pricing, at a discounted rate, of all prescription drugs.

(5) A tracking system to record all telephone calls from claimants and providers regarding the status of submitted medical bills so as to be able to track each inquiry.

(6) Data processing capacity to absorb all of the bureau's medical bill processing or at least that part of the processing which the bureau arranges to delegate.

(7) Capacity to store, retrieve, array, simulate, and model in a relational mode all of the detailed medical bill data so that analysis can be performed in a variety of ways and so that the bureau and its governing authority can make informed decisions.

(8) Wide variety of software programs which translate medical terminology into standard codes, and which reveal if a provider is manipulating the procedures codes, commonly called "unbundling."

(9) Necessary professional staff to conduct, at a minimum, authorizations for treatment, medical necessity, utilization

review, concurrent review, post-utilization review, and have the attendant computer system which supports such activity and measures the outcomes and the savings.

(10) Management experience and flexibility to be able to react quickly to the needs of the bureau in the case of required change in federal or state requirements.

(D) For purposes of division (C)(1) of this section, any provider panel used by a vendor shall provide reasonable access to providers, deliver cost-effective treatment, and achieve quality benchmarks as established by the administrator.

(E)(1) Information contained in a vendor's application for certification in the health partnership program, and other information furnished to the bureau by a vendor for purposes of obtaining certification or to comply with performance and financial auditing requirements established by the administrator, is for the exclusive use and information of the bureau in the discharge of its official duties, and shall not be open to the public or be used in any court in any proceeding pending therein, unless the bureau is a party to the action or proceeding, but the information may be tabulated and published by the bureau in statistical form for the use and information of other state departments and the public. No employee of the bureau, except as otherwise authorized by the administrator, shall divulge any information secured by the employee while in the employ of the bureau in respect to a vendor's application for certification or in respect to the business or other trade processes of any vendor to any person other than the administrator or to the employee's superior.

(2) Notwithstanding the restrictions imposed by division ~~(D)~~(E)(1) of this section, the governor, members of select or standing committees of the senate or house of representatives, the auditor of state, the attorney general, or their designees,

pursuant to the authority granted in this chapter and Chapter 4123. of the Revised Code, may examine any vendor application or other information furnished to the bureau by the vendor. None of those individuals shall divulge any information secured in the exercise of that authority in respect to a vendor's application for certification or in respect to the business or other trade processes of any vendor to any person.

~~(E)~~(F) On and after January 1, 2001, a vendor shall not be any insurance company holding a certificate of authority issued pursuant to Title XXXIX of the Revised Code or any health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code.

~~(F)~~(G)(1) The administrator may limit freedom of choice of health care provider or supplier by requiring, beginning ~~with the period set forth in division (B)(1) or (2) of this section~~ the forty-sixth day after the date of the injury or the forty-sixth day after the beginning date for treatment for the occupational disease, that claimants ~~shall~~ pay an appropriate out-of-plan copayment for selecting a medical provider not within the provider panel of a health partnership program vendor as provided for in this section.

(2) The administrator shall adopt rules, with the advice and consent of the bureau of workers' compensation board of directors, to allow an employee to continue to receive treatment from a medical provider who is not within the provider panel of a health partnership program vendor if the employee is receiving appropriate and quality care from that medical provider. The rules shall include criteria that the employee shall satisfy to be permitted to continue to receive treatment from that medical provider.

(3) Notwithstanding division (G)(1) of this section, an employee who satisfies the criteria specified in the rules adopted

by the administrator pursuant to division (G)(2) of this section may continue treatment with a medical provider not within the provider panel of a health partnership program vendor, if the employee is receiving appropriate and quality care from the medical provider.

~~(G)~~(H) The administrator, six months prior to the expiration of the bureau's certification or recertification of the vendor or vendors as set forth in division (B)(1) or (2) of this section, may certify and provide evidence to the governor, the speaker of the house of representatives, and the president of the senate that the existing bureau staff is able to match or exceed the performance and outcomes of the external vendor or vendors and that the bureau should be permitted to internally administer the health partnership program upon the expiration of the certification or recertification as set forth in division (B)(1) or (2) of this section.

~~(H)~~(I) The administrator shall establish and operate a bureau of workers' compensation health care data program. The administrator shall develop reporting requirements from all employees, employers and medical providers, medical vendors, and plans that participate in the workers' compensation system. The administrator shall do all of the following:

(1) Utilize the collected data to measure and perform comparison analyses of costs, quality, appropriateness of medical care, and effectiveness of medical care delivered by all components of the workers' compensation system.

(2) Compile data to support activities of the selected vendor or vendors and to measure the outcomes and savings of the health partnership program.

(3) Publish and report compiled data on the measures of outcomes and savings of the health partnership program and submit

the report to the president of the senate, the speaker of the house of representatives, and the governor with the annual report prepared under division (F)(3) of section 4121.12 of the Revised Code. The administrator shall protect the confidentiality of all proprietary pricing data.

~~(I)~~(J) Any rehabilitation facility the bureau operates is eligible for inclusion in the Ohio workers' compensation qualified health plan system or the health partnership program under the same terms as other providers within health care plans or the program.

~~(J) In~~ (K) Notwithstanding division (G) of this section, in areas outside the state or within the state where no qualified health plan or an inadequate number of providers within the health partnership program exist, the administrator shall permit employees to use a provider not within the provider panel of a qualified health plan or health partnership program vendor, including, if necessary, a nonplan or nonprogram health care provider and shall pay the provider for the services or supplies provided to or on behalf of an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code on a fee schedule the administrator adopts.

~~(K)~~(L) No health care provider, whether certified or not, shall charge, assess, or otherwise attempt to collect from an employee, employer, a managed care organization, or the bureau any amount for covered services or supplies that is in excess of the allowed amount paid by a managed care organization, the bureau, or a qualified health plan.

~~(L)~~(M) The administrator shall permit any employer or group of employers who agree to abide by the rules adopted under this section and sections 4121.441 and 4121.442 of the Revised Code to provide services or supplies to or on behalf of an employee for an

injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code through qualified health plans of the Ohio workers' compensation qualified health plan system pursuant to section 4121.442 of the Revised Code or through the health partnership program pursuant to section 4121.441 of the Revised Code. No amount paid under the qualified health plan system pursuant to section 4121.442 of the Revised Code by an employer who is a state fund employer shall be charged to the employer's experience or otherwise be used in merit-rating or determining the risk of that employer for the purpose of the payment of premiums under this chapter, and if the employer is a self-insuring employer, the employer shall not include that amount in the paid compensation the employer reports under section 4123.35 of the Revised Code.

**Sec. 4121.441.** (A) The administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall adopt rules under Chapter 119. of the Revised Code for the health care partnership program administered by the bureau of workers' compensation to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code.

The rules shall include, but are not limited to, the following:

(1) Procedures for the resolution of medical disputes between an employer and an employee, an employee and a provider, or an employer and a provider, prior to an appeal under section 4123.511 of the Revised Code. Rules the administrator adopts pursuant to division (A)(1) of this section may specify that the resolution procedures shall not be used to resolve disputes concerning

medical services rendered that have been approved through standard treatment guidelines, pathways, or presumptive authorization guidelines.

(2) Prohibitions against discrimination against any category of health care providers;

(3) Procedures for reporting injuries to employers and the bureau by providers;

(4) Appropriate financial incentives to reduce service cost and insure proper system utilization without sacrificing the quality of service;

(5) Adequate methods of peer review, utilization review, quality assurance, and dispute resolution to prevent, and provide sanctions for, inappropriate, excessive or not medically necessary treatment;

(6) A timely and accurate method of collection of necessary information regarding medical and health care service and supply costs, quality, and utilization to enable the administrator to determine the effectiveness of the program;

(7) Provisions for necessary emergency medical treatment for an injury or occupational disease provided by a health care provider who is not part of the program;

(8) Discounted pricing for all in-patient and out-patient medical services, all professional services, and all pharmaceutical services;

(9) Provisions for provider referrals, pre-admission and post-admission approvals, second surgical opinions, and other cost management techniques;

(10) Antifraud mechanisms;

(11) Standards and criteria for the bureau to utilize in certifying or recertifying a health care provider or a vendor for

participation in the health partnership program;

(12) Standards and criteria for the bureau to utilize in ~~penalizing or~~ decertifying a health care provider or a vendor from participation in the health partnership program.

(B) The bureau may enter into a contract with any health care provider or supplier certified by the bureau to participate in the health partnership program pursuant to the rules adopted under this section. The contract may include incentives and penalties that may be imposed within the discretion of the administrator based upon the health care provider's or supplier's compliance and performance.

(C) The administrator shall implement the health partnership program according to the rules the administrator adopts under this section for the provision and payment of medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under this chapter or Chapter 4123., 4127., or 4131. of the Revised Code.

**Sec. 4123.29.** (A) The administrator of workers' compensation, subject to the approval of the bureau of workers' compensation board of directors, shall do all of the following:

(1) Classify occupations or industries with respect to their degree of hazard and determine the risks of the different classes according to the categories the national council on compensation insurance establishes that are applicable to employers in this state;

(2)(a) Fix the rates of premium of the risks of the classes based upon the total payroll in each of the classes of occupation or industry sufficiently large to provide a fund for the compensation provided for in this chapter and to maintain a state

insurance fund from year to year. The administrator shall set the rates at a level that assures the solvency of the fund. Where the payroll cannot be obtained or, in the opinion of the administrator, is not an adequate measure for determining the premium to be paid for the degree of hazard, the administrator may determine the rates of premium upon such other basis, consistent with insurance principles, as is equitable in view of the degree of hazard, and whenever in this chapter reference is made to payroll or expenditure of wages with reference to fixing premiums, the reference shall be construed to have been made also to such other basis for fixing the rates of premium as the administrator may determine under this section.

(b) If an employer elects to obtain other-states' coverage pursuant to section 4123.292 of the Revised Code through either the administrator, if the administrator elects to offer such coverage, or an other-states' insurer, calculate the employer's premium for the state insurance fund in the same manner as otherwise required under division (A) of this section and section 4123.34 of the Revised Code, except that when the administrator determines the expenditure of wages, payroll, or both upon which to base the employer's premium, the administrator shall use only the expenditure of wages, payroll, or both attributable to the labor performed and services provided by that employer's employees when those employees performed labor and provided services in this state only and to which the other-states' coverage does not apply.

(c) The administrator in setting or revising rates shall furnish to employers an adequate explanation of the basis for the rates set.

(3) Develop and make available to employers who are paying premiums to the state insurance fund alternative premium plans. Alternative premium plans shall include retrospective rating plans. The administrator may make available plans under which an

advanced deposit may be applied against a specified deductible amount per claim.

(4)(a) Offer to insure the obligations of employers under this chapter under a plan that groups, for rating purposes, employers, and pools the risk of the employers within the group provided that the employers meet all of the following conditions:

(i) All of the employers within the group are members of an organization that has been in existence for at least two years prior to the date of application for group coverage;

(ii) The organization was formed for purposes other than that of obtaining group workers' compensation under this division;

(iii) The employers' business in the organization is substantially similar such that the risks which are grouped are substantially homogeneous;

(iv) The group of employers consists of at least one hundred members or the aggregate workers' compensation premiums of the members, as determined by the administrator, are expected to exceed one hundred fifty thousand dollars during the coverage period;

(v) The formation and operation of the group program in the organization will substantially improve accident prevention and claims handling for the employers in the group;

(vi) Each employer seeking to enroll in a group for workers' compensation coverage has an industrial insurance account in good standing with the bureau of workers' compensation such that at the time the agreement is processed no outstanding premiums, penalties, or assessments are due from any of the employers.

(b) If an organization sponsors more than one employer group to participate in group plans established under this section, that organization may submit a single application that supplies all of

the information necessary for each group of employers that the organization wishes to sponsor.

(c) In providing employer group plans under division (A)(4) of this section, the administrator shall consider an employer group as a single employing entity for purposes of group rating. No employer may be a member of more than one group for the purpose of obtaining workers' compensation coverage under this division.

(d) At the time the administrator revises premium rates pursuant to this section and section 4123.34 of the Revised Code, if the premium rate of an employer who participates in a group plan established under this section changes from the rate established for the previous year, the administrator, in addition to sending the invoice with the rate revision to that employer, shall send a copy of that invoice to the third-party administrator that administers the group plan for that employer's group.

(e) In providing employer group plans under division (A)(4) of this section, the administrator shall establish a program designed to mitigate the impact of a significant claim that would come into the experience of a private, state fund group-rated employer <u>or a taxing district employer</u> for the first time and be a contributing factor in that employer being excluded from a group-rated plan. The administrator shall establish eligibility criteria and requirements that such employers must satisfy in order to participate in this program. For purposes of this program, the administrator shall establish a discount on premium rates applicable to employers who qualify for the program.

(f) In no event shall division (A)(4) of this section be construed as granting to an employer status as a self-insuring employer.

(g) The administrator shall develop classifications of occupations or industries that are sufficiently distinct so as not

to group employers in classifications that unfairly represent the risks of employment with the employer.

(5) Generally promote employer participation in the state insurance fund through the regular dissemination of information to all classes of employers describing the advantages and benefits of opting to make premium payments to the fund. To that end, the administrator shall regularly make employers aware of the various workers' compensation premium packages developed and offered pursuant to this section.

~~(6) Make available to every employer who is paying premiums to the state insurance fund a program whereby the employer or the employer's agent pays to the claimant or on behalf of the claimant the first fifteen thousand dollars of a compensable workers' compensation medical-only claim filed by that claimant that is related to the same injury or occupational disease. No formal application is required; however, an employer must elect to participate by telephoning the bureau after July 1, 1995. Once an employer has elected to participate in the program, the employer will be responsible for all bills in all medical-only claims with a date of injury the same or later than the election date, unless the employer notifies the bureau within fourteen days of receipt of the notification of a claim being filed that it does not wish to pay the bills in that claim, or the employer notifies the bureau that the fifteen thousand dollar maximum has been paid, or the employer notifies the bureau of the last day of service on which it will be responsible for the bills in a particular medical-only claim. If an employer elects to enter the program, the administrator shall not reimburse the employer for such amounts paid and shall not charge the first fifteen thousand dollars of any medical-only claim paid by an employer to the employer's experience or otherwise use it in merit rating or determining the risks of any employer for the purpose of payment~~

~~of premiums under this chapter. A certified health care provider shall extend to an employer who participates in this program the same rates for services rendered to an employee of that employer as the provider bills the administrator for the same type of medical claim processed by the bureau and shall not charge, assess, or otherwise attempt to collect from an employee any amount for covered services or supplies that is in excess of that rate. If an employer elects to enter the program and the employer fails to pay a bill for a medical-only claim included in the program, the employer shall be liable for that bill and the employee for whom the employer failed to pay the bill shall not be liable for that bill. The administrator shall adopt rules to implement and administer division (A)(6) of this section. Upon written request from the bureau, the employer shall provide documentation to the bureau of all medical-only bills that they are paying directly. Such requests from the bureau may not be made more frequently than on a semiannual basis. Failure to provide such documentation to the bureau within thirty days of receipt of the request may result in the employer's forfeiture of participation in the program for such injury. The provisions of this section shall not apply to claims in which an employer with knowledge of a claimed compensable injury or occupational disease, has paid wages in lieu of compensation or total disability.~~

(B) The administrator, with the advice and consent of the board, by rule, may do both of the following:

(1) Grant an employer who makes the employer's semiannual premium payment at least one month prior to the last day on which the payment may be made without penalty, a discount as the administrator fixes from time to time;

(2) Levy a minimum annual administrative charge upon risks where semiannual premium reports develop a charge less than the administrator considers adequate to offset administrative costs of

processing.

**Sec. 4123.291.** (A) An adjudicating committee appointed by the administrator of workers' compensation to hear any matter specified in divisions (B)(1) to (7) of this section shall hear the matter within sixty days of the date on which an employer files the request, protest, or petition. An employer desiring to file a request, protest, or petition regarding any matter specified in divisions (B)(1) to (7) of this section shall file the request, protest, or petition to the adjudicating committee on or before twenty-four months after the administrator sends notice of the determination about which the employer is filing the request, protest, or petition.

(B) An employer who is adversely affected by a decision of an adjudicating committee appointed by the administrator may appeal the decision of the committee to the administrator or the administrator's designee. The employer shall file the appeal in writing within thirty days after the employer receives the decision of the adjudicating committee. The administrator or the designee shall hear the appeal and hold a hearing, provided that the decision of the adjudicating committee relates to one of the following:

(1) An employer request for a waiver of a default in the payment of premiums pursuant to section 4123.37 of the Revised Code;

(2) An employer request for the settlement of liability as a noncomplying employer under section 4123.75 of the Revised Code;

(3) An employer petition objecting to ~~the~~ an assessment ~~of a premium~~ pursuant to section 4123.37 of the Revised Code and the rules adopted pursuant to that section;

(4) An employer request for the abatement of penalties

assessed pursuant to section 4123.32 of the Revised Code and the rules adopted pursuant to that section;

(5) An employer protest relating to an audit finding or a determination of a manual classification, experience rating, or transfer or combination of risk experience;

(6) Any decision relating to any other risk premium matter under Chapters 4121., 4123., and 4131. of the Revised Code;

(7) An employer petition objecting to the amount of security required under division (C) of section 4125.05 of the Revised Code and the rules adopted pursuant to that section.

(C) The bureau of workers' compensation board of directors, based upon recommendations of the workers' compensation actuarial committee, shall establish the policy for all adjudicating committee procedures, including, but not limited to, specific criteria for manual premium rate adjustment.

**Sec. 4123.353.** (A) A public employer, except for a board of county commissioners described in division (G) of section 4123.01 of the Revised Code, a board of a county hospital, or a publicly owned utility, who is granted the status of self-insuring employer pursuant to section 4123.35 of the Revised Code shall do all of the following:

(1) Reserve funds as necessary, in accordance with sound and prudent actuarial judgment, to cover the costs the public employer may potentially incur to remain in compliance with this chapter and Chapter 4121. of the Revised Code;

(2) Include all activity under this chapter and Chapter 4121. of the Revised Code in a single fund on the public employer's accounting records;

(3) Within ninety days after the last day of each fiscal year, prepare and maintain a report of the reserved funds

described in division (A)(1) of this section and disbursements made from those reserved funds~~;~~

~~(4) Within ninety days after the last day of each fiscal year, obtain a written report prepared by a member of the American academy of actuaries, certifying whether the reserved funds described in division (A)(1) of this section are sufficient to cover the costs the public employer may potentially incur to remain in compliance with this chapter and Chapter 4121. of the Revised Code, are computed in accordance with accepted loss reserving standards, and are fairly stated in accordance with sound loss reserving principles~~.

(B) A public employer who is subject to division (A) of this section shall make the reports required by that division available for inspection by the administrator of workers' compensation and any other person at all reasonable times during regular business hours.

**Sec. 4123.37.** ~~In~~ (A) As used in this section ~~"amenable~~:

(1) "Amenable employer" has the same meaning as "employer" as defined in division (J) of section 4123.32 of the Revised Code.

(2) "Assessment" means any determination by the administrator of workers' compensation that a specific sum of money is owed by an employer under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code, except for amounts owed by an employer pursuant to section 4123.75 of the Revised Code.

(B) If the administrator ~~of workers' compensation~~ finds that any person, firm, or private corporation, including any public service corporation, is, or has been at any time after January 1, 1923, an amenable employer and has not complied with section 4123.35 of the Revised Code the administrator shall determine the period during which the person, firm, or corporation was an

amenable employer and shall forthwith give notice of the determination to the employer. Within twenty days thereafter the employer shall furnish the bureau of workers' compensation with the payroll covering the period included in the determination and, if the employer is an amenable employer at the time of the determination, shall pay a premium security deposit for the eight months next succeeding the date of the determination and shall pay into the state insurance fund the amount of premium applicable to such payroll.

If the employer does not furnish the payroll and pay the applicable premium and premium security deposit within the twenty days, the administrator shall forthwith make an assessment of the premium due from the employer for the period the administrator determined the employer to be an amenable employer including the premium security deposit according to section 4123.32 of the Revised Code if the employer is an amenable employer at the time of the determination, basing the ~~assessment~~ amount due upon the information in the possession of the administrator.

The administrator may issue an invoice or other similar billing notice demanding payment of any assessment, and the employer, upon receipt of the initial invoice or other similar billing notice, may file with the bureau a petition in writing verified under oath by the employer, or the employer's authorized agent having knowledge of the facts, setting forth with particularity the items of the assessment objected to, together with the reason for the objections.

(C) The administrator shall give to the employer assessed written notice of ~~the~~ an assessment and include in that notice a demand for payment in accordance with this division. The notice shall be mailed to the employer at the employer's residence or usual place of business by certified mail. Unless the employer to whom the notice of assessment is directed files with the bureau

within twenty days after receipt thereof, a petition in writing, verified under oath by the employer, or the employer's authorized agent having knowledge of the facts, setting forth with particularity the items of the assessment objected to, together with the reason for the objections, the assessment shall become conclusive and the amount thereof shall be due and payable from the employer so assessed ~~to the state insurance fund~~. When a petition objecting to an assessment is filed the bureau shall assign a time and place for the hearing of the same and shall notify the petitioner thereof ~~by certified mail~~. When an employer files a petition the assessment made by the administrator shall become due and payable ten days after the bureau sends notice of the finding made at the hearing ~~has been sent by certified mail~~ to the party assessed. An employer may first appeal an adverse decision to the administrator or the designee of the administrator as provided in section 4123.291 of the Revised Code, and subsequently an appeal may be taken from any finding to the court of common pleas of Franklin county upon the execution by the party assessed of a bond to the state in ~~double~~ the amount found due and ordered paid by the bureau conditioned that the party will pay any judgment and costs rendered against it for the ~~premium~~ assessment.

(D) When no petition objecting to an assessment is filed or when a finding is made affirming or modifying an assessment after hearing, a certified copy of the assessment as affirmed or modified may be filed by the administrator in the office of the clerk of the court of common pleas in any county in which the employer has property or in which the employer has a place of business. The clerk, immediately upon the filing of the assessment, shall enter a judgment for the state against the employer in the amount shown on the assessment. The judgment may be filed by the clerk in a loose leaf book entitled "special judgments for state insurance fund." The judgment shall bear the

same rate of interest, have the same effect as other judgments, and be given the same preference allowed by law on other judgments rendered for claims for taxes. An assessment or judgment under this section shall not be a bar to the adjustment of the employer's account upon the employer furnishing the employer's payroll records to the bureau.

(E) The administrator, for good cause shown, may waive a default in the payment of premium where the default is of less than sixty days' duration, and upon payment by the employer of the premium for the period, the employer and the employer's employees are entitled to all of the benefits and immunities provided by this chapter.

**Sec. 4123.411.** (A) For the purpose of carrying out sections 4123.412 to 4123.418 of the Revised Code, the administrator of workers' compensation, with the advice and consent of the bureau of workers' compensation board of directors, shall levy an assessment against all employers at a rate~~, of at least five but~~ not to exceed ten cents per one hundred dollars of payroll, such rate to be determined annually for each employer group listed in divisions (A)(1) to (3) of this section, which will produce an amount no greater than the amount the administrator estimates to be necessary to carry out such sections for the period for which the assessment is levied. In the event the amount produced by the assessment is not sufficient to carry out such sections the additional amount necessary shall be provided from the income produced as a result of investments made pursuant to section 4123.44 of the Revised Code.

Assessments shall be levied according to the following schedule:

(1) Private fund employers, except self-insuring employers--in January and July of each year upon gross payrolls of

the preceding six months;

(2) Counties and taxing district employers therein, except county hospitals that are self-insuring employers--in January of each year upon gross payrolls of the preceding twelve months;

(3) The state as an employer--in January, April, July, and October of each year upon gross payrolls of the preceding three months.

Amounts assessed in accordance with this section shall be collected from each employer as prescribed in rules the administrator adopts.

The moneys derived from the assessment provided for in this section shall be credited to the disabled workers' relief fund created by section 4123.412 of the Revised Code. The administrator shall establish by rule classifications of employers within divisions (A)(1) to (3) of this section and shall determine rates for each class so as to fairly apportion the costs of carrying out sections 4123.412 to 4123.418 of the Revised Code.

(B) For all injuries and disabilities occurring on or after January 1, 1987, the administrator, for the purposes of carrying out sections 4123.412 to 4123.418 of the Revised Code, shall levy an assessment against all employers at a rate per one hundred dollars of payroll, such rate to be determined annually for each classification of employer in each employer group listed in divisions (A)(1) to (3) of this section, which will produce an amount no greater than the amount the administrator estimates to be necessary to carry out such sections for the period for which the assessment is levied. The administrator annually shall establish the contributions due from employers for the disabled workers' relief fund at rates as low as possible but that will assure sufficient moneys to guarantee the payment of any claims against that fund.

Amounts assessed in accordance with this division shall be billed at the same time premiums are billed and credited to the disabled workers' relief fund created by section 4123.412 of the Revised Code. The administrator shall determine the rates for each class in the same manner as the administrator fixes the rates for premiums pursuant to section 4123.29 of the Revised Code.

(C) For a self-insuring employer, the bureau of workers' compensation shall pay to employees who are participants regardless of the date of injury, any amounts due to the participants under section 4123.414 of the Revised Code and shall bill the self-insuring employer, semiannually, for all amounts paid to a participant.

**Sec. 4123.47.** (A) The administrator of workers' compensation shall have an actuarial ~~audits~~ analysis of the state insurance fund and all other funds specified in this chapter and Chapters 4121., 4127., and 4131. of the Revised Code made at least once each year. The ~~audits~~ analysis shall be made and certified by recognized ~~insurance~~, credentialed property or casualty actuaries who shall be selected by the bureau of workers' compensation board of directors. ~~The audits shall cover the premium rates, classifications, and all other matters involving the administration of the state insurance fund and all other funds specified in this chapter and Chapters 4121., 4127., and 4131. of the Revised Code.~~ The expense of the ~~audits~~ analysis shall be paid from the state insurance fund. The administrator shall make copies of the ~~audits~~ analysis available to the workers' compensation audit committee at no charge and to the public at cost.

(B) The auditor of state annually shall conduct an audit of the administration of this chapter by the industrial commission and the bureau of workers' compensation and the safety and hygiene fund. The cost of the audit shall be charged to the administrative

costs of the bureau as defined in section 4123.341 of the Revised Code. The audit shall include audits of all fiscal activities, claims processing and handling, and employer premium collections. The auditor shall prepare a report of the audit together with recommendations and transmit copies of the report to the industrial commission, the board, the administrator, the governor, and to the general assembly. The auditor shall make copies of the report available to the public at cost.

(C) The administrator may retain the services of a recognized actuary on a consulting basis for the purpose of evaluating the actuarial soundness of premium rates and classifications and all other matters involving the administration of the state insurance fund. The expense of services provided by the actuary shall be paid from the state insurance fund.

**Sec. 4123.511.** (A) Within seven days after receipt of any claim under this chapter, the bureau of workers' compensation shall notify the claimant and the employer of the claimant of the receipt of the claim and of the facts alleged therein. If the bureau receives from a person other than the claimant written or facsimile information or information communicated verbally over the telephone indicating that an injury or occupational disease has occurred or been contracted which may be compensable under this chapter, the bureau shall notify the employee and the employer of the information. If the information is provided verbally over the telephone, the person providing the information shall provide written verification of the information to the bureau according to division (E) of section 4123.84 of the Revised Code. The receipt of the information in writing or facsimile, or if initially by telephone, the subsequent written verification, and the notice by the bureau shall be considered an application for compensation under section 4123.84 or 4123.85 of the Revised Code, provided that the conditions of division (E) of section

4123.84 of the Revised Code apply to information provided verbally over the telephone. Upon receipt of a claim, the bureau shall advise the claimant of the claim number assigned and the claimant's right to representation in the processing of a claim or to elect no representation. If the bureau determines that a claim is determined to be a compensable lost-time claim, the bureau shall notify the claimant and the employer of the availability of rehabilitation services. No bureau or industrial commission employee shall directly or indirectly convey any information in derogation of this right. This section shall in no way abrogate the bureau's responsibility to aid and assist a claimant in the filing of a claim and to advise the claimant of the claimant's rights under the law.

The administrator of workers' compensation shall assign all claims and investigations to the bureau service office from which investigation and determination may be made most expeditiously.

The bureau shall investigate the facts concerning an injury or occupational disease and ascertain such facts in whatever manner is most appropriate and may obtain statements of the employee, employer, attending physician, and witnesses in whatever manner is most appropriate.

The administrator, with the advice and consent of the bureau of workers' compensation board of directors, may adopt rules that identify specified medical conditions that have a historical record of being allowed whenever included in a claim. The administrator may grant immediate allowance of any medical condition identified in those rules upon the filing of a claim involving that medical condition and may make immediate payment of medical bills for any medical condition identified in those rules that is included in a claim. If an employer contests the allowance of a claim involving any medical condition identified in those rules, and the claim is disallowed, payment for the medical

condition included in that claim shall be charged to and paid from the surplus fund created under section 4123.34 of the Revised Code.

(B)(1) Except as provided in division (B)(2) of this section, in claims other than those in which the employer is a self-insuring employer, if the administrator determines under division (A) of this section that a claimant is or is not entitled to an award of compensation or benefits, the administrator shall issue an order no later than twenty-eight days after the sending of the notice under division (A) of this section, granting or denying the payment of the compensation or benefits, or both as is appropriate to the claimant. After conducting an investigation pursuant to division (A) of this section and not later than twenty-eight days after sending the notice pursuant to division (A) of this section, if the administrator determines that insufficient information exists to grant or deny the payment of compensation, benefits, or both to the claimant, the administrator may, with notice to both parties, issue an order dismissing the claim without prejudice. A claim that has been dismissed without prejudice pursuant to this division shall not constitute notice to the industrial commission or bureau of workers' compensation for purposes of division (A) of section 4123.84 of the Revised Code and shall not constitute an application to the industrial commission or bureau of workers' compensation for purposes of section 4123.85 of the Revised Code. Notwithstanding the time limitation specified in this division for the issuance of an order, if a medical examination of the claimant is required by statute, the administrator promptly shall schedule the claimant for that examination and shall issue an order no later than twenty-eight days after receipt of the report of the examination. The administrator shall notify the claimant and the employer of the claimant and their respective representatives in writing of the nature of the order and the amounts of compensation and

benefit payments involved. The employer or claimant may appeal the order pursuant to division (C) of this section within fourteen days after the date of the receipt of the order. The employer and claimant may waive, in writing, their rights to an appeal under this division.

(2) Notwithstanding the time limitation specified in division (B)(1) of this section for the issuance of an order, if the employer certifies a claim for payment of compensation or benefits, or both, to a claimant, and the administrator has completed the investigation of the claim, the payment of benefits or compensation, or both, as is appropriate, shall commence upon the later of the date of the certification or completion of the investigation and issuance of the order by the administrator, provided that the administrator shall issue the order no later than the time limitation specified in division (B)(1) of this section.

(3) If an appeal is made under division (B)(1) or (2) of this section, the administrator shall forward the claim file to the appropriate district hearing officer within seven days of the appeal. In contested claims other than state fund claims, the administrator shall forward the claim within seven days of the administrator's receipt of the claim to the industrial commission, which shall refer the claim to an appropriate district hearing officer for a hearing in accordance with division (C) of this section.

(C) If an employer or claimant timely appeals the order of the administrator issued under division (B) of this section or in the case of other contested claims other than state fund claims, the commission shall refer the claim to an appropriate district hearing officer according to rules the commission adopts under section 4121.36 of the Revised Code. The district hearing officer shall notify the parties and their respective representatives of

the time and place of the hearing.

The district hearing officer shall hold a hearing on a disputed issue or claim within forty-five days after the filing of the appeal under this division and issue a decision within seven days after holding the hearing. The district hearing officer shall notify the parties and their respective representatives in writing of the order. Any party may appeal an order issued under this division pursuant to division (D) of this section within fourteen days after receipt of the order under this division.

(D) Upon the timely filing of an appeal of the order of the district hearing officer issued under division (C) of this section, the commission shall refer the claim file to an appropriate staff hearing officer according to its rules adopted under section 4121.36 of the Revised Code. The staff hearing officer shall hold a hearing within forty-five days after the filing of an appeal under this division and issue a decision within seven days after holding the hearing under this division. The staff hearing officer shall notify the parties and their respective representatives in writing of the staff hearing officer's order. Any party may appeal an order issued under this division pursuant to division (E) of this section within fourteen days after receipt of the order under this division.

(E) Upon the filing of a timely appeal of the order of the staff hearing officer issued under division (D) of this section, the commission or a designated staff hearing officer, on behalf of the commission, shall determine whether the commission will hear the appeal. If the commission or the designated staff hearing officer decides to hear the appeal, the commission or the designated staff hearing officer shall notify the parties and their respective representatives in writing of the time and place of the hearing. The commission shall hold the hearing within forty-five days after the filing of the notice of appeal and,

within seven days after the conclusion of the hearing, the commission shall issue its order affirming, modifying, or reversing the order issued under division (D) of this section. The commission shall notify the parties and their respective representatives in writing of the order. If the commission or the designated staff hearing officer determines not to hear the appeal, within fourteen days after the expiration of the period in which an appeal of the order of the staff hearing officer may be filed as provided in division (D) of this section, the commission or the designated staff hearing officer shall issue an order to that effect and notify the parties and their respective representatives in writing of that order.

Except as otherwise provided in this chapter and Chapters 4121., 4127., and 4131. of the Revised Code, any party may appeal an order issued under this division to the court pursuant to section 4123.512 of the Revised Code within sixty days after receipt of the order, subject to the limitations contained in that section.

(F) Every notice of an appeal from an order issued under divisions (B), (C), (D), and (E) of this section shall state the names of the claimant and employer, the number of the claim, the date of the decision appealed from, and the fact that the appellant appeals therefrom.

(G) All of the following apply to the proceedings under divisions (C), (D), and (E) of this section:

(1) The parties shall proceed promptly and without continuances except for good cause;

(2) The parties, in good faith, shall engage in the free exchange of information relevant to the claim prior to the conduct of a hearing according to the rules the commission adopts under section 4121.36 of the Revised Code;

(3) The administrator is a party and may appear and participate at all administrative proceedings on behalf of the state insurance fund. However, in cases in which the employer is represented, the administrator shall neither present arguments nor introduce testimony that is cumulative to that presented or introduced by the employer or the employer's representative. The administrator may file an appeal under this section on behalf of the state insurance fund; however, except in cases arising under section 4123.343 of the Revised Code, the administrator only may appeal questions of law or issues of fraud when the employer appears in person or by representative.

(H) Except as provided in section 4121.63 of the Revised Code and division (K) of this section, payments of compensation to a claimant or on behalf of a claimant as a result of any order issued under this chapter shall commence upon the earlier of the following:

(1) Fourteen days after the date the administrator issues an order under division (B) of this section, unless that order is appealed;

(2) The date when the employer has waived the right to appeal a decision issued under division (B) of this section;

(3) If no appeal of an order has been filed under this section or to a court under section 4123.512 of the Revised Code, the expiration of the time limitations for the filing of an appeal of an order;

(4) The date of receipt by the employer of an order of a district hearing officer, a staff hearing officer, or the industrial commission issued under division (C), (D), or (E) of this section.

(I) ~~Payments~~ Except as otherwise provided in division (B) or (C) of section 4123.66 of the Revised Code, payments of medical

benefits payable under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code shall commence upon the earlier of the following:

(1) The date of the issuance of the staff hearing officer's order under division (D) of this section;

(2) The date of the final administrative or judicial determination.

(J) The administrator shall charge the compensation payments made in accordance with division (H) of this section or medical benefits payments made in accordance with division (I) of this section to an employer's experience immediately after the employer has exhausted the employer's administrative appeals as provided in this section or has waived the employer's right to an administrative appeal under division (B) of this section, subject to the adjustment specified in division (H) of section 4123.512 of the Revised Code.

(K) Upon the final administrative or judicial determination under this section or section 4123.512 of the Revised Code of an appeal of an order to pay compensation, if a claimant is found to have received compensation pursuant to a prior order which is reversed upon subsequent appeal, the claimant's employer, if a self-insuring employer, or the bureau, shall withhold from any amount to which the claimant becomes entitled pursuant to any claim, past, present, or future, under Chapter 4121., 4123., 4127., or 4131. of the Revised Code, the amount of previously paid compensation to the claimant which, due to reversal upon appeal, the claimant is not entitled, pursuant to the following criteria:

(1) No withholding for the first twelve weeks of temporary total disability compensation pursuant to section 4123.56 of the Revised Code shall be made;

(2) Forty per cent of all awards of compensation paid

pursuant to sections 4123.56 and 4123.57 of the Revised Code, until the amount overpaid is refunded;

(3) Twenty-five per cent of any compensation paid pursuant to section 4123.58 of the Revised Code until the amount overpaid is refunded;

(4) If, pursuant to an appeal under section 4123.512 of the Revised Code, the court of appeals or the supreme court reverses the allowance of the claim, then no amount of any compensation will be withheld.

The administrator and self-insuring employers, as appropriate, are subject to the repayment schedule of this division only with respect to an order to pay compensation that was properly paid under a previous order, but which is subsequently reversed upon an administrative or judicial appeal. The administrator and self-insuring employers are not subject to, but may utilize, the repayment schedule of this division, or any other lawful means, to collect payment of compensation made to a person who was not entitled to the compensation due to fraud as determined by the administrator or the industrial commission.

(L) If a staff hearing officer or the commission fails to issue a decision or the commission fails to refuse to hear an appeal within the time periods required by this section, payments to a claimant shall cease until the staff hearing officer or commission issues a decision or hears the appeal, unless the failure was due to the fault or neglect of the employer or the employer agrees that the payments should continue for a longer period of time.

(M) Except as otherwise provided in this section or section 4123.522 of the Revised Code, no appeal is timely filed under this section unless the appeal is filed with the time limits set forth in this section.

(N) No person who is not an employee of the bureau or commission or who is not by law given access to the contents of a claims file shall have a file in the person's possession.

(O) Upon application of a party who resides in an area in which an emergency or disaster is declared, the industrial commission and hearing officers of the commission may waive the time frame within which claims and appeals of claims set forth in this section must be filed upon a finding that the applicant was unable to comply with a filing deadline due to an emergency or a disaster.

As used in this division:

(1) "Emergency" means any occasion or instance for which the governor of Ohio or the president of the United States publicly declares an emergency and orders state or federal assistance to save lives and protect property, the public health and safety, or to lessen or avert the threat of a catastrophe.

(2) "Disaster" means any natural catastrophe or fire, flood, or explosion, regardless of the cause, that causes damage of sufficient magnitude that the governor of Ohio or the president of the United States, through a public declaration, orders state or federal assistance to alleviate damage, loss, hardship, or suffering that results from the occurrence.

**Sec. 4123.512.** (A) The claimant or the employer may appeal an order of the industrial commission made under division (E) of section 4123.511 of the Revised Code in any injury or occupational disease case, other than a decision as to the extent of disability to the court of common pleas of the county in which the injury was inflicted or in which the contract of employment was made if the injury occurred outside the state, or in which the contract of employment was made if the exposure occurred outside the state. If no common pleas court has jurisdiction for the purposes of an

appeal by the use of the jurisdictional requirements described in this division, the appellant may use the venue provisions in the Rules of Civil Procedure to vest jurisdiction in a court. If the claim is for an occupational disease, the appeal shall be to the court of common pleas of the county in which the exposure which caused the disease occurred. Like appeal may be taken from an order of a staff hearing officer made under division (D) of section 4123.511 of the Revised Code from which the commission has refused to hear an appeal. The appellant shall file the notice of appeal with a court of common pleas within sixty days after the date of the receipt of the order appealed from or the date of receipt of the order of the commission refusing to hear an appeal of a staff hearing officer's decision under division (D) of section 4123.511 of the Revised Code. The filing of the notice of the appeal with the court is the only act required to perfect the appeal.

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

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

(B) The notice of appeal shall state the names of the administrator of workers' compensation, the claimant, and the employer~~,~~; the number of the claim~~,~~; the date of the order

appealed from~~,~~; and the fact that the appellant appeals therefrom.

The administrator ~~of workers' compensation~~, the claimant, and the employer shall be parties to the appeal and the court, upon the application of the commission, shall make the commission a party. The party filing the appeal shall serve a copy of the notice of appeal on the administrator at the central office of the bureau of workers' compensation in Columbus. The administrator shall notify the employer that if the employer fails to become an active party to the appeal, then the administrator may act on behalf of the employer and the results of the appeal could have an adverse effect upon the employer's premium rates.

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

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

The claimant shall, within thirty days after the filing of the notice of appeal, file a petition containing a statement of facts in ordinary and concise language showing a cause of action to participate or to continue to participate in the fund and setting forth the basis for the jurisdiction of the court over the action. Further pleadings shall be had in accordance with the Rules of Civil Procedure, provided that service of summons on such

petition shall not be required and provided that the claimant may not dismiss the complaint without the employer's consent if the employer is the party that filed the notice of appeal to court pursuant to this section. The clerk of the court shall, upon receipt thereof, transmit by certified mail a copy thereof to each party named in the notice of appeal other than the claimant. Any party may file with the clerk prior to the trial of the action a deposition of any physician taken in accordance with the provisions of the Revised Code, which deposition may be read in the trial of the action even though the physician is a resident of or subject to service in the county in which the trial is had. The bureau of workers' compensation shall pay the cost of the stenographic deposition filed in court and of copies of the stenographic deposition for each party from the surplus fund and charge the costs thereof against the unsuccessful party if the claimant's right to participate or continue to participate is finally sustained or established in the appeal. In the event the deposition is taken and filed, the physician whose deposition is taken is not required to respond to any subpoena issued in the trial of the action. The court, or the jury under the instructions of the court, if a jury is demanded, shall determine the right of the claimant to participate or to continue to participate in the fund upon the evidence adduced at the hearing of the action.

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

(F) The cost of any legal proceedings authorized by this section, including an attorney's fee to the claimant's attorney to be fixed by the trial judge, based upon the effort expended, in the event the claimant's right to participate or to continue to participate in the fund is established upon the final

determination of an appeal, shall be taxed against the employer or the commission if the commission or the administrator rather than the employer contested the right of the claimant to participate in the fund. The attorney's fee shall not exceed forty-two hundred dollars.

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

(H)(1) An appeal from an order issued under division (E) of section 4123.511 of the Revised Code or any action filed in court in a case in which an award of compensation or medical benefits has been made shall not stay the payment of compensation or medical benefits under the award, or payment for subsequent periods of total disability or medical benefits during the pendency of the appeal. If, in a final administrative or judicial action, it is determined that payments of compensation or benefits, or both, made to or on behalf of a claimant should not have been made, the amount thereof shall be charged to the surplus fund account under division (B) of section 4123.34 of the Revised Code. In the event the employer is a state risk, the amount shall not be charged to the employer's experience, and the administrator shall adjust the employer's account accordingly. In the event the employer is a self-insuring employer, the self-insuring employer shall deduct the amount from the paid compensation the self-insuring employer reports to the administrator under division (L) of section 4123.35 of the Revised Code. <u>If an employer is a state risk and has paid an assessment for a violation of a specific safety requirement, and, in a final administrative or judicial action, it is determined that the employer did not</u>

violate the specific safety requirement, the administrator shall reimburse the employer from the surplus fund account created in division (B) of section 4123.34 of the Revised Code for the amount of the assessment the employer paid for the violation.

(2)(a) Notwithstanding a final determination that payments of benefits made to or on behalf of a claimant should not have been made, the administrator or self-insuring employer shall award payment of medical or vocational rehabilitation services submitted for payment after the date of the final determination if all of the following apply:

(i) The services were approved and were rendered by the provider in good faith prior to the date of the final determination.

(ii) The services were payable under division (I) of section 4123.511 of the Revised Code prior to the date of the final determination.

(iii) The request for payment is submitted within the time limit set forth in section 4123.52 of the Revised Code.

(b) Payments made under division (H)(1) of this section shall be charged to the surplus fund account under division (B) of section 4123.34 of the Revised Code. If the employer of the employee who is the subject of a claim described in division (H)(2)(a) of this section is a state fund employer, the payments made under that division shall not be charged to the employer's experience. If that employer is a self-insuring employer, the self-insuring employer shall deduct the amount from the paid compensation the self-insuring employer reports to the administrator under division (L) of section 4123.35 of the Revised Code.

(c) Division (H)(2) of this section shall apply only to a claim under this chapter or Chapter 4121., 4127., or 4131. of the

Revised Code arising on or after ~~the effective date of this amendment~~ July 29, 2011.

(3) A self-insuring employer may elect to pay compensation and benefits under this section directly to an employee or an employee's dependents by filing an application with the bureau of workers' compensation not more than one hundred eighty days and not less than ninety days before the first day of the employer's next six-month coverage period. If the self-insuring employer timely files the application, the application is effective on the first day of the employer's next six-month coverage period, provided that the administrator shall compute the employer's assessment for the surplus fund account due with respect to the period during which that application was filed without regard to the filing of the application. On and after the effective date of the employer's election, the self-insuring employer shall pay directly to an employee or to an employee's dependents compensation and benefits under this section regardless of the date of the injury or occupational disease, and the employer shall receive no money or credits from the surplus fund account on account of those payments and shall not be required to pay any amounts into the surplus fund account on account of this section. The election made under this division is irrevocable.

(I) All actions and proceedings under this section which are the subject of an appeal to the court of common pleas or the court of appeals shall be preferred over all other civil actions except election causes, irrespective of position on the calendar.

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

Any action pending in common pleas court or any other court on January 1, 1986, under this section is governed by former

sections 4123.514, 4123.515, 4123.516, and 4123.519 and section 4123.522 of the Revised Code.

**Sec. 4123.66.** (A) In addition to the compensation provided for in this chapter, the administrator of workers' compensation shall disburse and pay from the state insurance fund the amounts for medical, nurse, and hospital services and medicine as the administrator deems proper and, in case death ensues from the injury or occupational disease, the administrator shall disburse and pay from the fund reasonable funeral expenses in an amount not to exceed fifty-five hundred dollars. The bureau of workers' compensation shall reimburse anyone, whether dependent, volunteer, or otherwise, who pays the funeral expenses of any employee whose death ensues from any injury or occupational disease as provided in this section. The administrator may adopt rules, with the advice and consent of the bureau of workers' compensation board of directors, with respect to furnishing medical, nurse, and hospital service and medicine to injured or disabled employees entitled thereto, and for the payment therefor. In case an injury or industrial accident that injures an employee also causes damage to the employee's eyeglasses, artificial teeth or other denture, or hearing aid, or in the event an injury or occupational disease makes it necessary or advisable to replace, repair, or adjust the same, the bureau shall disburse and pay a reasonable amount to repair or replace the same.

(B) The administrator, in the rules the administrator adopts pursuant to division (A) of this section, may adopt rules specifying the circumstances under which the bureau may make immediate payment for the first fill of prescription drugs for medical conditions identified in an application for compensation or benefits under section 4123.84 or 4123.85 of the Revised Code that occurs prior to the date the administrator issues an initial determination order under division (B) of section 4123.511 of the

Revised Code. If the claim is ultimately disallowed in a final administrative or judicial order, and if the employer is a state fund employer who pays assessments into the surplus fund account created under section 4123.34 of the Revised Code, the payments for medical services made pursuant to this division for the first fill of prescription drugs shall be charged to and paid from the surplus fund account and not charged through the state insurance fund to the employer against whom the claim was filed.

(C) The administrator, in the rules the administrator adopts pursuant to division (A) of this section, may identify specified medical services that are presumptively authorized and payable to a provider who provides any of the services identified in, and complies with the requirements set forth in, the rules the administrator adopts for the services rendered. The administrator, in the rules the administrator adopts under this division, shall limit the payment for these services to only those services rendered to a claimant during the time period beginning the date the administrator issues an order pursuant to division (B) of section 4123.511 of the Revised Code allowing a claim or allowing an additional condition to which the services relate and ending forty-five days after the date the order was issued.

If the claim or additional condition is ultimately disallowed in a final administrative or judicial order, and if the employer is a state fund employer who pays assessments into the surplus fund account created under section 4123.34 of the Revised Code, the payments for medical services made pursuant to this division for that claim or condition shall be charged to and paid from the surplus fund account and not charged through the state insurance fund to the employer against whom the claim or additional condition was filed.

(D)(1) If an employer or a welfare plan has provided to or on behalf of an employee any benefits or compensation for an injury

or occupational disease and that injury or occupational disease is determined compensable under this chapter, the employer or a welfare plan may request that the administrator reimburse the employer or welfare plan for the amount the employer or welfare plan paid to or on behalf of the employee in compensation or benefits. The administrator shall reimburse the employer or welfare plan for the compensation and benefits paid if, at the time the employer or welfare plan provides the benefits or compensation to or on behalf of employee, the injury or occupational disease had not been determined to be compensable under this chapter and if the employee was not receiving compensation or benefits under this chapter for that injury or occupational disease. The administrator shall reimburse the employer or welfare plan in the amount that the administrator would have paid to or on behalf of the employee under this chapter if the injury or occupational disease originally would have been determined compensable under this chapter. If the employer is a merit-rated employer, the administrator shall adjust the amount of premium next due from the employer according to the amount the administrator pays the employer. The administrator shall adopt rules, in accordance with Chapter 119. of the Revised Code, to implement this division.

(2) As used in this division, "welfare plan" has the same meaning as in division (1) of 29 U.S.C.A. 1002.

**Sec. 4123.82.** (A) All contracts and agreements are void which undertake to indemnify or insure an employer against loss or liability for the payment of compensation to workers or their dependents for death, injury, or occupational disease occasioned in the course of the workers' employment, or which provide that the insurer shall pay the compensation, or which indemnify the employer against damages when the injury, disease, or death arises from the failure to comply with any lawful requirement for the

protection of the lives, health, and safety of employees, or when the same is occasioned by the willful act of the employer or any of the employer's officers or agents, or by which it is agreed that the insurer shall pay any such damages. No license or authority to enter into any such agreements or issue any such policies of insurance shall be granted or issued by any public authority in this state. Any corporation organized or admitted under the laws of this state to transact liability insurance as defined in section 3929.01 of the Revised Code may by amendment of its articles of incorporation or by original articles of incorporation, provide therein for the authority and purpose to make insurance in states, territories, districts, and counties, other than the state of Ohio, and in the state of Ohio in respect of contracts permitted by division (B) of this section, indemnifying employers against loss or liability for payment of compensation to workers and employees and their dependents for death, injury, or occupational disease occasioned in the course of the employment and to insure and indemnify employers against loss, expense, and liability by risk of bodily injury or death by accident, disability, sickness, or disease suffered by workers and employees for which the employer may be liable or has assumed liability.

(B) Notwithstanding division (A) of this section:

(1) No contract because of that division is void which undertakes to indemnify a self-insuring employer against all or part of such employer's loss in excess of at least ~~fifty~~ three hundred thousand dollars from any one disaster or event arising out of the employer's liability under this chapter, but no insurance corporation shall, directly or indirectly, represent an employer in the settlement, adjudication, determination, allowance, or payment of claims. The superintendent of insurance shall enforce this prohibition by such disciplinary orders

directed against the offending insurance corporation as the superintendent of insurance deems appropriate in the circumstances and the administrator of workers' compensation shall enforce this prohibition by such disciplinary orders directed against the offending employer as the administrator deems appropriate in the circumstances, which orders may include revocation of the insurance corporation's right to enter into indemnity contracts and revocation of the employer's status as a self-insuring employer.

(2) The administrator may enter into a contract of indemnity with any such employer upon such terms, payment of such premium, and for such amount and form of indemnity as the administrator determines and the bureau of workers' compensation board of directors may procure reinsurance of the liability of the public and private funds under this chapter, or any part of the liability in respect of either or both of the funds, upon such terms and premiums or other payments from the fund or funds as the administrator deems prudent in the maintenance of a solvent fund or funds from year to year. When making the finding of fact which the administrator is required by section 4123.35 of the Revised Code to make with respect to the financial ability of an employer, no contract of indemnity, or the ability of the employer to procure such a contract, shall be considered as increasing the financial ability of the employer.

(C) Nothing in this section shall be construed to prohibit the administrator or an other-states' insurer from providing to employers in this state other-states' coverage in accordance with section 4123.292 of the Revised Code.

(D) Notwithstanding any other section of the Revised Code, but subject to division (A) of this section, the superintendent of insurance shall have the sole authority to regulate any insurance products, except for the bureau of workers' compensation and those

products offered by the bureau, that indemnify or insure employers against workers' compensation losses in this state or that are sold to employers in this state.

**Sec. 4123.93.** As used in sections 4123.93 and 4123.931 of the Revised Code:

(A) "Claimant" means a person who is eligible to receive compensation, medical benefits, or death benefits under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code.

(B) "Statutory subrogee" means the administrator of workers' compensation, a self-insuring employer, or an employer that contracts for the direct payment of medical services pursuant to division ~~(L)~~(M) of section 4121.44 of the Revised Code.

(C) "Third party" means an individual, private insurer, public or private entity, or public or private program that is or may be liable to make payments to a person without regard to any statutory duty contained in this chapter or Chapter 4121., 4127., or 4131. of the Revised Code.

(D) "Subrogation interest" includes past, present, and estimated future payments of compensation, medical benefits, rehabilitation costs, or death benefits, and any other costs or expenses paid to or on behalf of the claimant by the statutory subrogee pursuant to this chapter or Chapter 4121., 4127., or 4131. of the Revised Code.

(E) "Net amount recovered" means the amount of any award, settlement, compromise, or recovery by a claimant against a third party, minus the attorney's fees, costs, or other expenses incurred by the claimant in securing the award, settlement, compromise, or recovery. "Net amount recovered" does not include any punitive damages that may be awarded by a judge or jury.

(F) "Uncompensated damages" means the claimant's demonstrated

or proven damages minus the statutory subrogee's subrogation interest.

**Sec. 4729.80.** (A) If the state board of pharmacy establishes and maintains a drug database pursuant to section 4729.75 of the Revised Code, the board is authorized or required to provide information from the database in accordance with the following:

(1) On receipt of a request from a designated representative of a government entity responsible for the licensure, regulation, or discipline of health care professionals with authority to prescribe, administer, or dispense drugs, the board may provide to the representative information from the database relating to the professional who is the subject of an active investigation being conducted by the government entity.

(2) On receipt of a request from a federal officer, or a state or local officer of this or any other state, whose duties include enforcing laws relating to drugs, the board shall provide to the officer information from the database relating to the person who is the subject of an active investigation of a drug abuse offense, as defined in section 2925.01 of the Revised Code, being conducted by the officer's employing government entity.

(3) Pursuant to a subpoena issued by a grand jury, the board shall provide to the grand jury information from the database relating to the person who is the subject of an investigation being conducted by the grand jury.

(4) Pursuant to a subpoena, search warrant, or court order in connection with the investigation or prosecution of a possible or alleged criminal offense, the board shall provide information from the database as necessary to comply with the subpoena, search warrant, or court order.

(5) On receipt of a request from a prescriber or the

prescriber's delegate approved by the board, the board may provide to the prescriber information from the database relating to a patient who is either of the following, if the prescriber certifies in a form specified by the board that it is for the purpose of providing medical treatment to the patient who is the subject of the request;

(a) A current patient of the prescriber;

(b) A potential patient of the prescriber based on a referral of the patient to the prescriber.

(6) On receipt of a request from a pharmacist or the pharmacist's delegate approved by the board, the board may provide to the pharmacist information from the database relating to a current patient of the pharmacist, if the pharmacist certifies in a form specified by the board that it is for the purpose of the pharmacist's practice of pharmacy involving the patient who is the subject of the request.

(7) On receipt of a request from an individual seeking the individual's own database information in accordance with the procedure established in rules adopted under section 4729.84 of the Revised Code, the board may provide to the individual the individual's own database information.

(8) On receipt of a request from the medical director of a managed care organization that has entered into a data security agreement with the board required by section 5111.1710 of the Revised Code, the board may provide to the medical director information from the database relating to a medicaid recipient enrolled in the managed care organization.

(9) On receipt of a request from the director of job and family services, the board may provide to the director information from the database relating to a recipient of a program administered by the department of job and family services.

(10) On receipt of a request from the administrator of workers' compensation, the board ~~may~~ shall provide to the administrator information from the database relating to a claimant under Chapter 4121., 4123., 4127., or 4131. of the Revised Code.

(11) On receipt of a request from a requestor described in division (A)(1), (2), (5), or (6) of this section who is from or participating with another state's prescription monitoring program, the board may provide to the requestor information from the database, but only if there is a written agreement under which the information is to be used and disseminated according to the laws of this state.

(B) The state board of pharmacy shall maintain a record of each individual or entity that requests information from the database pursuant to this section. In accordance with rules adopted under section 4729.84 of the Revised Code, the board may use the records to document and report statistics and law enforcement outcomes.

The board may provide records of an individual's requests for database information to the following:

(1) A designated representative of a government entity that is responsible for the licensure, regulation, or discipline of health care professionals with authority to prescribe, administer, or dispense drugs who is involved in an active investigation being conducted by the government entity of the individual who submitted the requests for database information;

(2) A federal officer, or a state or local officer of this or any other state, whose duties include enforcing laws relating to drugs and who is involved in an active investigation being conducted by the officer's employing government entity of the individual who submitted the requests for database information.

(C) Information contained in the database and any information

obtained from it is not a public record. Information contained in the records of requests for information from the database is not a public record. Information that does not identify a person may be released in summary, statistical, or aggregate form.

(D) A pharmacist or prescriber shall not be held liable in damages to any person in any civil action for injury, death, or loss to person or property on the basis that the pharmacist or prescriber did or did not seek or obtain information from the database.

**Section 102.** That existing sections 4121.129, 4121.44, 4121.441, 4123.29, 4123.291, 4123.353, 4123.37, 4123.411, 4123.47, 4123.511, 4123.512, 4123.66, 4123.82, 4123.93, and 4729.80 of the Revised Code are hereby repealed.

**Section 201.** All items in are hereby appropriated out of any moneys in the state treasury to the credit of the designated fund. For all appropriations made in this act, those in the first column are for fiscal year 2014, and those in the second column are for fiscal year 2015.

| FND | AI | AI TITLE | Appropriations | |
|---|---|---|---|---|
| | | BWC BUREAU OF WORKERS' COMPENSATION | | |
| Workers' Compensation Fund Group | | | | |
| 7023 | 855401 | William Green Lease Payments to OBA | $ 16,026,100 | $ 0 |
| 7023 | 855407 | Claims, Risk and Medical Management | $ 118,338,586 | $ 118,338,586 |
| 7023 | 855408 | Fraud Prevention | $ 12,114,226 | $ 12,114,226 |
| 7023 | 855409 | Administrative Services | $ 105,857,276 | $ 105,357,276 |
| 7023 | 855410 | Attorney General Payments | $ 4,621,850 | $ 4,621,850 |

| | | | | | |
|---|---|---|---|---|---|
| 8220 | 855606 | Coal Workers' Fund | $ 147,666 | $ 147,666 | 1611 |
| 8230 | 855608 | Marine Industry | $ 75,527 | $ 75,527 | 1612 |
| 8250 | 855605 | Disabled Workers Relief Fund | $ 319,718 | $ 319,718 | 1613 |
| 8260 | 855609 | Safety and Hygiene Operating | $ 19,161,132 | $ 19,161,132 | 1614 |
| 8260 | 855610 | Gear Program | $ 5,000,000 | $ 5,000,000 | 1615 |
| 8290 | 855604 | Long Term Care Loan Program | $ 100,000 | $ 100,000 | 1616 |
| TOTAL WCF Workers' Compensation Fund Group | | | $ 281,762,081 | $ 265,235,981 | 1617 1618 |
| Federal Special Revenue Fund Group | | | | | 1619 |
| 3490 | 855601 | OSHA Enforcement | $ 1,731,000 | $ 1,731,000 | 1620 |
| 3FW0 | 855614 | BLS SOII Grant | $ 116,919 | $ 116,919 | 1621 |
| TOTAL FED Federal Special Revenue Fund Group | | | $ 1,847,919 | $ 1,847,919 | 1622 |
| TOTAL ALL BUDGET FUND GROUPS | | | $ 283,610,000 | $ 267,083,900 | 1623 |

WILLIAM GREEN LEASE PAYMENTS 1624

Of the foregoing appropriation item 855401, William Green Lease Payments, up to $16,026,100 shall be used to make lease payments to the Treasurer of State at the times they are required to be made during the period from July 1, 2013 to June 30, 2015, pursuant to leases and agreements made under section 154.24 of the Revised Code. If it is determined that additional appropriations are necessary for such purpose, such amounts are hereby appropriated. 1625 1626 1627 1628 1629 1630 1631 1632

WORKERS' COMPENSATION FRAUD UNIT 1633

Of the foregoing appropriation item 855410, Attorney General Payments, $828,200 in each fiscal year shall be used to fund the expenses of the Workers' Compensation Fraud Unit within the Attorney General's Office. These payments shall be processed at the beginning of each quarter of each fiscal year and deposited 1634 1635 1636 1637 1638

into the Workers' Compensation Section Fund (Fund 1950) used by the Attorney General.

SAFETY AND HYGIENE

Notwithstanding section 4121.37 of the Revised Code, the Treasurer of State shall transfer $20,382,567 cash in fiscal year 2014 and $20,161,132 cash in fiscal year 2015 from the State Insurance Fund to the Safety and Hygiene Fund (Fund 8260).

OSHA ON-SITE CONSULTATION PROGRAM

The Bureau of Workers' Compensation may designate a portion of appropriation item 855609, Safety and Hygiene Operating, to be used to match federal funding for the federal Occupational Safety and Health Administration's (OSHA) on-site consultation program.

VOCATIONAL REHABILITATION

The Bureau of Workers' Compensation and the Rehabilitation Services Commission shall enter into an interagency agreement for the provision of vocational rehabilitation services and staff to mutually eligible clients. The bureau shall provide $605,407 in fiscal year 2014 and $605,407 in fiscal year 2015 from the State Insurance Fund to fund vocational rehabilitation services and staff in accordance with the interagency agreement.

FUND BALANCE

Any unencumbered cash balance in excess of $45,000,000 in the Workers' Compensation Fund (Fund 7023) on the thirtieth day of June of each fiscal year shall be used to reduce the administrative cost rate charged to employers to cover appropriations for Bureau of Workers' Compensation operations.

**Section 211.** DEPUTY INSPECTOR GENERAL FOR BWC AND OIC FUNDING

To pay for the FY 2014 costs related to the Deputy Inspector General for the Bureau of Workers' Compensation and Industrial

Commission, on July 1, 2013, and on January 1, 2014, or as soon as possible after each date, the Director of Budget and Management shall transfer $212,500 in cash from the Workers' Compensation Fund (Fund 7023) to the Deputy Inspector General for the Bureau of Workers' Compensation and Industrial Commission Fund (Fund 5FT0).

To pay for the FY 2015 costs related to the Deputy Inspector General for the Bureau of Workers' Compensation and Industrial Commission, on July 1, 2014, and on January 1, 2015, or as soon as possible after each date, the Director of Budget and Management shall transfer $212,500 in cash from the Workers' Compensation Fund (Fund 7023) to the Deputy Inspector General for the Bureau of Workers' Compensation and Industrial Commission Fund (Fund 5FT0).

If additional amounts are needed, the Inspector General may seek Controlling Board approval for additional transfers of cash and to increase the amount appropriated in appropriation item 965604, Deputy Inspector General for the Bureau of Workers' Compensation and Industrial Commission.

**Section 741.10.** Except as otherwise provided in this act, the amendments to Revised Code sections in Section 101 of this act apply to all claims filed pursuant to Chapter 4121., 4123., 4127., or 4131. of the Revised Code on or after the effective date of Section 101 of this act.

**Section 741.20.** Division (B) of section 4123.512 of the Revised Code, as amended by this act, applies to an appeal filed pursuant to that section on or after the effective date of that section.

**Section 803.10.** Law contained in the Main Operating Appropriations Act of the 130th General Assembly that applies generally to the appropriations made in that act also applies generally to the appropriations made in this act.

**Section 806.10.** The provisions of law contained in this act, and their applications, are severable. If any provision of law contained in this act, or if any application of any provision of law contained in this act, is held invalid, the invalidity does not affect other provisions of law contained in this act and their applications that can be given effect without the invalid provision or application.

**Section 812.10.** Except as otherwise specifically provided in this act, the amendment, enactment, or repeal by this act of a section of law is exempt from the referendum under Ohio Constitution, Article II, Section 1d and section 1.471 of the Revised Code and therefore takes effect immediately when this act becomes law.

**Section 812.20.** The amendment, enactment, or repeal by this act of the divisions and sections of law listed below are subject to the referendum under Ohio Constitution, Article II, Section 1c and therefore take effect on the ninety-first day after this act is filed with the Secretary of State.

All Revised Code sections in Section 101 of this act.

Sections 741.10 and 741.20 of this act.