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Bill Analysis

Sub. S.B. 7*

126th General Assembly
(As Reported by S. Insurance, Commerce, & Labor)

Sen. Cates

BILL SUMMARY

Determination and payment of workers' compensation benefits

- Reduces the 40-week waiting period for the filing of an application for permanent partial disability compensation (PPD) to 26 weeks.
- Changes the amount of time an employee may receive payments for wage loss suffered as a result of returning to employment other than the employee's former position of employment or for being unable to find employment consistent with the employee's physical capabilities.
- Specifies reasons an employee is not entitled to permanent total disability compensation (PTD).
- Allows any party to void a settlement agreement if an employee dies during the 30-day period after approval of a final settlement agreement.
- Revises conditions under which a final settlement agreement may be filed without an employer's signature and establishes related notification requirements.
- Specifies that an employee receiving compensation for PTD due to a traumatic brain injury is entitled to receive that compensation regardless of the employee's subsequent employment in a sheltered workshop so long as the employee does not receive more than $2,000 in compensation from the job per calendar quarter.

* *This analysis was prepared before the report of the Senate Insurance, Commerce, and Labor Committee appeared in the Senate Journal. Note that the list of co-sponsors and the legislative history may be incomplete.*

- Adds that persons, while confined to a county jail in lieu of incarceration in a state or federal correctional institution, as well as those persons confined in any state or federal correctional institution as under continuing law, may not receive compensation or benefits during the period of confinement.

- Revises fingering numbering for PPD.

- Increases the award for facial disfigurement from $5,000 to $10,000.

Coverage under the Workers' Compensation Law

- Modifies the continuing jurisdiction of the Industrial Commission to make a modification, change, finding, or award from six years in the absence of the payment of medical benefits and ten years in the absence of payment of compensation to a five-year limit in those cases.

Definition of injury

- Specifies that "injury" includes psychiatric conditions where the claimant's psychiatric conditions have arisen from sexual conduct in which the claimant was forced by threat of physical harm to engage or participate.

- Specifies that if a condition that pre-existed an injury is substantially aggravated by the injury, and that substantial aggravation is documented by objective diagnostic findings, objective clinical findings, or objective test results, once that condition has returned to a level that would have existed without the injury, no compensation or benefits are payable because of the pre-existing condition.

Public records

- Specifies that information concerning claims filed with the Bureau of Workers' Compensation or the Industrial Commission, including information identifying a claimant's address and telephone number, is not a public record under the Public Records Law (sec. 149.43) and is not open to the public, except to journalists as described below.

- Permits a journalist to request claimants' addresses and phone numbers and requires the Commission or the Bureau to disclose those requested addresses and telephone numbers.

Compliance with the Workers' Compensation Law

- Allows the Administrator to furnish the Tax Commissioner with a list containing the name and social security number or employer identification number of any employer and request that the Tax Commissioner report the total amount of compensation paid that the employer reported on the employer's annual tax return.

- Requires the Tax Commissioner, after receiving the Administrator's list, to disclose the total amount of compensation paid that the employer reported.

Disputes and appeals

- Specifies that a claimant may not dismiss a complaint filed with a court of common pleas concerning an appeal of an Industrial Commission decision without the employer's consent if the employer is the party that filed the initial appeal.

- Permits the Administrator to specify in the rules concerning procedures for resolution of medical disputes that those procedures must not be used to resolve disputes concerning medical services rendered that have been approved through standard treatment guidelines, pathways, or presumptive authorization guidelines.

Anti-fraud provisions

- Expands the definition of workers' compensation fraud to include altering, forging, or creating workers' compensation certificates to falsely show correct coverage, providing false information when that information is needed to determine an employer's actual premium or assessment, and failing to secure or maintain workers' compensation coverage with the intent to defraud the Bureau.

- Prohibits persons, health care providers, managed care organizations, and their owners from obtaining or attempting to obtain by deception payments under the Workers' Compensation Law to which they are not entitled.

- Authorizes monetary penalties and debarment for persons, health care providers, managed care organizations, and their owners for obtaining or attempting to obtain by deception payments under the Workers'

Compensation Law to which they are not entitled and specifies procedures for enforcing these provisions.

Self-insuring employers

- Requires the Administrator to adopt rules permitting the Administrator to assess penalties for failure to timely pay an assessment that incrementally increase the longer the assessment remains unpaid.

Fines and penalties

- Increases the penalty for overdue premium payments from the existing *required* tiered penalty, based on overdue periods, ranging from 2% to a maximum of 12% of the premium due to a *permissive* flat $30 fine plus a tiered penalty beginning at 3% of the premium due for 11 to 30 days past due, and increasing every 30 days thereafter, capped at the prime interest rate plus 10% times the premium due.

Direct deposit of payments under the Workers' Compensation Law

- Expressly permits the Administrator to utilize direct deposit of funds for all disbursements the Workers' Compensation Law authorizes the Administrator to pay, and requires the Administrator to adopt rules regarding utilizing direct deposit.

- Requires the Administrator to notify claimants about the utilization of direct deposit and to furnish debit cards and instructions for use of those cards to claimants.

- Allows the Administrator to enter into contracts with an agent to supply debit cards to claimants to access payments and to enter into contracts with an agent and agreements with financial institutions to credit debit cards with the amounts specified by the Administrator.

- Allows the Administrator to require any payee to provide written authorization designating a financial institution and account number to which a payment may be credited via direct deposit.

Miscellaneous

- Increases a cap on specified attorney's fees from $2,500 to $4,200.

- Allows the Administrator or self-insuring employer, as appropriate, to deduct attorney's fees and necessary expenses from a lump sum payment and pay that amount directly to and solely in the name of the attorney if specified procedures are followed relative to child support orders.

- Removes the requirement that the Administrator publish and report compiled data concerning the measures of outcomes and savings of the qualified health plan system used by self-insuring employers.

- Designates the Bureau of Workers' Compensation Special Investigation Department a criminal justice agency, and allows the Department to apply to access the computerized databases administered by the National Crime Information Center or the Law Enforcement Automated Data System (LEADS) in Ohio and other criminal databases.

- Specifies that the bill's provisions apply to claims arising on and after the bill's effective date and specified pending claims.

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CONTENT AND OPERATION

I. Determination and payment of workers' compensation benefits

Wage loss

Currently, an employee who suffers a wage loss, either as a result of returning to work other than his former position or as a result of being unable to find employment consistent with his physical capabilities, receives compensation on a weekly basis at 66 2/3% of his weekly wage loss for up to 200 weeks; this amount may not exceed the statewide average weekly wage, which was $670.27 in 2003. (Sec. 4123.56(B).)

Under the bill, an employee receives wage loss payments if the employee suffers a wage loss as a result of returning to employment other than the employee's former position due to an injury or occupational disease (commonly referred to as "working wage loss"). The amount of compensation is set at 66 2/3% of the difference between the employee's average weekly wage and the employee's present earnings, and this amount may not exceed the statewide average weekly wage. Further, while the payments may continue for a maximum of 200 weeks, the payments are reduced by the corresponding number of weeks in which the employee receives wage loss payments for participating in a prescribed rehabilitation program.

An employee who suffers a wage loss as a direct result of being unable to find employment consistent with the employee's physical capabilities resulting from the employee's injury or occupational disease (commonly referred to as "nonworking wage loss") receives compensation at 66 2/3% of the difference between the employee's average weekly wage and the employee's present earnings, not to exceed the statewide average weekly wage, for a maximum of 52 weeks. The first 26 weeks of compensation for "nonworking wage loss" is in addition to the maximum of 200 weeks of payments allowed for "working weekly wage loss." Under the bill, if the employee receives compensation for "nonworking wage loss" in excess of 26 weeks, the number of weeks of compensation allowable for "working wage loss" must be reduced by the corresponding number of weeks in excess of 26, and up to 52, that is allowable for "working wage loss."

The bill specifies that an employee may not receive more than 226 weeks of working and nonworking wage loss in the aggregate. (Sec. 4123.56(B).)

Permanent partial disability

Waiting period

Current law authorizes compensation for permanent partial disability compensation based upon a calculation of the percentage of the employee's permanent disability and for scheduled losses for the loss of specified parts of the body. A claimant may file an application for the determination of the percentage of partial disability resulting from a work-related injury or occupational disease 40 weeks after the date of the last payment of TTD compensation or 40 weeks after the date of injury or contraction of the occupational disease in the absence of TTD compensation. The bill shortens this period to 26 weeks after termination of TTD payments. (Sec. 4123.57.)

Finger numbering

Continuing law specifies a schedule of compensation for an employee who loses a finger that is based on which finger the employee lost. The bill revises the numbering of each finger as listed in the table below. The bill does not change the length of time for which compensation is received for each finger. (Sec. 4123.57(B).)

Identification of finger under current law	Identification of finger under the bill
Thumb.	First finger, commonly known as thumb.
First finger, commonly known as index finger.	Second finger, commonly known as index finger.
Second finger.	Third finger.
Third finger.	Fourth finger.
Fourth finger, commonly known as the little finger.	Fifth finger, commonly known as the little finger.

Permanent total disability

Under current law, an employee who qualifies for permanent total disability compensation (PTD) receives an award weekly to continue until his death. The award takes into consideration both the employee's average weekly wage and the statewide average weekly wage. The statewide average weekly wage (SAWW) was $670.27 in 2003. Currently, a PTD award is equal to 66 2/3% of the employee's average weekly wage. However, the award must be no less than 50% of the SAWW ($335.14), and no more than 66 2/3% of the SAWW ($402.32). If

the employee's average weekly wage is less than 50% of the SAWW at the time of the injury, the employee receives an amount equal to the employee's average weekly wage.

The bill specifies that the SAWW used to make this calculation is the SAWW in effect on the date of injury or on the date the disability due to the occupational disease begins. (Sec. 4123.58(A).)

Under current law, the loss or loss of use of both hands or both arms, or both feet or both legs, or both eyes, or of any two thereof, constitutes total and permanent disability.[1] The bill specifies that permanent total disability shall be compensated only when at least one of the following applies to the claimant:

(1) The claimant has lost, or lost the use of both hands or both arms, or both feet or both legs, or both eyes, or of any two thereof; however, the loss or loss of use of one limb does not constitute the loss or loss of use of two body parts;

(2) The impairment resulting from the employee's injury or occupational disease prevents the employee from engaging in sustained remunerative employment utilizing the employment skills that the employee has or may reasonably be expected to develop. (Sec. 4123.58(C).)

The bill further specifies that permanent total disability cannot be compensated when the reason the employee is unable to engage in sustained remunerative employment is due to any of the following reasons, whether individually or in combination:

(1) Impairments of the employee that are not the result of an allowed injury or occupational disease;

(2) Solely the employee's age or aging;

(3) The employee retired or otherwise voluntarily abandoned the workforce for reasons unrelated to the allowed injury or occupational disease;

(4) The employee has not engaged in educational or rehabilitative efforts to enhance the employee's employability, unless such efforts are determined to be in vain. (Sec. 4123.58(D).)

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[1] *In 2002, the Ohio Supreme Court held that the loss of an arm entails the "separate entities of the hand and arm, thus entitling" the claimant to PTD (*State ex rel. Thomas, v. Indus. Comm. of Ohio *(2002), 97 Ohio St.3d 37, 38).*

Traumatic brain injury

The bill specifies that if an employee is awarded compensation for permanent total disability because the employee sustained a traumatic brain injury, the employee is entitled to that compensation regardless of the employee's employment in a sheltered workshop subsequent to the award, on the condition that the employee does not receive income, compensation, or remuneration from that employment in excess of $2,000 in any calendar quarter. As used for purposes of this provision, "sheltered workshop" means a state agency or nonprofit organization established to carry out a program of rehabilitation for handicapped individuals or to provide these individuals with remunerative employment or other occupational rehabilitating activity. (Sec. 4123.58(F).)

Facial or head disfigurement

In case an injury or occupational disease results in serious facial or head disfigurement that either impairs or may in the future impair the opportunities to secure or retain employment, current law requires the Administrator to make an award of compensation as the Administrator deems proper and equitable, in view of the nature of the disfigurement. This award is capped at $5,000 under existing law, and is increased to $10,000 by the bill. (Sec. 4123.57(B).)

Final settlements

Current law permits a state fund employer or its employee to file an application with the Administrator for approval of a final settlement of a claim. The application must include the settlement agreement, reasons for the settlement, and the signatures of the claimant and employer. However, an agreement does not have to be signed by the employer if the employer is no longer doing business in Ohio. (Sec. 4123.65(A).)

The bill permits a claimant to file an application without an employer's signature in the following situations:

(1) The employer is no longer doing business in Ohio;

(2) The claim no longer is in the employer's industrial accident or occupational disease experience as provided in current law and the claimant is no longer employed with that employer;

(3) The employer has failed to comply with current law requirements concerning payment of employer premiums.

If such an application is filed, and the employer still is doing business in Ohio, the Administrator is required to send written notice of the application to the

employer immediately upon receipt of the application. The agreement does not have to contain the employer's signature if the employer fails to respond to the notice within 30 days after receipt. (Sec. 4123.65(A).)

The bill further specifies that if an employee dies during the 30-day period after the approval of a final settlement agreement the settlement can be voided by any party for good cause shown. (Sec. 4123.65(C).)

County prisoners

Continuing law specifies that compensation or benefits are not payable to a claimant during the period of confinement of the claimant in any state or federal correctional institution whether in this or any other state for conviction of violation of any state or federal criminal law. The bill adds that compensation or benefits also are not payable to a claimant while that claimant is confined in any county jail in lieu of incarceration in a state or federal correctional institution. (Sec. 4123.54(I).)

Continuing jurisdiction of the Industrial Commission and Administrator

Currently, the Industrial Commission and the Administrator have continuing jurisdiction over each workers' compensation case, and the Commission may modify or change its former findings and orders. However, no modification, change, finding, or award with respect to a claim may be made regarding disability, compensation, dependency, or benefits after six years from the date of the injury in the absence of the payment of medical benefits, in which case the modification, change, finding, or award must be made within six years after the payment of the medical benefits. In the absence of payment of compensation (as opposed to medical benefits) or wages in lieu of compensation, the modification, change, finding, or award must be made within ten years from the date of the last payment of compensation or the date of the death of the claimant. The bill reduces the time within which the Commission may make a modification, change, finding, or award in the cases described above to five years. (Sec. 4123.52.)

II. Definition of injury

Psychiatric conditions arising from forced sexual conduct

Current law defines "injury," for purposes of determining coverage under the Workers' Compensation Law, to include any injury, whether caused by external accidental means or accidental in character and result, that was received in the course of and arising out of the injured employee's employment. Under existing law, "injury" includes psychiatric conditions that have arisen from an

injury or occupational disease. The bill specifies that this provision applies when the injury or occupational disease has been sustained by the claimant. It also adds that "injury" includes psychiatric conditions where the claimant's psychiatric conditions have arisen from sexual conduct in which the claimant was forced by threat of physical harm to engage or participate. For purposes of this provision, the bill defines "sexual conduct" to mean vaginal intercourse between a male and female; anal intercourse, fellatio, and cunnilingus between persons regardless of gender; and, without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal cavity of another. Penetration, however slight, is sufficient to complete vaginal or anal intercourse. (Sec. 4123.01(C)(1) and (I).)

Substantial aggravation of a pre-existing condition

The bill specifies that a condition that pre-existed an injury is not considered an "injury" for purposes of workers' compensation coverage unless that pre-existing condition is substantially aggravated by the injury. Under the bill, that substantial aggravation must be documented by objective diagnostic findings, objective clinical findings, or objective test results. The bill states that while subjective complaints may be evidence of that substantial aggravation, subjective complaints without objective diagnostic findings, objective clinical findings, or objective test results are insufficient to substantiate a substantial aggravation. If a condition that pre-existed an injury is substantially aggravated by the injury, and that substantial aggravation is documented by objective diagnostic findings, objective clinical findings, or objective test results, the bill specifies that once that condition has returned to a level that would have existed without the injury, no compensation or benefits are payable because of the pre-existing condition. (Secs. 4123.01(C)(4) and 4123.54(G).)

III. Public records

Confidentiality of claimant files; journalist exception concerning addresses and phone numbers

Current law requires all proceedings of the Industrial Commission to be shown on its record, which is a public record (sec. 4121.10). However, also under current law, claimants' files are confidential (sec. 4123.88). A person must receive prior authorization to examine a claimant's file or any file pertaining thereto, and district or staff hearing officers or other Commission or BWC employees must receive authorization to divulge information regarding any claim or appeal, except when divulging information to a member of the Commission or the employee's superior. (Sec. 4123.88(A).) Under the bill, meetings of the Commission are a matter of public record except that all of the provisions discussed in the paragraphs below also apply to that record (sec. 4121.88).

The bill specifies that claimant files are not public records under the Public Records Law (sec. 149.43) and that any information directly or indirectly identifying the address or telephone number of a claimant, regardless of whether the claimant's claim is open or closed, is not a public record. Further, the bill specifies that, except as described in the next paragraph, information kept by the Commission or the BWC concerning claimant files is for the exclusive use and information of the Commission and the BWC in the discharge of their official duties, and are not open to the public and cannot be used in any court in any action or proceeding pending therein, unless the Commission or BWC is a party to the action or proceeding. The information, however, may be tabulated and published by the Commission or BWC in statistical form for the use and information of other state agencies and the public. (Sec. 4123.88(B) and (C).)

Under the bill, upon receiving a written request made and signed by a journalist,[2] the Commission or BWC must disclose to the journalist the address or addresses and telephone number or numbers of claimants, regardless of whether a claim is active or closed, and the dependents of those claimants. A journalist is permitted to request this information for multiple workers or dependents in one written request. A journalist must include all of the following in the written request:

(1) The journalist's name, title, and signature;

(2) The name and title of the journalist's employer;

(3) A statement that the disclosure of the information sought is in the public interest.

The bill prohibits the Commission and BWC to inquire as to the specific public interest served by the disclosure of information requested by a journalist. (Sec. 4123.88(D).)

IV. Compliance with the Workers' Compensation Law

Tax Commissioner

The bill permits the Administrator to furnish to the Tax Commissioner, on a quarterly basis, a list in a format approved by the Tax Commissioner containing

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[2] Journalist means a person engaged in, connected with, or employed by any news medium, including a newspaper, magazine, press association, news agency, or wire service, a radio or television station, or a similar medium, for the purpose of gathering, processing, transmitting, compiling, editing, or disseminating information for the general public (sec. 4123.88(E) and sec. 149.43, not in the bill).

the name and social security number or employer identification number of any employer, and to request that the Tax Commissioner, on a quarterly basis, report the total amount of compensation paid that the employer reported for the employer's annual tax return, for each employer contained on the Administrator's list.

Upon receipt of this list and request, the bill requires the Tax Commissioner to return to the Administrator, in a format designed by the Tax Commissioner, information identifying any employer listed by the Administrator who reported compensation paid to employees on the employer's most recent annual tax return and the total amount of compensation paid reported for the period for which that return is made. (Sec. 4123.271.) The bill specifically adds these disclosures to the list of exceptions from confidentiality requirements of the Tax Law (secs. 5703.21 and 5747.18).

V. Disputes and appeals

Appeals to courts of common pleas

Under continuing law, a claimant or an employer, with limited exceptions, may appeal an order of the Industrial Commission that affirms, modifies, or reverses a decision of a staff hearing officer to the appropriate court of common pleas. The person making the appeal must file a notice of appeal with the appropriate court (sec. 4123.512(A) and (B)). Subsequently, the claimant must file a petition with the court containing a statement of facts showing a cause of action to participate or to continue participating in the state insurance fund and setting forth the basis for the court's jurisdiction. Current law specifies that further pleadings are in accordance with the Ohio Rules of Civil Procedure, except that service of summons on the petition is not required. The bill adds that the claimant may not dismiss the complaint without the employer's consent if the employer is the party that filed the notice of appeal to the court (sec. 4123.512(D)).

Procedures for the resolution of medical disputes

Under continuing law, the Administrator, with the advice and consent of the Oversight Commission, must adopt rules under the Administrative Procedure Act for the Health Care Partnership Program, which BWC administers to provide medical, surgical, nursing, drug, hospital, and rehabilitation services and supplies to an employee for an injury or occupational disease that is compensable under the Workers' Compensation Law. These rules must include a rule establishing procedures for the resolution of medical disputes between an employer and an employee, an employee and a provider, or employer and a provider, prior to an appeal. The bill permits the Administrator, in adopting this rule, to specify that the resolution procedures must not be used to resolve disputes concerning medical

services rendered that have been approved through standard treatment guidelines, pathways, or presumptive authorization guidelines. (Sec. 4121.441(A)(1).)

VI. Anti-fraud provisions

Workers' compensation fraud

Current law prohibits any person, with purpose to defraud or knowing that the person is facilitating a fraud to do any of the following:

(1) Receive workers' compensation benefits to which the person is not entitled;

(2) Make or present or cause to be made or presented a false or misleading statement to secure payment for goods or services rendered under the Workers' Compensation Law;

(3) Alter, falsify, destroy, conceal, or remove any record or document that is necessary to determine the validity of a claim or the nature and validity of goods and services rendered; or

(4) Enter into an agreement or conspiracy to defraud the BWC or a self-insuring employer. (Sec. 2913.48(A)).

The bill expands the types of activities that may be considered workers' compensation fraud to include the following:

(1) Making or presenting or causing to be made or presented a false statement concerning manual codes, classification of employees, payroll, paid compensation or number of personnel when that information is needed to determine an employer's actual workers' compensation premium or assessment;

(2) Altering, forging, or creating a workers' compensation certificate to falsely show current or correct coverage;

(3) Failing to secure or maintain required workers' compensation coverage with the intent to defraud the BWC.

A violation of (1), (3), and (4), above, is a fifth degree felony if the value of the premiums and assessments unpaid is between $500 and $5,000. If the value is from $5,000 to just under $100,000, a violation of this provision is a fourth degree

felony, and a violation is a third degree felony if the value is $100,000 or more.[3] (Sec. 2913.48(B).)

The bill also further expands the definition of "services" for purposes of this workers' compensation fraud provision. Currently, "services" includes service provided by health care providers to claimants for workers' compensation benefits. Under the bill, "services" also includes any and all services provided by the BWC as a part of workers' compensation insurance coverage. (Sec. 2913.48(E)(3).)

Health care providers and managed care organizations

Monetary penalties

The bill prohibits persons, health care providers (HCP), managed care organizations (MCO), and owners[4] of a HCP or MCO from obtaining or attempting to obtain payments by deception[5] under the Workers' Compensation Law to which the person, HCP, MCO, or owner is not entitled under specified rules. In addition to any other penalties provided by law, a person, HCP, MCO, or owner that does so is liable for all of the following penalties:

(1) Payment of interest on the amount of the excess payments at the maximum interest rate allowable for real estate mortgages calculated from the date the payment was made to the person, owner, HCP, or MCO, to the date upon which repayment is made to the Bureau of self-insuring employer;

(2) Payment of an amount equal to three times the amount of excess payments;

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[3] Generally, if a court is required to impose a prison term on an offender, the court must impose a definite prison term as follows: (1) for a first degree felony, a prison term of between 3 to 10 years, (2) for a second degree felony, a prison term of between 2 to 8 years, (3) for a third degree felony, a prison term of between 2 to 5 years, (4) for a fourth degree felony, a prison term of between 6 to 18 months, or (5) for a fifth degree felony, a prison term of between 6 to 12 months (sec. 2929.14, not in the bill). Fines and other sanctions may also be imposed.

[4] The bill defines an "owner" as any person having at least a 5% ownership interest in a HCP or MCO (sec. 4121.444(F)(2)).

[5] The bill defines "deception" as acting with actual knowledge in order to deceive another or cause another or be deceived by (1) a false or misleading representation, (2) withholding of information, (3) preventing another from acquiring information, or (4) any other conduct, act, or omission that creates, confirms, or perpetuates a false impression as to a fact, the law, the value of something, or a person's state of mind. (Sec. 4121.444(F)(1).)

(3) Payment of a sum of not less than $5,000 and not more than $10,000 for each act of deception;

(4) All reasonable and necessary expenses that a court determines have been incurred by the Bureau or self-insuring employer in recovering these payments obtained by deception.

The bill authorizes the Attorney General to bring an action on behalf of the state, and authorizes self-insuring employers to bring actions on their own behalf, within six years after the conduct in violation of these provisions terminates. Further, the Attorney General, with the Administrator's approval, may settle or compromise any action to enforce these provisions.

All moneys collected by the Bureau under this provision are deposited into the State Insurance Fund; any moneys collected by a self-insuring employer are paid to the self-insuring employer. (Sec. 4121.444(A), (B), and (D).)

Debarment

In addition to the above monetary penalties, the bill provides further that the Administrator may terminate any agreement between the Bureau and a person, HCP, or MCO or its owner, and cease reimbursement to the person, HCP, MCO, or owner for services rendered, if the person, HCP, MCO, owner, or an authorized agent, officer, associate, manager, or employee of the person, HCP, or MCO (1) is convicted of or pleads guilty to workers' compensation fraud or to engaging in a pattern of corrupt activity or any other criminal offense related to the delivery of billing for health care benefits, (2) there exists an entry of judgment against such person and proof of the specific intent of that person to defraud in a civil action brought under the bill's fraud provisions, or (3) there exists an entry of judgment against such person in a civil action for engaging in a pattern of corrupt activity. However, the Administrator may not terminate the agreement of or reimbursement to a person, HCP, or MCO if the person, HCP, MCO, or its owner demonstrates that it did not directly or indirectly sanction the action of the authorized agent, associate, manager, or employee that resulted in the conviction, plea of guilty, or entry of judgment for workers' compensation fraud, for engaging in a pattern of corrupt activity, or any other criminal offense related to the delivery of billing for health care benefits.

A person, HCP, or MCO, and its owner, officers, authorized agents, associates, managers, or employees, that had its agreement with and reimbursement from the Bureau terminated by the Administrator is prohibited from:

(1) Directly providing services to any other Bureau provider or having an ownership interest in a provider of services that furnishes services to any other Bureau provider;

(2) Arranging for, rendering, or ordering services for claimants while debarred.

Additionally, the bill specifies that nothing in the provisions described above prohibits an owner, officer, authorized agent, associate, manager, or employee of a person, HCP, or MCO from entering into an agreement with the Bureau if the owner, officer, authorized agent, associate, manager, or employee demonstrates absence of knowledge of the action of the person, HCP, or MCO with which that individual or organization was formerly associated that resulted in a conviction, plea of guilty, or entry of judgment as described above. (Sec. 4121.444(C).)

Remedies for payments to claimants for medical assistance

The bill specifies that the availability of remedies described above, and of the remedies currently available for workers' compensation fraud and for engaging in a pattern of corrupt activity, for recovering benefits paid on behalf of claimants for medical assistance does not limit the Bureau's or a self-insuring employer's authority to recover excess payments to a person, HCP, MCO, or owner under state or federal law (sec. 4121.444(E)).

VII. Self-insuring employers

Penalties for failing to completely or timely report paid compensation and for late assessment payments

Under current law, self-insuring employers are required to certify to the BWC the amount of the self-insuring employer's paid compensation for the previous year. Additionally, self-insuring employers must pay assessments calculated by the Administrator that is based on the paid compensation reported by the self-insuring employer. (Sec. 4123.35(J) and (L).)

The bill requires the Administrator to adopt rules that permit the Administrator to add a $500 late fee penalty to the assessment if an employer fails to pay the assessment when due, plus an additional penalty amount as follows:

(1) For an assessment from 61 to 90 days past due, the prime interest rate, multiplied by the assessment due;

(2) For an assessment from 91 to 120 days past due, the prime interest rate plus 2%, multiplied by the assessment due;

(3) For an assessment from 121 to 150 days past due, the prime interest rate plus 4%, multiplied by the assessment due;

(4) For an assessment from 151 to 180 days past due, the prime interest rate plus 6%, multiplied by the assessment due;

(5) For an assessment from 181 to 210 days past due, the prime interest rate plus 8%, multiplied by the assessment due;

(6) For each additional 30-day period or portion thereof that an assessment remains past due after it has remained past due for more than 210 days, the prime interest rate plus 8%, multiplied by the assessment due.

For the purposes of calculating these penalties, the bill specifies that "prime interest rate" means the average bank prime rate, and specifies that the Administrator must determine the prime interest rate in the same manner as a county auditor determines the average bank prime rate under the Agricultural Districts Law (sec. 929.02, not in the bill). Under that law, county auditors must use statistical release H.15, "selected interest rates," a weekly publication of the Federal Reserve Board, or any successor publication to determine the average bank prime rate. If the statistical release H.15, or its successor, ceases to contain the bank prime rate information or ceases to be published, the county auditor must request a written statement of the average bank prime rate from the Federal Reserve Bank of Cleveland or the Federal Reserve Board.

An employer may appeal a late fee penalty and penalty assessment to the Administrator. (Sec. 4123.35(L).)

Self-insuring employer surplus fund opt-out

The bill permits a self-insuring employer to elect to pay compensation and benefits after adjudication directly to an employee or an employee's dependents by filing an application with the BWC not more than 180 and not less than 90 days before the first day of the employer's next six-month coverage period. If the self-insuring employer timely files the application, the application is effective on the first day of the employer's next six-month coverage period, provided that the Administrator must compute the employer's assessment for the surplus fund due with respect to the period during which that application was filed without regard to the filing of the application. On and after the effective date of the employer's election, the self-insuring employer must pay directly to an employee or to an employee's dependents compensation and benefits regardless of the date of the injury or occupational disease, and the employer receives no money or credits from the surplus fund on account of those payments and is not required to pay any

amounts into the surplus fund based on this election, which election, under the bill, is irrevocable. (Sec. 4123.512(H).)

The bill requires the Administrator to calculate the assessment for the portion of the surplus fund that is used for reimbursement to a self-insuring employer pursuant to the above-described provision in the normal manner, except that the Administrator must calculate the total assessment for this portion of the surplus fund only on the basis of those self-insuring employers that retain participation in reimbursement to the self-insuring employer, and the individual self-insuring employer's proportion of paid compensation must be calculated only for those self-insuring employers who retain participation in reimbursement rather than electing to opt out, as described above. (Sec. 4123.35(J).)

VIII. Fines and penalties for state fund employers

Increase of penalties for failure to pay premiums when due

Current law specifies that the Administrator must adopt a rule providing that when a state fund employer fails to pay the employer's premium when the premium is due, an amount equal to 3% of the premium must be added to the premium. If the failure to pay continues for more than one month, the premium is increased further in an amount equal to 2% of the premium for each additional month or part thereof, but the total of all additional amounts cannot exceed 12% of the premium.

The bill increases the amount of these penalties that the Administrator must adopt by rule. If the premium is late, under the bill, the Administrator may add a $30 late fee penalty to the employer's premium, plus an additional penalty amount calculated as follows:

(1) For a premium from 11 to 30 days past due, 3% of the premium due;

(2) For a premium from 31 to 60 days past due, the prime interest rate multiplied by the premium due;

(3) For a premium from 61 to 90 days past due, the prime interest rate plus 2%, multiplied by the premium due;

(4) For a premium from 91 to 120 days past due, the prime interest rate plus 4%, multiplied by the premium due;

(5) For a premium from 121 to 150 days past due, the prime interest rate plus 6%, multiplied by the premium due;

(6) For a premium from 151 to 180 days past due, the prime interest rate plus 8%, multiplied by the premium due;

(7) For a premium from 181 to 210 days past due, the prime interest rate plus 10%, multiplied by the premium due;

(8) For each additional 30-day period or portion thereof that a premium remains past due after it has remained past due for more than 210 days, the prime interest rate plus 10%, multiplied by the premium due.

For the purposes of calculating these penalties, the "prime interest rate" is determined in the same manner as is described for penalties assessed against self-insuring employers.

The bill permits an employer to appeal a late fee penalty or additional penalty to an adjudicating committee appointed by the Administrator. (Sec. 4123.32(E)(2) and (3).)

Under continuing law unchanged by the bill, these penalties paid by the employer are credited to the employer's account for rating purposes. Also under continuing law, the employer is not in default if the employer files an appropriate payroll report, within the time provided by law or within the time specified by the Administrator if the period for which the employer paid an estimated premium is less than eight months. If the employer pays the premiums within 15 days after being first notified by the Administrator of the amount due the penalties do not apply. (Sec. 4123.32(E).)

IX. Miscellaneous

Attorney's fees and expenses deducted from child support orders

Relative to child support orders, current law contains a requirement that, no later than the earlier of 45 days before a lump sum payment is to be made or, if the obligor's right to the lump sum payment is determined less than 45 days before it is to be made, the date on which that determination is made, the payor must notify the child support enforcement agency administering the support order of any lump sum payment of any kind of $150 or more that is to be paid to the obligor, hold each lump sum payment of $150 or more for 30 days after the date on which it would otherwise be paid to the obligor and, on order of the court or agency that issued the support order, pay all or a specified amount of the lump sum payment to the Office of Child Support in the Department of Job and Family Services (sec. 3121.037(A)(10)).

The bill specifies, however, that if a lump sum payment consists of workers' compensation benefits and the obligor is represented by an attorney with respect to

the obligor's workers' compensation claim, prior to issuing the required notice to the child support enforcement agency, the Administrator, for claims involving state fund employers, or a self-insuring employer, for that employer's claims, must notify the obligor and the obligor's attorney in writing that the obligor is subject to a support order and that the Administrator or self-insuring employer, as appropriate, must hold the lump sum payment for a period of 30 days after the Administrator or self-insuring employer sends this written notice, pending receipt of the information described below. (Sec. 3121.0311(A).)

The Administrator or self-insuring employer, as appropriate, must instruct the obligor's attorney in writing to file a copy of the fee agreement signed by the obligor, along with an affidavit signed by the attorney setting forth the amount of the attorney's fee with respect to the lump sum payment award to the obligor and the amount of all necessary expenses, along with documentation of those expenses, incurred by the attorney with respect to obtaining the lump sum award. The obligor's attorney must file the fee agreement and attorney affidavit with the Administrator or self-insuring employer, as appropriate, within 30 days after the date the Administrator or self-insuring employer sends the notice described above. (Sec. 3121.0311(B).)

Upon receipt of the fee agreement and attorney affidavit, the Administrator or self-insuring employer, must deduct from the lump sum payment the amount of the attorney's fee and necessary expenses and pay that amount directly to and solely in the name of the attorney within 14 days after the fee agreement and attorney affidavit have been filed with the Administrator or self-insuring employer.[6] (Sec. 3121.0311(C).)

After deducting any attorney's fee and necessary expenses, if the lump sum payment is $150 or more, the Administrator or self-insuring employer, as appropriate, must hold the balance of the lump sum award in accordance with the normal notification, holding, and payment requirements described above. (Sec. 3121.0311(D).)

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[6] *Under current law, a withholding or deduction for child support has priority over any order of attachment, any order in aid of execution, and any other legal process issued under state law against the same earnings, payments, or account (sec. 4123.034). However, in* Rowan v. Rowan *(1995) 72 Ohio St.3d 586, an attorney sued to intervene in the court's attempt to use a lump sum workers compensation settlement for child support because he had a contingent fee arrangement. The trial court deducted that fee from the lump sum payment, and that decision was upheld. The court specifically said that it did not offend the priority provision.*

Attorney's fee cap

Under current law, the cost of any legal proceedings for appealing a claim, including an attorney's fee to the claimant's attorney to be fixed by the trial judge, based upon the effort expended, in the event the claimant's right to participate or to continue to participate in the fund is established upon the final determination of an appeal, is taxed against the employer or the Industrial Commission if the Commission or the Administrator rather than the employer contested the right of the claimant to participate in the fund. Existing law caps the attorney's fee at $2,500, and the bill increases this cap to $4,200. (Sec. 4123.512(F).)

Payment by electronic transfer of funds

Under current law, a public official may make a direct deposit of funds by electronic transfer for any payment the official is permitted or required to make by issuing a check or warrant if the payee provides written authorization designating a financial institution and account number to credit the payment. Under the bill, the Administrator may *require* any payee to provide a written authorization designating a financial institution and an account number to which a payment made by direct deposit is to be credited. (Secs. 4123.311(A)(2) and 9.37, not in the bill.)

The bill requires the Administrator to inform claimants about the Administrator's utilization of direct deposit of funds by electronic transfer, furnish debit cards to claimants as appropriate, and provide claimants with instructions regarding use of those debit cards. The Administrator, with the advice and consent of the Oversight Commission, must adopt rules in accordance with the Administrative Procedure Act regarding utilization of the direct deposit of funds by electronic transfer. (Sec. 4123.311(B) and (C).)

The bill permits the Administrator to contract with an agent to supply debit cards for claimants to access payments made to them pursuant to the Workers' Compensation Law and credit those cards via electronic transfer with amounts the Administrator specifies. Current law allows a public official to contract with a financial institution for the services necessary to make direct deposits. The bill more specifically allows the Administrator to enter into agreements with financial institutions to credit debit cards with amounts specified by the Administrator by utilizing direct deposit of funds by electronic transfer. (Sec. 4123.311(A)(3) and (4).)

Qualified health care plan system reporting

Current law requires the Administrator to establish and operate a BWC Health Care Data Program. As part of this Program, the Administrator must

publish and report compiled data to the Governor, the Speaker of the House of Representatives, and the President of the Senate on January 1 and July 1 each year, reporting the measures of outcomes and savings of both the Health Partnership Program and the Qualified Health Plan System. The bill removes the requirement that the report contain the measures and savings of the Qualified Health Plan System. (Sec. 4121.44(H).)

Designation of BWC's Special Investigation Department as a criminal justice agency

BWC's Special Investigation Department deals with the prevention, detection, investigation, and prosecution of workers' compensation fraud. Under the bill the Department is a criminal justice agency in investigating reported violations of law relating to workers' compensation, and as such may apply for access to the computerized databases administered by the National Crime Information Center or the Law Enforcement Automated Data System (LEADS)[7] in Ohio and to other computerized databases administered for the purpose of making criminal justice information accessible to state and criminal justice agencies. (Sec. 4121.131.)

Applicability of bill's provisions

The bill specifies that the bill's provisions apply only to claims arising on and after the bill's effective date, except that the provisions explained above concerning a self-insuring employer's ability to elect to opt out of receiving reimbursements from the surplus fund also applies with respect to claims relative to that election that are pending on the effective date of this act. (Section 3.)

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	01-24-05	p. 60
Reported, S. Insurance, Commerce, & Labor	---	---

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[7] *LEADS is administered by the Superintendent of the State Highway Patrol, who must adopt rules establishing fees and guidelines for the operation of and participation in the LEADS program, which include criteria for granting and restricting access to information maintained in LEADS (sec. 5503.10, not in the bill).*