# Ohio Legislative Service Commission

## Final Analysis

Kelly Bomba

# Am. Sub. H.B. 52

131st General Assembly

(As Passed by the General Assembly)

*(For details of fiscal provisions of the act, see the LSC Budget in Detail, As Enacted (with FY 2015 Actual Expenditures); the LSC Comparison Document, As Enacted; and the LSC Greenbook, all of which are available online at www.lsc.ohio.gov/fiscal/bwc-oic-131/bwc-oic-131.htm)*

**Reps.** Hackett, Amstutz, Anielski, Baker, Barnes, Bishoff, Blessing, Boose, Boyd, Brown, Buchy, Burkley, Conditt, Cupp, Derickson, Dever, Dovilla, Duffey, Grossman, Henne, Kraus, McClain, S. O'Brien, Perales, Reineke, Retherford, Romanchuk, Schaffer, Sears, R. Smith, Sprague, Terhar, Thompson, Rosenberger

**Sens.** Manning, Bacon, Hottinger, Uecker, Patton

**Effective date:** June 30, 2015; certain provisions effective September 29, 2015; certain provisions effective other than those dates

## ACT SUMMARY

### Coverage and benefits

- Exempts volunteer corporate officers who work for a nonprofit corporation from coverage under Ohio's Workers' Compensation Law and prohibits these officers from electing coverage under the Law.

- Requires individuals who under continuing law may elect to be covered under the Law to make that election in accordance with rules adopted by the Administrator of Workers' Compensation with the advice and consent of the Bureau of Workers' Compensation (BWC) Board of Directors.

- Allows for a mentally or physically incapacitated dependent to continue receiving workers' compensation death benefits while employed in a sheltered workshop if the dependent earns $2,000 or less in a calendar quarter.

- Allows temporary total disability compensation to be paid without an offset for supplemental sick leave benefits provided by an employer if the employer and employee mutually agree in writing.

## Self-insuring employers

- Allows a self-insuring employer to furnish rehabilitation services directly to injured employees without prior approval from BWC.

- Requires a self-insuring employer to furnish or pay directly for various compensation and benefits that, under prior law, were allowed to be temporarily paid for from the Surplus Fund Account.

## Notice on appeal

- Adds to the notice that the Administrator must provide to an employer, upon appeal of an Industrial Commission order, that the results of the appeal may result in a recovery against an employer who is a noncomplying employer.

## Health Partnership Program appeals

- Requires appeals of BWC decisions regarding participation in the Health Partnership Program to be filed in the Franklin County Court of Common Pleas.

## Adjudicating Committee appeals

- Allows an employer to request the Administrator to waive a hearing on an employer's appeal of an adverse adjudicating committee decision.

- Requires the Administrator to decide whether to grant or deny a request to waive a hearing.

## Administration

- Changes recommendation and reporting requirements of the Workers' Compensation Audit Committee and the Workers' Compensation Actuarial Committee.

- Allows the Administrator, with the Board's advice and consent, to employ occupational safety and health professionals and support staff in the Division of Safety and Hygiene.

- Allows the Administrator to designate more than six positions in the unclassified civil service in the Division if continuing law requirements for those designations are satisfied.

- Removes the requirement that the Administrator make those civil service designations only with the Board's advice and consent.

## Additional changes

- Allows the Administrator to transfer investment earnings to fund the Disabled Workers' Relief Fund for claims occurring before January 1, 1987, rather than assessing private and public taxing district employers.

- Eliminates the Long-term Care Loan Fund Program and Fund.

- Requires the Administrator to study BWC operations and issue a report detailing how BWC's aggregate appropriations for fiscal years 2016 and 2017 may be reduced by 5%.

## Health services cost estimates

- Requires medical services providers to provide, beginning in 2017, a good-faith estimate of specified charges for all nonemergency services.

- Establishes, under the Office of Health Transformation, the Health Services Price Disclosure Study Committee and requires the Committee to study the impact and feasibility of requiring health services providers to provide cost estimates and produce a related report and separate recommendations.

- Requires the Medicaid Director to adopt rules to carry out this requirement.

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## CONTENT AND OPERATION

### Coverage and benefits

#### Volunteer corporate officers and coverage

(R.C. 4123.01(A))

Under the act, a volunteer corporate officer who works for a nonprofit corporation is not considered an "employee" for purposes of the Workers' Compensation Law. As a result, a nonprofit corporation (the "employer") is not required to obtain workers' compensation coverage for these individuals. Further, the act prohibits a nonprofit corporation and a volunteer corporate officer from electing coverage under the Law.

Under continuing law, the following individuals are not considered "employees" for purposes of the Workers' Compensation Law, but an employer may elect to cover these individuals: (1) a church minister in the exercise of ministry, (2) an officer of a family farm corporation, (3) an individual incorporated as a corporation, and (4) an employee of an employer who the Administrator of Workers' Compensation exempts from coverage requirements due to the employer's religious objection to insurance coverage. An employer who is a partnership or sole proprietorship also may elect to cover members of the partnership or the owner of the sole proprietorship.

The act continues these provisions but requires an employer who is electing to cover the above individuals to make the election in accordance with rules adopted by the Administrator with the advice and consent of the Bureau of Workers' Compensation (BWC) Board of Directors (Board). The act prohibits an individual from receiving benefits or compensation until BWC receives the election, rather than prohibiting an individual electing coverage from receiving coverage until BWC received notice of the election as under former law.

#### Death benefit eligibility

(R.C. 4123.59)

Under continuing law, a dependent of an employee who is killed as a result of an occupational disease or injury is eligible to receive death benefits until certain conditions are met. For a dependent who is mentally or physically incapacitated from having any earnings, death benefits continue until the individual is no longer so incapacitated. The act allows for such a dependent to continue receiving death benefits, even though the dependent is employed in a sheltered workshop, as long as the

dependent does not receive income, compensation, or remuneration from that employment in excess of $2,000 in any calendar quarter.

### Sick leave and temporary total disability compensation

(R.C. 4123.56)

Continuing law requires the amount of an employee's temporary total disability compensation (TTD) award to be offset by certain benefits the employee simultaneously receives. The act creates an exception to this requirement, allowing TTD to be paid without an offset for supplemental sick leave benefits provided by an employer if the employer and employee mutually agree in writing.

Continuing law requires TTD to be offset by payments paid for the same period or periods from either of the following sources:

- Temporary nonoccupational accident and sickness insurance paid pursuant to an insurance policy or program to which the employer has made the entire contribution or payment for providing insurance;
- A nonoccupational accident and sickness program fully funded by the employer.

## Self-insuring employers

### Rehabilitation services living maintenance and wage loss

(R.C. 4121.61, 4121.65, 4121.66, 4121.67, 4121.68, 4123.34, and 4123.35, with a conforming change in R.C. 4123.56)

Continuing law requires the Administrator to pay the expense of providing rehabilitation services, training, counseling, and living maintenance payments (payments to make up wage differentials when an employee returns to work) from the Surplus Fund Account within the State Insurance Fund.

The act requires a self-insuring employer to pay these expenses directly and eliminates a self-insuring employer's ability to have these expenses paid for from the Surplus Fund Account. With that, under the act, a self-insuring employer is no longer required to reimburse that account. The act also eliminates the former law requirement that a self-insuring employer obtain approval from the Administrator to pay these expenses directly. Under continuing law, the rehabilitation services furnished by a self-insuring employer must be of equal or greater quality and content as those provided by BWC.

Under continuing law, if an employee is injured, contracts an occupational disease, or dies in the course of and arising out of participation in a rehabilitation program, the employee or the employee's dependents may receive compensation and benefits under the Workers' Compensation Law. These payments are paid from the Surplus Fund Account. Under the act, a self-insuring employer must pay the compensation and benefits directly as part of the claim.

### Handicap Reimbursement Program

(R.C. 4123.34, 4123.343, and 4123.35)

The act also requires a self-insuring employer to furnish or pay directly for all compensation, benefits, or services due to an employee for an injury, occupational disease, or death caused by the employee's preexisting mental or physical handicap, rather than allowing that employer to participate in the Handicap Reimbursement Program.

Under former law, a self-insuring employer could elect to participate in the Handicap Reimbursement Program. Under that Program, a portion of the compensation or benefits payable for a claim involving an employee with a preexisting handicap may be charged to or reimbursed from the Surplus Fund Account. The Administrator must apportion the amount to be charged or reimbursed based on the percentage of the injury attributable to the preexisting mental or physical handicap. But with respect to claims under the Handicap Reimbursement Program involving a self-insuring employer, the Administrator was required to recoup payments from the Surplus Fund Account through assessments on the self-insuring employer participating in the Program based on the employer's proportion of paid compensation (payments made under the Workers' Compensation Law other than for medical benefits).

### Technical change

(R.C. 4123.351)

The act corrects an erroneous cross-reference.

## Notice to employer of appellate obligations

(R.C. 4123.512)

Under continuing law, if an Industrial Commission decision (or, in lieu of the Industrial Commission, a designated staff hearing officer decision) is appealed to a court, the Administrator must notify the employer involved in the claim that if the employer fails to become an active party to the appeal, the Administrator may act on the employer's behalf and the results of the appeal could have an adverse effect on the

employer's premium rates. Under the act, the Administrator also must inform the employer that the results of the appeal may result in a recovery from the employer if the employer is determined to be a noncomplying employer under continuing law.

## Health Partnership Program appeals

(R.C. 119.12)

The act requires appeals from BWC decisions regarding participation in the Health Partnership Program (HPP) to be filed in the Franklin County Court of Common Pleas. Under former law, those appeals generally were filed in the court of common pleas of the county in which the place of business of the provider or managed care organization was located or the provider was a resident. An administrative rule also required that a copy of such an appeal be filed in the Franklin County Court of Common Pleas.

## Appeals from adjudicating committee decisions

(R.C. 4123.291)

Under continuing law, an adjudicating committee appointed by the Administrator hears an employer's request, protest, or petition concerning certain premium-related matters. An employer may appeal an adverse decision of an adjudicating committee. Continuing law requires that the Administrator or the Administrator's designee hold a hearing on an employer's appeal. However, the act allows the employer to request, in writing, that the Administrator waive the hearing. The act requires the Administrator to decide whether to grant or deny a request to waive a hearing.

## Administration

### Workers' Compensation Audit and Actuarial Committees

(R.C. 4121.129; R.C. 4123.47, not in the act)

The act requires the Workers' Compensation Audit Committee to recommend to the Board an accounting firm to perform the Auditor of State's annual audit of the Safety and Hygiene Fund and the administration of the Workers' Compensation Law. Under continuing law, this audit must be conducted by the Auditor of State and must include audits of all fiscal activities, claims processing and handling, and employer premium collections.

The act eliminates a requirement that the Audit Committee recommend to the Board an actuarial firm to perform the required annual actuarial analysis of the workers' compensation funds.

The act also requires the Workers' Compensation Actuarial Committee to review and approve the various rate schedules prepared and presented by the BWC Actuarial Division or by actuarial consultants who contract with the Board. Under former law, the Actuarial Committee was required to review calculations on rate schedules and performance, but only those prepared by contracted actuarial consultants.

### Division of Safety and Hygiene employees

(R.C. 4121.37)

The act allows the Administrator, with the Board's advice and consent, to employ occupational safety and health professionals and support staff in the Division of Safety and Hygiene within BWC and eliminates references to employing investigators, clerks, and stenographers in the Division.

The act allows the Administrator to designate an unlimited number of Division positions in the unclassified civil service if continuing law requirements for those designations are satisfied. Former law limited the Administrator to six designations. The act also removes the requirement that the Administrator make these designations only with the Board's advice and consent. Under continuing law, positions designated in the unclassified civil service must be primarily and distinctively administrative, managerial, or professional in character. All other employees are in the classified service.

## DWRF assessments and alternative funding

(R.C. 4123.411 and 4123.419)

Under former law, the Administrator, with the Board's advice and consent, annually levied assessments against all employers to carry out the purposes of the Disabled Workers' Relief Fund (DWRF). DWRF is a fund that is used to make essentially cost-of-living payments to recipients of permanent and total disability compensation. DWRF consists of two accounts: one for claims occurring before January 1, 1987, and one for claims occurring on or after that date.

With respect to claims occurring before 1987, the act allows the Administrator to decide whether to levy assessments on employers for amounts necessary to sustain DWRF for those claims. Rather than levying these assessments, the act allows the Administrator, with the Board's advice and consent, to transfer amounts to DWRF from

investment earnings of the Surplus or Reserve accounts in the State Insurance Fund in amounts necessary to cover DWRF claims involving private and public taxing district employers (public employers other than the state as an employer). The act does not allow for these transfers to cover DWRF claims involving the state as an employer.

The act also eliminates a requirement that the Administrator make transfers from DWRF to the General Revenue Fund to reimburse the General Revenue Fund for moneys appropriated for disabled worker relief. These transfers were no longer being made.

## Long-term Care Loan Fund Program

(R.C. 4121.48 (repealed) and 4121.37)

The act eliminates the Long-term Care Loan Fund Program and Fund operated by the Administrator. The Program allowed the Administrator to make interest-free loans to nursing homes or hospitals so that they could purchase, improve, install, or erect, sit-to-stand floor lifts, ceiling lifts, other lifts, and fast electric beds and to pay for the education and training of personnel to implement a facility policy of no manual lifting of residents by employees.

The Fund was funded through transfers from the Safety and Hygiene Fund.

## Cost reduction study

(Section 6)

The act requires the Administrator to study BWC's operations and create a report detailing how BWC's aggregate appropriations over fiscal years 2016 and 2017 may be reduced by 5%. The Administrator must submit this report to the Speaker of the House of Representatives and the President of the Senate not later than December 29, 2015.

## Health services cost estimates

(R.C. 5162.80; Sections 7 and 11)

The act requires, beginning in 2017, a medical services provider to provide in writing, before products, services, or procedures are provided, a reasonable, good-faith estimate of all of the following for the provider's nonemergency products, services, or procedures:

- The amount the provider will charge the patient or the consumer's health plan issuer for the product, service, or procedure;

- The amount the health plan issuer intends to pay for the product, service, or procedure;

- The difference, if any, that the consumer or other party responsible for the consumer's care would be required to pay to the provider for the product, service, or procedure.

The act requires any health plan issuer contacted by a provider for the purpose of obtaining information so that the provider can comply with the act's requirement described above to provide the information to the provider within a reasonable time of the provider's request.

The act requires the Medicaid Director to adopt rules for the implementation of the act's requirements related to health services cost estimates, based on the Committee's recommendations (see "**Health Services Price Disclosure Study Committee**," below), not later than July 1, 2016. The act requires those rules address both of the following:

- How a cost estimate is to be provided to a consumer;

- The definition of "emergency products, services, or procedures."

A "health plan issuer" means an entity that is subject to Ohio insurance laws and rules or to the jurisdiction of the Superintendent of Insurance and that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a managed care organization under contract with the Department of Medicaid, and, if the services are to be provided on a fee-for-service basis, the Medicaid Program. A medical services provider is a person who is licensed, accredited, or certified under any of the following laws:

- Nursing Home and Residential Care Facilities Law;

- Hospital Law;

- Dentists and Dental Hygienists Law;

- Optometrists and Optical Dispensers Law;

- Physicians and Limited Practitioners Law;

- Psychologists Law;

- Chiropractors Law;

- Hearing Aid Dealers Law;
- Speech-Language Pathologists and Audiologists Law;
- Occupational Therapists, Physical Therapists, and Athletic Trainers Law;
- Counselors, Social Workers, and Marriage and Family Therapists Law;
- Orthotists, Prosthetists, and Pedorthists Law.

### Health Services Price Disclosure Study Committee

The act creates, under the Office of Health Transformation, the Health Services Price Disclosure Study Committee to study the impact and feasibility of carrying out the act's requirements relating to health services cost estimates described above. The Committee consists of interested parties and legislators.

The Committee must make a report of its findings and deliver the report to the Governor, the President and Minority Leader of the Senate, and the Speaker and Minority Leader of the House of Representatives not later than December 31, 2015. The act also requires the Committee to submit a separate report to those individuals that contains the following recommendations:

- A recommendation on how health plan issuers can provide comparison prices from the providers to their own enrollees for comparison purposes.
- Recommendations on required cost information disclosure for health plans offered through the health care exchange for consumer comparison purposes.

## HISTORY

| ACTION | DATE |
|---|---|
| Introduced | 02-10-15 |
| Reported, H. Insurance | 03-10-15 |
| Re-referred to H. Finance | 03-10-15 |
| Re-reported, H. Finance | 03-11-15 |
| Passed House (96-0) | 03-11-15 |
| Reported, S. Transportation, Commerce & Labor | 06-17-15 |
| Passed Senate (32-0) | 06-25-15 |
| Motion to reconsider (31-0) | 06-25-15 |
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| House concurred in Senate amendments (95-0) | 06-26-15 |

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