# Ohio Legislative Service Commission

**Bill Analysis**

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## H.B. 511

131st General Assembly
(As Introduced)

**Reps.** Kuhns and Boyd, Sykes, G. Johnson, Ramos, Antonio, Lepore-Hagan, Clyde, Boggs, Boyce, Phillips, Cera, Ashford, Patterson, Rogers, Sheehy, M. O'Brien, Celebrezze, Craig, K. Smith, Bishoff, Driehaus, Curtin, Leland, Sweeney, Fedor, Boccieri, Slesnick, Reece, S. O'Brien, Howse, Strahorn

## BILL SUMMARY

### Family and Medical Leave Insurance Program

- Creates the Family and Medical Leave Insurance Program to provide 12 weeks of family and medical leave insurance benefits during a 12-month period to an individual to address the individual's serious health condition, to care for a family member, or to bond with a new child.

- Requires the Director of Job and Family Services to conduct an actuarial evaluation before establishing the Program.

- Requires an employer to deduct and withhold premiums from an employee's wages and to remit those premiums to the Director under the Program.

- Establishes a criminal penalty for whoever fails to remit premiums withheld from an employee's wages.

- Permits an employer to elect to pay contributions to the Program on behalf of an employee.

- Allows an independent contractor to elect coverage and withdraw from coverage under the Program.

- Allows an employee whose employer offers greater leave than that under the federal Family and Medical Leave Act to opt out of participating in the Program.

- Requires an employer to comply with a collective bargaining agreement or employer policy providing employees with greater benefits than those under the Program.

- Requires an employee to take leave under the Program concurrently with leave taken under the federal Family and Medical Leave Act.
- Requires an employer to restore an individual returning from a period of leave to the individual's position before taking leave or to an equivalent position.
- Specifies that benefits are not subject to state income tax to the extent they are subject to federal income tax.
- Allows an individual whose claim for benefits is denied to appeal the decision to the Director.
- Prohibits an individual from receiving benefits for one year after the individual commits fraud in connection with a claim for benefits.
- Allows the Director to seek repayment of overpayments made to an individual.
- Prohibits an employer from taking an adverse employment action against an employee for participating in the Program.
- Permits the Director to assess a civil penalty against an employer who takes an adverse employment action against an employee as described above.
- Permits an employee to sue an employer for taking an adverse employment action against the employee as described above.
- Requires the Director to develop and implement an outreach program to educate the public about the Program.
- Requires the Director to submit a report regarding the Program to the General Assembly.
- Requires the Director to adopt rules for Program administration and enforcement.

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# CONTENT AND OPERATION

## Family and Medical Leave Insurance Program

The bill creates the Family and Medical Leave Insurance Program to be administered and enforced by the Director of Job and Family Services (Director). Under the Program, beginning July 1, 2020, an individual may receive family and medical leave insurance benefits for any of the following reasons:

- The individual has a serious health condition that makes the individual unable to perform the functions of one or more of the individual's jobs.
- The individual is caring for a new child during the first year after the birth or adoption of the child or the placement of the child through foster care.
- The individual is caring for a family member who has a serious health condition.
- The individual is taking any other leave from work authorized by the federal Family and Medical Leave Act.

For purposes of the bill, a "serious health condition" is an illness, injury, impairment, or physical or mental condition that involves:

- Inpatient care in a hospital, hospice, or residential health care facility; or

- Continuing treatment or continuing supervision by a health care professional.[1]

## Actuarial evaluation

The bill requires the Director, not later than July 1, 2017, to conduct an actuarial evaluation before establishing the Program (see **COMMENT** 1). The actuarial evaluation must determine the following information:

- The premium amounts necessary to sufficiently fund the Program;
- The balance necessary to ensure the actuarial soundness of the Family and Medical Leave Insurance Fund created in the bill;
- The administrative and technology costs necessary to establish and operate the Program.

However, the bill prohibits the Director from performing the actuarial evaluation unless the Director receives sufficient funding to do so. The Director may apply for and accept gifts, grants, donations, and any available federal funding to conduct the evaluation. Any funding the Director receives from these sources must be deposited into the Family and Medical Leave Insurance Fund created by the bill.[2]

## Funding

The Director may apply for and accept gifts, grants, donations, and other federal funding to pay for the costs to establish the Program and must transmit any funding from those sources to the Treasurer of State to be deposited into the Family and Medical Leave Insurance Fund. The Fund is a custodial fund (and thus is not subject to appropriations) created on the bill's effective date. The Treasurer of State has investment authority for the Fund, and interest on investment is credited to the Fund.

If the Director does not receive sufficient funds from the above sources to cover the costs to establish the Program, the Director may request an appropriation to cover those costs.[3]

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[1] R.C. 4143.01(O), 4143.02, and 4143.03(A); Section 3.

[2] Section 6.

[3] R.C. 4143.10(A) and (F); Section 3.

### Premiums

Once the Program is established, benefits are paid by assessing premiums on employees. Under the bill, beginning July 1, 2019, every employer is required to deduct and withhold premiums from an employee's wages (see **COMMENT** 2). An employer is not required to deduct and withhold premiums if the employer opts to pay contributions on behalf of an employee (see "**Contributions**," below), or the employee elects to opt out of participating in the Program (see "**Election to opt out**," below).

The Director must adopt rules to do all of the following regarding premiums:

- Establish a sliding scale for determining the amount of the premium each employee must contribute under the Program and the maximum amount an employee must pay annually;
- Establish procedures to adjust the amount of premiums each year to ensure the Fund's actuarial soundness;
- Establish the manner and schedule for employers to remit premiums to the Director.

The premiums are deducted and withheld from the employee's wages each time the employee is paid. An employee must provide the employee's employer with sufficient and correct information to enable the employer to deduct and withhold premiums, and to update the information as necessary. If an employee does not provide or update this information, the employer is not required to withhold or remit the premium and is not liable for failing to do so.

An employee is liable for premiums to the Program if an employer fails to withhold those premiums, unless the employer paid contributions to the Program on behalf of the employee (see "**Contributions**," below). An employee also is liable if the employer fails to remit a premium and the Director determines that the employee and employer colluded in that failure. If a premium is paid after the employer fails to deduct and withhold the payment, the premium cannot be collected from the employer; however, the employer is liable for any penalties for failing to deduct and withhold the premium.[4]

Whoever recklessly fails to remit the premiums withheld from an employee's wages is guilty of a fifth degree felony, which is punishable by:

- A prison term of 6 to 12 months,

[4] R.C. 4143.02(A) and 4143.10(B), (C), and (D); Section 4.

- A maximum $2,500 fine, and
- Other possible sanctions.[5]

### Contributions

The bill gives an employer the option of paying contributions to the Program on behalf of an employee. An employer that opts to pay contributions must begin making payments on July 1, 2019. The employer must follow the procedures prescribed by the Director in rules adopted under the bill to make those contributions. An employee is liable for the amount of the premium that would otherwise be due to the Program if the employer elects to pay contributions and fails to make those contributions to the Program.[6]

## Eligibility for benefits

Under the bill, an individual is eligible to receive family and medical leave benefits under the Program if the individual does all of the following:

- Files a claim for benefits;
- Consents to the release of certain confidential information;
- Demonstrates that the individual has been employed and worked for at least 680 hours during the individual's base period;
- Demonstrates that the individual's employer has withheld and remitted premiums or made contributions to the Program for at least one year;
- Attests in the claim that the individual has notified the individual's employer in writing of the intent to take leave for one of the reasons permitted under the Program.

An individual's "base period" is the first four of the last five completed calendar quarters immediately preceding the first day of an individual's 12-month period. For example, if an individual's 12-month period began on April 1, 2016, the individual's base period would consist of quarters 1, 2, and 3 of 2015, and quarter 4 of 2014. Quarter 4 of 2015 would be the last completed of the five preceding calendar quarters, and as such, would not be included in the base period.

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[5] R.C. 4143.99; R.C. 2929.24 to 2929.28, not in the bill.

[6] R.C. 4143.10(B) and (C) and 4143.02(A); Section 4.

If an individual does not have sufficient qualifying weeks and wages in the base period to be eligible for benefits, the individual's base period becomes the four most recently completed calendar quarters preceding the first day of the individual's 12-month period, the "alternate base period."

An individual filing a claim also must provide:

1. An attestation that the individual is not receiving workers' compensation or unemployment benefits in an amount that would exceed the individual's wages when combined with benefits available under the Program, and

2. A certification from a health care professional that the individual or the individual's family member has a serious health condition.

An eligible individual may receive benefits under the Program regardless of whether the individual is employed or is working at a different job while taking leave.

Within five business days after an individual has filed a claim, the Director must notify (1) the individual's employer that the individual has filed a claim, and (2) the individual that the premiums or contributions due under the Program have not been paid as required.[7]

### Actions that will not invalidate a claim

Under the bill, an individual's claim for benefits or eligibility to receive benefits under the Program cannot be invalidated because the individual failed to take any of the following actions:

- File a claim for benefits;
- Furnish notice to the individual's employer of the intent to take leave;
- Submit an attestation that the individual is not receiving workers' compensation or unemployment benefits as described above;
- Submit a certification that the individual or the individual's family member has a serious health condition.[8]

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[7] R.C. 4143.03(B) to (D), 4143.01(B), and 4143.02.

[8] R.C. 4143.03(E).

However, an individual may not receive benefits beyond two weeks until the individual takes at least one of these actions (see "**Waiting week and benefit amounts**," below).

### Independent contractors

An independent contractor may elect coverage under the Program by filing a notice of election of coverage in writing with the Director. The initial period of coverage is for a minimum of three years. The election is effective on the date the notice is filed. An independent contractor may elect to continue coverage for a minimum period of one year immediately following another period of coverage by filing an election of coverage, as described above, at least 30 days before the prior election period expires. An independent contractor may withdraw from coverage by filing a written notice with the Director within 30 days before the end of a period of coverage or during a period designated by the Director in rule. The withdrawal is effective 30 days after the notice is filed.[9]

### Election to opt out

An employee who is covered by an employer policy or collective bargaining agreement that provides the employee with greater leave than that provided by the federal Family and Medical Leave Act (see "**Collective bargaining**," below) may elect not to participate in the Program.

An employee who elects to opt out of participating in the Program is not liable for any premium or contribution that would otherwise be due under the Program.[10]

## Waiting week and benefit amounts

Under the bill, an eligible individual must serve a seven-day waiting period before the individual can receive the individual's first payment of benefits. This waiting period applies once in a 12-month period, regardless of how often the individual takes leave during that 12-month period. For example, if an individual takes two weeks of leave four separate times in a 12-month period, the individual is subject to only one waiting period during that 12-month period.

An individual who takes ten or more days of leave in a 12-month period receives benefits for the waiting period served. This benefit amount is reduced by the amount of

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[9] R.C. 4143.08 and 4143.02(A).

[10] R.C. 4143.06(B), 4143.10(E), and 4143.02(A).

any compensation the individual received from the individual's employer during the waiting period.

An individual may only receive benefits for a maximum of two weeks before the date on which the individual (1) files a claim, (2) notifies the individual's employer of the intent to take leave, or (3) provides the Director with the attestation and certification required to be eligible to receive benefits. The Director may provide an individual with benefits beyond the two weeks described above once the individual demonstrates the individual took one of the required actions as soon as was practicable.[11]

### Weekly benefit amount

Under the bill, the Director determines the amount of weekly benefits an eligible individual may receive. The Director must calculate the amount of benefits based on the average weekly wage the individual earns from the job from which the individual is taking leave; the average weekly wage from a different job is not considered when calculating this amount. The maximum weekly benefit amount an eligible individual may receive is $1,000 per week. The weekly benefit amount an individual may receive is determined as follows:

| Yearly earnings as a percentage of the statewide average weekly wage | Weekly benefit amount as a percentage of the individual's average weekly wage |
|---|---|
| 20% or less | 95% |
| More than 20% but less than or equal to 30% | 90% |
| More than 30% but less than or equal to 50% | 85% |
| More than 50% | 66% |

Beginning on January 1, 2021, the Director must annually adjust the maximum weekly benefit amount annually to reflect changes in the Consumer Price Index for the Midwest region for the previous calendar year.

The Director must make the first payment of benefits to an eligible individual within 14 calendar days after the individual files a claim. Subsequent payments are made biweekly after the first payment. An eligible individual may receive a maximum of 12 weeks of benefits payable during a 12-month period. Benefits cannot be paid for a period of less than eight consecutive hours of leave taken during one work week.[12]

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[11] R.C. 4143.04.

[12] R.C. 4143.05.

### Collective bargaining

A collective bargaining agreement or employer policy cannot diminish an individual's right to benefits under the Program, and the amount of Program benefits prevails over a conflicting provision in a public employee collective bargaining agreement. Any agreement to waive those rights is void; however, those rights do not apply to an individual who has opted out of participating in the Program.

Conversely, employers must comply with an agreement or policy that provides greater leave than that provided by the federal Family and Medical Leave Act (see **COMMENT** 3). These provisions apply to agreements or policies that are entered in to or modified on or after the bill's effective date.[13]

### Concurrency of leave

The bill requires that any leave taken by an individual under the Program runs concurrently with any leave the individual takes under the federal Family and Medical Leave Act. An employer also may require that Program leave be taken concurrently with leave allowed under the terms of disability or family care leave under a collective bargaining agreement or employer policy. The employer must provide employees with a written notice of the requirement to take this leave concurrently.[14]

### Job restoration

The bill requires an employer to restore an individual who has served a waiting period or taken leave under the Program to the position that the individual held before taking leave, or to an equivalent position.[15]

### Applicability of income taxes

Benefits an individual receives through the Program are not subject to state income tax to the extent the benefits are subject to federal income tax. However, if the benefits are subject to federal income tax, the Director must notify an individual of that fact and must follow all procedures prescribed by the Internal Revenue Service when deducting, withholding, and remitting the tax.[16]

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[13] R.C. 4117.10 and 4143.06(B), (C), and (D); Section 5.

[14] R.C. 4143.06(A).

[15] R.C. 4143.07(A).

[16] R.C. 4143.11 and 5747.01(A).

## Appealing a denied claim

An individual whose claim is denied may appeal the decision to the Director within 21 calendar days after the written denial was sent to the individual. The Director must decide the appeal within 21 days after receipt. An appeal determination is final and may be appealed in accordance with the Administrative Procedure Act.[17]

## Overpayments

### Fraud

An individual is barred from receiving benefits for one year after the individual willfully makes a false statement or misrepresents or willfully fails to report a material fact in connection with a claim.[18]

### Repayment of excess benefits

An individual who receives benefits in excess of the benefits to which the individual is entitled may be required to repay the excess benefits. The Director may seek repayment for any of the following reasons:

- The individual willfully made a false statement or misrepresented or willfully failed to report a material fact to a claim.
- The individual received benefits to which the individual is subsequently determined not to be entitled as a result of an appeal (see "**Appealing a denied claim**," above).
- The individual failed to demonstrate that the individual took the necessary actions to remain eligible for benefits (see "**Waiting week and benefit amounts**," above).
- The individual received benefits to which the individual was not entitled due to a mistake or a clerical error.

The Director must adopt rules to establish procedures to recover excess benefits. The Director may waive a repayment or part of a repayment if the Director decides that the recovery is against equity and good conscience.[19]

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[17] R.C. 4143.03(F).

[18] R.C. 4143.09(A).

[19] R.C. 4143.09(B) and 4143.02(A).

## Employment protection and nondiscrimination rights

The bill prohibits an employer from discharging, demoting, discriminating, or taking an adverse employment action against an employee at any time for any of the following reasons:

- The employee filed a claim or received benefits under the Program.
- The employee communicated to the employer an intent to file a claim for benefits, a complaint, or an appeal under the Program.
- The employee testified or otherwise assisted in a proceeding under the Program.[20]

### Administrative enforcement

The Director may assess a civil penalty of up to $3,000 per violation against an employer who violates the bill's adverse employment action prohibitions. An employer must have the opportunity for a hearing conducted in accordance with the Administrative Procedure Act before the Director assesses the penalty. If the employer fails to pay the penalty, the Director must forward the name of the employer and amount of the civil penalty to the Attorney General to collect the penalty. The employer must pay any fee assessed by the Attorney General for the collection of the penalty, in addition to the penalty itself. The penalty collected is deposited into the Family and Medical Leave Insurance Fund created under the bill.[21]

### Civil action

An aggrieved employee may sue an employer in a court of competent jurisdiction whom the employee believes violated the bill's adverse employment action prohibitions. If the court finds that the employer has committed a violation, the employer is liable to the aggrieved employee for any of the following:

- Damages in the amount of lost wages, salary, benefits, or other compensation;
- Damages for actual monetary losses sustained by the employee;
- Interest on damages calculated at the prevailing rate;

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[20] R.C. 4143.07(B).

[21] R.C. 4143.07(C).

- Equitable relief as appropriate.

Additionally, an employer may be liable for liquidated damages in an amount equal to (1) damages for lost wages, salary, benefits, or other compensation or (2) damages for actual monetary losses, if the employer cannot prove that a violation of the adverse employment action prohibitions was unintentional and was made in good faith.[22]

## Confidentiality

Under the bill, any personal information in the possession of the Director under the Program is confidential and is not a public record under Ohio's Public Records Law. The bill permits the following individuals to have access to an individual's Program files and records:

- A public employee in the performance of the public employee's official duties;
- The individual or a person authorized by the individual, with an authorization form signed by the individual;
- An employer or the employer's duly authorized representative, in connection with a pending claim of an individual employed by the employer;
- An individual who is assisting the Director, at the Director's request, on any matter regarding the administration of the Program.[23]

## Outreach program

The bill requires the Director to develop and implement an outreach program to educate the public about the Program. The outreach program must explain the following information about the Program:

- Eligibility requirements;
- The claims process;
- Weekly benefit amounts and maximum benefits payable;

[22] R.C. 4143.07(D).

[23] R.C. 4143.12, by reference to R.C. 149.43, not in the bill.

- Notice and medical certification requirements;
- Reinstatement and nondiscrimination rights;
- Confidentiality of records;
- The relationship between employment protection, leave from employment, and benefits under the Program and other laws, collective bargaining agreements, and employer policies;
- Other information the Director considers necessary.

The Director must develop a notice containing the above information. Employers must post the notice in a prominent location in the workplace and inform employees about the Program.[24]

## Program report

The bill requires the Director to submit an annual report to the standing committees of the House of Representatives and the Senate that are principally responsible for commerce and labor policy and those that are principally responsible for health and human services policy. The report must contain the following information about the Program:

- Projected and actual participation in the Program;
- Demographic information of participants, including gender, race, and ethnicity;
- Purpose and duration of leave taken by participants;
- Premium rates;
- Fund balances;
- Outreach efforts.

The Director must submit the first report to the standing committees by March 1, 2020. The reports must be made available to the public by posting the reports on the JFS website.[25]

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[24] R.C. 4143.14.

[25] R.C. 4143.13.

## Rules

Under the bill, the Director is required to adopt rules in accordance with the Administrative Procedure Act to administer and enforce the Program. The Director may adopt any additional rules that the Director considers necessary to administer and enforce the Program.[26]

## Effective date

The bill generally takes effect July 1, 2017, unless otherwise noted.[27]

## Definitions

The bill defines the following terms:

"Average weekly wage" means the amount obtained by dividing an employee's total wages for all qualifying weeks during the employee's base period by the number of qualifying weeks in the employee's base period.

"Child" means a biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, or a son or daughter of a person standing in loco parentis.

"Health care professional" means any of the following individuals who have been licensed or certified to practice in Ohio under the applicable law:

- A dentist or dental hygienist;
- A registered nurse, clinical nurse specialist, certified nurse-midwife, or licensed practical nurse;
- A pharmacist;
- A physician assistant;
- A person authorized to practice medicine and surgery, osteopathic medicine and surgery, or podiatry;
- A psychologist;
- A speech language pathologist or audiologist;

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[26] R.C. 4143.02.

[27] Section 3.

- An occupational therapist, physical therapist, physical therapist assistant, or athletic trainer;
- A professional clinical counselor, professional counselor, independent social worker, or social worker;
- A dietitian.

"Parent" means a biological, foster, or adoptive parent, stepparent, legal guardian, or other person who stood in loco parentis to a person when the person was a child.

"Yearly earnings" means the total wages an individual earns for the calendar year.

## COMMENT

1. The bill appears to create contingent legislation requiring the completion of the actuarial evaluation before the provisions of the Family and Medical Leave Insurance Program are put into place. It does not provide for how the costs of the actuarial evaluation will be paid if JFS cannot get sufficient funding through the sources authorized by the bill. However, it does require the Director to receive sufficient funding to cover the costs of the actuarial evaluation as a prerequisite to the evaluation being performed.

2. JFS is required to set premiums based on the amounts determined in the actuarial evaluation when the Program is established, regardless of whether the evaluation was completed. The bill does not include an alternative method for setting the amount of premiums in the event the actuarial evaluation cannot be completed before JFS is required to establish the Program.

3. Any state regulation of the right of private employers and employees to bargain collectively runs the risk of conflicting with, and potentially being preempted by, the federal National Labor Relations Act (NLRA).[28] Enacted in the 1930s, the NLRA does not contain an express preemption provision. Nevertheless, the U.S. Supreme Court has interpreted the NLRA as having broad and comprehensive applications to the field of private sector collective bargaining, and but for a few narrowly drawn exceptions, the NLRA takes supremacy over state law.

[28] 29 United States Code (U.S.C.) 151 *et seq*.

The Court has held that, when a state purports to regulate activities that are protected by section 7 of the NLRA[29] governing labor-management relations (e.g., the right to bargain collectively) or that constitute an unfair labor practice under section 8,[30] the state jurisdiction must yield to the federal law.[31] Another type of federal preemption, the so-called "*Machinists* preemption," prohibits state and local regulation of areas that have been left "to be controlled by the free play of economic forces."[32]

While states are not totally excluded from activities affecting private sector labor relations, federal preemption likely would be invoked whenever a court thought a very real potential of conflict between federal law and the state regulation existed. Preemption under the NLRA is inappropriate only if the conduct at issue is a peripheral federal concern, or if the conduct involves a significant state interest that heavily outweighs the interests of the National Labor Relations Board in maintaining exclusive jurisdiction.[33] When it is not clear whether the particular labor-relations activity being regulated by a state is covered under the NLRA, state courts are not the primary tribunals to adjudicate such issues. Rather, the National Labor Relations Board retains sole jurisdiction over those matters.[34]

## HISTORY

| ACTION | DATE |
| --- | --- |
| Introduced | 04-07-16 |

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[29] 29 U.S.C. 157.

[30] 29 U.S.C. 158.

[31] *San Diego Bldg. Trades Council, Millmen's Union Local 2020 v. J.S. Garmon,* 359 U.S. 236, 244 (1959).

[32] *Lodge 76, Internatl. Assn. of Machinists and Aerospace Workers, AFL-CIO v. Wisconsin Emp. Relations Comm.,* 427 U.S. 132 (1976).

[33] *Garmon,* 359 U.S. at 243-244.

[34] *Garmon* at 244-245.