Ohio Legislative Service Commission

Bill Analysis

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H.B. 34

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(As Introduced)
(Excluding appropriations, fund transfers, and similar provisions)

Rep. Hackett

BILL SUMMARY

Benefit payments

- Allows the Administrator of Workers' Compensation to pay for medical services identified by the Administrator and for the first fill of prescriptions occurring during an earlier timeframe than under current law.

- Allows for the medical services or first fill of prescriptions to be charged to the Surplus Fund Account if the claim is ultimately denied if the employer is a state fund employer who pays assessments into that account.

Health Partnership Program

- Requires, for a managed care organization (MCO) to be certified to participate in the Health Partnership Program (HPP), the MCO to have a provider panel that includes current HPP providers, provides reasonable access to providers, delivers cost-effective treatment, and achieves quality benchmarks.

- Allows the Administrator to limit a claimant's choice of provider to HPP certified providers beginning on the 46th day after the date of the injury or the 46th day after the beginning date for treatment of an occupational disease.

- Allows an employee who satisfies criteria adopted by the Administrator to continue receiving treatment from a nonpanel provider.

- Allows the Bureau of Workers' Compensation (BWC) to enter into a contract with any MCO certified by BWC to provide medical management and cost containment services in the HPP and to include in that contract incentives and penalties that may

be imposed by the Administrator based on the organization's compliance and performance.

- Allows BWC to contract with a BWC-certified health care provider or supplier and to include in that contract incentives and penalties that may be imposed by the Administrator based on the health care provider's or supplier's compliance and performance, rather than including penalties in rules as under current law.

Claims procedure

- Allows the Administrator to dismiss without prejudice, rather than deny, a claim that has insufficient medical information to allow the Administrator to determine whether the claim is compensable.

- Allows a claimant to refile the dismissed claim.

- Requires, for an appeal of an Industrial Commission decision filed with a court of common pleas on or after the bill's effective date, the notice of appeal to include the name of the Administrator.

Premium programs and assessments

- Eliminates the $15,000 Medical-Only Program.

- Permits public employers to participate in the BWC One Claim Program.

- Requires the Administrator to reimburse a state fund employer from the Surplus Fund Account for any assessments paid for a violation of a specific safety requirement if it is ultimately determined that the employer did not commit the violation.

- Eliminates the statutory minimum assessment amount for the Disabled Worker Relief Fund for claims arising before January 1, 1987.

- Expands the current law procedures regarding a notice of assessment of a workers' compensation premium to include any assessment made under Ohio's Workers' Compensation Law except assessments for payments relating to a claim involving a noncompliant employer.

- Allows a complying employer to appeal to an adjudicating committee any assessment described in the dot point immediately above, rather than only premium assessments under current law.

- Reduces the amount of bond an employer must file with a court if the employer appeals the assessment to the court to the amount of the assessment due rather than double that amount as under current law.

- Eliminates the requirement that the BWC send the notice of the date and time of a hearing to object to the assessment and the notice of the finding made at the hearing through certified mail.

Self-insuring employers

- Increases, from $50,000 to $300,000, the level in excess of which a self-insuring employer may seek insurance against liability for workers' compensation benefits arising from a single disaster or event.

- Eliminates the requirement that most self-insuring public employers annually obtain an actuarial report certifying the sufficiency of reserved funds to cover the costs that the employer may potentially incur under Ohio's Workers' Compensation Law and the reliability of computations and statements made with regard to those funds.

Additional changes

- Requires, rather than permits as under current law, the State Board of Pharmacy to provide information from the drug database relating to a workers' compensation claimant to the Administrator upon request.

- Requires the Workers' Compensation Investment Committee to review the Bureau's Chief Investment Officer and any investment consultants retained by the Administrator to assure effective management of the workers' compensation funds, rather than that the best possible return on investment is achieved as required under current law.

- Requires the Administrator to have an actuarial analysis, rather than actuarial audits, of the State Insurance Fund and other funds specified in the Workers' Compensation Law made at least once a year and revises the requirements for that analysis.

TABLE OF CONTENTS

CONTENT AND OPERATION

Timing of medical benefit payments

(R.C. 4123.511(I) and 4123.66)

The bill allows the Administrator of Workers' Compensation to pay certain medical benefits earlier than when those benefits must be paid under current law. Currently, the payment of medical benefits commence upon the earlier of either the date of the issuance of the staff hearing officer's order under the statutory appeals process or the date of the final administrative or judicial determination.

Under the bill, the Administrator, in the rules the Administrator adopts pursuant to continuing law concerning medical benefits, 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 bill requires the Administrator, in the rules the Administrator adopts, to limit the payment for these services to only those services rendered to a claimant within 45 days after the date the Administrator issues an order under continuing law allowing a claim or allowing an additional condition to which the services relate.

Similarly, the bill allows the Administrator, in the rules the Administrator adopts regarding medical benefits under continuing law, to adopt rules specifying the circumstances under which the Bureau of Workers' Compensation (BWC) may make immediate payment for the first fill of prescription drugs for medical conditions identified in an application for compensation or benefits under the Workers' Compensation Law that occurs prior to the date the Administrator issues an initial determination order granting or denying compensation, benefits, or both.

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 (an employer who pays premiums to the State Insurance Fund) who pays assessments into the Surplus Fund Account in the State Insurance Fund, the payments for medical services described above or for the first fill of prescription drugs for that claim or condition must 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.

The Health Partnership Program

(R.C. 4121.44; conforming change in R.C. 4123.93)

Provider panels

The Health Partnership Program (HPP) is the managed care portion of Ohio's Workers' Compensation system used by employers who pay premiums into the State Insurance Fund. The Administrator certifies a managed care organization (MCO) for a period of two years to provide medical management and cost containment services for the HPP. Under the bill, in addition to satisfying other continuing law requirements, to be certified an MCO must demonstrate arrangements and reimbursement agreements with a provider panel including a substantial number of medical, professional, and pharmacy providers participating in the HPP, selected on the basis of access, quality, and cost, instead of the providers currently being utilized by claimants as under current law. The bill requires any provider panel used by an MCO to provide reasonable access to providers, deliver cost-effective treatment, and achieve quality benchmarks established by the Administrator.

Access to providers

Similar to current law, the bill permits the Administrator to limit a claimant's freedom to choose a health care provider or supplier by requiring, beginning the 46th day after the date of the injury or the 46th day after the beginning date for treatment for the occupational disease (instead of the time period of MCO certification as under current law), that claimants pay an appropriate out-of-plan copayment for selecting a medical provider not within the MCO provider panel.

Under continuing law the Administrator must permit, in areas outside or within Ohio where no qualified health plan (a program similar to the HPP used mostly by self-insuring employers) or an inadequate number of providers within the HPP exist, employees to use a nonplan or nonprogram health care provider. In such circumstances, the Administrator must 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

the Workers' Compensation Law on a fee schedule the Administrator adopts. The bill expands this provision to permit employees to use a provider not within the MCO provider panel.

The bill also requires the Administrator to adopt rules, with the advice and consent of the BWC Board of Directors, to allow an employee to continue to receive treatment from a nonpanel medical provider if the employee is receiving appropriate and quality care from that medical provider. The rules must include criteria the employee must satisfy to be permitted to continue to receive treatment from that provider. If an employee satisfies the criteria specified in these rules and is receiving quality care from the medical provider, the employee may continue to receive treatment from that medical provider after the 46th day after the date of injury or the 46th day after the beginning date for treatment for the occupational disease, despite the requirements in the bill to the contrary.

Health Partnership Program contracts

(R.C. 4121.44 and 4121.441)

As mentioned above, current law requires the Administrator to certify one or more MCOs to provide medical management and cost containment services in the HPP, consistent with statutory standards. The bill allows BWC to contract with a certified MCO and to include in that contract any incentives and penalties that may be imposed on the MCO, at the Administrator's discretion, based on the MCO's compliance and performance.

Current law also allows for BWC to certify health care providers and suppliers to participate in the HPP if they satisfy the standards and criteria adopted by the Administrator, with the advice and consent of the BWC Board of Directors. The bill allows BWC to enter into a contract with any BWC-certified health care provider or supplier and to include in that contract incentives and penalties that may be imposed on the provider or supplier, at the Administrator's discretion, based on the MCO's compliance and performance. The bill also eliminates the current law requirement that the Administrator, with the advice and consent of the Board, adopt rules that establish standards and procedures for BWC to utilize in penalizing a health care provider or supplier.

Dismissal of an incomplete workers' compensation claim

(R.C. 4123.511(B), by reference to R.C. 4123.84 and 4123.85, not in the bill)

Under the bill, if the Administrator, after conducting an investigation and not later than 28 days after sending the receipt of a claim notice, determines that insufficient

information exists to grant or deny the claim, the Administrator may dismiss the claim without prejudice. The Administrator must send notice of the dismissal to both parties.

Thus, the claimant may refile the claim. However, a claim that has been dismissed without prejudice under the bill does not constitute notice to BWC or the Industrial Commission for purposes of tolling the statute of limitations for filing a claim under the Workers' Compensation Law.

According to BWC, currently, if insufficient medical information exists to approve the claim, the Administrator must deny the claim and the claimant may appeal that denial through the Industrial Commission.

Notice of appeal in workers' compensation claim cases

(R.C. 4123.512)

Current law generally allows a claimant or employer who is subject to an order of the Industrial Commission to appeal that order to the court of common pleas of the county in which the injury was sustained. The same sort of appeal is allowed if a claimant or employer is subject to an order of a staff hearing officer, and the Commission refuses to hear an appeal of that decision. In either case, the party wishing to appeal the decision must file a notice of appeal with the common pleas court. The bill requires the name of the Administrator of Workers' Compensation to be included on the notice, in addition to the current law requirement that the notice of appeal state the names of the claimant and the employer, the number of the claim, the date of the order appealed from, and the facts being appealed.

Elimination of the $15,000 Medical-Only Program

(R.C. 4123.29(A)(6))

The bill eliminates the $15,000 Medical-Only Program. Under the Program, a state fund employer or the employer's agent pays to a claimant or on behalf of the claimant the first $15,000 of a compensable workers' compensation medical-only claim (as opposed to a lost-time claim) filed by that claimant that is related to the same injury or occupational disease.

Public employers and the One Claim Program

(R.C. 4123.29(A)(4))

The bill permits a state fund, taxing district employer to participate in the One Claim Program, under which the employer may mitigate the impact of a significant claim that comes into the employer's experience for the first time and that is a

contributing factor in the employer being excluded from a group-rated plan under the BWC's group rating program. Currently, only private sector state fund employers may participate in the One Claim Program.

Violation of specific safety requirement assessments

(R.C. 4123.512(H))

Under continuing law, an employer is prohibited from violating a specific safety requirement to which the employer is subject. If the employer does violate the requirement, and an injury, disease, or death results from the violation, the claimant, under the Ohio Constitution, is entitled to an award of not greater than 50% nor less than 15% of the maximum award established by law in addition to the compensation received under the law for the claim. This is commonly referred to as a VSSR award.

Under the bill, if a state fund employer has paid an assessment for a VSSR, and, in a final administrative or judicial action, it is determined that the employer did not violate the specific safety requirement, the Administrator must reimburse the employer from the Surplus Fund Account created in continuing law for the amount of the assessment the employer paid for the violation.

Workers' compensation assessments

Disabled Work Relief Fund

(R.C. 4123.411)

In addition to paying premiums to the State Insurance Fund to cover workers' compensation claims, an employer pays assessments to BWC for other specialized funds and to cover administrative costs. These assessments include assessments to fund the Disabled Worker Relief Fund (DWRF), which is a fund that used to make essentially cost-of-living payments to recipients of permanent and total disability compensation. With respect to the DWRF assessment made for claims that occurred before January 1, 1987, the bill eliminates the requirement that the Administrator annually charge a minimum assessment of 5¢ per $100 of payroll. The bill retains the requirement that the assessment cannot exceed 10¢ per $100 of payroll and retains the current law requirements with respect to DWRF assessments for claims occurring on or after January 1, 1987.

Assessments generally

(R.C. 4123.37, with a conforming change in R.C. 4123.291)

The bill also expands current law procedures regarding a notice of assessment of a workers' compensation premium to include any assessment made under the Workers' Compensation Law except assessments for the payment of compensation or benefits in a claim involving a noncompliant employer. This expansion includes the ability to object to the assessment and the ability to obtain a lien for failing to pay the assessment.

The bill allows the Administrator to 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 BWC 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. This notice is similar to the continuing law procedure for providing notice of premium assessments; under the bill, however, the Administrator also must include in the notice a demand for payment. Under continuing law, within 20 days after receipt of the notice and demand for payment (as added by the bill), an employer may file with BWC 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 to which the employer objects, together with the reasons for the objections. If the employer does not file a petition, the assessment becomes conclusive and the amount is due and payable from the employer.

When a petition objecting to an assessment is filed, under continuing law BWC must assign a time and place for the hearing of the same and must notify the petitioner, although under the bill BWC is no longer required to send that notice via certified mail. The assessment becomes due and payable ten days after BWC sends notice of the finding made at the hearing (the bill also eliminates the requirement that this notice be sent via certified mail). Under the bill an employer may first appeal an adverse decision to the Administrator or the Administrator's designee through the adjudicating committee process under continuing law. Only after an appeal is taken through the adjudicating committee may the employer appeal to the Franklin County Court of Common Pleas in accordance with current law. If the party appeals to the court, the party must execute a bond to the state in the amount found due, reduced from double that amount as under current law, and ordered paid by BWC conditioned that the party will pay any judgment and costs rendered against it for the assessment.

Self-insurance indemnity for single event

(R.C. 4123.82)

The bill increases, from $50,000 to $300,000, the level in excess of which a self-insuring employer (an employer who pays compensation and benefits directly and does not pay premiums into the State Insurance Fund) may seek insurance against liability for workers' compensation benefits arising from a single disaster or event. Continuing law permits a self-insuring employer to obtain this particular coverage; otherwise, a self-insuring employer cannot indemnify or insure the employer's workers' compensation obligations.

Actuarial reporting requirement

(R.C. 4123.353)

The bill eliminates the current law requirement that a self-insuring public employer, except for a board of county commissioners with respect to the construction of a sports facility, a board of a county hospital, or a publicly owned utility, have prepared an actuarial report certifying whether the employer's reserved funds, which are required under continuing law, meet all of the following requirements:

- The funds are sufficient to cover the costs the public employer may potentially incur to remain in compliance with Ohio's Workers' Compensation Law.
- The funds are computed in accordance with accepted loss reserving standards.
- The funds are fairly stated in accordance with sound loss reserving principles.

Access to the drug database maintained by the State Board of Pharmacy

(R.C. 4729.80)

The bill requires, rather than permits as under current law, the State Board of Pharmacy, upon receipt of a request from the Administrator, to provide to the Administrator information from the drug database relating to a workers' compensation claimant. Under continuing law, the Board may establish and maintain a drug database. The Board must use the drug database to monitor the misuse and diversion of controlled substances and other dangerous drugs the Board includes in the database pursuant to rules adopted by the Board.

Review of workers' compensation fund investment policy and management

(R.C. 4121.129(C))

Under continuing law, the Workers' Compensation Investment Committee is required to review the performance of the Bureau of Workers' Compensation Chief Investment Officer and any investment consultants who are retained by the Administrator. This review is conducted to assure that the investments of the assets of the various workers' compensation funds are made in accordance with the investment policy approved by the Bureau of Workers' Compensation Board of Directors. Currently, the review is also conducted to assure that the best possible return on investment is achieved. Under the bill, the review is no longer conducted to assure the best possible return on investment is achieved and is instead conducted to assure compliance with the investment policy and effective management of the funds.

Annual actuarial analysis

(R.C. 4123.47; conforming change in R.C. 4121.129)

The bill requires the Administrator to have an actuarial analysis, rather than an actuarial audit as under current law, of the State Insurance Fund and other funds specified in the Workers' Compensation Law made at least once a year. The analysis required under the bill must be made and certified by recognized credentialed property or casualty actuaries selected by the BWC Board of Directors rather than by recognized insurance actuaries selected by the Board as under current law.

The bill also eliminates the current law requirement that the audits (or analysis under the bill) specifically cover the premium rates, classifications, and all other matters involving the administration of the State Insurance Funds and all other funds specified in the Workers' Compensation Law.

Application of statutory changes

(Sections 741.10 and 741.20)

Except as provided below, with respect to the changes made to the Workers' Compensation Law by the bill, the bill applies to all claims filed pursuant to the Law on or after the bill's effective date. With respect to the changes described under "**Notice of appeal in workers' compensation claim cases**" above, the bill applies to appeals filed on or after the bill's effective date.

HISTORY

ACTION	DATE
Introduced	02-05-13

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