Safety & Workers' Compensation Committee

Wednesday, October 15, 2014

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2014 Safety & Workers' Compensation Committee Calendar

Meetings begin at 10:00 a.m.

OMA Safety & Workers' Compensation Committee Meeting Sponsor:

OMA Safety & Workers' Compensation Committee

October 15, 2014

AGENDA

Welcome & Self-Introductions	Larry Holmes, Fort Recovery Industries Inc.
BWC Board Update	Tracie Sanchez, President, Lima Pallet Company Inc.
BWC Developments	Scott Weisend and Denny Davis, OMA Staff
Guest Speaker	Steve Buehrer, Administrator, Ohio Bureau of Workers' Compensation
Safety Update	Dianne Grote Adams, Safex
OMA Counsel's Report	Sue Wetzel, Bricker & Eckler LLP
Public Policy Report	Rob Brundrett, OMA Staff

Please RSVP to attend this meeting (indicate if you are attending in-person or by teleconference) by contacting Denise: dlocke@ohiomfg.com or (614) 224-5111 or toll free at (800) 662-4463.

Additional committee meetings or teleconferences, if needed, will be scheduled at the call of the Chair.

Thanks to Today's Meeting Sponsor:

Tracie J. Sanchez
Vice Chair of the Actuarial Committee, Member of the Medical Services & Safety Committee

Represents employers with 100 or fewer employees

Term expires June 12, 2015

Tracie Sanchez is the corporate president of the Lima Pallet Company, Inc. In 30 years of service to Lima Pallet, she learned to do most of the tasks Lima Pallet has to offer from fork lift operator to sales manager to become the President of Lima Pallet in 2001. She has a strong knowledge of cost savings programs BWC offers to Ohio's employers. She is also involved in the community by serving on the National Federation of Independent Business' Ohio Leadership Council. Mrs. Sanchez is a native of Lima, Ohio, where she lives with her husband, Jeffery, and their three children.

Administrator/CEO Stephen Buehrer

Ohio Governor John Kasich appointed Steve Buehrer as Administrator/CEO of the Ohio Bureau of Workers' Compensation in January 2011. He leads an agency of 2,000 employees that serves more than 225,000 employers and 1.3 million injured workers.

Known for his focus on fiscal responsibility, creating jobs, and emphasizing technology, Steve has helped engineer significant improvements within various levels of government over the past 20 years. He also has extensive experience with workers' compensation, previously serving as BWC's Chief of Human Resources. As a senator, Steve served as chairman of the Insurance, Commerce and Labor committee which oversaw all workers' compensation legislation.

Steve was a member of the Ohio Senate from 2007 until 2011. In addition to serving as the chairman of the Insurance, Commerce and Labor committee, he also was vice chairman of the Senate Highways & Transportation committee. In addition, Steve's colleagues elected him majority whip, the fourth ranking leadership position in the Senate. He also received the Technology Advocate Legislator of the Year award for 2010 from Technology for Ohio's Tomorrow. He won five Watchdog of the Treasury awards and was named National Legislator of the Year by the American Legislative Exchange Council in 2002. A nationally recognized leader, he serves as the chairman of the Midwest Council of State Government (CSG) and has served as national CSG vice chair.

Steve also served as a state representative for Ohio's 82nd House District (Defiance, Fulton and Williams counties). First elected in 1998, he was subsequently re-elected in November 2000, when his district became the 74th, and again in November 2002 and 2004. Steve's peers in the House recognized his leadership by electing him assistant majority floor leader for both the 124th and 125th General Assembly. As chairman of the State Government committee, he had responsibility for all workers' compensation legislation.

During his second and third terms as representative in the Ohio General Assembly, Steve authored and passed Ohio's two-year transportation budget, which provided funding for highway projects across the state. This legislation recreated the state's transportation funding structure and provided additional transportation-related support for state and local governments.

Beyond his legislative experience and accomplishments, Steve also has extensive experience in state government. Aside from serving as the Chief of Human Resources at BWC, he also was the Director of Legislative Affairs at the Ohio Bureau of Employment Services. Following that assignment, Steve served six months at the Ohio Department of Human Services, at the request of Governor George Voinovich, assisting with multiple management-improvement initiatives. He later accepted a position as Deputy Director at the Ohio Department of Administrative Services where he oversaw the communications and legislative offices and later the State Human Resources Division.

Steve earned a bachelor's in social studies education graduating summa cum laude from Bowling Green State University. He later earned his juris doctor from Capital University Law School graduating cum laude. He's married to his wife Cathy and has three sons, Benjamin, Simon and Daniel.

Modernizing BWC – The plan to reform the premium collection model

BWC is transitioning to a billing system that will provide more flexibility for employers while reducing overall systems costs. This change aligns BWC with standard industry practice and enables us to collect premiums before extending coverage. This transition becomes effective July 1, 2015, for private employers, and Jan. 1, 2016, for public employers. This conversion is part of BWC's ongoing efforts to modernize its operations and provide better service to Ohio's employers.

The benefits of prospective payment

A switch to a prospective billing system will provide the following benefits to Ohio employers:

- Overall base rate reduction of 2 percent for private employers and 4 percent for public employers;
- Opportunities for more flexible payment options (up to 12 installments);
- Better opportunities for BWC to provide quotes online or via the phone;
- Increased ability for BWC to detect employer non-compliance and fraud.

Transition credit

To eliminate the need for a double payment by employers, BWC will provide a one-time premium credit. For private employers, BWC will cover the August payroll report (covering the January through June 2015 premium) and the first two months (July and August 2015) of prospective premium. Public employers will receive a credit equivalent to one year of premium spread over the 2015 and 2016 policy years.

Key dates to remember

Starting this year, many important dates dealing with rating plan and program sign-up deadlines will change (see charts below).

For private employers enrolling for the 2015 policy year

Rating plan/program	New deadline
Experience snapshot	September 30
Group-experience rating	Monday prior to Thanksgiving (Nov. 24, 2014)
Group-retrospective rating, Deductible Program, Individual-retrospective rating, One Claim Program	Last business day in January (Jan. 30, 2015)
Destination: Excellence	Last business day in May (May 29, 2015)

For public employers enrolling for the 2016 policy year

Rating plan/program	New deadline
Experience snapshot	March 31
Group-experience rating	Last business day in May (May 29, 2015)
Group-retrospective rating, Deductible Program, Individual-retrospective rating, One Claim Program	Last business day in July (July 31, 2015)
Destination: Excellence	Last business day of November (Nov. 30, 2015)

For more information, contact your local service office, or visit **www.bwc.ohio.gov**.

Fact sheet updated July 2014

Key OSHA Activities – October 2014

Dianne Grote Adams
dgroteadams@safex.us

Recordkeeping Changes

Topic	Current Requirement	New Requirement Effective 1/1/2015
Fatality	Notify OSHA within 8 hours.	Notify OSHA within 8 hours
Work-related Hospitalization	Notify OSHA within 24 hours of hospitalization of 3 or more employees.	Notify OSHA within 24 hours of hospitalization of 1 or more employees.
Amputation	Not required in 1904	Notify OSHA within 24 hours.
Loss of Eye	Not required in 1904	Notify OSHA within 24 hours.

All employers covered by OSHA, even if exempt from injury and illness records (10 or fewer employees and/or list of low hazard industries) are required to follow reporting requirements.
Web portal under development.

OSHA Proposed Rule on Recordkeeping - UPDATE

Earlier in 2014, we mentioned that OSHA announced on November 8, 2013 a proposal to improve tracking of workplace injuries and illnesses.

- Comments due – March 8, 2014 *Extended to October 14, 2014*
- Public Meeting to be held – January 9, 2014
- The transcripts of the public meeting are now available.
- Nothing new beyond the transcripts to report.

Temporary Workers

Temporary Workers are the responsibility of the employer from OSHA's perspective. Injuries/illnesses to temporary workers belong on employer's OSHA log and the employer is responsible for making sure training, etc. requirements are met.

OSHA Chemical Management and Permissible Exposure Limits Request for Information.
October 9, 2014 OSHA published a RFI on Chemical Management and Permissible Exposure Limits. The goal is to reduce the number and prevent occupational illnesses caused by exposure to hazardous chemicals. The docket is open for 180 days. OSHA would like comments on streamlining the PEL Rulemaking Process and alternative approaches to chemical management (hazard bandking, task-based approaches).

Fatal Injuries
The Bureau of Labor Statistics has released the preliminary results of its National Census of Fatal Occupational Injuries. According to the BLS data, the number of fatal work injuries in 2013 was lower than the revised count of 4,628 fatal work injuries in 2012. However, the BLS found that fatal work injuries among Hispanic or Latino workers were higher in 2013, rising 7 percent.

News Release

U.S. Department of Labor

Sept. 11, 2014 Click to tweet this release!

OSHA announces new requirements for reporting severe injuries and updates list of industries exempt from record-keeping requirements

WASHINGTON – The U.S. Department of Labor's Occupational Safety and Health Administration today announced a final rule requiring employers to notify OSHA when an employee is killed on the job or suffers a work-related hospitalization, amputation or loss of an eye. The rule, which also updates the list of employers partially exempt from OSHA record-keeping requirements, will go into effect on Jan. 1, 2015, for workplaces under federal OSHA jurisdiction.

The announcement follows preliminary results from the Bureau of Labor Statistics' 2013 National Census of Fatal Occupational Injuries*.

"Today, the Bureau of Labor Statistics reported that 4,405 workers were killed on the job in 2013. We can and must do more to keep America's workers safe and healthy," said U.S. Secretary of Labor Thomas E. Perez. "Workplace injuries and fatalities are absolutely preventable, and these new requirements will help OSHA focus its resources and hold employers accountable for preventing them."

Under the revised rule, employers will be required to notify OSHA of work-related fatalities within eight hours, and work-related in-patient hospitalizations, amputations or losses of an eye within 24 hours. Previously, OSHA's regulations required an employer to report only work-related fatalities and in-patient hospitalizations of three or more employees. Reporting single hospitalizations, amputations or loss of an eye was not required under the previous rule.

All employers covered by the Occupational Safety and Health Act, even those who are exempt from maintaining injury and illness records, are required to comply with OSHA's new severe injury and illness reporting requirements. To assist employers in fulfilling these requirements, OSHA is developing a Web portal for employers to report incidents electronically, in addition to the phone reporting options.

"Hospitalizations and amputations are sentinel events, indicating that serious hazards are likely to be present at a workplace and that an intervention is warranted to protect the other workers at the establishment," said Dr. David Michaels, assistant secretary of labor for occupational safety and health.

In addition to the new reporting requirements, OSHA has also updated the list of industries that, due to relatively low occupational injury and illness rates, are exempt from the requirement to routinely keep injury and illness records. The previous list of exempt industries was based on the old Standard Industrial Classification system and the new rule uses the North American Industry Classification System to classify establishments by industry. The new list is based on updated injury and illness data from the Bureau of Labor Statistics. The new rule maintains the exemption for any employer with 10 or fewer employees,

regardless of their industry classification, from the requirement to routinely keep records of worker injuries and illnesses.

For more information about the new rule, visit OSHA's website at http://www.osha.gov/recordkeeping2014.

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Release Number: 14-1697-NAT

OSHA® FactSheet

Updates to OSHA's Recordkeeping Rule: Reporting Fatalities and Severe Injuries

OSHA's updated recordkeeping rule expands the list of severe injuries that all employers must report to OSHA. Establishments located in states under Federal OSHA jurisdiction must begin to comply with the new requirements on January 1, 2015. Establishments located in states that operate their own safety and health programs should check with their state plan for the implementation date of the new requirements.

What am I required to report under the new rule?

Previously, employers had to report the following to OSHA:

- All work-related fatalities
- Work-related hospitalizations of three or more employees

Starting in 2015, employers will have to report the following to OSHA:

- All work-related fatalities
- All work-related inpatient hospitalizations of one or more employees
- All work-related amputations
- All work-related losses of an eye

Who is covered under the new rule?

All employers under OSHA jurisdiction must report all work-related fatalities, hospitalizations, amputations and losses of an eye to OSHA, even employers who are exempt from routinely keeping OSHA injury and illness records due to company size or industry.

An amputation is defined as the traumatic loss of a limb or other external body part. Amputations include a part, such as a limb or appendage, that has been severed, cut off, amputated (either completely or partially); fingertip amputations with or without bone loss; medical amputations resulting from irreparable damage; and amputations of body parts that have since been reattached.

How soon must I report a fatality or severe injury or illness?

Employers must report work-related fatalities within **8 hours of finding out about them.**

Employers only have to report fatalities that occurred within 30 days of a work-related incident.

For any inpatient hospitalization, amputation, or eye loss **employers must report the incident within 24 hours of learning about it.** Employers only have to report an inpatient hospitalization, amputation or loss of an eye that occurs within 24 hours of a work-related incident.

How do I report an event to OSHA?

Employers have three options for reporting the event:

- By telephone to the nearest OSHA Area Office during normal business hours.
- By telephone to the 24-hour OSHA hotline at 1-800-321-OSHA (6742).
- OSHA is developing a new means of reporting events electronically, which will be available soon at www.osha.gov.

What information do I need to report?

For any fatality that occurs within 30 days of a work-related incident, employers must report the event **within 8 hours** of finding out about it.

For any inpatient hospitalization, amputation, or eye loss that occurs within 24 hours of a work-related incident, employers must report the event within 24 hours of learning about it.

Employers reporting a fatality, inpatient hospitalization, amputation or loss of an eye to OSHA must report the following information:

- Establishment name
- Location of the work-related incident
- Time of the work-related incident
- Type of reportable event (i.e., fatality, inpatient hospitalization, amputation or loss of an eye)
- Number of employees who suffered the event
- Names of the employees who suffered the event
- Contact person and his or her phone number
- Brief description of the work-related incident

Employers do not have to report an event if it:

- Resulted from a motor vehicle accident on a public street or highway. Employers must report the event if it happened in a construction work zone.
- Occurred on a commercial or public transportation system (airplane, subway, bus, ferry, streetcar, light rail, train).
- Occurred more than 30 days after the work-related incident in the case of a fatality or more than 24 hours after the work-related incident in the case of an inpatient hospitalization, amputation, or loss of an eye.

Employers do not have to report an inpatient hospitalization if it was for diagnostic testing or observation only. An inpatient hospitalization is defined as a formal admission to the inpatient service of a hospital or clinic for care or treatment.

Employers do have to report an inpatient hospitalization due to a heart attack, if the heart attack resulted from a work-related incident.

Where can I find more information?

For more information about the updated reporting requirements, visit OSHA's webpage on the revised recordkeeping rule at www.osha.gov/recordkeeping2014.

This is one in a series of informational fact sheets highlighting OSHA programs, policies or standards. It does not impose any new compliance requirements. For a comprehensive list of compliance requirements of OSHA standards or regulations, refer to Title 29 of the Code of Federal Regulations. This information will be made available to sensory-impaired individuals upon request. The voice phone is (202) 693-1999; teletypewriter (TTY) number: (877) 889-5627.

For assistance, contact us. We can help. It's confidential.

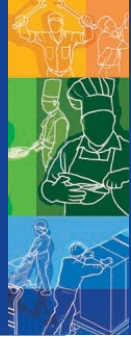
OSHA® Occupational Safety and Health Administration

www.osha.gov (800) 321-OSHA (6742)

U.S. Department of Labor

DEA FS-3745 09/2014

Recommended Practices



Protecting Temporary Workers

The Occupational Safety and Health Administration (OSHA) and the National Institute for Occupational Safety and Health (NIOSH) are aware of numerous preventable deaths and disabling injuries of temporary workers. One example is the death of a 27-year-old employed through a staffing agency to work as an equipment cleaner at a food manufacturing plant. While cleaning a piece of machinery, he came into contact with rotating parts and was pulled into the machine, sustaining fatal injuries. The manufacturing plant's procedures for cleaning the equipment were unsafe, including steps in which cleaners worked near the machine while it was energized and parts were moving. Additionally, while the company's permanent maintenance employees were provided with training on procedures to ensure workers were not exposed to energized equipment during maintenance or cleaning, this training was not provided to cleaners employed through the staffing agency. Source: Massachusetts Fatality Assessment and Control Evaluation (FACE) Program, 11MA050.

Workers employed through staffing agencies are generally called *temporary* or *supplied* workers. For the purposes of these recommended practices, "temporary workers" are those supplied to a host employer and paid by a staffing agency, whether or not the job is actually temporary. Whether temporary or permanent, **all workers always have a right to a safe and healthy workplace**. The staffing agency and the staffing agency's client (the *host employer*) are joint employers of temporary workers and, therefore, both are responsible for providing and maintaining a safe work environment for those workers. The staffing agency and the host employer must work together to ensure that the *Occupational Safety and Health Act of 1970* (the OSH Act) requirements are fully met. See 29 U.S.C. § 651. The extent of the obligations of each employer will vary depending on workplace conditions and should therefore be described in the agreement or contract between the employers. Their safety and health responsibilities will sometimes overlap. Either the staffing agency or the host employer may be better suited to ensure compliance with a particular requirement, and may assume primary responsibility for it. The joint employment structure requires effective communication and a common understanding of the division of responsibilities for safety and health. Ideally, these will be set forth in a written contract.

OSHA and NIOSH recommend the following practices to staffing agencies and host employers so that they may better protect temporary workers through mutual cooperation and collaboration. *Unless otherwise legally required, these recommendations are for the purpose of guidance and in some cases represent best practices.*

- **Evaluate the Host Employer's Worksite.** Prior to accepting a new host employer as a client, or a new project from a current client host employer, the staffing agency and the host employer should jointly review all worksites to which the worker might foreseeably be sent, the task assignments and job hazard analyses in order to identify and eliminate potential safety and health hazards and identify necessary training and protections for each worker. The staffing agency should provide a document to the host employer that specifies each temporary worker's specific training and competencies related to the tasks to be performed.

  Staffing agencies need not become experts on specific workplace hazards, but should determine what conditions exist at the worksite, what hazards may be encountered, and how to best ensure protection for the temporary workers. Staffing agencies, particularly those without dedicated safety and health professionals on staff, should consider utilizing a third-party safety and health consultant. For example, staffing agencies may be able to utilize the safety and health consultation services provided by their workers' compensation insurance providers. These consultation services are often offered to policyholders at little to no charge. Employers (staffing agencies and host employers) should inquire with their insurance providers about these services. Small and medium-sized businesses may request assistance from OSHA's free on-site consultation service. On-site consultation services are separate from enforcement and do not result in penalties or citations.

  If information becomes available that shows an inadequacy in the host employer's job hazard analyses, such as injury and illness reports, safety and health complaints or OSHA enforcement history, the staffing agency should make efforts to discuss and resolve those issues with the host employer to ensure that existing hazards are properly assessed and abated to protect the workers. In assessing worksite hazards, host employers typically have the safety and health knowledge and control of worksite operations. However, the staffing agency may itself perform an inspection of the workplace, if feasible, to conduct their own hazard assessment or to ensure implementation of the host employer's safety and health obligations for temporary workers.

- **Train Agency Staff to Recognize Safety and Health Hazards.** Many staffing agencies do not have dedicated safety and health professionals and, even when they do, these experts cannot be everywhere at once. By teaching agency representatives about basic safety principles and the hazards commonly faced by its temporary workers, the agency will be better equipped to discover hazards and work with the host employer to eliminate or lessen identified workplace hazards before an injury or illness occurs.

- **Ensure the Employer Meets or Exceeds the Other Employer's Standards.** When feasible, the host employer and staffing agency should exchange and review each other's injury and illness prevention program. Host employers should also request and review the safety training and any certification records of the temporary workers who will be assigned to the job. Host employers in certain industries, for example, will only accept bids from and hire staffing agencies that the host has previously verified as meeting the host employer's safety standards. Similarly, some staffing agencies work only with clients that have robust safety programs.

- **Assign Occupational Safety and Health Responsibilities and Define the Scope of Work in the Contract.** The extent of the responsibilities the staffing agency and the host employer have will vary depending on the workplace conditions and should be described in their agreement. Either the staffing agency or the host employer may be better suited to ensure compliance with

a particular requirement, and may assume primary responsibility for it. When feasible, the agency-host contract should clearly state which employer is responsible for specific safety and health duties. The contract should clearly document the responsibilities to encourage proper implementation of all pertinent safety and health protections for workers. This division of responsibilities should be reviewed regularly.

The tasks that the temporary worker is expected to perform, and the safety and health responsibilities of each employer, should be stated in the agency-host contract and should be communicated to the worker before that worker begins work at the job site. For example, should the job tasks require personal protective equipment, the contract should state what equipment will be needed and which employer will supply it. The worker should be informed of these details before beginning the job. Clearly defining the scope of the temporary worker's tasks in the agency-host contract discourages the host employer from asking the worker to perform tasks that the worker is not qualified or trained to perform or which carry a higher risk of injury. Defining, clarifying, and communicating the employers' and worker's responsibilities protects the workers of both the staffing agency and of the host employer. The contract should specify who is responsible for all such communications with the temporary worker.

- **Injury and Illness Tracking.** Employer knowledge of workplace injuries and investigation of these injuries are vital to preventing future injuries from occurring. Information about injuries should flow between the host employer and staffing agency. If a temporary worker is injured and the host employer knows about it, the staffing agency should be informed promptly, so the staffing agency knows about the hazards facing its workers. Equally, if a staffing agency learns of an injury, it should inform the host employer promptly so that future injuries might be prevented, and the case is recorded appropriately. The parties should therefore also discuss a procedure to share injury and illness information between the employers, ideally specifying that procedure contractually.

  NOTE on Injury and Illness Recordkeeping Requirements: Both the host employer and staffing agency should track and where possible, investigate the cause of workplace injuries. However, for statistical purposes, OSHA requires that injury and illness records (often called OSHA Injury and Illness Logs) be kept by the employer who is providing day-to-day supervision, i.e., controlling the means and manner of the temporary employees' work (the host employer, generally). See 29 CFR 1904.31(b)(2). The agency-host contract should therefore identify the supervising employer and state that this employer is responsible for maintaining the temporary workers' injury and illness records. Employers cannot discharge or contract away responsibilities that pertain to them under law. Further, the contract should specify which employer will make the records available upon request of an employee or an employee representative.

  The supervising employer is required to set up a method for employees to report work-related injuries and illnesses promptly and must inform each employee how to report work-related injuries and illnesses. However, both the staffing agency and the host employer should inform the temporary employee on this process and how to report a work-related injury or illness. See 29 CFR 1904.35(b).

  No policies or programs should be in place that discourage the reporting of injuries, illnesses or hazards. The OSH Act prohibits employers from retaliating against a worker for reporting an injury or illness, including for filing a workers' compensation claim for a work-related condition.

- **Conduct Safety and Health Training and New Project Orientation.** OSHA standards require site- and task-specific safety and health training. The training must be in a language the workers understand. Training helps to protect the workers of both the staffing agency and the host employer.

  The training of temporary workers is a responsibility that is shared between the staffing agency and the host employer. Staffing agencies should provide general safety and health training applicable to different occupational settings, and host employers provide specific training tailored to the particular hazards at their workplaces. The host employer and the staffing agency should each provide — separately or jointly — safety and health orientations for all temporary workers on new projects or newly-placed on existing projects. The orientation should include information on general worker-protection rights and workplace safety and health. At least one of the joint employers, generally the host employer, must provide worksite-specific training and protective equipment to temporary workers, and identify and communicate worksite-specific hazards. The temporary workers' tasks, as defined by the agency-host contract, should also be clearly communicated to the workers and reviewed with the host employer's supervisor(s). **Host employers should provide temporary workers with safety training that is identical or equivalent to that provided to the host employers' own employees performing the same or similar work**. Host employers should inform staffing agencies when such site-specific training for temporary workers has been completed. Informing workers and supervisors of their respective responsibilities agreed upon by the joint employers protects the workers of both the staffing agency and the host employer.

  - **First Aid, Medical Treatment, and Emergencies.** Procedures should be in place for both reporting and obtaining treatment for on-the-job injuries and illnesses. Temporary employees should be provided with information on how to report an injury and obtain treatment on every job assignment. Host employers should train temporary employees on emergency procedures including exit routes.

- **Injury and Illness Prevention Program.** It is recommended that staffing agencies and host employers each have a safety and health program to reduce the number and severity of workplace injuries and illnesses and ensure that their temporary workers understand it and participate in it. The employers' safety programs should be communicated at the start of each new project, whenever new temporary workers are brought onto an existing project, or whenever new hazards are introduced into the workplace.

  NOTE: Employers are required to have hazard-specific programs when workers are exposed to certain hazards. Such programs include bloodborne pathogens, hearing conservation, hazard communication, respiratory protection, and control of hazardous energy (lock-out/tag-out).

  Contractors and employers who do construction work must comply with standards in 29 CFR 1926, Subpart C, General Safety and Health Provisions. These include the responsibilities for each contractor/employer to initiate and maintain accident prevention programs, provide for a competent person to conduct frequent and regular inspections, and instruct each employee to recognize and avoid unsafe conditions and know what regulations are applicable to the work environment.

- **Injury and Illness Prevention Program Assessments.** The employers should identify and track performance measures key to evaluating the program's effectiveness. For both staffing agencies and host employers, a quality program will stipulate how there will be ongoing assessments to evaluate the consistency, timeliness, quality and adequacy of the program. Leading indicators, such as training and number of hazards identified and corrected, should be included in the assessments. Generally speaking, these assessments should take place at least on an annual basis with a competent internal team or a combined internal and external team. The value of these assessments is the resulting prioritized recommendations for program improvement.

- **Incidents, Injury and Illness Investigation.** In addition to reporting responsibilities, employers should conduct thorough investigations of injuries and illnesses, including incidents of close-calls, in order to determine what the root causes were, what immediate corrective actions are necessary, and what opportunities exist to improve the injury and illness prevention programs. It is critical that both the staffing agency and host employer are engaged in partnership when conducting these investigations.

- **Maintain Contact with Workers.** The staffing agency should establish methods to maintain contact with temporary workers. This can be as simple as the agency representatives touching base with the workers throughout the temporary assignment, such as when the representatives are at the site to meet with the host employer or to drop off paychecks, or by phone or email. The staffing agency has the duty to inquire and, to the extent feasible, verify that the host has fulfilled its responsibilities for a safe workplace.

  The staffing agency should have a written procedure for workers to report any hazards and instances when a worker's tasks are altered by the host employer from those previously agreed upon. The staffing agency and host employer should inform workers how to report hazards and/or changes to job tasks. For example, some staffing agencies have a hotline for their workers to call to report problems at the host employer's worksite. The staffing agency distributes this phone number during the orientation.

  The staffing agency should follow up on a worker's safety and health concerns and any complaints with the host employer, as well as investigate any injuries, illnesses and incidents of close calls.

How Can OSHA Help?

OSHA has a great deal of information to assist employers in complying with their responsibilities under the law. Information on OSHA requirements and additional health and safety information is available on the OSHA website (www.osha.gov). Further information on protecting temporary workers is available at the OSHA Temporary Worker webpage (www.osha.gov/temp_workers).

Workers have a right to a safe workplace (www.osha.gov/workers.html#2). For other valuable worker protection information, such as Workers' Rights, Employer Responsibilities and other services OSHA offers, visit OSHA's Workers' page.

The OSH Act prohibits employers from retaliating against their employees for exercising their rights under the OSH Act. These rights include raising a workplace health and safety concern with the employer, reporting an injury or illness, filing an OSHA complaint, and participating in an inspection or talking to an inspector. If workers have been retaliated

against for exercising their rights, they must file a complaint with OSHA within 30 days of the alleged adverse action. For more information, please visit www.whistleblowers.gov.

OSHA can help answer questions or concerns from employers and workers. To reach your regional or area OSHA office, go to OSHA's Regional and Area Offices webpage (www.osha.gov/html/RAmap.html) or call 1-800-321-OSHA (6742). OSHA also provides help to small and medium-sized employers. OSHA's On-site Consultation Program offers free and confidential advice to small and medium-sized businesses in all states across the country, with priority given to high-hazard worksites. On-site consultation services are separate from enforcement activities and do not result in penalties or citations. To contact OSHA's free consultation program, or for additional compliance assistance, call OSHA at 1-800-321-OSHA (6742).

Workers may file a complaint to have OSHA inspect their workplace if they believe that their employer is not following OSHA standards or that there are serious hazards. Employees can file a complaint with OSHA by calling 1-800-321-OSHA (6742) or by printing the complaint form and mailing or faxing it to your local OSHA area office. Complaints that are signed by an employee are more likely to result in an inspection.

If you think your job is unsafe or you have questions, contact OSHA at 1-800-321-OSHA (6742). It's confidential. We can help.

How Can NIOSH Help?

The National Institute for Occupational Safety and Health (NIOSH) is the federal agency that conducts research and makes recommendations to prevent worker injury and illness. Recommendations for preventing worker injuries and illnesses across all industries and for a wide variety of hazards are available on the NIOSH website (www.cdc.gov/niosh). To receive documents or more information about occupational safety and health topics, please contact NIOSH at 1-800-CDC-INFO (1-800-232-4636), TTY 1-888-232-6348.

The NIOSH Fatality Assessment and Control Evaluation (FACE) program investigates selected work-related fatalities to identify high-risk work injury situations and to make recommendations for preventing future similar deaths. Investigations are conducted by NIOSH and state partners. For more information and links to reports of temporary worker deaths, please visit www.cdc.gov/niosh/face. The Michigan and Massachusetts FACE programs have developed 1-2 page Hazard Alerts on temporary worker deaths that are available on their websites (www.oem.msu.edu/userfiles/file/MiFACE/TemporaryWorkerHA17.pdf and www.mass.gov/eohhs/docs/dph/occupational-health/temp-workers.pdf).

The NIOSH Health Hazard Evaluation (HHE) Program provides advice and assistance regarding work-related health hazards. NIOSH may provide assistance and information by phone, in writing, or may visit the workplace. The HHE Program can be reached at www.cdc.gov/NIOSH/HHE or 513-841-4382.

U.S. Department of Labor

Occupational Safety and Health Administration

CDC Workplace Safety and Health

NIOSH

DHHS (NIOSH) Publication Number 2014-139 OSHA - 3735-2014

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Ohio Manufacturers' Association

Workers' Compensation Counsel Report
October 15, 2014

By: Sue A. Wetzel, Esq.
Bricker & Eckler LLP

Regulatory Actions

Nothing significant to report.

Legislative Actions

Nothing significant to report.

Judicial Actions

Ohio Supreme Court Cases:

State ex rel. Parraz v. Diamond Crystal Brands, Inc., slip op. No. 2014-Ohio-4260

On October 2, 2014, the Supreme Court of Ohio handed down this per curiam decision finding that Claimant Elena Parraz was not entitled to payment of temporary-total-disability (TTD) compensation.

While at Diamond Crystal Brands, Inc., Ms. Parraz was employed under a union contract which contained a point-based attendance policy. Under this policy, employees would be terminated for accumulating 14 points. As of the date that Ms. Parraz was injured in July 2010, she had already acquired 10.5 attendance points. She continued to accumulate points, none of which were attributed to her industrial injury, until she was terminated on February 11, 2011 for having 14 points.

Following her termination, Ms. Parraz filed for TTD compensation. However, a district hearing officer (DHO) determined that she was not eligible for this benefit because she had voluntarily abandoned her employment by violating a written rule. The staff hearing officer (SHO) affirmed. Ms. Parraz then filed a complaint for writ of mandamus in the Tenth District Court of Appeals, claiming that she should not be barred from TTD compensation because her absences were merely negligent and not willful or intentional. The court overruled her objections. Accordingly, the Supreme Court was called on to determine whether a claimant's termination for violating a written attendance policy was evidence of voluntary abandonment justifying denial of TTD compensation.

To determine whether a discharge constitutes voluntary abandonment, the Supreme Court applied the test set forth in *State ex rel. Louisiana-Pacific Corp. v. Indus. Comm'n*: a discharge constitutes voluntary abandonment when it is the result of a claimant's violation of a written policy or rule that

(1) clearly defined the prohibited conduct, (2) had been previously identified by the employer as a dischargeable offense, and (3) was known or should have been known to the employee. Any voluntary act that the employee knew may lead to termination of employment may constitute voluntary discharge, and the conduct need not reach the level of intentional or willful conduct.

Here, because Ms. Parraz was aware of the policy, had a history of attendance problems irrespective of her workplace injury, and had been warned about the 14-point attendance policy, the Court found that the Industrial Commission (Commission) had not abused its discretion in determining that her termination was the result of voluntary abandonment precluding TTD compensation.

State ex rel. Rogers v. Salmon & Sons, Inc., 2014 Ohio 3689

On August 28, 2014, the Supreme Court affirmed the Tenth District Court of Appeals' denial of Claimant Kelvin Rogers's request for a writ of mandamus. After sustaining two work-related injuries in 2002 and 2005, Mr. Rogers effectively stopped working. Although he participated in vocational rehabilitation, his file was closed in August 2008 for failure to locate a new job. One evaluation completed in August 2009 determined that he was capable of performing light to light-medium physical employment, while another concluded that he did not have the stamina to complete physical tasks. Mr. Rogers applied for permanent-total-disability (PTD) compensation, but his application was denied in July 2011. His request for reconsideration was subsequently denied in September 2011. He then filed the instant mandamus order.

The Supreme Court, upholding the decision from the Tenth Appellate District, overruled the claimant's objections and denied the request for writ of mandamus. First, the Court found that the magistrate did not err when denying Mr. Rogers's request to depose Dr. Tosi. In determining whether to permit a request to depose, the Commission must determine if the request was reasonable. Here, Mr. Rogers did not provide an explanation, but instead merely presented the hearing officer with generic accusations that Dr. Tosi's report was "ambiguous and contradictory." Accordingly, the Court found that there was no abuse of discretion in denying the request to depose.

Additionally, Mr. Rogers argued that the Dr. Hogya's reports did not constitute "some evidence" on which the Commission could rely. Despite the claimant's assertion, the Courts found that Dr. Hogya's opinion that the claimant could perform light-duty work was not vague. Although Dr. Hogya had imposed lifting restrictions that technically rendered him unable to perform light-duty work, the restriction still enabled Mr. Rogers to perform sedentary work. As such, the Court determined that the Commission did not abuse its discretion in relying on the report.

Finally, Mr. Rogers argued that the magistrate erred by failing to give consideration to his rehabilitation efforts. He asserted that, because Dr. Hogya's report indicated that he could do sedentary work, the magistrate should have considered his vocational rehabilitation and the evaluations that demonstrated that he was not suited for such work. However, the Court concluded that the Commission, as the exclusive evaluator of disability, is not required to vocational evidence or rehabilitation reports. Therefore, because the Commission could determine that a claimant was capable of sedentary work despite vocational evidence to the

contrary, the Court found that this objection was without merit. The Court therefore overruled Mr. Rogers's objections and denied his writ of mandamus.

State ex rel. Cleveland Professional Football, LLC v. Buehrer, 2014 Ohio 3615

On August 27, 2014, the Ohio Supreme Court handed down this per curiam decision granting a writ of mandamus order the BWC to vacate its order transferring the entire experience rating from a former owner to the new owner. Cleveland AFL, LLC ("the former owner") was an arena football team in the Arena Football League (AFL) owned by Jim Ferraro. After the AFL filed bankruptcy proceedings in 2009, an investor group bought the league's assets and formed a new league. Mr. Ferraro then formed Cleveland Professional, LLC ("the new owner"), claiming that the new owner is different from the old one in that it does not employ certain players and coaches.

The new owner applied for workers' compensation coverage. In May 2010, the BWC determined that the new owner was a successor employer for workers' compensation purposes and thus was responsible for the financial rights and obligations of the old owner. The BWC therefore would base the new owners' premium rate on the experience of the former owner. In July 2010, the new owner filed a protest. Following an October 2010 hearing, a BWC committee denied the protest, noting the similarities between the two owners' business models, franchise names, logos, methods of covering players etc.

The new owner filed a complaint for a writ of mandamus alleging that the BWC had abused its discretion in finding that it was a successor to the former owner and by failing to sufficiently explain its decision. A magistrate determined that the evidence supported the BWC's conclusion but that the BWC abused its discretion in transferring the entire experience to the new owner. The appellate court agreed, concluding that the experience rating should be transferred proportionately to the amount of business transferred.

The Supreme Court was then called upon to address the issue of whether the evidence supports transfer of the entire experience rating or only a portion for the purpose of determining the premium rates assigned the new owner. In upholding the appellate court's decision, the Supreme Court found that the BWC's did not appear to have considered all the arguments or evidence. Thus, the Court agreed that the BWC's failure to address the evidence or adequately explain its decision to transfer the entire experience rating to the new owner was an abuse of discretion.

State ex rel. Floyd v. Formica Corp., 2014 Ohio 3614

On August 27, 2014, the Ohio Supreme Court handed down this per curiam decision finding that the Industrial Commission had not abused its discretion when it denied Claimant Darwin Floyd's application for TTD compensation. In affirming the judgment of the Tenth District Court of Appeals, the Supreme Court concluded that Mr. Floyd was no longer eligible for the benefit because he had abandoned the entire job market when he left Formica Corporation and retired.

In 2000, Mr. Floyd sustained a work-related injury. Following the subsequent surgery, he returned to light-duty work until January 2001. At that time, Formica could no longer accommodate his light-duty position, so Mr. Floyd began receiving TTD compensation. Notably,

Mr. Floyd applied for and began to receive Social Security retirement benefits in April 2001. His TTD compensation continued until June 2006 when his condition reached maximum medical improvement (MMI). Following another surgery in 2008, Mr. Floyd received TTD compensation until the condition again reached MMI in May 2009. After yet another surgery in November 2010, the hearing officer denied the request for TTD compensation, finding that Mr. Floyd had not been in the workforce as of November 2010 and had not tried to find any employment since 2001.

In determining whether the Commission's denial of TTD compensation was supported by evidence that the claimant had abandoned the job market, the Court concluded that a claimant's eligibility for TTD compensation depends not only on whether he is able to perform his duties, but also on whether he continues to be part of the *active* workforce. A claimant who is no longer part of the workforce can have no lost earnings and thus would not be eligible for TTD compensation. Should a claimant retire from the workforce for reasons unrelated to his industrial injury, he has voluntarily left the workforce. Such a determination is a fact-based inquiry grounded in the claimant's intent as established through all relevant circumstances.

Here, the Supreme Court found that the evidence demonstrated that Mr. Floyd was medically capable of performing light-duty work with different companies even though there was no light-duty work available at Formica. Further, Mr. Floyd chose to apply for and began receiving retirement benefits—a step he would not have taken had he intended to return to the workforce. Further, Mr. Floyd did not look for other employment after beginning to receive the retirement benefits in 2001. Accordingly, the Supreme Court found that he had already abandoned the entire workforce when he applied for TTD compensation in 2010 and was thus ineligible for such compensation.

State ex rel. Packaging Corp. of Am. v. Indus. Comm'n, 2014 Ohio 2871

On July 2, 2014, the Ohio Supreme Court handed down this per curium decision affirming the Tenth District Court of Appeals conclusion that the Commission did not abuse its discretion in awarding TTD compensation for Murphy's 2001 workers' compensation claim because it had relied on some evidence in reaching the decision.

Claimant Gregory Murphy suffered work-related injuries in April 2001 and September 2006. While receiving TTD compensation for his 2006 injury, he continued to see a doctor for pain attributed to the 2001 injury. Mr. Murphy was also involved in a motorcycle accident in 2009 that resulted to a concussion and closed head injury. Although his motion for approval of pain medication and treatments was initially denied, a hearing officer approved additional doctor treatments because Mr. Murphy had testified that his neck symptoms had increased while using weights during physical therapy for his 2006 shoulder claim.

In May 2010, Mr. Murphy filed a second request for TTD compensation, which was denied. On appeal, an SHO vacated the order and granted TTD benefits after relying on various forms and reports submitted as evidence. Packaging Corporation of America (PCA) then filed a complaint for a writ of mandamus in the Tenth District. The court of appeals concluded that the Commission had not abused its discretion because evidence demonstrated that the physical therapy for his 2006 claim aggravated the claimant's neck conditions allowed in his 2001 claim.

PCA argued that the Commission failed to consider various pieces of evidence that were favorable to the company's position. The court of appeals reiterated, and the Supreme Court affirmed, that the Commission has exclusive responsibility for evaluating the weight and credibility of the evidence before it. The Commission is not required to identify or explain the evidence it did not rely on or why one piece of evidence was considered more persuasive than another. It is not an abuse of discretion for the commission to rely on evidence that is contradicted by equally persuasive evidence. Because the Commission considered various reports and other evidence that happened to be favorable to Mr. Murphy's position, the court of appeals found and the Supreme Court affirmed that the Commission's order was based on some evidence supporting the decision to award TTD compensation.

TO: **OMA Safety and Workers' Compensation Committee**
FROM: **Rob Brundrett**
RE: **Public Policy Report**
DATE: **October 15, 2014**

Overview

The General Assembly has been on recess for the election season since early summer. They are expected to return the second week of November to begin a non-stop two month stretch known as the lame duck session.

Over the summer, the Bureau of Workers' Compensation has been working hard with a variety of stakeholders including, business, labor, and healthcare to make reforms to the medical portion of workers' compensation. They are hoping to get legislation through in lame duck in order to begin new pilot programs surrounding how medical management is deployed throughout the system.

Legislation and Rules

Another Billion Back

Governor John R. Kasich and Ohio Bureau of Workers' Compensation (BWC) Administrator/CEO Steve Buehrer announced a $1 billion rebate to Ohio's private and public sector workers' compensation customers, as well as a major new investment in worker safety research and training. "Another Billion Back" comes on the heels of last year's $1 billion rebate for workers' comp customers. Both rebates were made possible by strong investment returns in the workers' compensation fund.

Recently approved by the BWC Board of Directors, eligible employers will receive a rebate equal to 60 percent of premiums paid during the July 1, 2012 through June 30, 2013 policy year. The BWC began processing the checks earlier this month.

HB 143 Workers' Compensation Formulas (Dovilla R-Berea and Butler R-Oakwood)

HB 143 would require the BWC to include in the notice of premium rate that is applicable to an employer for an upcoming policy year the mathematical equation used to determine the employer's premium rate. According to the BWC this information is already available on the web for all employers to review. There would be a compliance cost to the BWC to send out repeat information. The sponsors of the bill say it is necessary because not everyone has internet access.

This bill was added to the workers' compensation MBR bill as a committee amendment in the House. The Senate removed the amendment from the final version of the bill. It is not expected to move in lame duck.

SB 176 Worker's Compensation Benefits (Seitz R-Green Township)

SB 176 would prohibit illegal and unauthorized aliens from receiving compensation and certain benefits under Ohio's Workers' Compensation Law. Senator Seitz has introduced this bill in previous General Assemblies. The bill has had two hearings. It most recently had a proponent testimony hearing in January.

HB 338 Test to Determine if Certain Individuals are an Employee Under BWC and Other Laws (McGregor R-Springfield and Hottinger R-Newark)
HB 338 exempts an individual who provides services for or on behalf of a motor transportation company transporting property from coverage under Ohio's Workers' Compensation Law, Ohio's Unemployment Compensation Law, and Ohio's Overtime Law if specified conditions apply to the individual. The bill was introduced in late November.

Initially the bill was expected to move. However it was pulled from hearings after it was determined that the changes in the bill could increase the unemployment compensation tax in the state of Ohio. Discussions continue on how to avert that result and still pass this bill in some form.

HB 462 and SB 290
Representative R. McGregor and Senator T. Patton introduced companion legislation that would permit a professional employer organization to file federal taxes in any manner permitted by federal law. This legislation came in response to the controversial rule package submitted by the BWC and supported by the major business which regulated the PEO industry.

The bill had three hearings in the Senate and one hearing in the House. There is speculation that the bill might receive consideration during lame duck.

HB 493 Mid-Biennium Review
The Governor introduced his Mid-Biennium Review (MBR) bill this winter. The bill was immediately broken into numerous smaller bills. The BWC portion of the MBR became House Bill 493. It contains two major law provisions. The first is clean up language allowing for the complete transition to prospective payments. The second is a creation of out of state coverage. The bill passed the legislature prior to summer recess and was supported by the OMA. A full bill analysis is included in your materials.

House Bill 539
Representative Henne introduced subrogation legislation late in the spring session. HB 539 has the potential to reduce claims cost for Ohio employers as they navigate through cases ripe for subrogation.

There are two elements to HB 539: 1) to defer charging workers' compensation claims to an employer's experience when a third party may be liable for the claim, and 2) to create a subrogation suspense account to which any deferral will be charged. In other words, the Bureau of Workers' Compensation would create a fund to insulate employers from the cost of claims from a workplace accident caused by a third party.

BWC Medical Reform
The legislature has no immediate plans to comprehensively overhaul the BWC; it still is feeling the effect of the Senate Bill 5 fight three years ago. However the BWC has been actively engaging with various stakeholders, including, trail lawyers, labor, business and healthcare. The goal of those meetings was to determine what sort of reforms could be accomplished through a general consensus.

The group began meeting in July and changes to the medical management portion of a claim was the topic. The group worked to find common ground where changes and

improvements to the system could be made. The BWC is in the process of getting draft language put together for lame duck legislation that would allow new medical management pilot programs.

The full report included in the materials was presented to the full Board in September.

Bureau of Workers' Compensation

San Allen Settlement

This summer, Ohio Bureau of Workers' Compensation (BWC) Administrator/CEO Steve Buehrer announced that the bureau reached an agreement to settle the San Allen case, a class action lawsuit filed in 2007 over BWC pricing policies that were in place between 2001 and 2008. The case involved premium subsidies from one set of employers (those not in group rating) to another set of employers (those in groups) that occurred because of the operation of the BWC's actuarial credibility tables during that time period.

According to OMA Connections Partner Roetzel & Andress: "As part of the agreement, a $420 million fund will be created to pay for claims to employers participating in the lawsuit, the attorney fees, court costs and the costs of administering the fund…The next step, once the court gives preliminary approval of the settlement, is for class members to receive instructions for submitting claims. Any unclaimed funds will be returned to the Bureau of Workers' Compensation State Insurance Fund to pay claims of injured workers, according to the release."

Originally, $860 million was awarded by the Eight District Court of Common Pleas.

OMA will keep members up-to-date as details are learned about who can submit claims, how claims are to be submitted, and when this can/will happen

BWC Staff Proposes 6.3 Percent Rate Cut

The Ohio Bureau of Workers' Compensation (BWC) staff proposed that the Board of Directors approve a 6.3 percent reduction to base rates beginning July 1. If approved, this cut would mark the eighth consecutive year in which private sector rates have either fallen or remained flat.

If approved, the 6.3 percent reduction will result in an overall decrease in collected premiums of $91 million compared to premiums under the current rates.

BWC and its actuarial consultant, Oliver Wyman, attributed the proposed reduction to better than previously expected claims frequency and claims severity.

The actual premium paid by individual private employers depends on a number of factors, including the expected future costs in their industry, their recent claims history, and their participation in various discount and savings programs.

Ballot Issues

Marijuana Ballot Issue

An organization attempting to qualify a ballot issue to authorize the use of medical marijuana failed to collect adequate voter signatures by the spring deadline. The measure will not be on the November ballot. The group says it will retry in November of 2015.

Ohio | Bureau of Workers' Compensation

Governor **John R. Kasich**
Administrator/CEO **Stephen Buehrer**

NEWS RELEASE

August 13, 2014

KASICH PROPOSES "ANOTHER BILLION BACK" FOR WORKERS' COMP CUSTOMERS

Strong Investment Returns & Good Management Fuel Another $1 Billion Rebate and Major New Investments in Workplace Safety

COLUMBUS – Governor John R. Kasich today joined Ohio Bureau of Workers' Compensation (BWC) Administrator/CEO Steve Buehrer to announce a $1 billion rebate to Ohio's private and public sector workers' compensation customers, as well as a major new investment in worker safety research and training. Dubbed "*Another Billion Back*," the rebate comes on the heels of last year's $1 billion rebate for workers' comp customers. Both rebates were made possible by strong investment returns in the workers' compensation fund.

Kasich made the announcement at Portfolio Creative, a Columbus company that recruits and staffs talent in all areas of design, marketing, communications and advertising. They are one of approximately 184,000 private and 3,800 public employers likely to receive a rebate.

"Sound fiscal management and a well-executed investment strategy continue to put BWC in a position where it can return money to its customers—Ohio's employers—but also to workers in the form of initiatives that help them stay safe on the job," said Kasich. Ohio continues its effort to transform the workers' comp system to be a better partner with employers and workers to help them succeed and stay safe, and the ability to make these types of significant rebates is part of that effort."

BWC's preliminary annualized return of investments was 8.9 percent over the last three fiscal years, including 13.3 percent in 2014. The State Insurance Fund net assets stand at $7.7 billion and its funding ratio far exceeds target guidelines set by the BWC Board of Directors. If approved by the BWC Board of Directors, eligible private and public employers would receive a rebate equal to 60 percent of premiums paid during the July 1, 2012 through June 30, 2013 policy year (calendar year 2012 for public employers). The proposal will be presented to the board at its August meeting, and if approved in its September meeting, BWC could begin issuing checks as early as October*.

Another Billion Back seeks to build on last year's $15 million investment in safety intervention grants with several initiatives that will ultimately enhance the safety, health and wellness of Ohio's workforce. Additionally, special safety training is proposed to reduce injuries among firefighters, whom frequently have very high workers' comp rates due to the dangerous and risky nature of their work. Additional information on the proposal can be found here.

"BWC's Division of Safety and Hygiene is a national leader in promoting safe and healthy workplaces," said Buehrer "Our safety services provide a superior return-on-investment. We want to encourage more and more employers to put safety education resources to work to keep their workers safe and reduce their workers' comp costs. Our new safety initiatives will make these efforts more effective and accessible for employers."

Buehrer added that BWC is also embarking on a safety campaign themed *Better Business Starts with Safety, Safety Starts at BWC* to reach Ohio employers and encourage them to take advantage of BWC's safety services before experiencing a workplace injury or illness. A microsite allows employers to compare injury rates and costs within and across industry sectors. It also links employers directly to BWC safety consultants, who can survey their workplace and advise them on preventing occupational injuries and illnesses in their workplaces. The campaign is a result of the safety commitment made as part of last year's *Billion Back* initiative, which also tripled safety grant funding to $15 million for each of fiscal years 2014 and 2015.

Another Billion Back is an example of BWC's work over the last four years to be a better partner in improving Ohio's business environment and helping encourage the state's economic revival. Sound financial and operational management has also allowed BWC to:

- Reduce average base rates for Ohio's private employers, bringing combined four-year collections down $409 million.
- Reduce average rates for public employers by an estimated $70 million, placing them at their lowest levels in at least 30 years.
- Commit $1.2 billion in transition credits to Ohio employers as part of the conversion to prospective billing.
- Expand safety funding, which resulted in allowed claims dropping below 100,000 for the first time.

**Eligible employers must be in good standing and have paid their January 1 to June 30 premiums.*

# # #

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Ohio | Bureau of Workers' Compensation

Another Billion Back

For employers and worker safety

Building on the momentum of last year's Billion Back plan, Another Billion Back, proposes to inject an additional $1 billion into Ohio's economy while making an unprecedented commitment to safe workplaces and a healthy, productive workforce.

The proposal:

- Provides a one-time rebate of $1 billion for private employers and public-taxing districts.
- Increases BWC's commitment to safety by up to $35 million over the next two years.
- Creates several new safety initiatives that leverage BWC's occupational health and safety expertise to create innovative solutions for improving the safety, health and wellness of Ohio's workforce.

$1 billion rebate

During its August meeting, the BWC Board of Directors will discuss the proposal to extend a $1 billion rebate for private employers and public-taxing districts paying into Ohio's workers' compensation system.

BWC's investments continue to perform well above expectations as a result of prudent management and a careful, conservative investment strategy. BWC's preliminary annualized return of investments was 8.9 percent over the last three fiscal years, including 13.3 percent in 2014. The State Insurance Fund net assets stand at $7.7 billion and a funding ratio above the target guidelines set by the BWC Board of Directors.

If approved by the board, each rebate would equal 60% of the employers' annual premium and checks will be distributed beginning in October. Private employers and public-taxing districts that pay premium into the State Insurance Fund and have active, up-to-date policies will be eligible for the rebate. Each employer's rebate will reflect 60% of what they were billed during the last policy period (July 1, 2012 to June 30, 2013 for private employers; January 1, 2012 to December 31, 2012 for public taxing districts).

To be eligible, private employers must have been in an active, reinstated, combined or debtor in possession status as of September 5; public taxing districts must also have been in an active or reinstated status as of September 5.

Employers with an outstanding BWC balance will have their rebate first applied to that balance.

Employers who report through a Professional Employer Organization should receive their rebate from their PEO, which is required to pass a portion of the rebate on to their members.

Safety Initiatives

We know the best workers' comp claim is the one that never happens and businesses that benefitted from the safety intervention grant program reduced the frequency of claims in the area of the intervention by 66%. Investments in safety create safer workplaces, prevent costly accidents and ultimately result in lower premiums for employers; this year's rebate plan includes several safety elements:

- **Advanced research to practice in workplace safety and health** for higher-education institutions and research organizations to promote innovation in areas of workplace safety and health such as overexertion; slips, trips, and falls; and musculoskeletal disorders. BWC expects to fund 10-15 projects a year at an annual cost of approximately $2 million.

- **Expansion of the Safety Council Program to incorporate health and wellness.** BWC currently sponsors and provides funding for more than 80 safety councils with 9,000 participating employers. With this proposal, BWC will require more training and seminars directed at improving the health and wellness of Ohio's workforce.

  Several studies demonstrate the need for employers to focus on overall wellness. Obese employees file two times the amount of workers' comp claims and are 25% more likely to have an accident (Northeast Business Group on Health); and, a study published in the Journal of Occupational and Environmental Medicine found that other co-morbidities like heart disease, diabetes, depression and asthma also increase injury risk.
- **Firefighter safety training.** Ohio Emergency Medical Services and the State Fire Marshal provide $500,000 to fund Fire Fighter I Training, a 120-hour class, to improve their safety, preparedness and response time during emergencies. BWC will commit another $1 million.
- **Safety Intervention Grant Program:** The popular Safety Grants Program provides matching funds up to $40,000 for employers to purchase equipment that will substantially reduce or eliminate injuries and illnesses. The program was expanded last year and has gained significant popularity and a record $15 million in grants was awarded to 535 employers over the last year. The most previously granted through the program in one year was $4 million. BWC already approved another $15 million for the fiscal year that began July 1, and will propose additional commitments of $15 million for each of the next two years (fiscal years 2016 and 2017).
- **Development of safety curricula and funding for skilled labor training programs.** BWC will collaborate with business, labor and higher education to create, implement and fund safety programming as part of required training in high-risk specialties such as carpentry, welding and plumbing. Under the program, BWC will incent two-year universities and trade schools to include the developed safety programming as part of the education provided to those looking to attain skilled labor positions. BWC's financial commitment to this program will be $1 million.

Ohio Legislative Service Commission

Bill Analysis

Erika Padgett

H.B. 462

130th General Assembly
(As Introduced)

Reps. McGregor, Hayes, Young

BILL SUMMARY

- Permits a professional employer organization to file federal taxes in any manner permitted by federal law.

CONTENT AND OPERATION

Federal tax filing

Under continuing law, a "professional employer organization" (PEO) is a business entity that enters into an agreement with one or more client employers for the purpose of coemploying (sharing of the responsibilities and liabilities of being an employer) all or part of the client employer's workforce at the client employer's work site. This arrangement is governed by a PEO agreement, which is a written contract to coemploy employees between a PEO and a client employer with a duration of not less than 12 months in accordance with the requirements of the PEO Law.[1]

The bill permits a PEO to file federal taxes in any manner permitted by federal law.[2] Presumably this provision would allow a PEO to file taxes under the client employer's or the PEO's employer identification number for federal tax purposes, depending upon which method is permitted by federal law. Currently, under rules adopted by the Bureau of Workers' Compensation (which administers and enforces the PEO Law), a PEO must pay and report wages for shared employees under the tax identification number of the PEO for federal tax purposes.[3]

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[1] R.C. 4125.01(B) to (E).

[2] R.C. 4125.031.

[3] Ohio Administrative Code 4123-17-15(D)(2).

Ohio Legislative Service Commission

Final Analysis

Kelly Bomba

Sub. H.B. 493

130th General Assembly
(As Passed by the General Assembly)

Reps. Sears and Henne, Hackett, Huffman, Stebelton, Wachtmann

Sens. Bacon, Faber, Peterson, Schaffer, Seitz

Effective date: September 17, 2014; certain provisions effective July 1, 2015

ACT SUMMARY

Prospective payment of premiums

- Requires, rather than permits as under former law, the Administrator of Workers' Compensation (Administrator) to calculate workers' compensation premiums for most employers on a prospective, rather than retrospective, basis, beginning policy year 2015.
- Requires most employers to pay premiums on an annual basis, rather than semiannually as under former law.
- Allows the Administrator to adopt rules to permit periodic premium payments and to set an administrative fee for these periodic payments.
- Adjusts the calculation for employer payments to the Disabled Worker Relief Fund.
- Makes other changes to conform the Workers' Compensation Law to the prospective payment system.

Premium security deposits

- Eliminates the requirement for most employers commencing coverage on or after July 1, 2015, to pay a premium security deposit.
- Makes an employer a "noncomplying employer" immediately upon a transfer from the Premium Payment Security Fund Account to the State Insurance Fund due to the employer's account being uncollectible, rather than extending coverage for eight months as under former law.

Payroll reporting

- Requires, for a policy year commencing on or after July 1, 2015, a private employer other than a professional employer organization (PEO) to submit a payroll report on or before August 15 each year unless otherwise specified by the Administrator in rules.

- Requires private employers to include, for payroll reports submitted on or after July 1, 2015, the number of employees employed during the preceding policy year from July 1 through June 30.

- Eliminates the forfeiture penalty for failing to submit a payroll report and allows the Administrator to adopt rules setting forth a penalty, including exclusion from alternative rating plans and discount programs.

- Revises the requirements for public sector payroll reports.

Late payments and reports

- Increases, beginning policy year 2015, the additional amount of premium or assessment due from an employer who fails to timely submit a payroll report from 1% of the amount due to 10% of the amount due and eliminates the cap for the penalty amount.

- Requires, beginning policy year 2015, the Administrator to adopt a rule to allow the Administrator to assess a penalty on an employer who fails to pay a premium or assessment when due at the interest rate established by the State Tax Commissioner for most delinquent taxes and eliminates the tiered penalty system.

Professional employer organizations (PEOs)

- Requires PEOs to pay premiums on a monthly basis beginning July 1, 2015, and to submit payroll reports on a monthly basis beginning August 1, 2015.

- Permits, rather than requires, the Administrator to adopt rules establishing a PEO security requirement for workers' compensation premiums beginning July 1, 2015.

- Requires, if a PEO fails to make timely payment of premiums or assessments, the Administrator to revoke the PEO's registration under the PEO Law.

Interstate claims

- Eliminates the requirement to obtain Ohio coverage for an out-of-state employee who temporarily works in Ohio if the employee's home state law lacks a provision

similar to the Ohio law that exempts out-of-state employees temporarily working in Ohio from the duty to obtain Ohio coverage.

- Requires the Administrator or a self-insuring employer to disallow a claim in which the employee or the employee's dependents (1) receive an Ohio award after previously pursuing or otherwise electing to accept an award for that claim in another state or (2) receive an Ohio award and subsequently pursue or otherwise elect to accept an award for that claim in another state.

- Limits the ability to collect compensation and benefits from an employee or the employee's dependents in claims pursued and decided in multiple jurisdictions to only the Administrator or a self-insuring employer, instead of allowing any employer to take such an action as under former law.

- Adds an other-states' insurer as a party from whom the Administrator or self-insuring employer may recover compensation, benefits, and costs in claims pursued and decided in multiple jurisdictions.

- Requires the Administrator or a self-insuring employer to dismiss a claim for which the Administrator or self-insuring employer does not receive an election of Ohio coverage within the continuing law time period, rather than suspending the claim as under former law.

Other-states' coverage

- Allows the Administrator to provide limited other-states' coverage to provide workers' compensation coverage for Ohio employees who are temporarily working in another state in addition to other-states' coverage.

- Prescribes procedures the Administrator must follow to secure a vehicle through which to provide limited other-states' coverage, which is similar to how the Administrator selects the vehicle for other-states' coverage under continuing law.

- Eliminates the requirement that an employer who has other-states' coverage segregate payroll on the employer's annual payroll report based upon whether an employee is covered under other-states' coverage.

- Allows the Administrator to adopt rules with respect to the information to be excluded from the calculation of an employer's state fund premium when the employer obtains other-states' coverage through the Administrator, rather than requiring the information to be excluded as under former law.

Benefit payments

- Allows the Administrator to pay for the first fill of prescriptions occurring during an earlier timeframe than under continuing law.

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

Health Partnership Program

- Statutorily permits the Bureau of Workers' Compensation (BWC) to summarily suspend a health care provider's certification to participate in the Health Partnership Program (HPP) and specifies procedures regarding the suspension.

- Expands the example in the definition of "peer review committee" to include a peer review committee of BWC or the Industrial Commission that reviews the professional qualifications and performance of providers certified by BWC to participate in the HPP.

- Requires that type of peer review committee to follow the confidentiality requirements pertaining to committee records and proceedings as set forth in continuing law, subject to specified exceptions.

Claims procedure

- Requires, for an appeal of an Industrial Commission decision filed with a court of common pleas on or after September 17, 2014 (the act's effective date), the notice of appeal to include the name of the Administrator.

Premium programs and assessments

- 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 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.

Self-insuring employers

- 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 former 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 Board to provide information from the drug database to a managed care organization's medical director if specified conditions are satisfied.

- Places the Chief Ombudsperson and assistant ombudspersons in the unclassified service, and makes changes regarding their appointment and removal.

- Requires all ombudsperson system staff to comply with Ohio's Ethics Laws and the Industrial Commission Nominating Council's human resource and ethics policies.

- 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 former 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.

- Changes the method by which "good standing" is determined for purposes of qualifying for a group rating program.

- Eliminates a requirement in the BWC budget for the FY 2014-FY 2015 biennium that any unencumbered cash balance in excess of $45 million in the Workers' Compensation Fund on June 30 of each fiscal year be used to reduce the administrative cost rate charged to employers.

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CONTENT AND OPERATION

Prospective payment

The act requires, rather than permits as under former law, the Administrator of Workers' Compensation (Administrator), beginning in policy year 2015, to calculate and bill workers' compensation premiums on a prospective basis for all employers other than professional employer organizations (PEOs) and state employers. Under former

law, the Administrator was required to adopt rules, with the advice and consent of the Bureau of Workers' Compensation (BWC) Board of Directors, to make premium payments for the State Insurance Fund due on or before the end of a coverage period. These payments are often referred to as "retrospective payments" or "payments in arrears." However, the Administrator, with the BWC Board's advice and consent, also had the authority to adopt rules to allow for a prospective payment system – that is, a system under which an employer pays for the coverage before the coverage period starts.

The act eliminates the retrospective payment requirement with respect to public employers other than the state and private employers other than PEOs. The act also eliminates the requirement that these employers pay prospectively only if the Administrator adopts rules to establish a prospective payment system, and instead requires them to pay prospectively as provided in the act. As discussed under "**Prospective payment rules**," below, some requirements in those rules were codified by the act, some requirements were eliminated, and some will be in rules that the Administrator must adopt under the act.[1]

Private employers other than PEOs

Payment of premiums – private employers

Beginning with the policy year commencing July 1, 2015, the act requires each private employer (except PEOs) and each publicly owned utility to pay premiums prospectively (policy years for private employers run from July 1 through June 30).[2] Under the act, these employers must pay estimated premiums annually every June, instead of semiannually every January and July as under former law, for coverage during the immediately succeeding policy year. Similar to former law, these estimated premiums are fixed by the Administrator for the employment or occupation of each employer and are determined by the classifications, rules, and rates made and published by the Administrator. The act also requires each of these employers to pay any additional amount to the State Insurance Fund that is determined to be due from the employer by applying the Administrator's rules, based on the employer's actual payroll report (see "**Payroll reports and reconciliation – private employers**," below).

Continuing law requires the Administrator to adopt rules to permit private employers to make periodic payments of these premiums. Under the act, these rules must also cover the periodic payment of assessments and must be adopted with the

[1] R.C. 4123.32, 4123.322, 4123.35, and 4123.41 with conforming changes throughout the act.

[2] See Ohio Administrative Code (O.A.C.) 4123-17-01.

BWC Board's advice and consent. Additionally, the act allows the Administrator to set an administrative fee for these periodic payments.[3]

BWC must provide an employer who makes timely premium payments a notice that, under the act, serves as the employer's proof of workers' compensation coverage. This proof is similar to the former law certificate of compliance (see "**Proof of workers' compensation coverage**," below).[4] If a private employer or public utility fails to pay these premiums or assessments when due, the employer may be subject to the penalty charges listed in "**Charges for failure to pay premiums or assessments**," below.

Initiating coverage – private employers

After July 1, 2015, a private employer who first subscribes to the State Insurance Fund on any day other than July 1 must pay premiums according to rules adopted by the Administrator, with the BWC Board's advice and consent, for the remainder of the policy year for which the coverage is effective. Continuing law prescribes the content of these rules. The rules must require a private employer to file both of the following:

(1) An initial application for coverage;

(2) An estimate of the employer's payroll for the period the Administrator determines pursuant to rules the Administrator adopts (former law specified that the rule must require the estimate to cover the unexpired period beginning on the application date through the following June 30).

The act specifically requires the employer to pay an application fee (under former law, this was required only if the Administrator elected to adopt rules to establish a prospective payment system – see "**Prospective payment rules**," below). Failure to pay this fee, or, as under continuing law, to provide all of the information required in the application, may result in a denial of coverage. Until policy year 2015, an employer who initiates coverage must pay the semiannual premiums from time to time upon the expiration of the respective periods for which payments have been made.[5]

Payroll reports and reconciliation – private employers

For policy years commencing on or after July 1, 2015, the act requires private employers other than PEOs to submit a payroll report to BWC on August 15 of each

[3] R.C. 4123.35.

[4] R.C. 4123.35(A) and 4123.83, with a conforming change in R.C. 4123.54.

[5] R.C. 4123.35(A), 4123.32(F), and 4123.322(A).

year unless otherwise specified by the Administrator in rules. The employer must include all of the following in the report:

(1) The number of employees localized in Ohio employed during the preceding policy year for the period from July 1 through June 30;

(2) The number of such employees localized in Ohio employed at each kind of employment and the aggregate amount of wages paid to these employees (similar to payroll reports submitted prior to the policy year commencing July 1, 2015);

(3) Additional information if the employer has other-states' coverage (see "**Other-states' coverage**," below) or has employees covered under the federal Longshore and Harbor Workers' Compensation Law (continuing law).

Continuing law requires, for policy years commencing prior to July 1, 2015, that this payroll report be submitted in January of each year and include the number of employees employed during the preceding calendar year.[6]

The act also requires a "reconciliation" of estimated premiums with actual payroll upon the Administrator receiving the payroll report. Upon receiving an employer's payroll report, the Administrator must adjust the premium and assessments charged to the employer to account for the difference between the estimated gross payroll (as calculated under "**Payment of premiums – private employers**," above) and actual gross payroll. Any balance determined to be due to the Administrator must be immediately paid by the employer and any balance due to the employer must be credited to the employer's account.[7]

The act eliminates the $500 forfeiture that was required under former law for failing to file a payroll report. Instead, the Administrator may adopt rules setting forth penalties for failure to submit the payroll report, including exclusion from alternative rating plans and discount programs.[8]

Additionally, the act assigns to an employer who fails to file a payroll report a modified premium and assessment rate calculated at 110% of the estimated payroll of the employer. Former law required that the employer's premium be increased by 1%, but by no less than $3 and no more than $15.[9]

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[6] R.C. 4123.26, with a conforming change in R.C. 4123.27.

[7] R.C. 4123.35(A) and 4123.322(A) and (B).

[8] R.C. 4123.26(E) and (F) and 4123.322.

[9] R.C. 4123.32(D)(1).

The act eliminates the requirement that the report be mailed to BWC at its main office in Columbus, and instead requires only that the report be submitted to BWC. The act also eliminates requirements for the form on which payroll reporting must be made. Former law, which required specific procedures for filling out the form, is replaced in the act by a requirement that the payroll report must be submitted on a form prescribed by BWC. The act also eliminates the authority of BWC to require the information be returned to BWC within the period fixed by BWC.[10]

Elimination of the premium security deposit

The act eliminates, for policies effective July 1, 2015, and after, the requirement that each employer, upon instituting workers' compensation coverage, must submit a premium security deposit. Under continuing law for policies effective prior to July 1, 2015, the deposit amount equals 30% of the employer's estimated premium payment for eight months of coverage. The premium security deposit may not be greater than $1,000 or less than $10.[11] Though the act generally eliminates the premium security deposit, the act permits the Administrator to require, if the Administrator determines that an employer is an amenable employer (see "**Premiums and assessments for amenable employers**," below) prior to the policy year commencing July 1, 2015, the employer to pay a premium security deposit (under former law, an amenable employer was required to pay the deposit).[12]

The Premium Payment Security Fund Account

Continuing law requires the Administrator to set aside into an account of the State Insurance Fund called the Premium Payment Security Fund (renamed the Premium Payment Security Fund Account by the act), sufficient money to pay for any uncollected premiums due from an employer (see "**Penalties for failure to pay premiums or assessments**," below). Although the Premium Payment Security Fund was referred to as an account within the State Insurance Fund, former law treated it as a fund in the custody of the Treasurer of State subject to various commingling and accounting restrictions. The act eliminates the special commingling and accounting restrictions.[13]

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[10] R.C. 4123.26, 4123.32(E) (renumbered (D) by the act), and 4123.322.

[11] R.C. 4123.32, 4123.36, and 4123.37.

[12] R.C. 4123.37.

[13] R.C. 4123.34(D).

Public employers

Payment of premiums – public employers

The act requires public employers, other than state agencies, to transition to prospective payment of premiums by the policy year commencing on January 1, 2017. Policy years for public employers run from January 1 through December 31.[14] The following table outlines the time by which premium and assessment payments must be made by public employers during the transition period.

For payments and assessments due for a policy year that commences:	Due dates for premium and assessment payments:
On or before January 1, 2014 (same as under retrospective payment system)	• At least 45% of the total amount due by May 15 of the year immediately following the conclusion of the policy year • The remainder of the amount due by September 1 of the year immediately following the conclusion of the policy year
January 1, 2015	• At least 50% of the annual amount due by May 15, 2016 • The remainder of the amount due by September 1, 2016
January 1, 2016	• At least 50% of the annual premium estimated by BWC by May 15, 2016 • The remainder of the estimated premium by September 1, 2016
On or after January 1, 2017	• The total amount of the annual premium estimated by BWC by December 31 of the year immediately preceding the policy year

If a public employer fails to pay these premiums or assessments when due, the employer may be subject to the penalty charges listed in "**Charges for failure to pay premiums or assessments**," below.

Similar to private employers, the act also requires the Administrator, with the BWC Board's advice and consent, to adopt rules to permit public employers to make periodic payments of premiums and assessments. The rules must provide for the assessment of interest charges, if appropriate, and for the assessment of penalties when

[14] See O.A.C. 4123-17-01.

an employer fails to make timely payments and may establish an administrative fee for periodic payments.[15]

Initiating coverage – public employers

Similar to continuing law, under the rules the Administrator must adopt to establish a prospective payment system (see "**Prospective payment rules**," below), a public employer other than the state or a state university or college, upon initiating coverage, must file with the application an estimate of the employer's payroll for the period the Administrator determines under rules the Administrator adopts (under former law, the rule had to require the payroll cover the period beginning on the application date to the following December 31). Additionally, the public employer must pay the amount the Administrator determines by rule in order to establish initial coverage.[16]

Payroll reports and reconciliation – public employers

The act requires BWC, for each policy year commencing on or after January 1, 2016, to furnish by November 1 to the fiscal officer of each public employer taxing district (those public employers other than the state) forms showing the estimated premium due from the public employer taxing district for the forthcoming policy year. On or before February 15 immediately following the conclusion of a policy year, the fiscal officer must report the amount of money expended by the public employer taxing district during the policy year for the services of employees covered by Ohio's Workers' Compensation Law. BWC must then reconcile the report with the premiums and assessments charged to the public employer taxing district to account for the difference between estimated gross payroll and the actual gross payroll. The public employer taxing district must immediately pay any balance due to BWC, and any balance found due to the public employer must be credited to the public employer's account.

The act also allows the Administrator to adopt rules setting forth penalties for failure to submit the payroll report, including exclusion from alternative rating plans and discount programs. The act eliminates the former law requirement that the Administrator must adopt a similar payroll estimate reporting rule and penalties for failure to timely file those estimates if the Administrator elects to adopt rules establishing a prospective pay system.

Under continuing law, for policy years that begin prior to January 1, 2016, BWC is required to furnish the fiscal officer of each public employer taxing district with a

[15] R.C. 4123.41.

[16] R.C. 4123.32(F) and 4123.322.

form containing the premium rates applicable to the public employer. The fiscal officer must report on this form the amount of money expended during the previous 12 calendar months for the services of employees covered by the Workers' Compensation Law and must calculate on the form, the premium due. The public employer must pay the amount due according to the schedule outlined in "**Payment of premiums – public employers**," above.[17]

Revising basic rates

Under continuing law, the Administrator, with the BWC Board's advice and consent, must set the rates for each class of occupation or industry in order to maintain the solvency of the State Insurance Fund. These rates are commonly referred to as the basic or base rates.

Under continuing law, for policy years commencing prior to July 1, 2016, revisions of these rates must be in accordance with the oldest four of the last five calendar years of the combined accident and occupational disease experience of the Administrator in the administration of the Workers' Compensation Law. For policy years commencing on or after July 1, 2016, the act requires revisions of basic rates for private employers to be in accordance with the oldest four of the last five policy years.

Similarly the act requires that revisions for base rates of public employers must be in accordance with the oldest four of the last five policy years. For most public employers, then, the method of revision of basic rates does not change, as public employer policy years are the same as calendar years.[18]

Penalties for failure to pay premiums or assessments

Under the act, similar to former law, whenever an employer fails to pay a premium due, and the Administrator determines the employer's account to be uncollectible, the Administrator must cover the default by transfer from the Premium Payment Security Fund Account to the State Insurance Fund. After that transfer, the employer must be considered a noncomplying employer for purposes of the Workers' Compensation Law. Under former law, the transfer amount was enough to cover the default in excess of the premium security deposit (which is eliminated under the act), and the transfer established coverage of the employer for the period covered by the premium security deposit. Only after the premium security deposit coverage period (eight months) was an employer considered to be a noncomplying employer for purposes of the Workers' Compensation Law under former law. The act also eliminates

[17] R.C. 4123.41(A) and 4123.322.

[18] R.C. 4123.34.

former law procedures by which a noncomplying employer could have ceased being a noncomplying employer, which included reimbursing the amount transferred.[19]

The act modifies the former law penalty charges levied against an employer who fails to pay premiums when due for a policy year commencing on or after July 1, 2015, and broadens the penalty authority to also apply to unpaid assessments.

For a policy year commencing on or after July 1, 2015, the act allows the Administrator to assess a penalty at the certified interest rate established by the Tax Commissioner for most overdue taxes. The rate for calendar year 2014 is 3%.[20] Under continuing law, the penalty cap is 15% of the premium due. For a policy year commencing prior to July 1, 2015, continuing law imposes a penalty of $30 plus an amount determined under a statutory schedule.[21]

Discounts for early payment

Continuing law allows the Administrator to grant an employer a discount for early payment of premiums. Under the act, the Administrator may give an employer a discount if the employer pays the employer's annual estimated premium in full prior to the start of the policy year for which the premium is due. Previously, the Administrator could grant a discount to a private employer who paid the employer's semi-annual premium at least one month prior to the last day the payment was due. For public sector employers, the Administrator could grant a discount to an employer who paid the full premium on or before May 15.[22]

Collections of amounts due

Under continuing law, when an amount is payable to the state, the officer, employee, or agent responsible for administering the law under which the amount is payable must immediately proceed to collect the amount or cause the amount to be collected. If the amount is not paid within 45 days after payment is due, the officer, employee, or agent must certify the amount to the Attorney General for further collection efforts. For purposes of these continuing law collection requirements, the act sets the due date for premiums due under the Workers' Compensation Law at 30 days

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[19] R.C. 4123.36.

[20] *See* Office of Budget and Management, "Prompt Payment: Calendar Year 2014 Interest Rate for Late Payment to Vendors," October 28, 2013, http://media.obm.ohio.gov/obm/forms-memos-archives/memos/Prompt%20Pay%20Interest%20Rate%20Letter%20for%20CY%202014.pdf.

[21] R.C. 4123.32.

[22] R.C. 4123.41(F) and 4123.29(B)(1).

after the date upon which employers must submit actual payroll reports for the corresponding policy year pursuant to the Workers' Compensation Law. All other payments required under the Workers' Compensation Law, including a payment due for purposes of continuing coverage, are due on the date specified in the Law, unless otherwise provided in a rule adopted by the Administrator with the BWC Board's advice and consent.[23]

Disabled Workers' Relief Fund (DWRF) assessments

Under continuing law, the Administrator, with the BWC Board's advice and consent, must levy an assessment against all employers to carry out the purposes of the Disabled Workers' Relief Fund (DWRF). DWRF 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 act eliminates the requirement that the Administrator annually charge a minimum assessment of 5¢ per $100 of payroll.

The act also adjusts the payroll period for which DWRF assessments are made to reflect the transition to prospective premium payments.

Under continuing law, for policy years commencing prior to July 1, 2015, private employers are levied DWRF assessments in January and July of each year upon gross payrolls of the preceding six months. For policy years commencing on or after July 1, 2015, the act requires these assessments to be levied in the month of June immediately preceding each policy year upon gross payrolls estimated for that policy year. Similarly, public employer taxing districts continue to be assessed in January of each year upon gross payrolls of the preceding 12 months for policy years commencing prior to January 1, 2016. For policy years commencing on or after January 1, 2016, public employers are assessed in the month of December immediately preceding each policy year upon gross payrolls estimated for that policy year. The state as an employer continues to be subject to assessments levied in January, April, July, and October of each year upon gross payrolls of the preceding three months, or, as added by the act, at other intervals that the Administrator establishes.

The assessments levied pursuant to the act's adjusted schedules must be reconciled to account for differences between estimated payroll and actual payroll upon the employer submitting the payroll report as required under "**Payroll reports and**

[23] R.C. 4123.323 and R.C. 131.02, not in the act.

reconciliation – private employers" and "**Payroll reports and reconciliation – public employers**," above.[24]

The act purports to repeal R.C. 4121.419; however, that section does not exist. It is likely that the act intended to repeal R.C. 4123.419. The repeal of R.C. 4123.419 would have eliminated a current law requirement to make transfers from the DWRF to the General Revenue Fund to reimburse the General Revenue Fund for moneys appropriated for disabled worker relief (per BWC, those transfers are no longer being made).[25]

Prospective payment rules

The act requires, rather than permits under former law, the Administrator to adopt certain rules to establish a system of prospective premium payments. The act eliminates the requirement that the Administrator adopt rules that were similar to statutory requirements for payroll reporting and penalties for failing to file the reports that are added by the act as outlined in "**Payroll reports and reconciliation – public employers**" and "**Payroll reports and reconciliation – private employers**," above.

The requirements for the remaining rules are largely unchanged by the act and include the rules governing initiating coverage, rules for completing periodic payroll reports, and the following rules:

(1) The assessment of a penalty for late payroll reconciliation reports and for late payment of any reconciliation premium, which must allow the Administrator to assess additional penalties if the employer's actual payroll substantially exceeds the estimated payroll;

(2) The establishment of a transition period during which time BWC must determine the adequacy of existing employer premium security deposits, the establishment of provisions for additional premium payments during the transition, and the provision of credit of premium security deposits toward the first premium due from an employer under the specific prospective payment rules;

(3) The establishment of penalties for late payment or failure to comply with the Administrator's rules.[26]

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[24] R.C. 4123.411.

[25] R.C. 4123.419 and telephone conversation with Kelly Carey, BWC Legislative Liaison, July 24, 2014.

[26] R.C. 4123.322.

Payment of premiums for professional employer organizations (PEOs)

Under the act, beginning August 1, 2015, each PEO must submit a monthly payroll report containing the number of employees employed during the preceding calendar month. The report is to contain the number of those employees employed at each kind of employment and the aggregate amount of wages paid to those employees. The act allows the Administrator to adopt rules setting forth penalties for failure to submit these payroll reports, including exclusion from alternative rating plans and discount programs.[27]

Under the act, for each policy year commencing on or after July 1, 2015, a PEO must pay premiums and assessments on a monthly basis. The Administrator fixes the amount of premium for the prior month based on the actual payroll of the employer. The act also allows, rather than requires as under former law, beginning July 1, 2015, the Administrator to adopt rules under the Administrative Procedure Act to require a PEO to provide security in the form of a bond or letter of credit. Under former law, the Administrator was required to permit a PEO to make periodic payments of prospective premiums and assessments to BWC as an alternative to providing the security required by the rule.

Under the act, if a PEO fails to make a timely payment of premiums or assessments as required by the Workers' Compensation Law, the Administrator must revoke the PEO's registration pursuant to the continuing law PEO revocation procedures. Upon revocation, under continuing law each client employer associated with that PEO must file payroll reports and pay premiums directly to the Administrator on its own behalf at a rate determined by the Administrator based solely on the claims experience of the client employer.[28]

Estimating the state's contribution

Continuing law requires the Administrator, on or before July 1 of each year, to estimate the gross payroll of all state employers for the succeeding biennium or fiscal year. The Administrator must then determine and certify for the Office of Budget and Management the rates that must be applied to that payroll estimate to produce an amount equal to the estimated cost of awards or payments made during that fiscal period. The resulting rate must be applied and made part of the gross payroll calculation for that period and amounts collected must be remitted to BWC.

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[27] R.C. 4123.26(C) and (F).

[28] R.C. 4123.35(A), 4123.32(D)(4), and 4125.05; Section 5; and R.C. 4125.06, not in the act.

Under the act, if the historical amounts remitted to BWC are greater or less than historical awards or claim payments, the difference must be returned to the state employer or recovered by BWC in a manner determined by the Administrator. This provision appears to require BWC to reconcile amounts paid by the state for workers' compensation coverage with amounts paid by BWC for claims of employees of state employers for the corresponding period. Former law prescribed a reconciliation process, based on whether errors in estimating payroll occurred.[29]

Proof of workers' compensation coverage

Continuing law requires BWC to issue a notice upon receiving an employer's premium stating that the employer is in compliance with the Workers' Compensation Law. The employer must then post this notice.

The act requires BWC to issue the notice at least annually, rather than at the time of payment. To reflect the change to a prospective payment system, the notice must state that it is proof of workers' compensation coverage and that the coverage is contingent on the employer continuing to make payments of premiums and assessments due. Under former law, the notice indicated the time period for which the payment was made, since the premium was paid after the coverage period.[30]

Interstate workers' compensation claims

Workers' compensation coverage for nonresidents

Continuing law generally requires every employer to carry workers' compensation coverage for their employees. The act eliminates the requirement for an employer to obtain coverage under Ohio's Workers' Compensation Law for an out-of-state employee who temporarily works in Ohio if the employee's home state law lacks a provision similar to the Ohio law that exempts out-of-state employees who temporarily work in Ohio from the duty to obtain Ohio coverage. Under continuing law, if a nonresident employee is insured under another state's workers' compensation law or similar laws, the employee and the employee's dependents are not entitled to receive compensation or benefits under Ohio's Workers' Compensation Law on account of injury, disease, or death arising out of or in the course of employment while temporarily within Ohio. The rights of the employee and the employee's dependents

[29] R.C. 4123.40.

[30] R.C. 4123.83, with conforming changes in R.C. 1561.31, 4123.35(A), and 4123.54.

under the other state's laws are the exclusive remedy against the employer on account of the injury, disease, or death.[31]

Claims in multiple jurisdictions

Continuing law prohibits an employee or the employee's dependents who receive a decision on the merits of a claim for compensation or benefits under Ohio's Workers' Compensation Law (an "Ohio award") from filing a claim for the same injury, occupational disease, or death in another state under that state's workers' compensation laws. Similarly, an employee or the employee's dependents who receive a decision on the merits of a claim under another state's workers' compensation laws cannot file a claim for an Ohio award for the same injury, occupational disease, or death. A decision on the merits is a decision determined or adjudicated for compensability of a claim and not on jurisdictional grounds.[32]

Under the act, the Administrator or a self-insuring employer must disallow a claim if either of the following circumstances occur:

(1) An employee or the employee's dependents receive an Ohio award for the same injury, occupational disease, or death for which the employee or the employee's dependents *previously* pursued or otherwise elected to accept workers' compensation benefits and received a decision on the merits under another state's laws or recovered damages under another state's laws (similar to former law, as discussed below).

(2) An employee or the employee's dependents receive an Ohio award and *subsequently* pursue or otherwise elect to accept workers' compensation benefits or damages under another state's laws for the same injury, occupational disease, or death as the claim for which the Ohio award was made.

In addition to disallowing the claim, similar to former law the act permits the Administrator or the self-insuring employer to collect from the employee or the employee's dependents the amounts paid in the Ohio award and any interest, attorney's fees, and costs incurred in collecting that payment. Additionally, with respect to the circumstance described under (2) above, the act allows the Administrator or self-insuring employer also to collect the amounts paid in the Ohio award from the employee's other-states' insurer. Continuing law allows the Administrator or self-insuring employer to collect any costs incurred by an employer in contesting or responding to any claim filed by the employee or the employee's dependents for the

[31] R.C. 4123.01(A)(1)(d) (repealed) and R.C. 4123.54(H).

[32] R.C. 4123.542.

same injury, occupational disease, or death that was filed after the original claim for which the employee or the employee's dependents received a decision on the merits.[33]

Continuing law requires, if the Administrator collects any costs incurred by an employer, those costs to be forwarded to the employer, but the act limits those costs to only the costs incurred by the employer in contesting or responding to the claim. The act removes the requirement to forward on to the employer any interest, awards, or attorney's fees the Administrator collects.[34]

Under former law, in addition to the Administrator, *any* employer could have pursued the collection activities described immediately above. Additionally, the act eliminates the former law requirement that if any employee or the employee's dependents pursued workers' compensation benefits or recover damages from the employer under another state's laws, the amount awarded or recovered, whether paid or to be paid in future installments, had to be credited on the amount of any award of compensation or benefits made to the employee or the employee's dependents by BWC.[35]

Continuing law requires an employee or the employee's dependents to sign an election affirming the employee's decision to receive an Ohio award. The act requires the Administrator or self-insuring employer to dismiss a claim for an Ohio award if the election is not signed within 28 days after the Administrator or self-insuring employer submits the request. Under former law, that claim was suspended until the signed election was received.[36]

Claimant election

The act creates an exception to the prohibition against a claimant filing an Ohio claim after receiving a decision on the merits of the claim in another state. Under the act, in the event a workers' compensation claim has been filed in another jurisdiction *on behalf of* an employee or the employee's dependents, and the employee or dependents subsequently elect to receive an Ohio award, the employee or dependent must withdraw or refuse acceptance of the workers' compensation claim filed in the other jurisdiction in order to pursue an Ohio award. If the employee or dependents were awarded workers' compensation benefits or had recovered damages under the other state's laws, any compensation and benefits awarded under Ohio law are to be paid

[33] R.C. 4123.54(H)(2), renumbered to (H)(2) and (3).

[34] R.C. 4123.54(H)(2), renumbered to (H)(4) by the act.

[35] R.C. 4123.54(H)(2).

[36] R.C. 4123.54(H)(5), renumbered to (H)(6) by the act.

only to the extent to which those payments exceed the amounts paid under the other state's laws. If the employee or dependent fails to withdraw or to refuse acceptance of the workers' compensation claim in the other jurisdiction within 28 days after a request made by the Administrator or a self-insuring employer, the Administrator or self-insuring employer must dismiss the employee's or employee's dependents' Ohio claim.[37]

Other-states' coverage

Continuing law allows an employer to obtain other-states' coverage from the Administrator, if the Administrator elects to offer it, or from an other-states' insurer.

The act creates two types of other-states' coverage. The first, "other-states' coverage," is similar to the former law type of other-states' coverage. Under the act, "other-states' coverage" is insurance coverage secured by an eligible employer for workers' compensation claims of employees who are in employment relationships localized in a state other than Ohio or those employees' dependents. Other-states' coverage is limited to covering employees who are in employment relationships localized in another state. Under the act, "other-states' coverage" also generally refers to coverage secured by an eligible employer for workers' compensation claims that arise in a state other than Ohio where an employer elects to obtain coverage through either the Administrator or an other-states' insurer.[38]

The second is "limited other-states' coverage," which is coverage provided by the Administrator to an eligible employer for workers' compensation claims of employees who are in an employment relationship localized in Ohio but are temporarily working in another state, or those employees' dependents.

Under law largely retained by the act with respect to other-states' coverage, under the act if the Administrator elects to secure a vehicle through which the Administrator will provide other-states' coverage or limited other-states' coverage, the Administrator must go through the state's competitive bidding process to select one or more insurers. The Administrator, with the advice and consent of the BWC Board, must award the contract to provide other-states' or limited other-states' coverage to one or more other-states' insurers that are the lowest and best bidders.[39]

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[37] R.C. 4123.54(H)(6) and 4123.542.

[38] R.C. 4123.01(L), (M), and (N) and 4123.82.

[39] R.C. 4123.292(B) and (C).

If the Administrator elects to offer other-states' coverage or limited other-states' coverage, under continuing law the Administrator must adopt rules to implement that coverage. Similar to the immunity provided in continuing law for other-states' coverage, under the act the BWC Board and the individual Board members, the Administrator, and BWC do not incur any obligation or liability if another state determines that the limited other-states' coverage does not satisfy the requirements specified in that state's workers' compensation law for obtaining workers' compensation coverage in that state.[40]

If an employer elects to obtain other-states' coverage or limited other-states' coverage, under the act the employer must submit a written notice to the Administrator stating that election on a form prescribed by the Administrator (former law, with respect to other-states' coverage, did not require a particular form to be used). If the employer elects to obtain that coverage through an other-states' insurer, as under continuing law the employer also must submit the name of the other-states' insurer through whom the employer has obtained that coverage.[41]

The act revises the procedures for calculating the premiums applicable to a state fund employer that has other-states' coverage through the Administrator. With respect to an employer who obtains other-states' coverage through an other-states' insurer, the act maintains the requirement that the Administrator, when calculating that employer's state fund premium, must exclude the expenditure of wages, payroll, or both attributable to the labor performed or services provided to which the other-states' coverage applies. However, for employers who obtain other-states' coverage through the Administrator, the Administrator may establish in rule an alternative calculation of the employer's state fund premium to appropriately account for the expenditure of wages, payroll, or both attributable to the labor performed or services provided to which the other-states' coverage applies.[42]

The act eliminates the former law procedures for calculating other-states' coverage premiums excluding expenditures for wages, payroll, or both for labor performed and services provided that are covered through the State Insurance Fund. The act also eliminates the requirement that the Administrator calculate an employer's other-states' coverage premium separate from the premium calculated for the State Insurance Fund.[43] Additionally, the act removes the former law requirement that an

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[40] R.C. 4123.292(D) and (E).

[41] R.C. 4123.292(A) and (C).

[42] R.C. 4123.29(A)(2).

[43] R.C. 4123.292(C) and (E), repealed by the act.

employer segregate the employer's payroll in the employer's annual payroll report based upon whether the labor performed or services provided were covered through the State Insurance Fund or through other-states' coverage. Instead, for purposes of the employer's annual payroll report, the employer must list information only for the employees whose employment is localized in Ohio and any other information the Administrator requires in rules the Administrator adopts with the advice and consent of the BWC Board.[44]

Under the act, if an employer fails to pay the employer's premium for other-states' coverage, the Administrator must consider the employer to be noncompliant for the purposes of having other-states' coverage. The employer's Ohio premiums for any and all noncompliant periods of time must be calculated in the same manner as otherwise required under the act and continuing law, using both the wages reported in Ohio and the wages that the employer claimed would be reported to the other-states' insurer for securing coverage. Under former law, if the employer failed to pay the other-states' coverage premium, the employer was considered to be noncompliant for purposes of other-states' coverage but not for purposes of Ohio's Workers' Compensation Law.[45]

Payment for first fill of prescriptions

The act allows the Administrator to pay certain medical benefits earlier than when those benefits must be paid under continuing law. Generally, the payment of medical benefits commences 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.

The act allows the Administrator, in the rules the Administrator adopts regarding medical benefits under continuing law, to adopt rules specifying the circumstances under which BWC may make immediate payment for the first fill of prescription drugs for medical conditions identified in a claim 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 who pays assessments into the Surplus Fund Account in the State Insurance Fund, the payments for the first fill of prescription drugs for that claim or condition must be charged to and

[44] R.C. 4123.26(A) and (B).

[45] R.C. 4123.292(A).

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.[46]

The Health Partnership Program

Summary suspension of certification

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. A health care provider must be certified by BWC to participate in the HPP, and the Administrator may limit provider access to claimants by requiring a claimant to pay an appropriate out-of-plan copayment for selecting a medical provider not within the HPP.[47]

The act statutorily permits BWC to summarily suspend the certification of a provider to participate in the HPP without a prior hearing. BWC already had this ability and could revoke a certification, under rules adopted by the Administrator for the HPP. Under the act, BWC may summarily suspend the certification of a provider other than a hospital if BWC determines any of the following apply to the provider:

- The professional license, certification, or registration held by the provider to practice the provider's profession has been revoked or suspended for an indefinite period of time or for a period of more than 30 days, subsequent to the provider's certification to participate in the HPP (similar to the administrative rule).

- The provider has been convicted of or has pleaded guilty to workers' compensation fraud or engaging in a pattern of corrupt activity, or has been convicted of or pleaded guilty to any other criminal offense related to the delivery of or billing for health care services (same as the administrative rule).

- BWC determines, by clear and convincing evidence, that the continued participation by the provider in the HPP presents a danger of immediate and serious harm to claimants (similar to the administrative rule).[48]

The act permits BWC to suspend a provider's HPP certification due to the suspension or revocation of a provider's professional qualifications as explained above,

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[46] R.C. 4123.511(I) and 4123.66.

[47] R.C. 4121.44 and 4121.441, not in the act.

[48] R.C. 4121.443(A); O.A.C. 4123-6-02.5.

even if the suspension or revocation of those professional qualifications is stayed by a court or agency order.

Under the act, BWC must issue a written order of summary suspension by certified mail or in person in accordance with the Administrative Procedure Act. A court may stay execution of the order during pendency of any appeal if the court finds that execution of the order pending appeal will cause an unusual hardship to the appellant and that staying execution of the order will not threaten the health, safety, or welfare of the public. If the provider subject to the summary suspension requests an adjudicatory hearing by BWC, the act requires the date set for the hearing to be not later than 15 days, but not earlier than seven days, after the provider requests the hearing, unless otherwise agreed to by both BWC and the provider.[49]

Any summary suspension imposed under the act remains in effect, unless reversed on appeal, until a final adjudication order issued by BWC pursuant to the act and the Administrative Procedure Act takes effect. BWC must issue its final adjudication order within 75 days after completion of its hearing. A failure to issue the order within the 75-day time period results, under the act, in dissolution of the summary suspension order but does not invalidate any subsequent, final adjudication order.

The act also requires that the summary suspension of a certification of a provider not affect the ability of that provider to receive payment for services rendered prior to the effective date of the suspension.[50]

Peer review committee

Definition

The act expands the example in the definition of peer review committee to include a peer review committee of BWC or the Industrial Commission that reviews the professional qualifications and performance of providers certified by BWC to participate in the HPP.[51]

Confidentiality of proceedings and records

The act makes the peer review committee confidentiality requirements in continuing law applicable to a BWC peer review committee that is responsible for

[49] R.C. 4121.443, by reference to R.C. 119.07 and R.C. 119.12, not in the act.

[50] R.C. 4121.443(E).

[51] R.C. 2305.25(E)(2)(j).

reviewing the professional qualifications and the performance of providers certified by BWC to participate in the HPP. However, the act provides that the proceedings and records within the scope of the peer review committee are subject to discovery or court subpoena and may be admitted into evidence in a criminal, administrative, or civil action that is initiated, prosecuted or adjudicated by BWC. The act also permits BWC to share proceedings and records within the scope of the peer review committee, including claimant records and claimant file information, with law enforcement agencies, licensing boards, and other governmental agencies involved in prosecuting, adjudicating, or investigating an alleged violation of applicable law or administrative rule. In contrast, health care entities may only share records produced or presented during a peer review committee only if the records are used for peer review purposes. BWC's sharing of a record with a law enforcement agency, a licensing board, or another governmental agency does not affect the confidentiality of the record. If BWC chooses to share a confidential record, the recipient is required to take appropriate measures to maintain the confidentiality of the information.

Except as described above and similar to other peer review committee proceedings, under the act an individual who testifies before a BWC peer review committee is not allowed or required to testify in any lawsuit regarding those proceedings. Additionally, information otherwise available from its original source remains available for use in a lawsuit, but it must be obtained from that source and not from the BWC peer review committee proceedings.[52]

Notice of appeal in workers' compensation claim cases

The act requires the name of the Administrator to be included on the notice of appeal to a court of common pleas of an Industrial Commission order or a staff hearing officer's order if the Industrial Commission declines to hear an appeal. Continuing law requires that the notice of appeal also state the names of the claimant and the employer, the claim number, the date of the order appealed from, and the fact the appellant is appealing the order.[53]

Ombudsperson system

The Workers' Compensation Ombudsperson System assists claimants and employers in matters dealing with the BWC and the Industrial Commission. The act places the Chief Ombudsperson and the assistant ombudsperson in the unclassified service (other system staff remain in the classified service). The Chief Ombudsperson,

[52] R.C. 2305.252.

[53] R.C. 4123.512.

under the act, serves at the pleasure of the Industrial Commission Nominating Council. Under continuing law, the Chief Ombudsperson serves a six-year term and cannot be transferred, demoted, or suspended during the Chief's tenure. However, under the act, the Chief Ombudsperson can be removed by the Nominating Council upon a vote of no fewer than nine Nominating Council members. Under former law, the Chief Ombudsperson and assistant ombudspersons could be removed only for malfeasance or neglect of duty upon a notice and a hearing.

The act requires only the Chief Ombudsperson, rather than all ombudspersons as under former law, to devote the Chief Ombudsperson's full time and attention to the duties of the ombudsperson's office.

Under the act, in the event of a vacancy in the position of Chief Ombudsperson, the Nominating Council may appoint a person to serve as acting chief ombudsperson until a chief ombudsperson is appointed. The acting chief ombudsperson is under the Nominating Council's direction and control and may be removed by the Nominating Council with or without just cause.

With respect to the assistant ombudspersons, the act eliminates their six-year terms of service and instead requires them to serve at the pleasure of the Chief Ombudsperson. The act also eliminates the limitation that an assistant ombudsperson can be removed only on the grounds of malfeasance or neglect of duty upon notice and public hearing. Additionally, the former law restrictions on transfers, demotions, or suspensions no longer apply to assistant ombudspersons.

The act requires the ombudsperson system staff, including the Chief Ombudsperson, to comply with Ohio's Ethics Laws and the Nominating Council's human resource and ethics policies. Additionally, the act applies the continuing law prohibition against the Chief Ombudsperson or assistant ombudspersons expressing any opinions as to the merit of a claim the correctness of a decision by the various officers or agencies as the decision relates to a claim for benefits or compensation to all ombudsperson system staff. The staff also have a right to examine claim files consistent with the continuing law authority of the Chief and assistant ombudspersons to examine those files and discuss the contents with the parties in interest.[54]

Public employers and the One Claim Program

The act permits a state fund, taxing district employer to participate in the One Claim Program.[55] Under that Program, the employer may mitigate the impact of a

[54] R.C. 4121.45.

[55] R.C. 4123.29(A)(4).

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. Under former law, only private sector state fund employers could participate in the One Claim Program.

Violation of specific safety requirement assessments

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 act, 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.[56]

Actuarial reporting requirement

The act eliminates the former 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, met 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.[57]

[56] R.C. 4123.512(H).

[57] R.C. 4123.353.

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

The act requires, rather than permits as under former 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. This includes any information in the database related to prescriptions for the claimant that were not covered or reimbursed under the Workers' Compensation Law. 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.

Additionally, under the act the Board must provide, on receipt of a request from a pharmacist or the pharmacist's Board-approved delegate, 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. The act also requires the Board to provide a prescriber or the prescriber's Board-approved delegate information regarding a current or referred patient upon request. Under former law the Board was permitted, but not required to provide this information.

On receipt of a request from the medical director of a managed care organization (MCO), under the act the Board must provide to the medical director information from the database relating to a workers' compensation claimant assigned to the MCO, including information in the database related to prescriptions for the claimant that were not covered or reimbursed under the Workers' Compensation Law, if both of the following apply:

(1) The MCO has entered into a contract with the Administrator to participate in the HPP;

(2) The MCO has entered into a data security agreement with the Board.

The required data security agreement governs the MCO's use of the Board's drug database.[58] (See **Comment**.)

[58] R.C. 4729.80 and 4121.447, with a conforming change in R.C. 4729.86.

Review of workers' compensation fund investment policy and management

Under continuing law, the Workers' Compensation Investment Committee is required to review the performance of the BWC 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 BWC Board. Under the act, the review also is conducted to assure compliance with the investment policy and effective management of the funds, rather than to assure the best possible return on investment was achieved, as under former law.[59]

Annual actuarial analysis

The act requires the Administrator to have an actuarial analysis, rather than actuarial audits as under former 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 act must be made and certified by recognized credentialed property or casualty actuaries selected by the BWC Board rather than by recognized insurance actuaries selected by the Board as under former law. The Workers' Compensation Investment Committee must recommend to the Board the actuarial firm to perform the analysis. Under former law, the Committee recommended the accounting firm.

The act also eliminates the former law requirement that the audits (or analysis under the act) 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.[60]

Premiums and assessments for amenable employers

If the Administrator finds that an employer is subject to the Workers' Compensation Law (an "amenable" employer), continuing law requires the Administrator to determine the period of time during which the employer was an amenable employer and to provide notice of the determination to the employer. Upon receiving the determination, the employer must provide BWC with payroll covering the period included in the determination. If the employer is an amenable employer at the time of the determination, the employer must pay the amount of premium applicable to that payroll. Under the act, the amenable employer must also pay assessments

[59] R.C. 4121.129(C).

[60] R.C. 4123.47, with conforming changes in R.C. 4121.129.

applicable to that payroll. Continuing law prescribes procedures for appealing and collecting the amount assessed.[61]

Group-rating

Continuing law requires that each employer seeking to enroll in a group for workers' compensation coverage must have an account in good standing with BWC. The act requires the Administrator to adopt rules setting forth the criteria by which the Administrator will determine whether an employer's account is in good standing. Under former law, an account was in good standing if at the time that the agreement was processed no outstanding premiums, penalties, or assessments were due from the employer. The act also adjusts eligibility to participate in the Group-Rating Program, requiring the group to have at least 100 employer-members (continuing law), or the aggregate premiums of the members, as determined by the Administrator are estimated (rather than expected as under former law) to exceed $150,000 during the coverage period.[62]

Self-insuring PEOs and client employers

Under the act, the Administrator must work with self-insuring PEOs and with other stakeholders to address the issue of the appropriate experience rating to assign to a client employer who leaves such a PEO to obtain coverage through the State Insurance Fund. The Administrator must prepare a report of the Administrator's findings on the issue and must submit that report to the General Assembly by December 31, 2014.[63]

Unencumbered cash balance in the Workers' Compensation Fund

The act eliminates a provision of the BWC budget for the FY 2014-FY 2015 biennium that required any unencumbered cash balance in excess of $45 million in the Workers' Compensation Fund (Fund 7023) on June 30 of each fiscal year be used to reduce the administrative cost rate charged to employers.[64]

Application of statutory changes

With respect to the act's changes to the portions of the Workers' Compensation Law governing other-states' coverage and interstate claims, the act applies to all claims

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[61] R.C. 4123.37, with a conforming change in R.C. 4123.291.

[62] R.C. 4123.29(A)(4).

[63] Section 8.

[64] Sections 3 and 4.

filed pursuant to the Law on or after September 17, 2014 (the act's effective date). With respect to the changes described under "**Notice of appeal in workers' compensation claim cases**" above, the act applies to appeals filed on or after that date.[65]

Severability

The act includes a severability provision. Under this provision, the items of law contained in the act, and their applications, are severable. If any item of law contained in the act, or if any application of these items, is held invalid, the invalidity does not affect other items of law contained in the act and their applications that can be given effect without the invalid item of law or application.[66]

COMMENT

The amendments and sections enacted in this act regarding the drug database maintained by the State Board of Pharmacy were also included in H.B. 341 and H.B. 483 of the 130th General Assembly. The language used in R.C. 4729.80 and 4729.86 of this act differs from the language used in those sections in H.B. 341 and H.B. 483, which have identical language.

The substance of R.C. 4121.447 enacted in this act was also included in H.B. 341 and H.B. 483, although the provision was numbered R.C. 4121.443 in those acts. The provision enacted as R.C. 4121.443 in H.B. 341 and H.B. 483 have been renumbered to R.C. 4121.447.

HISTORY

ACTION	DATE
Introduced	03-18-14
Reported, H. Insurance	04-09-14
Passed House (88-4)	04-09-14
Reported, S. Commerce & Labor	05-28-14
Passed Senate (32-0)	05-28-14
House concurred in Senate amendments (82-13)	06-03-14

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[65] Sections 6 and 7.

[66] Section 9.

H.B. 539

130th General Assembly
(As Introduced)

Reps. Henne, McGregor, Sears, Becker, Wachtmann, DeVitis, Butler

BILL SUMMARY

- Temporarily defers the charging of workers' compensation claims to a state fund employer's experience when a third party may be liable for the claim.
- Creates the Subrogation Suspense Account (SSA) within the State Insurance Fund to which any such deferral will be charged.
- Allows a state fund employer to apply to an adjudicating committee appointed by the Administrator to defer the experience resulting from that claim.
- Requires the Administrator, with the advice and consent of the Bureau of Workers' Compensation Board of Directors, to adopt rules to establish requirements and procedures for an adjudicating committee to follow when determining whether a claim is likely to be subrogated.
- Requires the Administrator, at the end of the deferral period, to charge the employer's experience for the amount of compensation or benefits paid in a claim and charged to the employer's individual account in the SSA for that claim.
- Prohibits the Administrator from charging the employer's experience for any amount credited to the employer's individual SSA as a result of moneys collected through the subrogation process.

CONTENT AND OPERATION

Temporary deference of charging experience

The bill requires the Administrator of Workers' Compensation to temporarily defer a state fund employer's experience for payments made in a workers'

compensation claim if the Administrator is likely to be subrogated to the rights of a workers' compensation claimant. Subrogation involves the Administrator recouping payments made in a workers' compensation claim from a third party (see "**Subrogation**," below). A state fund employer is an employer who pays premiums into the State Insurance Fund to secure workers' compensation coverage. The employer's experience in being responsible for its employees' workers' compensation claims may be used in calculating the employer's premium (see "**Background – calculation of premium rates**," below). Thus, a deferral in charging an employer's experience may result in a deferral in an increase in the employer's workers' compensation premiums as a result of the claim.

Procedural for deferral

The bill provides two avenues for the experience deferral: (1) if the Administrator makes the Administrator's own determination that a claim is likely to be subrogated, or (2) a state fund employer requests such a deferral.[1]

With respect to the latter avenue, if a state fund employer believes that a workers' compensation claim may be subject to third-party subrogation, the bill allows the employer to file a request with an adjudicating committee appointed by the Administrator to defer the experience resulting from that claim. Under continuing law, the employer must file the request on or before 24 months after the Administrator sends notice of the determination about which the employer is filing the request. The adjudicating committee must hear the request within 60 days of the date on which the employer files the request.

Under the bill, the Administrator, with the advice and consent of the Bureau of Workers' Compensation Board of Directors, must adopt rules to establish requirements and procedures for an adjudicating committee to follow when determining whether a claim is likely to be subrogated. As under continuing law, if the employer is adversely affected by a decision of the adjudicating committee, the employer may appeal the decision to the Administrator or the Administrator's designee. The employer must file the appeal in writing within 30 days after the employer receives the adjudicating committee's decision. The Administrator or the designee must hear the appeal and hold a hearing.[2]

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[1] R.C. 4123.932.

[2] R.C. 4123.291 and 4123.933(A).

Determination that a claim is likely to be subrogated

Upon a final determination made pursuant to the adjudicating committee process described above, or upon the Administrator's own determination, that the Administrator is likely to be subrogated to the rights of a claimant under the continuing law subrogation process, the bill prohibits the Administrator from charging the experience of that employer for any compensation, benefits, or both paid in relation to that claim until the earlier of the following:

(1) Three years after the date the injury occurred or occupational disease was diagnosed or, if an employee dies in the course of and arising out of the employee's employment, the date of the employee's death;

(2) The conclusion or settlement of any actions that involve the Administrator as a statutory subrogee in relation to the claim.

Instead, under the bill, during that time period, the Administrator must charge the payments in the workers' compensation claim to the employer's account within the Subrogation Suspense Account.[3]

Subrogation Suspense Account

The bill creates within the State Insurance Fund the Subrogation Suspense Account (SSA). The SSA is to be used to defer costs related to subrogation claims so that the experience of an employer is not affected by a claim that is likely eligible for third-party subrogation. If a final determination is made under the bill that the Administrator is likely to be subrogated, the bill requires the Administrator to create an individual account within the SSA for the employer whose experience the claimant's claim would otherwise affect.

The bill limits the use of the moneys held in the SSA to reimbursement to the State Insurance Fund of amounts paid on a claim that is not charged to an employer's experience pursuant to the bill. To fund the SSA, the bill requires the Administrator, in establishing premium rates under continuing law, to take into account the necessity of ensuring sufficient money is set aside in the SSA to cover any claim amounts for which the Administrator temporarily suspends charging an employer's experience (similar to the current law procedures regarding the Premium Payment Security Fund).[4]

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[3] R.C. 4123.932 and 4123.933(B).

[4] R.C. 4123.34 and 4123.933(A).

Deposit of subrogated funds

Continuing law prescribes procedures that the Administrator (or any other statutory subrogees) and a claimant must follow with respect to the distribution of funds that are subrogated in a third-party claim. With respect to any money collected by the Administrator under that process, continuing law requires the Administrator to deposit the money collected into the appropriate account within the State Insurance Fund. Similar to current law, the bill requires any amount deposited to be credited to the experience of the employer against whom the experience of the corresponding claim was charged (potentially resulting in lower premiums). However, if, at the time an amount is deposited, the corresponding claim is being charged to the employer's individual account in the SSA, the bill requires any amount deposited to be credited to the employer's individual account in the SSA.[5]

End of deferral period

Upon the conclusion of the deferral period during which an employer's experience is not charged under the bill, the bill requires the Administrator to charge the employer's experience for the amount of compensation or benefits paid in a claim and charged to the employer's individual account within the SSA for that claim. However, the Administrator cannot charge the employer's experience for any amount credited to the employer's individual SSA as a result of moneys collected through the subrogation process. The Administrator must then credit the SSA in the amount the Administrator charges to the employer's experience.

The bill requires any additional compensation or benefits incurred in that claim after the deferral period to be charged to the employer's experience.[6]

Subrogation

The Workers' Compensation Law[7] creates a right of subrogation in favor of the Administrator or other statutory subrogees against a third party. A statutory subrogee is the entity responsible to pay workers' compensation claims. Essentially a statutory subrogee may recoup money from a third party against whom a claimant has a cause of action so that the statutory subrogee is reimbursed for money it pays out on a workers' compensation claim.

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[5] R.C. 4123.931(K).

[6] R.C. 4123.933(C).

[7] R.C. Chapters 4121., 4123., 4127., and 4131.

Stated simply, if Mr. Smith, in the course of his employment, is injured when Mr. Jones collides with his vehicle, Mr. Smith may receive workers' compensation benefits and also may sue Mr. Jones. If Mr. Smith sues Mr. Jones, then Mr. Smith's employer, or the Administrator, as appropriate, may seek reimbursement from the amount Mr. Smith recovers in the third-party suit.

The Workers' Compensation Law contains procedures to follow regarding subrogation claims. Under continuing law, the Administrator's right of subrogation is automatic, regardless of whether the Administrator is joined as a party in an action by a workers' compensation claimant against a third party. The Administrator may pursue an action against a third party as well.[8]

Background – calculation of premium rates

Ohio law requires the Administrator to fix premiums "sufficiently large" to provide a fund for the benefits authorized in the Workers' Compensation Law and "to maintain a state insurance fund from year to year." Subject to the approval of the BWC Board, the Administrator classifies occupations or industries with respect to their degree of hazard, determines the risks of different classes according to the categories the National Council on Compensation Insurance establishes, and fixes the premium rates for coverage of the risks based upon the total payroll in each classification.[9]

Premium rates are fixed for each classification based upon total payroll. The Administrator must establish a rate for each classification. The total losses compared with the total payroll of each classification establishes the rate of contribution from employers within that classification. The system includes two basic premium rates – the basic rate and the experience, or merit, rate (employers qualify for one or the other). The Administrator calculates the basic rate for each of the classifications of occupations, and the Administrator does not include any individual employer's experience when calculating basic rates. If an employer is experienced-rated, the employer's rate is determined by modifying the basic rate applicable to the employer by the employer's experience of losses incurred and premiums paid.[10] A premium is expressed as an amount for each $100 of payroll. Rates are revised annually on July 1, and employers pay premiums in accordance with the schedule specified in the Workers' Compensation Law and in rules adopted by the Administrator.[11]

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[8] R.C. 4123.93 and 4123.931.

[9] R.C. 4123.29(A), not in the bill, and Ohio Administrative Code (O.A.C.) 4123-17-04.

[10] Fulton, Philip J., *Ohio's Workers' Compensation Law*, § 14.4 (4th Ed. 2011).

[11] R.C. 4123.34 and R.C. 4123.35, not in the bill, and O.A.C. 4123-17-01 to 4123-17-04.

HISTORY

ACTION	DATE
Introduced	05-14-14

H0539-I-130.docx/ks

A Pathway to Better Care

Recommendations from the BWC Stakeholder Healthcare Summit

September 2014

Ohio | Bureau of Workers' Compensation

SECTION I: Executive Summary

How Ohio's workers' compensation community is going to make getting back to work work better.

More than 20 years ago, a cohort of business, labor, and medical representatives came together to create the Health Partnership Program (HPP), which ushered in the era of managed care and provided significant improvements to key claims management processes within Ohio's workers' compensation system. As part of this journey, Ohio established itself as a national leader in workers' compensation, largely as a result of the reforms that accompanied HPP.

In late July, after 40 hours of discussions, a team of 30 people, many of whom represented the leading policy thinkers in Ohio's medical and workers' compensation communities, came together to create a path to provide better care for at-risk claimants.

In the process, the team clearly sent a message: our system continues to work well today, but collectively, we think it can be even better – and we intend for Ohio to become the leader on a major issue vexing workers' compensation carriers and systems all across the country.

The five-day BWC Healthcare Summit was an outgrowth of a May discussion BWC facilitated with the BWC Board of Directors around that one central question: how should we go about providing better care for claimants who are not receiving optimal outcomes? That discussion crystallized a number of related questions that BWC and other stakeholders had been tackling over the preceding months, which included:

- How can the system better identify claimants at risk of a poor outcome?
- How should Ohio's workers' compensation system deal with co-morbid conditions and other health issues that – while unrelated to the physical workplace injury – continue to impede care and often preclude a claimant from recovering?
- What barriers exist that prevent coordination of care among workers' comp providers, primary-care physicians, and MCOs, and how do we remove those barriers?
- For all parties, how do we design incentives that encourage the right behaviors and drive better results for the claimant?

Collectively, the group generated 23 tasks in five areas of care management it believed would result in more claimants receiving faster, more comprehensive care at a lower cost to the system. More broadly, the team came up with three guiding principles that would shape the reformation and evolution of BWC's care system. They are:

1. Claimants at risk of poorer outcomes should have their care managed by a high-quality provider-of-record (POR).
2. PORs should establish comprehensive treatment plans that consider not only a claimant's workplace injuries but other physical, social, and behavioral health issues that could impact the claimant's successful return to work.
3. The MCO should support high-quality PORs through coordinating the exchange of information among key parties and removing barriers that prevent the claimant from returning to work.

The following report provides a more thorough synopsis of the team's collective work product. For background purposes, it highlights some of the key data points that motivated the group to look at ways to improve care. It also highlights what a claimant's optimal care path could look like and what the team's work plan over the next 12-15 months looks like to accomplish some tasks and test other concepts. Finally, it includes the working papers that resulted from the BWC Healthcare Summit, detailing the key steps and associated tasks relating to the claimant's aspirational care path.

Participants

The associations listed below participated in the BWC Healthcare Summit and support efforts to improve care coordination and provide high-quality care for claimants at a reasonable cost to Ohio employers.

AultComp MCO

CareWorks

Central Ohio Primary Care

Communications Workers of America

CompManagement Health Systems, Inc.

National Federation of Independent Businesses

Occupational Health Link

Ohio Association for Justice

Ohio Association of Claimants' Counsel

Ohio Chamber of Commerce

Ohio Farm Bureau Federation

Ohio Hospital Association

Ohio Manufacturers Association

Ohio Self Insurers Association

Ohio State Chiropractic Association

OhioHealth

SECTION II: Ohio and its current state of care

While Ohio's current workers' compensation medical care system works well for the majority of claimants, there are approximately 15-20 percent who experience poor health outcomes and remain off work for long periods of time. However, upon review of these claims, BWC discovered that many of these 15-20 percent of claimants did not endure especially severe injuries. In fact, the most common diagnoses among lost-time[1] claimants are sprains and strains. This begs the question: what is causing the long durations of disability among these individuals?

When a claimant has existing health conditions at the time of his or her workplace injury, this can complicate the claimant's ability to recover and return to work. Further, research has shown that Ohioans are generally in poorer health compared to residents of other states. Thus, it is reasonable to assume that many of these lost-time claimants have co-morbidities[2], which are likely hindering their ability to return to work.

The Burden of Lost-Time Claims

In a given year, BWC receives approximately 90,000 to 110,000 workers' compensation claims. Historically, 75-85 percent of these claims are low intensity; the worker receives treatment at an emergency room or urgent-care facility and quickly returns to work. However, in fiscal year 2013, approximately 17,000 claimants missed more than seven days. Of these 17,000 lost-time claims:

- Nearly 50 percent missed more than 45 days of work and approximately 32 percent missed more than 100 days;
- The average cost per lost-time claim was 30-40 times greater than the average cost of a medical-only claim;
- Nearly one in five lost-time claimants was physically dependent on opiates; and
- Total lost productivity was nearly 2 million days.

Health Status of Ohioans

Ohioans are generally in poorer health, both physically and mentally, relative to residents of other states. According to the Commonwealth Fund, there were 37 states that had healthier workforces than Ohio in 2009.[3]

The table below shows some additional data concerning the physical and mental health status of Ohioans as well as the incidence of specific health conditions among the Ohio population compared to other states.[4] In all of these categories, Ohio is within the bottom third.

	2014 rank among states plus DC
Ohioans average 4.1 poor mental health days per 30 days.	35th
Ohioans average 4.2 poor physical health days per 30 days.	34th
Twenty percent of Ohioans have limited activity due to physical, mental, or emotional problems (2012).	41st
Five percent of Ohioans suffer from coronary heart disease.	43rd
Approximately one in three Ohioans has high blood pressure.	35th
Nearly 12 percent of Ohioans suffer from diabetes.	45th
Nearly one in three Ohioans is obese.	38th

[1] A lost-time claim occurs when the claimant misses more than seven days of work.
[2] A co-morbidity refers to the simultaneous presence of one or more medical conditions or diseases.
[3] The Commonwealth Fund, *Aiming Higher: Results from a State Scorecard on Health System Performance* (October 2009).
[4] United Health Foundation. America's Health Rankings 2014.

Impacts of Co-morbidities on Workers' Compensation Claims

The data presented above can have significant implications for workers' compensation claims. Research conducted by the Workers' Compensation Research Institute (WCRI) found that co-morbidities such as diabetes, hypertension and heart problems can lead to longer delays in return to work.[5]

Condition	Presence	% with no RTW at one year	Average lost-time duration
Diabetes	Treated in last year	20 percent	11.6 weeks
	Condition not present	14 percent	10.5 weeks
Hypertension	Treated in last year	16 percent	11.5 weeks
	Condition not present	14 percent	10.2 weeks
Heart problems	Treated in last year	21 percent	14.0 weeks
	Condition not present	13 percent	10.4 weeks

Because Ohioans are generally in poorer health relative to those living in other states, it is reasonable to assume that a higher percentage of workers' compensation claimants have at least one of the aforementioned co-morbid conditions. Based on that assumption, one could also reasonably conclude that a higher percentage of claims are susceptible to poorer outcomes. Therefore, workers' compensation injuries cannot be considered in isolation. When treating a workplace injury, the claimant's broader health status must be taken into account.

[5] Thumula, V., Savych, B & Victor R. *Predictors of Worker Outcomes*. Workers' Compensation Research Institute (June 2014).

SECTION III: The potential future state of care in Ohio's workers' compensation system

In looking at how to improve care from the perspective of the claimant, there were two significant process considerations that emerged. First, for approximately 85 percent of claimants, today's workers' compensation care system works well. These claimants:

- Sustain a minor injury at work;
- Go to either the emergency room, an urgent-care facility, or an occupational medicine clinic for treatment;
- Have perhaps 1-2 follow-up visits at most; and,
- Miss little to no time as a result of the workplace injury.

So while we consider broader changes for those claimants whose outcomes are poor, the team didn't want to disrupt the care process for the majority whose experience is positive. Thus, the team agreed that some bifurcation through analytics is necessary to provide a more personalized experience to the minority of claims that are truly at risk.

Second, for optimal success in managing the care for those determined to be at risk, it's important to understand the claimant's perspective as well as the immediate issues he or she is facing. Most likely, the claimant is:

- Entering the workers' compensation system for the first time and therefore has no familiarity with it;
- Suffering a moderate to serious workplace injury, which is likely causing physical pain and general discomfort;
- Uncertain about near-term financial issues that may result from missing an extended period of work;
- Not going to be able to receive treatment for the workplace injury from his or her primary-care physician, who may not be in BWC's network; and,
- Therefore not really sure who will be able to help him or her navigate through the system.

For these cases to have more successful outcomes, it's important that all parties anticipate these needs and proactively attempt to communicate with the claimant on how best to resolve them. This would include providing a personalized treatment plan and corresponding set of services that will optimize the chances of a successful return to work. The plan should consider:

- The nature of the workplace injury;
- Other physical, social, or behavioral health challenges that play a role in preventing a claimant from returning to work;
- Geography and other personal demographics; and,
- Environmental factors that compete for the claimant's focus on returning to work.

To try and provide a path that allows all parties to contribute toward successfully achieving a better outcome for at-risk claimants, the team looked at the process from the perspective of a claimant. They subsequently identified key needs at different stages of the claim and matched those needs up with the party best positioned to resolve that need. The potential future state of care emerged from that discussion and is described below.

Fulfilling the needs of at-risk claimants

To safely and successfully return to work, I need to know…

…what to expect

The most important thing when I am injured at work is to get my injury treated immediately. After I receive emergent care…

- BWC will let me know my claim is in process and provide me with a standardized road map indicating who will help me on my journey back to work.
- My MCO will also obtain a complete picture of my overall health and wellness so they can identify physical, social, or behavioral issues that could complicate my recovery.

…who will lead my recovery

Because I am likely to have health insurance, I want my primary-care physician (PCP) involved. However, I also know that my PCP likely isn't part of BWC's network. But if I am at risk of a poor outcome, my MCO can…

- Educate me on selecting a provider-of-record (POR) from a transparent marketplace that provides information on which providers achieve optimal outcomes.
- Help me set up an appointment.
- Work through the POR to engage my PCP where appropriate.

…what my path back to work – and to life – looks like

Now that I have selected a POR, I want to know how long it's going to take me to recover from my workplace injury. My POR will work with…

- My primary-care physician and establish a coordinated treatment plan that allows the POR to successfully identify the actual extent and nature of my workplace injury and account for other health issues that may affect my ability to return to work.
- My MCO to make sure that any barriers to care are removed and my recovery can progress quickly and safely.
- Me, so I understand what's happening and why and can actively participate in my recovery.

…how I will make ends meet

My POR told me that I am likely to miss a fairly significant amount of time from work, so I need to know that I'll be okay financially. To alleviate those concerns…

- BWC will work with me to get my compensation set up where appropriate and walk me through the process to minimize confusion and surprise.
- My MCO will work with the POR and my employer to identify opportunities for me to return to work in a modified-duty capacity that will allow me to recover from my workplace injury.

…how to stay in control of managing my claim

Throughout this process, I need access to critical, up-to-date claim information 24 hours a day. BWC will work with other key parties involved in coordinating my care to…

- Implement the "My Claims" page, which will serve as a comprehensive dashboard that allows me to obtain information on compensation, medical treatment, and general developments in my claim.
- Expand this concept to allow me to accept "pushes" via email and/or text that remind or encourage me to carry out certain tasks associated with my claim.

SECTION IV: Appendix

During the course of the Healthcare Summit, the stakeholder team went to great efforts to look at how care should be provided to claimants at risk of poorer outcomes. The appendix contains two documents that reflect the collective work product of the team. The first outlines the aspirational journey of the claimant; in essence, it reflects key milestones in the claimant's recovery process and identifies key considerations for moving forward.

The second document is the "Punch List," or the initial pass at key tasks in support of bringing the aspirational journey to life. The team fully expects the task list to change as this project evolves, but it wanted to provide a good framework for taking this vision and making it become the reality of how Ohio's workers' compensation system coordinates and provides high-quality care for its claimants.

Activating the claimant's aspirational journey

What we've built: The stakeholder group has re-engineered the medical-care model used to care for claimants to provide more coordinated, higher-quality services for claimants at risk of poorer outcomes. The re-engineered model is governed by three key philosophies:

1. Claimants at risk of poorer outcomes should have their care managed by a high-quality provider of record (POR).
2. The POR establishes a comprehensive treatment plan that considers the claimant's workplace injuries, other physical and behavioral health issues, and social factors.
3. The MCO supports high-quality PORs through coordinating the exchange of information among key parties and removing barriers that prevent the claimant from returning to work.

Claim

Claim milestone	Current state	Proposed solution	Mechanism for providing solution	Outstanding tasks/questions
Instructions to claimant after initial treatment	FROI is filed, and claimant waits for MCO to contact him/her to collect demographic information.	Issue a standardized document identifying key contacts and next steps as the claim is filed.	BWC, the MCO, or the employer will provide standardized document. This should be coupled with the FROI.	Need to create/modify standard document that identifies resources, outlines next steps, and deals with FAQs.

Adjudication

Claim milestone	Current state	Proposed solution	Mechanism for providing solution	Outstanding tasks/questions
Claim needs to be evaluated and triaged to appropriate risk stratification early in the claim	Except for low-intensity claims (minor injury with low appeal rate that are auto adjudicated), all claims are processed similarly. This accounts for roughly 30-40 percent of claims annually.	BWC would provide a tool (composite score) to identify those at risk based on claims, physical, social, and behavioral health information, potentially leveraging work done previously (potentially including the Integrated Services Delivery Model project).	MCOs would collect the following data streams: • Claims data (including modifying the FROI to collect information on secondary insurance and the claimant's primary-care physician); • Demographic info (including age, work history, work culture, education, and geography {access to care}); • Physical health issues (including family history and co-morbidities); • Social issues (including smoking status and alcohol use); and, • Behavioral health issues.	Need to build risk-stratification tool. Need to deploy tool to MCOs. Need to determine how to pass data to BWC in a manner that BWC remains "blind" (e.g. – it is aware there is elevated risk but not aware of the specific conditions/issues above and beyond physical injury). NOTE: BWC would have to work with MCOs for research purposes to have secure access to the underlying data on conditions in claims for the purposes of tuning and refining the risk-stratification tool.

Activating the claimant's aspirational journey

Care

Claim milestone	Current state	Proposed solution	Mechanism for providing solution	Outstanding tasks/questions
Injured workers that appear to be in need of follow-up care (e.g. – three or more visits) need to select a POR.	The selection of a POR occurs based on a variety of mechanisms – mostly because of a recommendation.	The claimant would select a certified, high-quality POR to manage his or her claim by having access to tiered providers.	As part of the on-boarding process, the MCO could advise the claimant on how to select a POR.	Need to finalize definition of a POR. Current thinking suggests a POR should: • Establish relationship with claimant; • Establish treatment plan; • Oversee care; • Set expectations on recovery and RTW; • Communicate and follow up with claimant's PCP; • Establish workability plan; and, • Be measured on performance and outcomes. BWC needs to work with the provider community to: • Identify performance and outcome metrics; and • Explore and build compensation model that incents providers with a monetary bonus or other reward for work as a high-quality POR. Need to set up process to allow high-quality PORs more flexibility to treat while relying on outcomes. Finally, BWC needs to develop a strategy to greatly improve education and training of PORs.

Activating the claimant's aspirational journey

Case Management

Claim milestone	Current state	Proposed solution	Mechanism for providing solution	Outstanding tasks/questions
POR to coordinate with PCP	Unless the PCP is a workers' comp provider, this does not routinely happen today.	The POR would coordinate either directly or indirectly with the PCP to identify and manage general health issues that may delay recovery and return to work.	The process could work as follows: • The claimant is confirmed to be at risk. • The PCP is informed and made at least an ancillary partner in the claim. • One or more co-morbid conditions are present that are relevant to the treatment of a claim (a co-morbid condition may have no bearing on the workplace injury). • The POR establishes a treatment plan with support from PCP. • Information is provided to the MCO; the MCO may help identify issues and coordinate with the POR/PCP to ensure necessary information is exchanged. • The MCO provides information back to the PCP as the claimant recovers so the PCP can ultimately assume management of the patient once his/her claim is successfully resolved.	Need to define strategy for engaging PCPs, including: • How do we incent participation? • How do we work with a PCP without requiring him/her to officially join BWC's network? • How do we build these processes without imposing significant administrative burdens on the system? Engaging PCP networks (through other plans such as Medicaid): • What does the incentive structure look like? • How do we standardize exchange of information?
Identify those claimants at risk due to social/behavioral health issues and offer services where the presence of those issues inhibits recovery and return to work	This does not routinely happen today.	Develop screening criteria to determine whether biopsychosocial consulting services should be provided to a claimant. For those determined to be in need, include these services as part of their comprehensive treatment plan.	Claimants at risk of potential social/behavioral health issues could be identified through a survey tool or referral from any party. Then, the process could work as follows: • Objective benchmarks are established along with corollary processes and procedures to govern utilization of these services. • The MCO, POR, and/or a case manager could identify at-risk claimants. • The MCO will coordinate with the POR for services. • The MCO would work with the POR to use panel providers that are health psychologists with required recovery/return to work focus. • The specialist provides intervention services according to established guidelines.	Need to develop or adopt a screening tool. Need to establish guidelines and goals for counseling. Need to build capacity of behavioral health psychologists to provide CBT services. Need to educate claimants and employers to reduce resistance, lessen the stigma about claimants being labeled with behavioral issues, and allay concerns about claims being predisposed for having a psych allowance.

Activating the claimant's aspirational journey

Case Management

Claim milestone	Current state	Proposed solution	Mechanism for providing solution	Outstanding tasks/questions
Comprehensive treatment plan and return-to-work expectations	The system doesn't currently identify at-risk claimants. Therefore, they don't consistently receive comprehensive treatment plans and often don't routinely select a POR.	The POR would establish a comprehensive treatment plan and a workability plan with documented restrictions that allow a claimant to return to work in modified duty where possible.	BWC would make a provisional determination that evaluates whether or not the claim occurred in the course and scope of employment without adjudicating on specific ICD-9s for a limited period of time (30-90 days). Depending on performance: • A high-performing POR would have flexibility to establish a treatment plan he or she deems to be appropriate. • A conventional POR could submit a comprehensive treatment plan based on published guidelines. • A conventional POR could also submit a treatment plan for the MCO to consider and review. The treatment plan would be provided to the MCO, and the POR will discuss accountability and set expectations for the claimant. In situations where a POR expects that a condition will be permanent, the MCO should immediately begin efforts to coordinate vocation services if claimants cannot return to job of work injury.	Need to change BWC's determination process to provide provisional allowances, especially on at-risk claims. Need to determine how to evaluate and measure PORs and define how this is done. Need to settle on strategy for use of comprehensive treatment guidelines. Need to re-engineer processes to accommodate different types of PORs with different authority to treat. Must capture metrics and report on certain metrics BWC doesn't routinely report on, such as release to return to work, refusal of voc services, etc.

Activating the claimant's aspirational journey

Return to Work

Claim milestone	Current state	Proposed solution	Mechanism for providing solution	Outstanding tasks/questions
Setting employer and claimant expectations concerning return to work and modified duty.	In many cases, some combination of the employer, the MCO, the POR, and/or the TPA investigates whether modified-duty work is available.	The MCO should establish a modified-duty plan where possible in conjunction with the POR.	The process could work as follows: • The MCO should coordinate and document the POR's treatment plan (restrictions). • The MCO should also understand the employer's ability to accommodate those restrictions. • The MCO could then work with the POR to establish a plan for the claimant to return to work in a modified-duty capacity/ TWP capacity. • In conjunction with the POR, the MCO should review ability for modified duty offsite for SF employers.	MCOs would need to set up process to do this effectively and consistently (if it doesn't exist). If the employer cannot accommodate the restrictions or refuses to provide for vocational services, the employer must certify the time off (and this information must be captured). Evaluating the adequacy of incentives to encourage employers to actively participate in modified-duty plans
POR incentives/pay for performance	Providers are paid for services rendered based on BWC's fee schedules.	Exceptional PORs should be eligible to receive bonus payments (e.g. – shared savings) for exceptional performance in the realm of return to work, readmission, and cost control.	(needs to be determined)	Based on appropriate performance metrics, BWC would pay PORs potentially more for the additional responsibilities they have as a POR and for better-than-expected return to work outcomes for their claimants.

Activating the claimant's aspirational journey

Additional Tasks

Administrative

The system needs to…	We would do this because…	The key parties involved in this could be…
Either coordinate and/or subrogate effectively with third-party payers to keep costs low for State-Fund employers. Claims must be flagged for subrogation.	All parties want to make sure that BWC pays primarily for only those costs related to treatment that's appropriate for a successful recovery from the workplace injury.	• BWC because it has a subrogation process; • MCOs because they're involved with provider payment; and/or, • A third party contracted on behalf of the system.

Provider – Measurement and Process

The system needs to…	We would do this because…	The key parties involved in this could be…
Risk adjust for claims based on the severity and complexity of the claim.	Many high-quality providers are reluctant to take on more complex claims because there is no incentive.	• Providers would lead the design of the risk-adjustment models; and, • BWC (or whoever ultimately owns the responsibility of the networks).
Establish consensus- or evidenced-based guidelines.	It would provide clarity and reduce the administrative burden involved with establishing treatment plans presently for various injury types.	Primarily providers with support from BWC and the MCOs since the guidelines have to be grounded in what's considered clinically appropriate.
Develop a more thoughtful approach to recruiting and maintaining a provider network.	Want to attract and retain high-quality providers and work with them on issues as they arise.	The providers and whomever else is responsible for network management.
Examine how to align BWC's administrative process with mainstream medical where possible.	It would minimize the long-standing argument that workers' compensation is different because the creation/retention of medical records, exchange of information, bill payment, and authorization processes are considered unique.	• Providers (or other plans) would have to help with defining what's standard; • Attorneys would have to consider whether those changes are legal/appropriate; and, • Customers (business and labor) would have to be comfortable with less/different documentation while attempting to manage a claim.
Establish an appeals process for providers contesting their respective performance scores.	BWC would need to allow providers to have due-process rights where they feel an error or omission has occurred.	BWC and the providers.

Provider – Measurement and Process

Help a claimant identify a PCP (preferably an established PCMH) if different than the POR, and where appropriate, offer to connect them with resources to help them obtain secondary health insurance.	The system is intended to only care for the injuries arising from the workplace accident – not broader health conditions. Yet those conditions often need treatment for management of the claim to progress.	This could be a role quarterbacked by either the MCO or a community navigator.
Establish quality-based performance goals for PORs (with the potential to eliminate certain episodes of care) to govern both incentive payments and increased flexibility.	It would allow customers to make more informed decisions and enable the system to provide more flexibility to higher-quality PORs based on data.	All parties.

HEALTHCARE SUMMIT – PUNCH LIST FOR ACTIVATING THE CLAIMANT'S ASPIRATIONAL JOURNEY

What we've built: The stakeholder group has re-engineered the medical-care model used to care for claimants to provide more coordinated, higher-quality services for claimants at risk of poorer outcomes. The re-engineered model is governed by three key philosophies:

1. Claimants at risk of poorer outcomes should have their care managed by a high-quality provider of record (POR).
2. The POR establishes a comprehensive treatment plan that considers the claimant's workplace injuries, other physical and behavioral health issues, and social factors.
3. The MCO supports high-quality PORs through coordinating the exchange of information among key parties and removing barriers that prevent the claimant from returning to work.

Current punch list of activities

CLAIM

Task	Lead	Dependencies	Short-term plan (30 days)	Long-term plan (30 days +)
Create standardized document	BWC (with support from stakeholders)	None	MCOs will provide copies to BWC of what they send to employers by 8/15. BWC will draft documents by 8/29.	Implement in fourth quarter of calendar year 2014.
Modify FROI	BWC (with input from stakeholders)	None	---	Add name of PCP and secondary insurance to FROI as part of a review of FROI in fourth quarter of calendar year 2014.

ADJUDICATION

Task	Lead	Dependencies	Short-term plan (30 days)	Long-term plan (30 days +)
MCOs collect standard data set	MCOs	None	MCOs will provide lists of data elements they routinely collect today by 8/15.	BWC will work with MCOs to implement a plan to collect information and pass it along blindly to BWC in fourth quarter of calendar year 2014.
PHASE ONE: Build claimant risk-stratification tool based primarily around the nature of the workplace injury.	BWC		---	BWC will pilot a modest claimant risk-stratification tool and deploy it to MCOs in early 2015.
PHASE TWO: Improve claimant risk-stratification tool to consider the impacts of physical, behavioral, and social issues.	BWC	MCOs collecting data	---	BWC will begin modeling revised claimant risk-stratification tool with physical, behavioral, and social data in mid-2015.

CARE

Task	Lead	Dependencies	Short-term plan (30 days)	Long-term plan (30 days +)
Redefine POR responsibilities	Providers (with support from BWC and stakeholders)	None	BWC will engage the 222 Committee to formally adopt POR responsibilities and conceive a framework for successful education and communication of those responsibilities.	---
Establish objective, risk-adjusted performance metrics for PORs and providers	BWC (with support from provider community)	None	BWC will engage both the 222 Committee as well as a subset of other workers' comp providers to develop these metrics.	BWC will pilot a concept that mitigates downside risk for participating PORs beginning in early 2015.
Build incentive model with appropriate due process	BWC (with support from provider community)	Provider performance metrics	---	BWC will work with the 222 Committee as well as a subset of other workers' comp providers to build a compensation-model concept to support the implementation of performance metrics in early 2015.
Implement revised POR model (education)	BWC (with support from stakeholders)	Redefinition of POR; Establishment of performance metrics; Construction of compensation model	BWC will host an educational session with its high-volume workers' comp providers to share potential changes to the POR model.	BWC will work with its Board where appropriate to modify rules in a manner that's consistent with the 222 Committee's recommendations.
Coordinate with PCP on general health/co-morbid issues	Providers (with support from BWC and other stakeholders)	None	BWC will engage the 222 Committee on strategy for engaging PCPs.	BWC will work with its high-quality PORs to coordinate care with PCPs as part of an attempt to conduct a pilot in early 2015.
Identify behavioral-health psychologists	BWC	None	BWC will conceive a strategy for building network infrastructure to support behavioral interventions for at-risk claimants determined to need services (or otherwise referred).	BWC will build out this network in the fourth quarter of calendar year 2014.
Adopt behavioral health screening tool and corresponding guidelines for use in evaluation of potential at-risk claimants	BWC (with support from providers)	None	The 222 committee will make a recommendation on both the use of a survey mechanism and guidelines governing its use.	The survey tool can be used as part of an attempt to conduct a pilot in early 2015.

Coordinate with behavioral-health psychologists	Providers (with support from MCO)	Identification of behavioral-health psychologists	BWC will engage the 222 Committee on strategy for engaging behavioral-health psychologists.	High-quality PORs can coordinate care with behavioral health psychologists as part of an attempt to conduct a pilot in early 2015.
Submit comprehensive-treatment plan	MCOs and providers	Implementing revised POR model	---	High-quality PORs can form a joint workgroup with MCOs on the required elements and submission of comprehensive treatment plans in anticipation of an attempt to conduct a pilot in early 2015.

RETURN TO WORK

Task	Lead	Dependencies	Short-term plan	Long-term plan
Establish modified-duty plan	MCOs	None	---	BWC will coordinate discussions between MCOs and employers on how to standardize the modified-duty evaluation process for implementation in early 2015.
Revisit employer incentives for offering modified duty	BWC (with support from stakeholders)	None	---	BWC will evaluate the adequacy of its modified-duty incentives and consider alternatives to encourage more active participation.

ADDITIONAL TASKS

Task	Lead	Dependencies	Short-term plan	Long-term plan
Determine network adequacy (address issues of quality and accessibility)	BWC (with support from stakeholders)	Implementing revised POR model	BWC will come up with a plan to inventory its current network.	TBD
Subrogate for costs not deemed to be related to care	BWC	None	---	TBD
Establish consensus-based guidelines	BWC and providers (with support from MCOs)	None	BWC will engage the 222 Committee to make a recommendation on whether to proceed with guidelines and, if approved, whether to adopt or build them.	TBD
Establish provider recruitment plan	BWC (with support from stakeholders)	Determining network adequacy	---	TBD
When appropriate, help claimants to identify a PCP and/or to obtain secondary health insurance	MCOs (with support from stakeholders)	None	---	At the next mandatory MCO program, a representative from OHA will train the MCOs on how to connect eligible individuals to

				Medicaid or the online health insurance exchanges
Designate an ombudsperson/problem solver to assist providers with issues	MCOs	None	---	Require that each MCO has someone in this position.

Short-term pilot consideration goal: BWC could set up 1-3 pilot projects to test the effectiveness of this model. An example of how a pilot could be established is as follows:

- PORs who rate above a certain threshold on the provider-resource report (incorporating risk adjustment) would be eligible to participate.
- BWC could identify a population of at-risk claims with a wide distribution of outcomes (thus demonstrating that successful care can have an impact on the duration of disability).
- Claimants who appear to have an alleged injury consistent with the population of at-risk claims would participate in a process where:
  - The MCO would collect all requisite data from the claimant.
  - The MCO provides a list of high-quality PORs for the claimant as part of the education process around selection of POR.
  - If a claimant selects a high-quality POR, the POR would be granted a pre-determined number of days to establish the appropriate conditions for which to allow the claim.
  - The POR would make contact with the claimant's PCP and then establish a comprehensive treatment plan that attempts to resolve those physical, behavioral, and social factors that the POR believes impede the claimant's path back to work.
  - In conjunction with the POR, the MCO could attempt to establish a plan for the claimant to engage in modified duty.
- BWC could measure the success of the pilot(s) based on:
  - Impacts of duration of disability relative to prior claims with similar conditions (or current ones where the claimant opted to select a different POR); and,
  - Overall costs to determine whether the outcomes were more or less expensive.
- BWC could provide incentives to PORs and MCOs based on optimal outcomes.

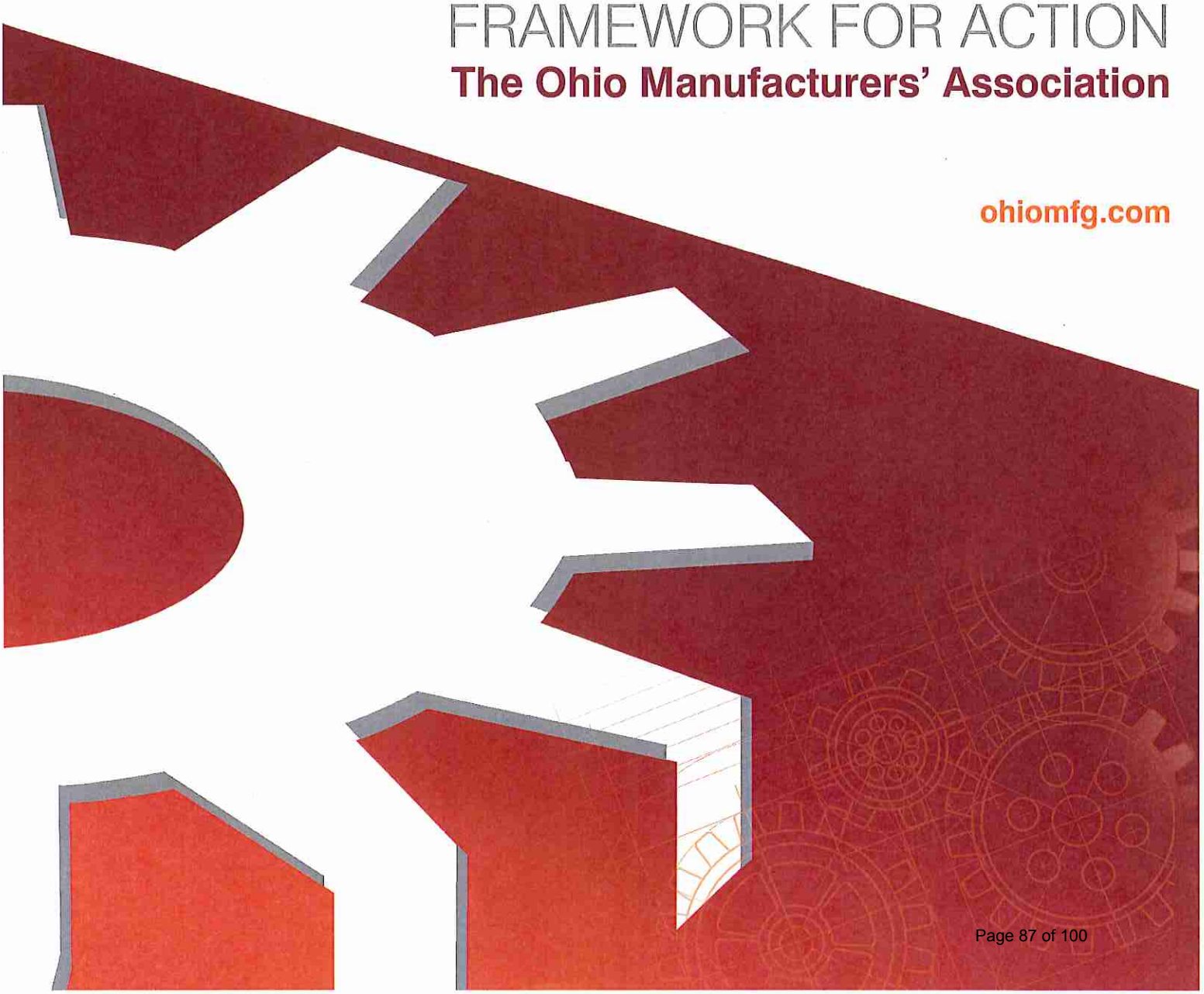
This exercise could be done potentially in collaboration with broader health pilots taking place in Cleveland and Cincinnati. We could also consider initiating a pilot in Columbus in partnership with the Health Collaborative of Greater Columbus.

The Ohio Manufacturers' ASSOCIATION

OMA PUBLIC POLICY FRAMEWORK FOR ACTION

The Ohio Manufacturers' Association

ohiomfg.com



OMA

Public Policy Framework for Action

Manufacturing is responsible for 17% of Ohio's Gross Domestic Product; this is greater than the contribution of any other Ohio industry sector. Manufacturing is the engine that drives Ohio's economy.

In the competitive domestic and global economies, every public policy decision that affects Ohio's business climate affects Ohio's manufacturing competitiveness. In turn, Ohio's manufacturing competitiveness determines the ability of the state to grow its economy and create jobs.

Ohio manufacturers require public policies that attract investment and protect the state's manufacturing legacy and advantage. These policies apply to a wide variety of issues that shape the business environment within which manufacturers operate.

MAJOR POLICY GOALS INCLUDE THE FOLLOWING:

- **An Efficient, Competitive Tax System**
- **A Lean, Productive Workers' Compensation System**
- **Access to Reliable, Economical, Diverse Energy Resources**
- **A Fair, Stable, Predictable Civil Justice System**
- **Science-based, Technologically Achievable, and Economically Reasonable Environmental Regulations**
- **A Modern Public Resource Infrastructure**
- **An Educated, Highly Skilled Workforce**

The Ohio Manufacturers' Association

Policy Goal:
A Lean, Productive Workers' Compensation System

An efficient and effective workers' compensation system benefits workers, employers, and the economy of the state and is built on the following principles:

- Injured workers receive benefits that are prompt and adequate for getting back to work quickly and safely.
- Rates are established by sound actuarial principles, so that employers pay workers' compensation rates commensurate with the risk they bring to the system.
- The system is financed with well-functioning insurance mechanisms, including reserving and investment practices that assure fund solvency and stability.
- The benefit delivery system deploys best-in-class disability management practices that drive down costs for employers and improve service and outcomes for injured parties.
- The system consistently roots out fraud, whether by employers, workers or providers.

Fundamental priorities for future action are three:

The Bureau of Workers' Compensation (BWC) should reform its medical management system to lower cost and improve medical quality through better coordination of care and development of a payment system that creates incentives for best clinical practices. In doing this, the BWC should build on emerging best practices in the private sector health care system, such as patient-centered medical homes.

The Ohio General Assembly should seek statutory reforms of benefit definitions, so that the claims adjudication process is more predictable, less susceptible to fraud and manipulation, and less costly, both for workers and employers.

The Industrial Commission should record hearings, so that the hearing process is more transparent and any appeals have a record on which to build.

Safety & Workers' Compensation

BWC Safety Grants Going Like Hotcakes

The Ohio Bureau of Workers' Compensation (BWC) recently approved 127 safety grants for Ohio employers totaling more than $3.5 million. BWC designed the Safety Intervention Grant Program to assist Ohio employers in reducing illnesses and injuries and to create a partnership with them to establish best practices for accident and injury prevention.

A listing of approved grants with summaries of each employer's intervention is available here.

Safety grants provide for a 3-to-1 match up to a maximum of $40,000. Quarterly data reports and follow-up case studies help BWC determine the effectiveness of employers' safety interventions and establish best practices. *10/7/2014*

"Another Billion Back" Checks Start to Mail this Month

The Bureau of Workers' Compensation (BWC) will begin issuing checks in October equaling 60% of premiums eligible employers paid during the July 1, 2012 through June 30, 2013 policy year under its Another Billion Back program.

BWC must have employers' current mailing address on file to mail rebates. Employers with an e-account may verify their address by logging in here. Employers without an e-account may contact their regular BWC representative, or call 1-800-644-6292. *9/26/2014*

Is Your Company Owed a Refund in the *San Allen, Inc. vs. BWC* Case?

The parties have reached a proposed settlement in the *San Allen, Inc., et al. v. Ohio Bureau of Workers' Compensation* (BWC) case. This class action case, which began back in December 2007 and included a class of approximately 270,000 Ohio businesses, arose out of allegations that the BWC had overcharged state-fund Ohio employers that were not group-rated between the years 2001 and 2008.

Pursuant to the proposed settlement, the BWC has agreed to create a Settlement Fund in the gross amount of $420,000,000. After deductions for attorneys' fees and other associated costs and expenses, the remainder of the fund will be paid on a pro rata basis to qualifying Class Members who file timely claims. The Court will consider the proposed settlement at a Final Approval Hearing on November 19, 2014.

OMA Connections Partner, Frantz Ward, breaks down the steps to making a claim. Note that proofs of claims must be postmarked no later than October 22, 2014. *9/29/2014*

Like Safety? And Contests? Read On!

The Bureau of Workers' Compensation (BWC) has announced that its Safety Innovations Competition is getting a face-lift this year with new rules and new prizes. This competition encourages and recognizes development of innovative solutions that help to reduce workplace injuries and illnesses.

The competition is open to all employers with a BWC policy number, including self-insured and public employers.

The top five entries will display their innovation at the 2015 Ohio Safety Congress & Expo where they'll be awarded cash prizes ranging from $1,000 to $7,000.

Click here to learn more about the competition and access the online application. Employers must complete the online application by Oct. 31, 2014. *9/24/2014*

A Pathway to Better Medical Management

This week Bureau of Workers' Compensation (BWC) staff presented a final report of stakeholders, including the OMA, from a Health Care Summit organized by the BWC. The aim of the BWC and its stakeholders is "to improve care coordination and provide high-quality care for claimants at a reasonable cost to Ohio employers."

For approximately 85% of claimants, the data suggests that the care system works fairly well. The report focuses on the remainder of claimants, those at risk of poor outcomes.

Last week, BWC Administrator Steve Buehrer and the governor's director of the Office of Health Care Transformation, Greg Moody, met with the OMA board of directors to discuss this initiative, which has

the potential to make Ohio a model for workers' comp medical care management. *9/25/2014*

If You "Snail Mail" Your BWC Premium Payment, Take Note of New Address!

Starting this week, for employers that submit their Bureau of Workers' Compensation (BWC) premium via U.S. mail, please note the new mailing address: Ohio Bureau of Workers' Compensation, P.O. Box 89492, Cleveland, OH 44101-6492.

The BWC changed its payment lockbox provider, from Chase to Key Bank, and will no longer use the Columbus address. Please note that there is no longer a separate overnight/express/signature required address. All payments may be sent to this new address.

Return envelopes that are sent with invoices and payroll reports will include the new address. As long as you use the envelope BWC sends out, you will not need to take any additional action. If you do not use the envelopes provided, please update the address in your system.

Payroll reporting and premium payments may also be made online. BWC offers a go-green discount of 1 percent for eligible companies that do their business online. *9/15/2014*

New OSHA Recordkeeping & Reporting Rule Summarized

OSHA has issued a final rule that modifies recordkeeping and reporting requirements for employers. The most significant change requires an employer to notify OSHA within twenty-four (24) hours of when an employee suffers a work-related, in-patient hospitalization, amputation, or loss of an eye.

OMA Connections Partner, Frantz Ward, has summarized provisions of the recently passed OSHA rule. *9/17/2014*

Ohio Supreme Court Says 'No' to Post-Retirement Temporary Total Compensation

OMA Connections Partner, Dinsmore, reports that on August 27, 2014, the Ohio Supreme Court issued its unanimous opinion in *State, ex rel. Floyd v. Formica Corp.*, ruling that where a claimant voluntarily retires from the workforce following an injury, he or she becomes ineligible for a new period of temporary total disability while recovering from a post-retirement surgery.

The court upheld the Industrial Commission's denial of temporary total compensation, stating: "Because temporary-total-disability compensation is intended to compensate an injured worker for loss of earnings while the industrial injury heals, a claimant who is no longer part of the workforce can have no lost earnings."

Dinsmore predicts this case will serve as a precedent for future cases with similar facts. *9/11/2014*

Today is Last Chance for On-Time BWC Premium Payment

Employer premium payments and payroll reports for the first half of 2014 were due to the Bureau of Workers' Compensation on Tuesday, September 2. Any employer whose premium for isn't paid by today, Friday, September 5, will not get their Billion Back rebate! *9/4/2014*

Timeline of *San Allen* Settlement Claims Processing

OMA Connections Partner, Bricker & Eckler LLP, created this timeline to help eligible employers understand the process to claim their potential settlement proceeds in the *San Allen Inc. v. Ohio Bureau of Workers' Compensation* case, which was settled for $420 million.

This case involved a large class of private employers seeking nearly $1 billion in alleged Bureau of Workers' Compensation (BWC) overcharges based on their non-participation in group discounts.

The official website for the case contains information about the settlement and claims process. Employers should consult it if they have any questions. It is run by the Settlement Administrator, Garden City Group. The Settlement Administrator is to process the notices & claims. Bricker & Eckler LLP was appointed by the court as the Special Master, and serves as the "eyes and ears" of the court to make sure the process is as smooth as possible. The Special Master oversees the work of the Settlement Administrator.

If you have questions not answered by the website, please contact Bricker attorneys: William Mason, Christopher Ernst, or Sue Wetzel. *8/26/2014*

***Another Billion Back* Would Send $126M to Ohio Local Governments**

The Ohio Bureau of Workers' Compensation (BWC) would return an estimated $126.1 million to 3,800 local public employers under *Another Billion Back*, a

proposal announced by Governor John Kasich and Administrator/CEO Steve Buehrer on August 13.

The amount each eligible public employer would receive equals approximately 60 percent of their billed workers' compensation premium from the 2012 policy year. Out of the $126.1 million that could be returned, cities would receive the largest portion of the rebate – approximately $46.2 million – followed by schools receiving $44.3 million, counties receiving $18.7 million and townships receiving $7.8 million.

Here are the rebate totals by county and entity-type. *8/25/2014*

Critical! Workers' Comp. Premium Due September 2

Ohio private employers have until September 2, 2014 to file payroll reports and submit workers' compensation premiums for the period covering January 1 to June 30, 2014.

According to Kimberly Kline, Office of Strategic Direction, Ohio Bureau of Workers' Compensation, "With the announcement of *Another Billion Back* it is crucial that payroll and premium get reported and paid on-time by the end of this month. ... Employers must be in an active, reinstated, combined or debtor in possession status as of September 5th to qualify for the rebate."

Pay and report on time to protect your 60% rebate! *8/18/2014*

Safety Resources from BWC

The Ohio BWC Division of Safety & Hygiene offers more than 74 occupational safety, health and ergonomic courses for Ohio employees. Classes are held online and throughout the state at BWC's regional service offices, and they are free for those who work for employers with active workers' compensation coverage.

Here's the August BWC Safety Update, packed with safety tips and resources.

And, because wellness affects safety in the workplace, learn more and find resources for health maintenance and improvement from BWC here. *8/18/2014*

Another Billion Back

This week Governor John R. Kasich and Ohio Bureau of Workers' Compensation (BWC) Administrator/CEO Steve Buehrer announced a $1 billion rebate to Ohio's private and public sector workers' compensation customers, as well as a major new investment in worker safety research and training. "*Another Billion Back*" comes on the heels of last year's $1 billion rebate for workers' comp customers. Both rebates were made possible by strong investment returns in the workers' compensation fund.

If approved by the BWC Board of Directors, eligible employers will receive a rebate equal to 60 percent of premiums paid during the July 1, 2012 through June 30, 2013 policy year. The proposal will be presented to the board at its August meeting, and if approved in its September meeting, BWC could begin issuing checks as early as October.

Here's a media statement issued by OMA commending the governor and Administrator Buehrer on the many improvements the bureau is making.

Administrator Buehrer is a scheduled guest presenter at the OMA's Safety & Workers' Compensation policy committee meeting on October 15. Register for call-in or in-person attendance at My OMA. *8/13/2014*

How Do Your Injury Rates and Costs Stack Up?

The Bureau of Workers' Compensation (BWC) is embarking on a safety campaign themed *Better Business Starts with Safety, Safety Starts at BWC* to encourage employers them to take advantage of BWC's safety services before experiencing a workplace injury or illness.

BWC's new microsite allows employers to compare injury rates and costs within and across industry sectors. It also links employers directly to BWC safety consultants, who can survey their workplace and advise them on preventing occupational injuries and illnesses. *8/13/2014*

What does 'Substituted' Drug Test Result Mean?

OMA Connections Partner, Working Partners®, provides this information about a 'substituted' drug-test result. Working Partners® helps employers develop and maintain a drug-free workplace. *8/10/2014*

Judge Selects Bricker & Eckler LLP to Administer $420 Million in *San Allen* Refunds

Last week, Ohio Bureau of Workers' Compensation (BWC) Administrator/CEO Steve Buehrer announced that the bureau had reached an agreement in principle to settle the *San Allen* case, a class action

lawsuit filed in 2007 over BWC pricing policies that were in place between 2001 and 2008. Employers that were not in a group rating program during the contested years will be awarded a settlement.

This week, Judge Richard McMonagle appointed Bricker and Eckler LLP to serve as Special Master for administering the claims of the BWC settlement. Its work will be distribution of funds to claimants.

Bricker & Eckler is long-time legal counsel to OMA. *8/01/2014*

BWC Designing Health Care Management Improvements

The Bureau of Workers' Compensation (BWC) has begun a process that will lead to improvements in its health care management system. BWC aims to lower cost and improve medical quality through better coordination of care and development of a payment system that creates incentives for best clinical practices.

Greg Moody, Governor Kasich's capable director of the Office of Healthcare Transformation, delivered an opening presentation to a group of stakeholders, including the OMA, the BWC invited to help design the improvement path. His presentation, "Inevitable Transformation: How Health Care Delivery Is Changing," will be of interest to all human resource managers responsible for health care decisions and to all workers' compensation managers looking for better results in the management of claims. So will a second presentation Moody gave on trends in managed care and patient-centered medical homes. *7/29/2014*

BWC Settles San Allen Case for $420 Million

This week, Ohio Bureau of Workers' Compensation (BWC) Administrator/CEO Steve Buehrer announced that the bureau has reached an agreement in principle to settle the San Allen case, a class action lawsuit filed in 2007 over BWC pricing policies that were in place between 2001 and 2008. The case involved premium subsidies from one set of employers (those not in group rating) to another set of employers (those in groups) that occurred because of the operation of the BWC's actuarial credibility tables during that time period.

According to OMA Connections Partner Roetzel & Andress: "As part of the agreement, a $420 million fund will be created to pay for claims to employers participating in the lawsuit, the attorney fees, court costs and the costs of administering the fund…The next step, once the court gives preliminary approval of the settlement, is for class members to receive instructions for submitting claims. Any unclaimed funds will be returned to the Bureau of Workers' Compensation State Insurance Fund to pay claims of injured workers, according to the release."

Originally, $860 million was awarded by the Eight District Court of Common Pleas.OMA will keep members up-to-date as details are learned about who can submit claims, how claims are to be submitted, and when this can/will happen.

Here's more from Roetzel & Andress. *7/24/2014*

Details of BWC's Switch to Prospective Premium Payment

Did you miss OMA's webinar this week in which Bureau of Workers' Compensation (BWC) staff presented the availability of safety grants and details of the BWC's switch to prospective payment of premium?

You can catch the recorded webinar in the OMA's online video library. Use your My OMA login. Search under Workers' Compensation Management. *7/24/2014*

Pardon Me, What Did You Say?

Are you having trouble getting your employees to use their hearing protection? This web page from NIOSH might help convince them. The site has examples of what moderate and severe hearing loss sound like and contains a link to a hearing loss simulator.

This and lots more good safety insights and tips in BWC's July 2014 Safety Update. *7/10/2014*

New BWC Media & Marketing Web Site

Find your regional Bureau of Workers' Compensation (BWC) business development manager, request a speaker for an event or meeting, learn about the latest program offerings, and check on the BWC calendar of events by visiting its new Media & Marketing web page.

This new webpage replaces the former Media Center and is accessible from the Quick Links section of the BWC home page. *7/15/2014*

BWC Changing Provider of Benefits Debit Cards

Many injured workers, guardians and dependents receive workers' compensation benefit payments through direct deposit, but some receive their benefits on debit cards.

Although this doesn't directly affect employers, the Bureau of Workers' Compensation (BWC) announced it is switching banks for its electronic benefit debit card program. Starting in August, Key Bank will become the new program manager. Benefit recipients will receive new cards in the mail and will receive their first payment on their new Key Bank debit cards on August 28.

The existing Chase VISA cards will remain active, although no new funds will be deposited to those cards after August 27.

Here's more information. *7/15/2014*

Workers' Comp Billing System Update

The Bureau of Workers' Compensation is changing the way it bills for workers' compensation coverage. The agency has asked us to share with you its recent letter about the changes. *7/7/2014*

Comparison of TPA Performance of Key Claims Management Services

'Handicap reimbursement' is a Bureau of Workers' Compensation (BWC) program designed to allow employers to gain claim-cost relief where certain pre-existing medical conditions among injured workers add recovery time and cost to the claim. For example, an injured worker with arthritis or diabetes may have a slower or more costly recovery due to the non-work related condition. When handicap reimbursement relief is awarded, employers contain costs that are out of their control.

When a claim receives a 'full and final settlement', the claimant is awarded a dollar amount that is considered to be a fair final payment on the claim. In order to settle a claim, the employer, the claimant and the BWC must all agree that the claim can be settled and for what amount. When a claim is settled, any reserve amount on the claim is eliminated from the employer's claims experience, and, therefore, reduces premium costs.

See how OMA Workers' Compensation Services stack up to competitors on finding and processing these important claim cost-containment strategies. *7/10/2014*

BWC Asks Supreme Court to Hear *San Allen* Appeal

The Ohio Bureau of Workers' Compensation (BWC) announced it will ask the Supreme Court to hear its appeal in *San Allen v. Buehrer*, a class action law suit alleging the BWC overcharged non-group rated businesses by $860 million. The BWC hopes to have the lower court's decision overturned.

Here's a briefing on the matter from OMA Connections Partner, Bricker & Eckler LLP. *7/1/2014*

Marijuana Ballot Issue Misses Deadline

An organization attempting to qualify a ballot issue to authorize the use of medical marijuana failed to collect adequate voter signatures by this week's deadline. The measure will not be on the November ballot. The group says it will retry in November of 2015. *7/2/2014*

HB33 **INDUSTRIAL COMMISSION BUDGET** (HACKETT R) To make appropriations for the Industrial Commission for the biennium beginning July 1, 2013, and ending June 30, 2015, and to provide authorization and conditions for the operation of Commission programs.

Current Status: 3/26/2013 - **SIGNED BY GOVERNOR**; Eff. 3/26/2013
State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_33

HB34 **WORKERS' COMPENSATION BUDGET** (HACKETT R) 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.

Current Status: 3/26/2013 - **SIGNED BY GOVERNOR**; Eff. 3/26/2013
State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_34

HB59 **BIENNIAL BUDGET** (AMSTUTZ R) To make operating appropriations for the biennium beginning July 1, 2013, and ending June 30, 2015; to provide authorization and conditions for the operation of state programs.

Current Status: 6/30/2013 - **SIGNED BY GOVERNOR**; Eff. 6/30/2013; Some Eff. 9/29/2013; Others Various Dates
State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_59

HB143 **WORKERS' COMPENSATION** (DEVITIS A, BUTLER, JR. J) To require the Administrator of Workers' Compensation to include in the notice of premium rate that is applicable to an employer for an upcoming policy year the mathematical equation used by the Administrator to determine the employer's premium rate.

Current Status: 5/14/2013 - House Insurance, (First Hearing)
State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_143

HB338 **WORKERS' COMPENSATION-UNEMPLOYMENT COMPENSATION COVERAGE** (MCGREGOR R, HOTTINGER J) To establish a test to determine whether an individual providing services for or on behalf of certain motor transportation companies is considered an employee under Ohio's Overtime, Workers' Compensation, and Unemployment Compensation Laws.

Current Status: 3/12/2014 - House Commerce, Labor and Technology, (Fifth Hearing)
State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_338

HB431 **WORKERS' COMPENSATION-MEDICAID ELIGIBILITY STUDY COMMITTEE** (SEARS B, HENNE M) To create the Workers' Compensation and Medicaid Eligibility Study Committee.

Current Status: 2/25/2014 - Referred to Committee House Health and Aging
State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_431

HB462 **PROFESSIONAL EMPLOYER ORGANIZATION-FEDERAL TAXES** (MCGREGOR R) To permit a professional employer organization to file federal taxes in any manner permitted by federal law.

Current Status: 3/18/2014 - House Insurance, (First Hearing)
State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_462

HB472 **MBR-MID-BIENNIUM BUDGET REVIEW** (MCCLAIN J) To make operating and other appropriations and to provide authorization and conditions for the operation of state programs.

Current Status: 3/26/2014 - House Ways and Means, (Third Hearing)

State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_472

HB493 **MBR-WORKERS' COMPENSATION** (SEARS B, HENNE M) To make changes to Ohio's Workers' Compensation Law and to make an appropriation.

Current Status: 6/16/2014 - **SIGNED BY GOVERNOR**; Eff. 9/17/2014 Other Provisions Eff. 7/1/2015

State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_493

HB539 **WORKERS' COMPENSATION CLAIMS** (HENNE M) To defer the charging of workers' compensation claims to an employer's experience when a third party may be liable for the claim and to create the Subrogation Suspense Account within the State Insurance Fund to which any such deferral will be charged.

Current Status: 6/3/2014 - House Insurance, (First Hearing)

State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_539

SB176 **ILLEGAL ALIENS-WORKERS' COMPENSATION** (SEITZ B) To prohibit illegal and unauthorized aliens from receiving compensation and certain benefits under Ohio's Workers' Compensation Law.

Current Status: 1/29/2014 - Senate Commerce and Labor, (Second Hearing)

State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_SB_176

SB290 **PROFESSIONAL EMPLOYER ORGANIZATION-FEDERAL TAXES** (PATTON T) To permit a professional employer organization to file federal taxes in any manner permitted by federal law.

Current Status: 6/3/2014 - Senate Insurance and Financial Institutions, (Third Hearing)

State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_SB_290

SB368 **DISABILITY COMPENSATION** (SCHIAVONI J) To make an individual who has lost the use of a body part due to a brain injury or spinal cord injury eligible for partial disability and permanent total disability compensation under the Workersâ€™ Compensation Law.

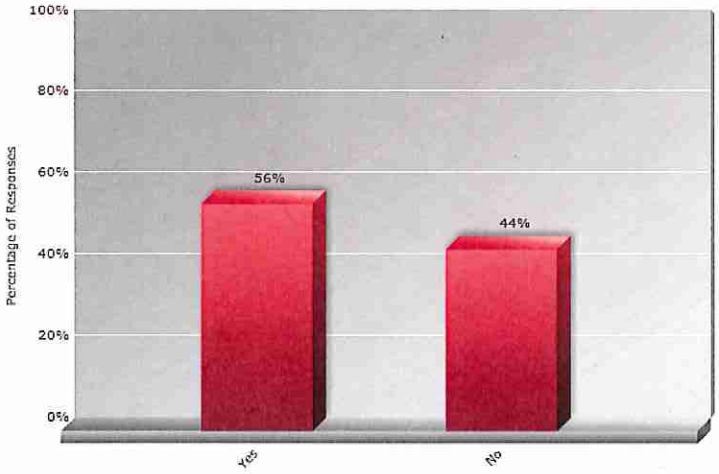
Current Status: 10/9/2014 - Introduced

State Bill Page: http://www.legislature.state.oh.us/bills.cfm?ID=130_SB_368

OMA Committee Meeting
Participant Survey Results August 2014

Have you attended a committee meeting IN PERSON in the past year?

Answer	Percentage	Number
Yes	56 %	15
No	44 %	12
Number of Respondents: 27		



What was the best part about attending an OMA policy committee meeting in person?

Themes:

- **Information** – "The information on how pending policies impact the economics of business in Ohio."
- **Networking** - "I enjoy the personal interaction and the important sidebar conversations."
- **Access to elected officials** – "Hearing directly from administration or legislative representatives."
- **Meeting design** – "It is easier to ask questions of the guest speakers when you are in the room."

What changes to policy committee meetings should OMA consider?

Time management –

"Sometimes there is not enough time to properly accomplish the business."

"I'd like to figure out way to attend without losing the entire day from the office."

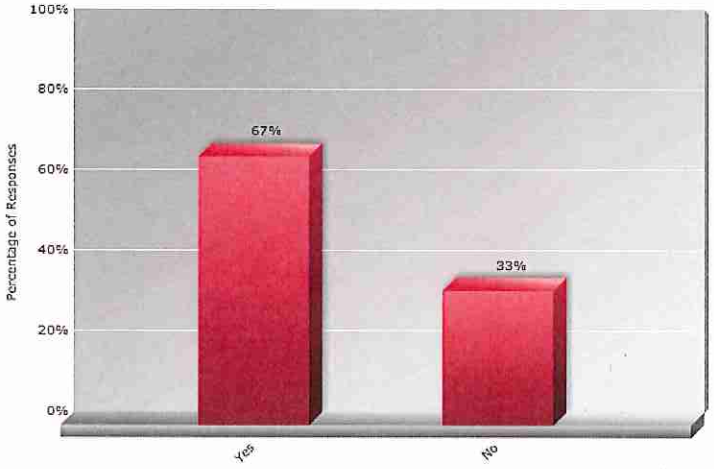
"More time for networking, shared perspectives, learning through interaction."

"Lengthen them."

"Shorten them."

Have you participated in an OMA policy committee meeting VIA PHONE in the past year?

Answer	Percentage	Number
Yes	67 %	16
No	33 %	8
Number of Respondents: 24		



What would improve OMA policy committee meeting participation via phone?

Themes:

Interaction – "Ask people on the phone for their reactions more frequently."

Technology –

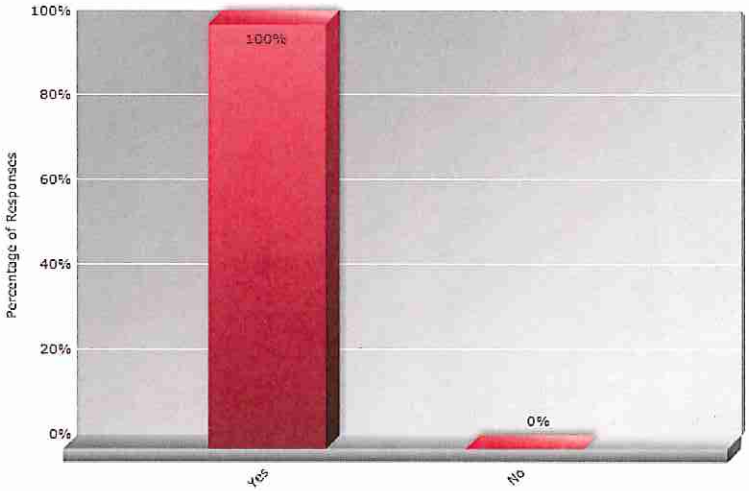
"Webinar or improved system that does not allow callers to interfere with the meeting."

"It would be nice to be able to view the meetings by internet."

"It is difficult to hear the speakers and attendees who have questions or comments."

OMA emails the committee materials to you whether or not you register for the policy committee meeting(s). Is this of value to you?

Answer	Percentage	Number
Yes	100 %	20
Number of Respondents: 20		



Should OMA consider any changes to the meeting materials?

"Making sure they are as brief as possible while still being meaningful."

"Adding an executive summary."

"More detailed index."

"Have archives online for reference." (See ohiomfg.com footer)