Julie A. Cameron *Legislative Service Commission*
Virginia McInerney

Bill Analysis

S.B. 7

126th General Assembly
(As Introduced)

Sen. Cates

BILL SUMMARY

Determination and payment of workers' compensation benefits

- Changes "permanent partial disability" (PPD) and "permanent total disability" (PTD) to "permanent partial impairment" (PPI) and "permanent total impairment," (PTI) respectively, throughout the Workers' Compensation Law.

- Eliminates the 40-week waiting period for the filing of an application for PPI, (formally PPD, compensation) when the employee has reached maximum medical improvement.

- Changes the amount of time for which an employee can receive payments for wage loss suffered as a result of returning to employment other than his former position of employment or for being unable to find employment consistent with his physical capabilities.

- Specifies an employee is not entitled to permanent total impairment compensation when the employee's age is the primary reason he is prevented from engaging in or acquiring the capacity to engage in sustained remunerative employment.

- Specifies that an employee's death during the 30-day period after approval of a final settlement agreement voids that agreement, but allows the deceased employee's dependent to file an application for the deceased employee's compensation and benefits.

- Revises conditions under which a final settlement agreement may be filed without an employer's signature and establishes related notification requirements.

- Allows a district hearing officer to terminate compensation for temporary total disability if compensation has been paid prior to the officer determining whether the claimant has reached maximum medical improvement (MMI) and the hearing officer subsequently determines that the claimant has reached MMI.

- Specifies that the district hearing officer may terminate the temporary total disability compensation as of a date prior to the hearing in which the hearing officer determined the claimant reached MMI, and requires the hearing officer to declare any payment made after that date as an overpayment to be recovered as specified in continuing law.

- Specifies that the loss or loss of use of one arm does not additionally constitute the loss or loss of use of one hand and that the loss or loss of use of one leg does not additionally constitute the loss or loss of use of one foot.

- Prohibits the Administrator of Workers' Compensation (Administrator) from making an award to a deceased employee's spouse or a dependent for the employee's loss of use of a member when no award was given prior to the employee's death unless the Administrator receives medical evidence that the employee had a conscious awareness of the loss of use prior to death.

- Specifies that an employee receiving compensation for PTI due to a traumatic brain injury is entitled to receive that compensation regardless of the employee's subsequent employment.

- Modifies living maintenance payments to be equal to the amount of temporary total benefits the claimant would receive if the claimant received those benefits.

- Adds that persons, while confined to a county jail, 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 PPI.

- Permits the Administrator of Workers' Compensation to adopt rules, identifying medical conditions that have a historical record of being

allowed whenever included in a claim, and to grant immediate allowance and make immediate payment of medical bills for those medical conditions.

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 four-year limit in those cases, but makes special provision for claims involving specified occupational diseases and prosthetic devices.

- Prohibits an employee from simultaneously seeking benefits under the federal "Energy Employees Occupational Illness Compensation Program Act of 2000" (EEOICP) and Ohio's Workers' Compensation Law.

- Specifies that an employee who elects to seek compensation and is entitled to receive compensation under the EEOICP is not entitled to receive benefits under Ohio's Workers' Compensation Law for the illness covered by the EEOICP.

Definition of injury

- Places limitations upon compensation and medical benefits for a condition, impairment, or disease process that preexisted an injury and requires documented objective clinical findings and test results concerning substantial worsening and acceleration relative to such claims.

- Allows workers' compensation coverage for psychiatric conditions that result from a rape or sexual assault that occurs in the course of and arising out of employment, regardless of whether the employee sustains a physical injury requiring treatment.

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

- Prohibits the issuance of a building permit for a commercial or residential building without evidence of compliance with the Workers' Compensation Law by all contractors and subcontractors performing work on the project.

- Requires municipal corporations, boards of county commissioners, and boards of township trustees, or their respective building departments, to require the person requesting approval for plans for a building or issuance of a building permit to submit evidence that all contractors and subcontractors working on the building are in 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 to each employee as 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 to each employee 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 show correct coverage, soliciting, offering, or receiving kickbacks or rebates for the referral of goods or services for which reimbursement may be made, 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.

- Prohibits 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 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 a penalty for each 30 days or portion thereof that a self-insuring employer fails to timely or completely report paid compensation or fails to pay its assessment, but requires a hearing prior to assessment.

- Permits the Administrator, instead of the Self-inuring Employers Evaluation Board, to assess an amount against self-insuring employers who misrepresent the amount of paid compensation.

- Authorizes the Administrator, rather than the Self-insuring Employers Evaluation Board, to assess a fine or penalty against, or revoke or refuse to renew the self-insuring status of, a self-insuring employer.

- Requires the Self-insuring Employers Evaluation Board to hear appeals from self-insuring employers who have been assessed a fine or penalty or who have had their status revoked or not renewed.

- Specifies that the Self-insuring Employers Evaluation Board's vote to affirm or vacate the Administrator's assessment of a fine or penalty must be by majority vote, and that a decision to affirm the Administrator's

decision to revoke or not renew an employer's self-insuring status must be by a unanimous vote.

Fines and penalties

- Increases the penalty for overdue premium payments from the existing tiered penalty, based on overdue periods, ranging from 3% to a maximum of 12% of the premium due to a flat $45 fine plus a tiered penalty beginning at 10% for up to 30 days past due and increasing every 30 days thereafter.

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

- 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.

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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 direct result of returning to employment other than the employee's former position due to a limitation in the employee's physical capabilities caused solely by the allowed conditions in the employee's claim (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 at the time of the injury or "date of disease" (explained in a paragraph below) 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 at the time of the injury or "date of disease" (explained in the paragraph below) and the employee's present earnings, not to exceed the statewide average weekly wage, for a maximum of 26 weeks or for a maximum of 52 weeks if, at any time while the employee is receiving nonworking wage loss, the benefit period for unemployment compensation is in extension.[1] Neither the filing for nor receipt of nonworking wage loss can affect an injured employee's application for permanent total impairment compensation.

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[1] *The Director of Job and Family Services may extend statewide the benefit period for receipt of regular unemployment compensation and the receipt of extended unemployment benefits in accordance with specified statutory criteria during periods of excessive unemployment (sec. 4141.301).*

The bill specifies that an employee may not receive more than 200 weeks of working and nonworking wage loss in the aggregate. Furthermore, the bill specifies that for purposes of determining an employee's average weekly wage in claims involving an occupational disease, the "date of disease" means either of the following:

(1) The date an occupational disease is first diagnosed by a licensed physician;

(2) For an occupational disease described in the schedule of diseases,[2] or other occupational disease that results from exposure to fibrosis-producing or toxic dusts, fumes, mists, vapors, gases, or liquids, or other toxic materials, or a combination of those, the date that the employee first misses work as a result of the occupational disease. (Sec. 4123.56(B).)

Date of termination of TTD if a district hearing officer determines claimant has reached MMI

Under current law, compensation for a claimant's temporary total disability (TTD) is paid and continues for a duration based upon the attending physician's medical report. If the employer disputes the physician's report, then, under continuing law, payments may be terminated only upon application and hearing by a district hearing officer. Payments continue pending determination of the matter, except that TTD compensation may not be paid if certain circumstances occur, including that the claimant reaches "maximum medical improvement" (MMI). (Sec. 4123.56(A).)[3]

Under the bill, when a claimant receives TTD compensation pending a determination by a district hearing officer as to whether the employee has reached MMI because of a conflict in medical evidence, and the hearing officer subsequently determines that the employee has reached MMI, the hearing officer may terminate the compensation paid for TTD as of the date prior to the hearing in which the hearing officer made that determination, and if the hearing officer so terminates that compensation, the hearing officer must declare that compensation

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[2] *Current law contains a non-exclusive schedule of compensable occupational diseases (sec. 4123.68).*

[3] *The Ohio Supreme Court held in* State ex rel. Russell v. Indus. Comm. *(1998), 82 Ohio St.3d 516, that the appropriate date to terminate disputed TTD compensation on the basis of MMI is "the date of the termination hearing, and the Commission may not declare an overpayment for payments received by the claimant before that date" (Russell at 516 (syllabus)).*

paid subsequent to the date of termination to be an overpayment to be recovered pursuant to continuing law.[4] (Sec. 4123.56(A).)

Permanent partial disability

Change of permanent "disability" to permanent "impairment"

The terms "disability" and "impairment" are not defined in the Workers' Compensation Law (R.C. Chapters 4121., 4123., 4127., and 4131.), and the two terms are not synonymous for workers' compensation purposes. In *Meeks v. Ohio Brass Co.* (1984), 10 Ohio St.3d 147, the Ohio Supreme Court restated the Industrial Commission's *Medical Examination Manual's* definitions of the terms:

> "Impairment" is a medical term measuring the amount of the claimant's anatomical and/or mental loss of function as a result of the allowed injury/occupational disease. The examining physician evaluates impairment.
>
> "Disability" is a legal term indicating the effect that the medical impairment has on the claimant's ability to work. Disability is determined by the Industrial Commission and its hearing officer.

According to the Ohio Supreme Court, the Commission is required to consider a broad range of pertinent factors in determining the degree to which a claimant's ability to work has been impaired because of the claimant's disability; these factors include the doctor's reports and opinions, any evidence concerning the claimant's age, education, work record, psychological or psychiatric profile, and any sociological evidence. *State ex rel. Stephenson v. Indus. Comm.* (1987), 31 Ohio St.3d 167. These factors often are referred to as the *Stephenson* factors by legal practitioners or other persons associated with the workers' compensation system.

The bill changes "permanent partial disability" (PPD) and "permanent total disability" (PTD) to "permanent partial impairment" (PPI) and "permanent total impairment," (PTI) respectively, throughout the Workers' Compensation Law.

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[4] Under current law, recovery of overpayments is made by withholding amounts from future payments as follows: (1) no withholding for the first 12 weeks of TTD benefits, (2) 40% of all TTD and PPD awards until the amount overpaid is refunded, (3) 25% of any PTD award until the amount overpaid is refunded, (4) if a court of appeals or the Supreme Court reverses the allowance of the claim upon appeal, no amount of compensation may be withheld (sec. 4123.511(J)).

(Secs. 4121.32, 4121.35, 4121.36, 4123.01, 4123.032, 4123.033, 4123.07, 4123.28, 4123.343, 4123.35, 4123.411 to 4123.414, 4123.416, 4123.419, 4123.512, 4123.54, 4123.541, 4123.56 to 4123.62, 4123.64, 4123.651, 4123.66, 4123.68, 4123.70, 4123.80, 4123.82, 4123.84, 4127.03, and 4127.06.)

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. The bill permits an employee to file an application for permanent partial impairment compensation without waiting 40 weeks if the employee's TTD benefits were terminated because the employee reached maximum medical improvement. (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. (Sec. 4123.58.)

The bill renames "permanent total disability" as "permanent total impairment" (see "***Change of permanent 'disability' to permanent 'impairment'***," above) and specifies that "permanent and total impairment" means that the physical or mental limitations that directly result from the allowed conditions in the employee's claim or claims prevent the employee from engaging in sustained remunerative employment, however, a staff hearing officer may consider an employee's age in determining whether the employee is prevented from engaging in, or from acquiring the capacity to engage in sustained remunerative employment through education, training, rehabilitation, or other similar efforts. An employee is not entitled to PTI when the employee's age is the primary reason that the employee is prevented from engaging in or acquiring the capacity to engage in that employment. (Sec. 4123.58(F).)

PTI for a traumatic brain injury continued regardless of future employment

Current Bureau of Workers' Compensation (BWC) policy permits an individual receiving PTI compensation due to the loss of two or more scheduled body parts to be employed while receiving PTD compensation. The bill specifies that an employee awarded compensation for PTI because the employee sustained a traumatic brain injury is entitled to that compensation regardless of the employee's employment subsequent to the award (sec. 4123.58(E)).

Loss or loss of use of arm or leg constituting loss or loss of use of the corresponding hand or foot

Current law specifies that 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 PTD.[5] The bill specifies that the loss or loss of use of one arm does not thereby additionally constitute the loss or loss of use of one hand and the loss or loss of

[5] *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).*

use of one leg does not thereby additionally constitute the loss or loss of use of one foot. (Sec. 4123.58(C).)

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. 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 and a second written notice within 45 days after the first notice is sent, if the employer does not respond to the first notice. The agreement does not have to contain the employer's signature if the employer fails to respond to the notice within 60 days after receipt or if the claim that is the subject of the agreement no longer remains in the employer's accident or occupational disease experience. (Sec. 4123.65(A).)

The bill further specifies that an employee's death during the 30-day period after the approval of a final settlement agreement voids the settlement. However, an employee's dependent may file an application for any compensation and benefits to which the deceased employee was entitled under the Workers' Compensation Law. (Sec. 4123.65(C).)

Benefits received by deceased employee's spouse or dependents

Under continuing law, when an employee has sustained the loss of a member by severance, but no award has been made on account thereof prior to the employee's death, the Administrator of Workers' Compensation must make an award for the loss which is payable to the surviving spouse or the deceased employee's dependents. The bill adds that when an employee has sustained the loss of use of a member but no award has been made prior to the employee's death, the Administrator must make an award for the loss of use of the deceased employee's member and pay that award to the deceased employee's spouse or dependents. However, the bill prohibits the Administrator from making an award for the loss of use unless the Administrator receives medical evidence that the employee had a conscious awareness of the loss of use prior to the employee's death. (Sec. 4123.57(B).)

Living maintenance

Current law requires that living maintenance payments be paid to a claimant if the Administrator determines that the claimant could probably be rehabilitated in order to return to work or to lessen or remove a handicap and the claimant agrees to undergo rehabilitation. Living maintenance payments are paid for a period or periods that do not exceed six months in the aggregate, unless review by the Administrator reveals that the claimant will be benefited by an extension of such payments. Under current law living maintenance payments are paid in weekly amounts, not to exceed the amount the claimant would receive if the claimant were being compensated for TTD, but not less than 50% of the current SAWW ($670.27 in 2003). (Sec. 4121.63.)

Continuing law specifies the amount of compensation an employee receives for TTD. An employee receives 66 2/3% of the employee's average weekly wage (AWW) so long as the disability is total. That amount of compensation cannot exceed the maximum amount of weekly compensation that is equal to the SAWW, and cannot be less than 33 1/3% of the SAWW, unless the employee's wages is less than 33 1/3% of the SAWW, in which case the employee receives the employee's full wages. For the first 12 weeks of TTD compensation, however, an employee receives 72% of the employee's full weekly wages, but the amount of weekly compensation cannot exceed a maximum amount that is less than either the SAWW or 100% of the employee's net take-home weekly wage. (Sec. 4123.56(A).)

The bill adjusts the amount of living maintenance payments a claimant receives weekly to be equal to the amount the claimant would receive if the claimant were being compensated for TTD. Therefore, under the bill, living maintenance payments are calculated and paid in accordance with the paragraph above. (Sec. 4121.63.)

Immediate allowance of specified medical conditions

The bill permits the Administrator of Workers' Compensation, with the advice and consent of the Workers' Compensation Oversight Commission, to adopt rules that identify specified medical conditions that have a historical record of being allowed whenever included in a claim. The Administrator may grant immediate allowance of and make immediate payment of medical bills for any medical condition identified in those rules upon the filing of a claim involving that medical condition. If an employer contests the allowance of a claim involving any medical condition identified in those rules, and the claim is disallowed, the bill specifies that payment for the medical condition included in that claim must be charged to and paid from the Surplus Fund. (Sec. 4123.511(A).) The immediate allowance of specified medical conditions permitted in the bill was previously

authorized as a pilot program, which expires September 30, 2005, as do the current rules adopted for the immediate allowance of specified medical conditions (see Am. Sub. H.B. 183 of the 125th General Assembly).

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. (Sec. 4123.54(I).)

II. Coverage under the Workers' Compensation Law

Continuing jurisdiction

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. (Sec. 4123.52.)

The bill reduces the time within which the Commission may make a modification, change, finding, or award in the cases described above to four years. However, except as described below, the Commission may make a modification, change, finding, or award with respect to medical benefits within four years after the date of the last treatment for which medical benefits have been paid or ordered to be paid. For purposes of this provision, the bill defines "medical benefits" as payments to or on behalf of an employee for a hospital bill, medical bill for a licensed physician or hospital, an orthopedic or prosthetic device, or a prescription medication. (Sec. 4123.52(A) and (G).)

Under the bill, in all cases for a claim involving an occupational disease appearing in the schedule of those diseases,[6] or other occupational disease resulting from exposure to fibrosis-producing or toxic dusts, fumes, mists, vapors, gases, or liquids, or other toxic materials, or a combination of those, the jurisdiction of the Commission and the authority of the Administrator over each case continues for four years. However, the jurisdiction to make a modification, change, finding, or award in that type of claim with respect to compensation, dependency, or medical benefits may extend beyond four years, up to a maximum of six months after the date an employee first becomes totally disabled as a result of the occupational disease that is the subject of his claim; after this six-month period, the four-year time limitation again applies. (Sec. 4123.52(B).)

Subject to the limitation described below, in all cases for a claim involving a prosthetic device as described below, the jurisdiction of the Commission and the authority of the Administrator over each case is continuing, except that the Commission may only make a modification, change, finding, or award in that claim with respect to medical benefits and compensation for TTD. Any TTD compensation allowed under this provision can be for a period up to nine months after the date of the provision, implanting, affixing, repair, or replacement of the prosthetic device. This provision applies only to a claim involving an employee to whom either of the following applies:

(1) He has a prosthetic device that was provided under an allowed claim and the employee's physician determines that the prosthetic device needs to be repaired to replaced; or

(2) The employee's physician determines prior to the divestment of the Commission's or Administrator's authority that an employee will require a prosthetic device, or the replacement or repair of an existing prosthetic device as a direct result of an allowed condition in a claim at a period subsequent to the determination of the employee's physician and subsequent to the time at which the Commission's and Administrator's authority otherwise would be divested in the absence of this provision.

The bill defines "prosthetic device" as an internal or external artificial part provided to an employee that substitutes for a missing or reconstructed limb or joint of the employee. (Sec. 4123.52(C).)

The bill further specifies that the Commission may not make any modification, change, finding, or award that awards compensation for a back

[6] *Current law contains a non-exclusive schedule of compensable occupational diseases (sec. 4123.68).*

period in excess of two years before the date of filing an application for that compensation unless written notice of the specific part or parts of the body injured is provided to the Bureau or Commission, as is required under current law. (Sec. 4123.52(D).)

Coverage under the federal Energy Employees Occupational Illness Compensation Program Act of 2000

The federal Energy Employees Occupational Illness Compensation Program Act of 2000, 114 Stat. 1654, 42 U.S.C. 7384 et seq., (EEOICP) provides federal workers' compensation coverage and medical benefits to United States Department of Energy (DOE) contractor and subcontractor employees who worked at certain DOE facilities and sustained a covered illness or occupational illness from exposure to toxic substances. The EEOICP defines "covered illness" as an illness or death resulting from exposure to a toxic substance (42 U.S.C. § 7385s). The definition of occupational illness includes covered beryllium illness, specified cancers, and chronic silicosis (42 U.S.C. § 7384l(15)).

Under the bill, an employee otherwise covered by Ohio's Workers' Compensation Law may elect to seek compensation under the EEOICP for an occupational illness or a covered illness of the employee rather than seek compensation for an occupational illness or a covered illness under Ohio's Workers' Compensation Law. However, the bill stipulates that while an employee is pursuing benefits under the EEOICP, the employee cannot simultaneously pursue benefits under Ohio's Workers' Compensation Law for the occupational illness or covered illness.

The bill further specifies that any employee making an election to seek compensation under the EEOICP who becomes entitled to compensation under the EEOICP is not entitled to receive workers' compensation benefits under Ohio's Workers' Compensation Law for the covered illness or occupational illness for which the employee made that election. (Sec. 4123.542.)

III. Definition of injury

Substantial worsening of a pre-existing injury

The Workers' Compensation Law currently defines "injury" 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. The bill expands the definition of "injury" to include a condition, impairment, or disease that pre-existed an injury if that pre-existing condition or impairment is substantially worsened or the disease process is substantially accelerated by the injury and is documented by objective clinical findings and test

results. If the worsening or acceleration is not documented by objective diagnostic findings and test results, the condition, impairment, or disease process is excluded from the definition of "injury." (Sec. 4123.01(C)(1)(b) and (2)(d).) The bill specifies that compensation and medical benefits are payable only for the disability or impairment that results from the substantial worsening of the preexisting condition or impairment, or the substantial acceleration of the disease process. The bill prohibits payment of compensation or benefits because of the preexisting condition, impairment, or disease process once that condition, impairment, or disease process has returned to a level that would have existed without the injury (sec. 4123.54(G)).

Rape and sexual assault

The bill further expands the definition of "injury" to include psychiatric conditions arising from a rape or sexual assault that occurs in the course of and arising out of the employee's employment regardless of whether the employee sustains a physical injury requiring treatment. The bill defines "sexual assault" as an offense under the Criminal Laws (Title 29 of the Revised Code) specifying that it is a crime to knowingly cause another person to engage in an unwanted sexual act by force or threat. (Secs. 4123.01(C) and (I).)

Certain conditions are excluded from the definition of "injury" under current law and hence are not compensable under the Workers' Compensation Law. These are:

(1) Psychiatric conditions except where the conditions have arisen from an injury or occupational disease;

(2) Injuries or disability caused primarily by the natural deterioration of tissue, an organ, or part of the body;

(3) An injury or disability incurred in voluntary participation in employer-sponsored recreation or fitness activity if the employee waived his rights to compensation and benefits before engaging in the activity. (Secs. 4123.01(C) and 4123.54.)

To exceptions (2) and (3) above, the bill adds "impairment."

IV. 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) an 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,[7] the Commission or BWC must disclose to the journalist the address or addresses and telephone number or numbers of specified 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.

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[7] *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 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).)

V. Compliance with the Workers' Compensation Law

Contractors and subcontractors verification of coverage

Before beginning construction, existing law requires an owner to submit the plans, drawings, and other data for a building to which the Ohio Building Code applies (nonresidential buildings) to a certified municipal, township, or county building department to receive a building permit. If no certified local building department has jurisdiction, then the documentation must be submitted to the Superintendent of the Division of Industrial Compliance in the Department of Commerce. (Sec. 3791.04(A).) Continuing law prohibits the owner from proceeding with the construction, erection, alteration, or equipment of any such building prior to receiving a building permit. Current law specifies that plans or specifications must not be approved unless the building represented would comply with the Building Standards Law (Chapters 3781. and 3791. of the Revised Code) or any rules adopted under those laws. (Sec. 3791.04(C) and (D)(1).)

The bill also prohibits plans and specifications from being approved or inspection approval given unless the owner requesting approval provides evidence that all contractors with whom the owner of the building or structure has contracted, and all subcontractors with whom these contractors have contracted to erect, repair, construct, or equip the building or structure, on or before the owner requests approval, are in compliance with the Workers' Compensation Law (sec. 3791.04(D)(2)). Under existing law made applicable by the bill, whoever violates this approval requirement may be fined up to $500 (sec. 3791.04(M)).

Similarly, the bill also specifies that boards of county commissioners, boards of township trustees, legislative authorities of municipal corporations, or their respective building departments, prior to approving plans for construction or issuing a building permit, must require the person requesting approval or a permit to provide evidence that all contractors with whom the owner of the building or structure has contracted, and all subcontractors with whom these contractors have contracted to erect, construct, repair, or alter the building or structure, on or before the date the person requests approval, are in compliance with the Workers' Compensation Laws. (Secs. 307.37(G), 505.75(D), and 715.30.)

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

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 to each employee 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 to each employee 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).

VI. 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).)

VII. 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 or misleading statement or other misrepresentation 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) Soliciting, offering, or receiving any remuneration in cash or in kind, including kickbacks or rebates, in connection with a referral for the furnishing of goods or services for which reimbursement may be made under the Workers' Compensation Law, except for contracts to provide services under the Bureau's health care partnership program entered into between a managed care organization or qualified health plan and an organization that secures a group rating for workers' compensation coverage for employers that are members of the organization;[8]

[8] *The Administrator must offer to insure the obligations of employers under group rating plans that pool the risk of employers within the group provided that the employers in the*

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

(4) Failing to secure or maintain required workers' compensation coverage.

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.[9] (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 health care providers (HCP), managed care organizations (MCO), and owners[10] of a HCP or MCO from obtaining or attempting to obtain payments by deception[11] under the Workers' Compensation Law to which the

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group meet specified statutory criteria, including the requirement that all employers in a group are members of an organization that was formed for purposes other than obtaining group workers' compensation insurance and that has been in existence for at least two years prior to the application for group coverage (sec. 4123.29(A)(4)).

[9] 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.

[10] 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)).

[11] The bill defines "deception" as acting with actual knowledge of, in deliberate ignorance of, or reckless disregard to the truth or falsity of, any representation or information 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,

HCP, MCO, or owner is not entitled under specified rules. In addition to any other penalties provided by law, a 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 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;

(3) Payment of a sum of not less than $5,000 and not more than $10,000 for each act of deception. However, a HCP, MCO, or owner is liable for this sum only upon proof of a specific intent of the HCP, MCO, or owner to defraud.

(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 HCP or MCO or its owner, and cease reimbursement to the HCP, MCO, or owner for services rendered, if the HCP, MCO, owner, or an authorized agent, officer, associate, manager, or employee of the HCP or MCO (1) is convicted of or pleads

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or perpetuates a false impression as to a fact, the law, the value of something, or a person's state of mind. Proof of specific intent to defraud is not required, except when the Administrator seeks to impose a penalty of $5,000 to $10,000 upon a HCP, MCO, or owner, or seeks to debar a HCP, MCO, or owner from further health care provider agreements with the Bureau for engaging in a pattern of corrupt activity. (Sec. 4121.444(F)(1).)

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 HCP or MCO if the 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 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;

(3) Receiving reimbursement in the form of direct payments from the Bureau of indirect payments of Bureau funds in the form of salaries, shared fees, contracts, kickbacks, or rebates from or through any participating provider.

An owner, officer, authorized agent, associate, manager, or employee of a HCP or MCO may enter into an agreement with the Bureau if the HCP, MCO, owner, officer, authorized agent, associate, manager, or employee demonstrates absence of knowledge of the action of the HCP or MCO with which the individual or organization was formerly associated that resulted in a 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. (Sec. 4121.444(C).)

Additionally, the bill specifies that nothing in the provisions described above prohibits an owner, officer, authorized agent, associate, manager, or employee of a 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 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.

Remedies for payments to claimants for medical assistance

The bill specifies that the availability of remedies described above, and 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 HCP, MCO, or owner under state or federal law (sec. 4141.444(E)).

VIII. 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).)

Under the bill, the Administrator is required to adopt rules permitting the Administrator to do both of the following:

(1) For each 30 days or portion thereof during which a self-insuring employer fails to timely or completely report paid compensation, to assess a penalty equal to the lesser of 5% of the reported compensation on the prior year's report or $1,500;

(2) For each 30 days or portion thereof during which a self-insuring employer fails to pay its assessment, to assess a penalty equal to the lesser of $3,000 or the amount owed.

Assessment of penalties by the Administrator instead of the Self-insuring Employers Evaluation Board

The Administrator presently is required to refer all complaints against a self-insuring employer and all questions as to whether a self-insuring employer continues to meet the standards for self-insurance to the Self-insuring Employers Evaluation Board, which must investigate and may order the employer to take specified corrective action. The Board action need not be by formal hearing, but whatever action is ordered must be signed by at least two of the three Board members. If by a hearing conducted in accordance with the Administrative Procedure Act and Bureau rules, the Board determines that the employer has failed to correct the problems, the Board must recommend to the Administrator either (1) revocation of the employer's self-insurance status or (2) another penalty which

may include probation or a civil penalty not to exceed $10,000 for each failure. A specific recommendation for revocation must be by unanimous vote of the Board; a recommendation of any other penalty must be by majority vote. (Sec. 4123.352.)

Current law prohibits a self-insuring employer from misrepresenting the amount of "paid compensation" by that employer for assessment purposes under the Workers' Compensation Law. The Board may impose the above penalties on a self-insuring employer that does so, or may assess an amount not more than ten times the difference between the assessment paid and the amount that should have been paid, along with any other penalty determined by the Board. (Sec. 4123.25(B).)

The bill removes the Board's authority to assess a fine or penalty against a self-insuring employer and vests that authority in the Administrator.

The bill requires the Administrator or his designee to hold a hearing, after notice to the self-insuring employer of the hearing, before that assessment or before revoking or refusing to renew an employer's self-insuring status, although it does not require the Administrator to take any such action against a self-insuring employer. The Administrator must, with the advice and consent of the Workers' Compensation Oversight Commission, adopt rules in accordance with the Administrative Procedure Act for the assessment of a fine or penalty against a self-insuring employer. All sums collected under this provision are paid into the Self-insurance Assessment Fund.

Under the bill, a self-insuring employer may appeal to the Board, the Administrator's assessment of a fine or penalty against the self-insuring employer or the revocation or refusal to renew the employer's self-insuring status within 30 days after receipt of notice of such fine, penalty, or action. Filing an appeal stays the Administrator's order. The Board is required to conduct a hearing and to affirm or vacate the Administrator's assessment of a fine or penalty, which must be by majority vote. The Board's decision to affirm the Administrator's decision to revoke or refuse to renew an employer's self-insuring status must be unanimous. (Sec. 4123.352(C).)

IX. Fines and penalties

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. If the premium is late, under the bill, a $45 late fee penalty is added to the employer's premium, plus an additional amount calculated as follows:

(1) For a premium from one to 30 days past due, 10% of the premium due;

(2) For a premium from 31 to 60 days past due, 15% of the premium due;

(3) For a premium from 61 to 90 days past due, 20% of the premium due;

(4) For a premium over 90 days past due, 30% of the premium due; and for each additional 30-day period or portion thereof beyond 90 days that a premium remains past due, an additional 10% of the premium due, incrementally increased as appropriate based on the number of additional 30-day periods or portion thereof that the premium remains past due. (Sec. 4123.32(E)(2).)

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).)

X. Miscellaneous

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)[12] 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.)

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[12] *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).*

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 (Section 3).

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	01-24-05	p. 60

s0007-i-126.doc/kl